

**UNIVERSITY OF GHANA**

**TRADITIONAL BELIEFS, PRACTICES AND MATERNAL HEALTH  
IN THE SEKYERE SOUTH DISTRICT OF GHANA**

**BY**

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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,  
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR  
THE AWARD OF MASTER OF PHILOSOPHY DEGREE IN  
SOCIOLOGY**

**JULY, 2015**

**DECLARATION**

I hereby declare that except for references to other people's works, which have been duly acknowledged, this work is the result of my own research. I also declare that to the best of my knowledge this thesis has never been presented in whole or part for the award of another degree elsewhere.

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**DEDICATION**

To the woman whose womb cradled me as a child, the bosom that embraced the whining baby, whose warm hearth fed me and to all the women in the village where lies buried my umbilical cord, I say...

Ayekoo!



## ACKNOWLEDGEMENT

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## ABSTRACT

The research studies the traditional beliefs and practices about pregnancy, childbirth and postpartum periods in the Sekyere South District of Ashanti Region. Its objectives are to document the social meanings attached to pregnancy and childbirth, to examine the beliefs and practices about pregnancy, childbirth and postpartum periods and to interrogate the practices that promote maternal health in the community. Applying principally a qualitative approach, a total of thirty five respondents, guided by saturation theory, were interviewed. A multistage sampling was used in sampling twenty-seven members of the community which comprised people who have ever been parents, pregnant women and elderly people. In addition, eight key informants - medical doctors, midwives and traditional birth attendants were sampled through purposive sampling and snowball sampling.

The study reveals that preference for female child was emphasised among the indigenes because the female child will procreate and perpetuate the matrilineage. Also, persistent spiritual, behavioural and dietary practices were held by the indigenes during pregnancy, childbirth and postpartum periods. Prominent among the traditional practices was the patronage of the services of traditional birth attendants by women seeking to conceive and pregnant women. In addition, foods such as ripe plantain, roasted plantain, snails, okra, etc. were tabooed. However, these traditional beliefs and practices are janus-faced in that though some were considered deleterious to the health of the women and fetuses by health workers, the indigenes considered other practices as helpful in averting and reducing maternal and neonatal morbidity or death. For instance, as a behavioural restriction, pregnant women were cautioned not to fight or eat in public to avoid the evil eyes of spirits and people who seek to harm their babies. Moreover, families played great role in taking care of the mothers and babies which constituted a form of social capital,

ensuring the safety of the mothers and babies and preventing postnatal depression during the postpartum periods.

The study recommended among others a healthy reconciliation of both the biomedical model of health care and the traditional system of health care. Also, the need to strengthen the health insurance policy of the country to prevent women who seek the help of untrained traditional birth attendants and herbalist was noted.



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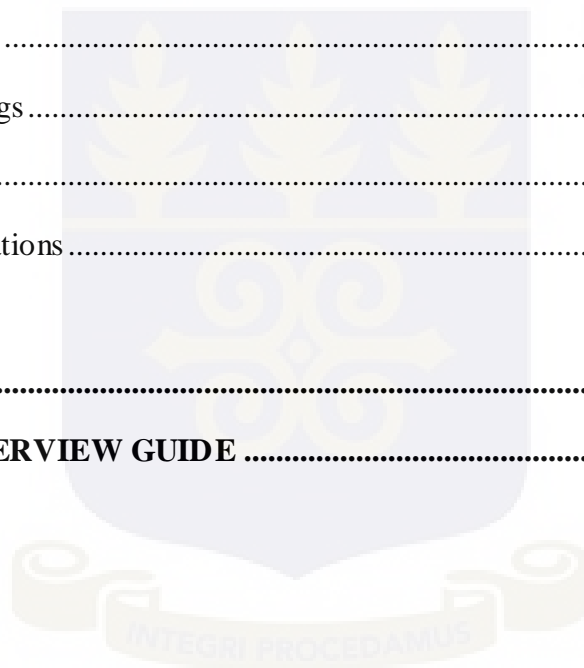
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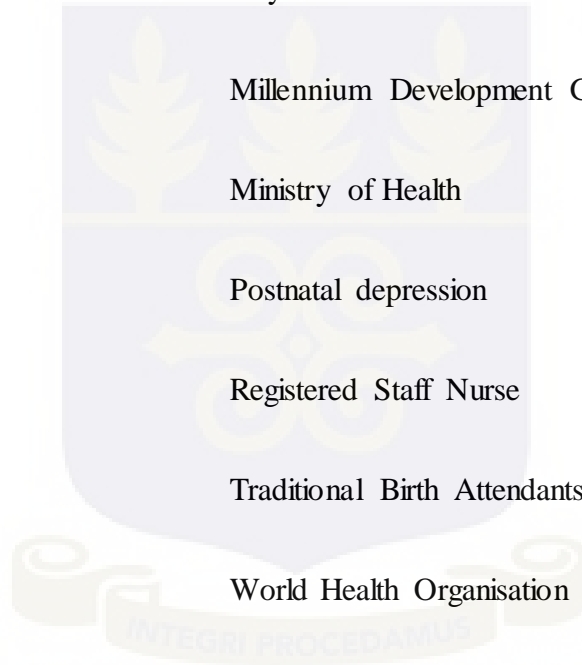


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**LIST OF ACRONYMS**

ANC	Antenatal Clinic
CHAG	Christian Health Association of Ghana
FGD	Focus Group Discussion
FPD	Foeto-pelvic Disproportion
HBM	Health Belief Model
KII	Key Informant Interview
MDG	Millennium Development Goal
MoH	Ministry of Health
PND	Postnatal depression
RSN	Registered Staff Nurse
TBA	Traditional Birth Attendants
WHO	World Health Organisation



## CHAPTER ONE

### GENERAL INTRODUCTION

#### 1.1 Background to the study

Over the years, issues about maternal health have attracted global attention with many women falling to their death during pregnancy and childbirth. According to the statistics of the World Health Organisation (WHO), in 2008 800 women died every day from causes related to pregnancy and childbirth.<sup>1</sup> The WHO's annual global report on women who died in 2008 due to complications of pregnancy and childbirth was estimated at 358,000 (ibid).

In sync with the global picture was a worrying world regional report that revealed that more women in developing countries compared to women in the developed countries died as a result of complications related to pregnancy and child birth (WHO, 2010). Out of the estimated 358,000 who died globally, developing countries recorded 355,000 representing 99 percent (WHO, 2010). Additionally, the risk of a woman dying in her lifetime out of pregnancy-related complications in a developing country is noted to be 25 times higher as compared to a woman in a developed country<sup>1</sup>. The regional distribution of the figures on the probability of a woman of reproductive age dying as a result of pregnancy related complications which was measured in 2008 stood at 1 in 31 for Sub-Saharan Africa, 1 in 110 for Oceania, 1 in 120 for South Asia and 1 in 4,300 for the developed regions (WHO, 2010).

Furthermore, in terms of maternal mortality rate distribution amongst developing regions, Eastern Asia recorded 41, Western Asia 68, Latin America and the Caribbean 85, North Africa 92, South-Eastern Asia 160, Oceania 230, South Asia 280, with Sub-

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<sup>1</sup> [http://www.who.int/gho/maternal\\_health/en/index.html](http://www.who.int/gho/maternal_health/en/index.html) accessed 12th June 2013

Saharan Africa recording the highest figure of 640 in 2008 ( WHO, 2010). Clearly, amongst the developing regions, sub-Saharan Africa recorded the highest in terms of adult lifetime risk of maternal death. Maternal mortality obviously is an acute problem in the developing countries but worse in sub-Saharan Africa.

In Ghana, maternal mortality exists as one of the health challenges to contend with in view of the difficulty in attaining MDG 5 (Ministry of Health, 2008). Also, a report of the CIA World Fact book placed the country 32nd on world maternal mortality rate index. The country's maternal mortality ratio currently stands at 350 death/100,000 live births.<sup>2</sup>

To question what accounts for the loss of many women to maternal death leads to the enumeration of direct and indirect obstetric causes as reasons for maternal death. Notable among the direct causes of maternal mortality are hypertensive disorders, infections, severe bleeding, etc.<sup>1</sup> According to Khan et al. (2006), severe bleeding (34%), infections (10%), hypertensive disorders (9%) and obstructed labours (4%) are the principal direct causes of maternal mortality in Africa while indirect causes accounts for 20%. Besides the number of women that die due to complications during pregnancy and childbirth, some would have to contend with permanent sequelae. It is estimated that when a single woman dies there are thirty to fifty others who experience infection, injury or diseases.<sup>3</sup>

In fact, the litany of long term consequences of pregnancy related complications are as varying and ample as the figures that lose their lives. For example, uterine prolapse, infertility, pelvic inflammatory disease, vaginal fistulae are a few of the known maternal morbidities that are associated with pregnancy related complications. In

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<sup>2</sup> <https://www.cia.gov/library/publications/the-world-factbook/geos/gh.html> accessed on 12th June, 2013

<sup>3</sup> [www.safemotherhood.org/2010](http://www.safemotherhood.org/2010) accessed on 8th September, 2013

addition, the death of a woman means that many children would be left motherless. It is reported that these children are ten times likely to lose their lives within two years as compared to children with both parents surviving (Safe Motherhood, 2007 as cited in Lori and Boyle, 2011). Yet, these statistics enumerated above do not reflect the figures on the ground since unreported cases of deaths and poor collection of data especially in developing countries put some of the figures in obscurity (Ronsmans et al., 2006).

Actually, the international community has not been silent about this challenge and in an effort to combat the menace, several programmes and policies have been implemented. In support of the fight for the lives of women in securing maternal health, the World Bank and two United Nations (UN) agencies — the United Nations Family Planning Association and World Health Organisation instituted the Safe Motherhood project in 1987 (Starrs , 1987 as cited in Berer and Ravindran, 2000). This global initiative had as its set target to achieve maternal and reproductive health through the promotion of antenatal care, the provision of family planning services and post abortion care, ensuring that there is skilled attendance at delivery, etc<sup>3</sup>.

Furthermore, in 2000, 189 states approved the United Nation's Millennium Development Declaration. The fifth of the eight United Nation's Millennium Development Goals (MDG 5), centred on promoting and improving maternal health in the world. The duo aim of the goal were structured around reducing maternal mortality rate by three quarters (75%) between 1990 and 2015 and achieving a universal access to maternal health by 2015 (Waage et al., 2010; Wilmoth et al., 2012 ). Though these programmes promised to deal with challenges of reproductive health of women, the hope of achieving the purpose for which they were drafted often appeared far from reach if not stymied by challenges since the statistics above reveal that several years after the declaration and implementation of these programmes, little can be said to have been

achieved despite the efforts of the international agencies. This is affirmed by Hogan et al. (2010 as cited in Waage et al., 2010) that out of the eight Millennium Development Goals the first and sixth are on course in terms of achievement but achievement of progress for the fifth is lagging.

Ensuring maternal health will not only require drafting of policies but the acknowledgement of the fact that there are multiple factors whose role in addressing maternal health must be considered. Variables such as culture and socio-economic status have been noted to be prime in determining maternal health (Crissman et al., 2013; Moyer et al., 2012). Therefore, in dealing with maternal health issues, the need to acknowledge the role of culture and traditions of society deserves much attention than what pertains.

## **1.2 Problem Statement**

Maternal mortality, morbidity and pregnancy complications have existed as familiar terms on the global setting as the battle for maternal health continues. With an annual decline in the global maternal mortality ratio recorded at 2.3% below the projected 5.5% target to achieving MDG 5, it is evident that maternal mortality is still an issue of grave concern (WHO, 2010)<sup>1</sup>. Infections (10%), hypertension (19%), anaemia (12%) bleeding (17%) unsafe abortion (11%) obstructed labour (7%) and other causes (24%) are the percentage distribution of causes of maternal death in Ghana (Ministry of Health, 2008).

In the Ashanti Region, the achievement of the MDG 5 remains a mirage as the period for achieving the Millennium Development Goals target comes to a close in 2015. This is as a result of the fact that the region remained the highest to record high maternal

death rate in terms of the regional distribution of maternal mortality in the country.<sup>4</sup> Though the MDG 5 target for improved maternal health is set at 185 per 100, 000 live births the region's maternal death ratio was as high as 315 per 100,000 live births as compared to all other regions in the country; eclampsia and haemorrhage were the leading cause of maternal mortality in the region.

These reports reflect that, with medical causes enumerated and the medical solutions established, deaths due to complications related to pregnancy and child birth must reduce. Therefore, the challenge remains that maternal death in the region is clearly not entirely tied to medical causes only. Worthy of note is the fact that maternal health is not achieved only through improving biomedical conditions but also through factors like household conditions, environmental conditions, factors deeply rooted in culture, parity, education, etc. (Crissman et al., 2013; Igberase, 2012). Though, pregnancy and childbirth remain phenomena that occur in every human society and transcend the watershed of ancient civilization, yet there remains a patent fact that despite its universality, there are diverse perceptions, conceptions, beliefs and practices that surround the phenomena (Brathwaite and Williams, 2004; Liamputtong et al., 2005). In fact, Choudhry (1997) admitted that there exist a virtual universal association of pregnancy and childbirth with “culturally based ceremonies and rituals” (p.533). These beliefs, norms, attitudes, values and practices associated with childbirth are peculiar to and defined by the cultural context in which child birth occurs (Mercer & Stainton, 1984 as cited in Choudhry, 1997; Hoang et al., 2009; Liamputtong et al., 2005).

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<sup>4</sup><http://thechronicle.com.gh/ashanti-region-fails-to-meet-mdg-target-on-maternal-deathas-more-women-die-during-delivery/> Accessed on 2nd July 2013

For instance, in the Western world, pregnancy and childbirth are issues influenced by biomedical orientation unlike what pertains in the non-Western societies where each phase of life is marked by elaborate rituals and cultural practices. Pregnancy may obviously be phenomena that cut across all societies but there is a need to view them not only as a biological process also as a period fraught with undertones of traditional beliefs and cultural practices (Adams et al., 2005, Brathwaite and Williams, 2004, Robertson, 2001; Hoang et al. (2009).

Although the advent of modernisation and industrialisation seems to have given the biomedical model of health care primacy over existing traditional and local practices there seem to be a thriving medical syncretism in the sense that, some cultures allow both models to coexist so long as they do not have negative effects on the health of the mother and child (Birch et al., 2009; Tagoe-Darko and Gyasi, 2013). However, literature on some of the indigenous community's cultural practice about women such as female genital mutilation, male child preference, abdominal massage, etc. have revealed how these practices conflict with the biomedical model of practice and can be deleterious and inimical to the health of pregnant women (Adams et al., 2005; Amooti-Kaguna and Nuwaha, 2000; Chapman, 2006; Crissman et al., 2013; Igberesi, 2012; Senah, 2003).

Clearly, culture wields an influence on the health of a woman in pregnancy and childbirth since the handling and care offered during the season is dependent on the beliefs, ideas and prohibitions of the people (Fischer, 2002; Liampttong et al., 2005). Therefore, improving maternal health is as much a medical as well as socio-cultural issue. In view of this, there is a need to study the contributions of beliefs and practices of the people and maternal health while seeking an understanding of the culture and beliefs about pregnancy and childbirth from the perspective of the people. This study therefore seeks to explore the traditional beliefs and practices about pregnancy and child birth and

exhume their contributions to maternal health in the Sekyere South District of the Ashanti Region.

### **1.3 General Objective**

The general objective of the study is to explore the traditional beliefs and practices associated with pregnancy, childbirth and postpartum period among the indigenes of the Sekyere South District.

### **1.4 Specific Objectives**

The specific objectives of the study are as follows:

1. To examine the social meanings attached to the phenomenon of pregnancy and childbirth in the socio-cultural setting of the respondents.
2. To explore the beliefs and practices associated with pregnancy and childbirth.
3. To explore the beliefs and practices associated with postpartum period.
4. To interrogate the practices which promote/enhance maternal health in the society.

### **1.5 Research Approach**

The research approach adopted for the study is principally qualitative orientation. Being a qualitative study, key methods in data collection included in-depth interviews, focus group discussion and key informants interview with the aid of an interview guide. These were used to solicit information from the indigenes in the study area. In all, thirty-five (35) respondents including key informants were interviewed to shed light on the traditional beliefs and practices about pregnancy, childbirth and postpartum period.

### **1.6 Purpose of the study**

The intent of this phenomenological study was to explore the traditional beliefs and practices on pregnancy, childbirth and postpartum period among the indigenes of Sekyere South District. In the process, social meanings attached to pregnancy, dietary practices, behavioural restrictions, care and support offered by the family/community were covered. The population of study comprised women who have ever been pregnant and men who have ever been parents, midwives, medical officers and traditional birth attendant/herbalists. An in-depth interview was employed to solicit for information from the respondents which illuminated the contributions of traditional beliefs and practices on maternal health.

### **1.7 Significance of the Study**

The findings of the study will be useful for literature on maternal health. Also, it will be useful to the Ministry of Health and other health organisations who seek the health of women especially women in satellite communities in the country. Stakeholders such as NGO's, gender advocacy groups, international organisations, etc. will find the findings useful in drafting policies and programmes.

As a micro-level study, the data could be used to complement other macro-level data in the analysis and drafting of policies related to maternal health issues in the country. The findings of this study could throw light on traditional practices in the district and aid in reducing maternal and neonatal mortality. Finally, the study will supplement existing literature on maternal and rural health in the Sekyere South District and Ghana at large.

### 1.8 Organization of the Study

The study is organized into eight chapters. Chapter One gives a general introduction and provides the definition of concepts for the study. The rest of the study is organized as follows: Chapter Two reviews the literature on cultural practices and beliefs about pregnancy, childbirth and postpartum period as well as provides the theoretical or conceptual frameworks and links them to the study. The Health Belief Model and social facts concept served as the theories for the study. In Chapter Three, the research methodology used for the research was discussed.

Chapter Four presents an introduction to the culture of the Asante ethnic group in Ghana. Chapter Five features the presentation of the socio-demographic data of respondents. Chapter Six borders on the social meanings attached to pregnancy and childbirth in the community of study. Chapter Seven provides a detailed account of the behavioural, dietary restrictions, etc. during pregnancy, childbirth and postpartum period. Finally, Chapter Eight concludes the study with a summary of the key findings followed by the recommendations.

### 1.9 Definition of Concepts

The definition of concepts is for the purpose of clarifying technical terms that are not known to readers who do not belong to the field of study to ensure their familiarity with the terms. In addition, the concepts that have been defined are terms used by the researcher which may not have been used in the conventional usage of the field as well as to give indicators of the terms as it is used in this study. The following concepts below have been identified and defined:

**Childbirth:** Childbirth is the delivery of a baby from the mother's womb. It marks the end of pregnancy. It is also referred to as labour or parturition. Among the folks, it is the

beginning of life and confers social status on an individual. It marks an important stage of life in the society which calls for appropriate rituals to be performed.

**Cultural practices:** The customary defined attitudes, dietary prohibitions, ideas, rituals and behavioural restrictions of a particular community. These practices have existed overtime. For the purpose of the study, the terms traditional practice and cultural practice will be used interchangeably.

**Direct Obstetric Death:** It is death that occurs due to hitches during pregnancy childbirth and postpartum period. It could also be as a result of inappropriate treatment, mistakes and medical errors during pregnancy, childbirth and postpartum period or subsequent health complication as a result of any of the conditions mentioned. An example is death that occurs due to complications of anaesthesia or caesarean section.

**Epidural Anaesthesia:** It is an injection which when administered makes the nerves insensitive and prevents one from feeling pain. It is administered on a woman in labour to subside the pains of delivery.

**Foetal Distress:** They are signs in a pregnant woman whose occurrence during and before childbirth indicate that health condition of a foetus is fatal. Several signs could be used to identify foetal distress and these include change in the heart rate of a foetus, presence of abnormal substance in the amniotic fluid, presence of a dark green faecal matter from the foetus or labour slowing down abnormally.

**Foeto-Pelvic Disproportion (FPD):** It occurs when the head of the foetus is unable to pass through the pelvis of a woman in labour. The degree of difference in sizes could be attributed to foetal factors or pelvic size.

**Indirect Obstetric Death:** Indirect obstetric deaths are deaths resulting from earlier existing disease, or diseases that developed in the course of the pregnancy that is worsened by biological effects of pregnancy.

**Maternal Mortality:** This means death as a result of a woman being pregnant or within 42 days of termination of pregnancy regardless of the site of the pregnancy and how long the pregnancy lasted. It is considered death due to any cause worsened by the pregnancy or emanating from any activity related to ensuring the wellbeing of a woman and the baby during pregnancy, childbirth or postpartum period.

**Maternal Health:** For this study, the health of the mother refers to the safety and wellbeing of a woman and a baby from the period of conception, pregnancy, childbirth and post-partum period. Both the neonate and the mother were mentioned because the health of a mother is closely linked to the health of a child. The safety and wellbeing are achieved when the spiritual, physiological and emotional needs are catered for by the society.

**Postnatal Depression (PND):** Postnatal depression usually happens to a mother after birth of a new baby. Symptoms include fatigue, mood swings, insomnia, irritability, suicidal thought, difficulty in taking care of the new born baby, etc. Though postnatal depression could be mistaken for baby blues since they have common symptoms the symptoms of the former are severe and last longer than that of the later.

**Precipitous Labour:** It refers to labour that occurs faster than the average three hours of labour a woman must go through before childbirth.

**Traditional Beliefs:** The existing doctrines, religious views or ideas about something in a particular society. These include doctrines and teachings about the existence of supernatural such as sorcery, witchcraft, divination, etc.

**Traditional Birth Attendants:** They are elderly females in the community who attend to issues related to pregnancy and childbirth. These women are accepted and respected in the communities they practice. They acquire their skills through apprenticeship or as a family trade. In most cases, they also serve as herbalist or traditional healers. Their services are indispensable in poor communities where access to skilled personnel is limited.



## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

This chapter is divided into two parts. The first part looks at the literature review. Literature from several sources was sought. Periodicals, annual reports, books, articles, to mention but just a few were the sources that the researcher consulted to get foreknowledge about the research topic for the study. Exposure to these resources further moulded the researchers approach to the study and influenced decisions on methods of data collection, conceptual framework, etc. The second part of the chapter is the theoretical framework for the study. The theoretical framework served as the perspective or guide as to how the research problem will be tackled with regard to the outlined objectives for the research (Kumekpor, 2002) and its relevance to the study.

#### 2.2. Traditional Beliefs and Cultural Practices during Pregnancy, Childbirth and Postpartum period

Pregnancy and childbirth are not modern phenomena and before the advent of modernisation, folks had ways of ensuring that a woman was properly handled during such times. The evolution of the world into a global village and the adoption of biomedicine has not done much to curtail the traditional way of handling pregnancy and childbirth and some people understandably hold on to their cultural norms, beliefs and practices in a bid to ensure that there is safe delivery (Brathwaite and Williams, 2004; Chapman, 2006; Liamputtong, 2005). This part of the thesis seeks to enumerate and highlight the various social meanings attached to pregnancy and the traditional beliefs and practices pertaining to pregnancy, childbirth and postpartum periods which different groups practice to ensure that the mother and child are safe. This was done under the

themes: social meaning attached to pregnancy, spirituality, dietary practices and behavioural restrictions/ other traditional beliefs and practices about maternal health and care.

### **2.2.1 Social Meanings attached to Pregnancy and childbirth**

While pregnancy may be viewed as a biological occurrence, in some settings it is a phenomenon that is fraught with sociocultural interpretations. Quite prominent among such interpretations is the fact that pregnancy and childbirth- fertility is a definition of a woman's social status and in an effort to attain social status of womanhood, many women employ several traditional means, though these pose threat to their health (Chapman, 2006; Fischer, 2002). Proving one's fertility may not be the only means to define one's status rather a multiple of factors such as giving birth to the preferable sex of a child in the society.

In Ghana, childlessness is considered one of the worst tragedies that can befall a woman (Fischer, 2002; Sarpong, 1974). People who do not have children are considered unlucky and despised (Fischer, 2002). Infertility is often attributed to the machinations of witches or supernatural powers or a womb that is too hot or too cold to allow for the development of a baby (Fischer, 2002). Fortes (1960 as cited in Senah, 2003) in a study of the Ghanaian society confirmed this cultural value about procreation held among Ghanaian communities by expressing that bareness is believed to be the result of the operations of witches and wizards or demonic spirits. Prolific procreation is very much emphasised and an obvious prestige (Sarpong, 1974). Several reasons account for the emphasis on childbirth and or prolific procreation in Ghana. Among the array of reasons are prestige, the indispensable help offered by children in household chores and family trade, affirming ones womanhood/manhood, and maturity, etc.

According to Chapman (2006), childbirth is important since children were considered social wealth by respondents during a study in Mozambique. In a related report, Brathwaite and Williams (2004) in a study of Chinese immigrants in Canada revealed that children are considered social wealth of the family who will take care of their aged parents as well as perpetuate the lineage. These societal beliefs in support of childbirth could call for pressure on newly married couples who fail in this regard especially in their first year of marriage.

For instance, Chapman (2006) related the ordeal of women who have reproductive problems in Central Mozambique. It is noted that women who consistently lose their babies during birth are perceived of as “spirit wives”- “*mukadziwaMupfukwa*” (Chapman, 2006, p. 504). Such women are branded unlucky and believed to be married to spirits: “Any woman who experiences frequent miscarriage or stillbirth or whose infants and children do not survive is suspected of being a spirit’s wife, as is a woman who has difficulty in delivery...” (Chapman, 2006, p.504).

Ironically, this form of branding serves to save some women from debts but not without societal stigma and vulnerability. Considering the fact that having babies who thrive secures a woman’s marriage and assurance of not having to refund “lobolo” (Chapman, 2006, p. 504), some women take on the title of spirit wife for fear that history of recurrent still birth will in future lead her in debt when she has to repay the “lobolo” for not producing children who survived. Payment of lobolo (bride price) is a sign that there has been a transfer of the “right in uxorem” which is the reproductive right of the woman from her family to the man’s family (Nukunya, 1992). Therefore, failure to give birth to surviving children, in this case, calls for a return of the lobolo as well as divorce. In view of that, most women with reproductive health problems claim the title and refuse to enter into marriage contract that will call for the repayment of lobolo should it happen

that none of their children survive. However, to remedy the situation and avoid humiliation, women resort to diverse sources such as seeking the help of traditional birth attendants, traditional priests, drinking herbs, praying to fertility gods, etc. (Fischer, 2002, Sarpong, 1974).

Conversely, Mo tshe Ring and Roche (2011) reported that, most women in Tibet as a practice resort to wrapping a piece of cloth from a new mother's robe to the umbilical cord of the baby which is tied to a string and hung around the neck of a woman. This is believed to aid women who wish to get pregnant and have a baby.

In view of the efforts women go through to conceive, they are perceived as vulnerable as they make efforts to meet societal expectations to keep their womanhood status in such societies. The vulnerability women encounter in their effort to confirm social status is affirmed by Chapman (2006, p. 508-509):

“As women navigate dangerous social and biological processes in an effort to demonstrate fertility, and thus attain social womanhood, their reproductive vulnerability becomes manifest as much if not more in social ways than in bodily ways.”

Moreover, although childbirth is notably emphasised, the belief in giving birth to the preferred sex of a child is equally stressed since some cultural provisions emphasise on respect for the birth of a male child to a female child. For instance, Kartchner and Callister (2003) in a phenomenological study of Chinese birth experience revealed the preference for a male child over a female child and the prevalence of female infanticide. Male children are known to take care of the elderly parents as well as perpetuate the rite that ensures that the soul of the dead are performed (Meyers, 1997 as cited in Kartchner and Callister, 2003). The females on the other hand marry and join the family of their husbands which does not make the birth of a female an attractive preference unlike a male child.

Furthermore, the belief that the female child will pay dowry and offer her services to the husband's family after marriage makes a male child a good sex preference in the India society than the female child (Choudhry, 1997). Though cultures and beliefs evolve and are modified with time and interaction with other cultures yet a change in location did not affect the traditions of immigrants as preference for male child in India were portrayed by immigrants in North America as they grieved when they give birth to a female child in their new environment to express their disappointment (Choudhry, 1997). Though the working class women, Choudhry (1997) opined, were much adept at switching and accepting the new culture unlike non-working class, most of the traditional practices linger on in the new environment of the immigrants.

Also, Mo tshe Ring and Roche (2011) revealed a similar preference for a male child which was exhibited among the participants in Gzhongba and Dpa' sde villages in Tibet. The reasons advanced by participants for preference of a male child over a female child included the fact that the female's productive labour will not be beneficial to the family since she will be married off to serve another household. The male child on the other hand is perceived as physically strong, and will remain in the family and labour for them. In view of this, ceremonies and rituals are performed in honour of the birth of a male child. Mo tshe Ring and Roche (2011, p. 58) opined that among the people in Gzhongba and Dpa' sde villages, when a new baby is a male, a conch is blown at the "Ma Ni hall" and a birth celebration is held in respect of the family having a preferred sex of a child. A female child is only celebrated when the couple have had enough male children and have had one after wishing for one. However, families that are affluent celebrate the birth of every child. The baby is named seven days after birth and the gift given during this occasion is a chance for the maternal family to flaunt their affluence as well as express their joy over the birth of a male child. Similarly, among the participants

in Choudhry's (1997) study, the birth of a male child was marked by gift giving and celebration by families.

As a result of the preference for male child over a female child and the elaborate celebrations held in honour of the birth of a male child in such societies, most women engage in diverse practices in an effort to influence the outcome of the pregnancy to get a child of a particular sex preference in the community in which they live. For instance, the gift-giving ceremony and celebration of the birth of a male child unlike the birth of a female child in India leads many women into drinking herbs and fasting in their quest to have a male child (Raman, 1988 as cited in Choudhry, 1997). On the contrary, among the Asante of the Aka ethnic group of Ghana, the female child is very much appreciated. In the making of decisions, the Asante, uphold the contributions of the female. Such respect for the female child translates into why the Queen mother's decision is prime in choosing of the chief (Kwadwo, 2002; Nukunya, 1992) a high position among this group of people.

While women in India resort to drinking herbs and fasting in their quest to give birth to a child of a particular sex preference, women in Gzhongba and Dpa' sde villages pray at the monastery (Mo tshe Ring and Roche 2011). The issue of sex preference leads to the quest to predict the sex of a child before it is even born though this does not do much to change the sex of the child. While Kartchner and Callister (2003) reported of the use of scanners in China, predicting the sex of the child in Tibet, according to Mo tshe Ring and Roche (2011), is done by studying the shape of the belly as well as interpreting the dreams of the woman. Thus, a protruding and round belly is an indication that a woman will give birth to a male child while the reverse holds true for a female baby-

when the belly does not protrude or become rounded. Likewise in Egypt, Boules<sup>5</sup> reported that the sex of the baby is predicted in the sixth month of the baby by studying the shape of the belly of a pregnant woman. When the belly is perfectly round it is considered to be a boy while the reverse means it is a girl.

Furthermore, dreams about “butterflies”, “flowers” and “beautiful birds” are interpreted to mean that a woman will give birth to a girl while dreams about “snakes, lions, knives and arrows” are interpreted to mean that a woman will give birth to a baby boy (Mo tshe Ring and Roche, 2011, p. 50). Also, an ethnographic study by Adams et al. (2005) revealed that women create make shift labour space using stones and the colour of the stones used to contain the afterbirth during labour are used to indicate the sex of the child

### **2.2.2 Secrecy**

The belief that pregnancy and childbirth is a status that makes a woman vulnerable to harm by others (Chapman, 2006) leads to the adoption of practices that will guarantee the safety of mother and child. Among some cultures, secrecy about pregnancy and childbirth forms part of the variety of activities and practices to ensure the protection of the unborn child as well as the mother from potential harm.

An in-depth qualitative interview administered on eight female village consultants in November 2007 and February 2008 in Gzhongba and Dpa' sde villages in Tibet by Mo tshe Ring and Roche (2011) revealed the secrecy surrounding pregnancy. Mo tshe Ring and Roche (2011) reported that women in Tibet are supposed to keep their pregnancy secret and not divulge it to family members until the family eventually find

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<sup>5</sup>[http://www.cmrc.com.au/assets/files/pubs/cultural\\_birthing\\_practices\\_and\\_experiences.pdf](http://www.cmrc.com.au/assets/files/pubs/cultural_birthing_practices_and_experiences.pdf)

out themselves. Informing them at the early stage is considered a taboo and light work is often advised upon the family's eventual discovery of her condition. A similar practice was found among the participants in Chapman's (2006) study, where open discussion about early pregnancy or telling neighbours about one's status is likened to leaving the key to the house to strangers to allow them to come and steal from the house. Pregnancy is undeniably considered a family secret "segredo da casa" according to participants (Chapman, 2006, p. 499). Women in Muccessua in Mozambique according to Chapman (2006) have trepidation about the outcome of their pregnancy which is heightened by the beliefs of the people concerning safety of a mother and the unborn child against jealous and envious neighbours or rivals in their dominant polygynous setting.

With a cultural belief that pregnancy is "a good fortune and an impending social wealth" and with the understanding that witches and sorcery can be used by envious neighbours to harm people who have better things in society, women have fears about the unborn child and therefore delay announcing and talking about their pregnancy (Chapman, 2006, p. 497). If a woman fails to adhere to this age old tradition and blabs at the onset of the pregnancy to the hearing of neighbours, she could suffer miscarriage or abortion.

In view of this, series of symbolic actions or non-verbal traditions are followed before pregnancy is announced to the family. A pregnant woman in Muccessua in Mozambique breaks the news of her pregnancy to the husband by passing a plate of beads to the husband who later presents the items on the same plate to the parents as an announcement of the wife's pregnancy. According to them, one is prone to misfortune - "azar"- and these symbolic gestures in place of verbal announcement of news about pregnancy affirm their belief of keeping the pregnancy secret as well as avoid the "azar" misfortune which is believed to be contagious (Chapman, 2006, p. 498). The reason

expressed for the fear of open discussion about pregnancy stem from the belief that misfortunes such as deformity, still birth, etc. are transmittable by word of mouth-through telling and retelling of the misfortune among the people.

Similarly, Adam's et al. (2005) asserted that Tibetan women who are pregnant have a general fear that jealousy that stem from one who has no child, or lost a child or even a woman without the preferred gender of a child could make them attention for such people to bewitch them. This could cause them to have miscarriage, delayed or difficult labour and a change of the child from the often preferred male neonate to a female when it is born. This has often resulted in the way in which news about pregnancy is shrouded in secrecy even among the family members. Besides having to keep the pregnancy secret by not telling other people, women go to the extent where they “would wrap layers of aprons in such a way as to make it less obvious” (Adams et al., 2005, p. 830). Hence, women conceal pregnancy in order to avoid arousing the jealousy of other villagers.

The practice of concealing news about pregnancy often leads to deliberate acts of not preparing for the baby in ways like bedding, blankets, clothing, choosing a name etc. Flouting such cultural restrictions is a taboo for the same reason that anticipation of the baby could arouse the jealousy of others and put the child at risk. This kind of act according to Adams et al. (2005) contravenes the principles of the biomedical model of safe delivery as well as put the baby and mother at risk in diverse ways. Notable among the risks and dangers of adhering to practice of secrecy is the fact that the mother may not receive the often needed support of other community members in the form of food, supplies, transportation, etc. due to their lack of knowledge of the pregnancy of the individual. Not only is this inimical to the health of the women but also it is an affront to the biomedical health theory. Brathwaite and Williams (2004) reported that ensuring the

survival of a baby involves been modest about describing the baby. Bragging about the beauty or size of the baby is tabooed in that it could lead to the gods killing the child.

### **2.2.3 Spirituality Surrounding Pregnancy/Childbirth/Postpartum Period**

An ethnographic research by Adams et al. (2005) to ascertain Tibetans' perception of safe delivery in comparison to Western understanding of safe delivery revealed the diverse ways by which they ensure the safety of pregnant woman and the foetus before and after delivery. These include spiritual beliefs which are believed to protect the mother and the child.

Participants in the study confirmed that infants are susceptible to attacks by evil spirits since their presence could cause them to fall sick. Also, infants are known to have an intuition that can tell when a spirit is lurking in a vicinity. In view of this, Tibetans closely monitor the behaviour of an infant to determine whether a visitor or a stranger who visits a household carries an evil spirit. Thus, when a baby cries before the arrival of a visitor, it is assumed that the baby foresees the arrival of evil spirits and when the child cries too much with the arrival of a visitor it is explained that the infant's "soul"- "bla" is not compatible with the spirit of the visitor (Adams et al., 2005, p. 827).

Adams et al. (2005) maintained that, among the Tibetans, there is the belief that there are two types of spirits- the benevolent and malevolent spirit. The benign spirits are gods of the local mountains, rocks, rivers (locally referred to as "dak, tsan, or klu") who are believed to have good spirit in protecting the people, their social and natural environment but when provoked they can unleash mayhem on the offender in the form of natural disaster, loss of property, wealth, sickness, etc. as well as attack vulnerable people such as pregnant women and children (p. 826). Conversely, the malevolent spirit is unpredictable-"temperamental and sensitive" and can be provoked unknowingly and

they come in the form of ghost of deceased people, zombies, demons, etc (Adams et al., 2005, p. 827). Notably, these spirits are believed to enter the community by riding “piggy-back” of unsuspecting visitors /strangers who enter houses in the community as well as lurk in certain places at night (Adams et al., 2005; Mo tshe Ring and Roche, 2011).

One can only thread these abode of the spirits and secure their protection by using amulets, seeking prayers and blessings and driving away the spirits that visitors bring into their homes by employing the services of spiritualists like monks and lamas. Owing to the fear of the spirits carried by strangers and vulnerability of pregnant women and babies to these spirits, the clinic as well as the workers are associated with and perceived as an environment that inhabits bad spirits and thus when visited, one is likely to be attacked by any of the spirits. Additionally, considering the fact that people die at hospitals in the presence of staff who are strangers to them, this spiritual perception confirms their fears, determines their patronage of services of the county health facilities and are therefore convinced to avoid seeking healthcare from the hospitals as well as help of workers (ibid). In view of the fear of strangers entering their home with evil spirits, allowing the health workers into their homes become another challenge for fear that these strangers will enter their homes with bad spirits that can cause harm to their pregnant women, babies and the household as a whole.

Likewise, Mo tshe Ring and Roche (2011) reported that for fear that strangers who enter the compound of the house will carry along evil spirit “gdon” or ghosts “dre” to harm a new born, the mother and the child are kept away from strangers for a month and fire is built in the courtyard after naming ceremony or straw is left at the courtyard for guests to use to build fire (p. 59). Depending on the sex of the baby, the fire may be lit on the left or right side of the door. It is lit on the left side if it is a girl and on the right

if it is a boy. While sitting around the fire the guests spit behind them. This is believed to ward off evil.

In a related study, Abrahams et al. (2002) recounted that among Xhosa-speaking women of Cape Town South Africa, the fear of spiritual attack of a pregnant woman and the baby through sorcery and witchcraft leads to most women seeking traditional healing services to fortify themselves. In addition, Sarpong (1974), Tagoe-Darko and Gyasi (2013) and Fischer (2002), reported similar practices of fortifying pregnancy and protecting the mother right after conception by seeking spiritual protection from traditional birth attendants and priests. Consequently, women combine both the biomedical health treatment and the traditional treatment (Fischer, 2002).

Moreover, spirituality surrounding pregnancy and childbirth is rife among the Asante of the Akan ethnic group of Ghana. This is affirmed by Boaduo (2011) who intimated that issues of spirituality that surround the life of the Asante starts during pregnancy and it never ends. There are several rituals and practices that are performed by them to express their dislike for the death of a child or a mother during pregnancy. The Asante's have an aversion for markings on the body, based on the belief that every individual will account to their maker (God) when one dies and so one must have every part of the body intact to present it to their maker after death (Boaduo, 2011).

Despite this belief, the Asante's have never failed to make markings on the body on health grounds. Thus, in the event where a child is believed to die repeatedly only to be born again by the same mother, marks are made on one or both sides of the cheeks or on the corners of the mouth of the baby to prevent such mothers from experiencing still birth. In some instances, funny names are imposed on the child, to shame the baby who is believed to be torturing the mother and dying again every time it is born as well as terminate the baby's recurrent death. Names that reflect that a child was born

consecutively include “Donko [slave], Sumina [dumping ground], and Asaaseasa [space for grave is finished], Bosuo [dew] and Binka (let some remain) or Yinka [this one should remain]” (Agyekum, 2006, p. 221; Boaduo, 2011, p. 79). Such unattractive names, *apentedin* as they are called in the local parlance, it is believed, will truncate the child’s recurrent birth (Agyekum, 2006). Clearly, among the Asante, spiritual interventions are taken to curtail maternal and child mortality and their aversion for both are expressed in the names given to the child. There are times when the services of a traditional spiritual healer are employed to determine the causes of the successive death of the child of a woman or the occurrences of such in a family.

Several rituals are performed and children born through the help of traditional healers are given names such as “bagyina” [one specifically catered to survive]’ or “ntoba” [the child who has been bought from the ancestors] (Boaduo, 2011, p. 80). Others recommend that the hair of the baby is not cut but left to grow into dreadlocks often referred to as “mpesempese” as a mark of a child who was kept alive through the help of traditional spiritual healers (Boaduo, 2011, p. 80). A related study about the belief in recurrent death of infants is shared by Ogunjuyigbe (2004) in his study of infant mortality among the Yoruba of Nigeria. According to Ogunjuyigbe (2004) respondents believed that Abiku children (children whose deaths are recurrent) are spirit children who enjoy torturing their mothers. These children are characterised by their deformity when born, one believed to have been inflicted on it by a medicine man before its death, frequency in getting sick and their failure to respond to modern medical care. It is therefore accepted that such children should have their ailments treated by spiritual healer and the pregnancy fortified by spiritualist to protect the baby. The fear of losing a child and experiencing recurrent stillbirth leads women into consulting herbalists.

Continuing, Chapman (2006) described that women in Muccesua sought spiritual protection and healing for disease they consider as spiritual. Thus, a case study of eighty-three (83) women of reproductive age in Muccesua revealed that the perception of the etiology of the sickness determined the form of preventive or curative measure to be pursued by a woman (Chapman, 2006). Three forms or causes of illness were noted during the interview- illnesses such as cold, malaria, and tuberculosis are deemed “illness from God”, illness sent by God”- “doenc,asmandadas” or “illnesses of the world” since they were believed to be naturally caused and are thus treatable by the biomedical system(Chapman, 2006, p. 495).

For instance, mosquitoes are seen as natural agents that cause malaria and any sickness that emanate from such a natural cause is not connected to the pregnancy. Illnesses that were believed to be “symptoms of pregnancy”- “sintomas da gravidez” included dizziness, sore legs, back pain, etc. Since they were ailments considered to be related to the pregnancy they are perceived to be treatable through the biomedical system. The final and most dreaded by most pregnant women is the illness that is perceived to be caused by an enemy or a malevolent spirit-“illness provoked by bad spirits”- “doenc,as do mauesp´rito” (Chapman, 2006, p. 496). This category of illness meshed in all the serious reproductive problems such as haemorrhage, delay in giving birth, birth complications etc., and for such illnesses they are believed to be caused by witchcraft or sorcery and thus treatable by consulting traditional healer.

Chapman (2006,) opined that the fear of such “personalistic” harm was expressed in women’s choices for church-based and indigenous or “traditional” healing in the informal sector for protection and treatment during pregnancy, as this third category of reproductive threat is strongly believed to be untreatable in the biomedical sector” ( p. 496).Thus, women’s definition and perception of the cause and source of their illness

determines their health seeking behaviour and in this case most reproductive health problems and challenges were attributed to spiritual machinations and therefore dictated the form of treatment. This form of interpretation of etiology of reproductive health related challenges and its treatment not only is inimical to the health of the women but also it is an affront to the biomedical health theory.

#### **2.2.4 Food Taboos/Dietary Practices**

Women in different parts of the world have different experiences when it comes to handling pregnancy, childbirth and postpartum period. Several reasons are given for the practices during pregnancy and postpartum period and among the developing world, food taboo is observed or imposed as a cultural practice. Demissie et al. (1998) defined food taboo as “the practice of avoidance of foods due to cultural food beliefs” (p. 1). According to Sarpong (1974), “preparation for a ‘good labour’ starts right from the moment the pregnancy is discovered. Pregnant women often have to observe many taboos. There are certain actions forbidden them. They may not eat certain foods or drink certain liquids” (p. 85). Several reasons account for the avoidance of particular foods as well as the encouragement of the consumption of others. Sheer dislike for the food could be a reason for the avoidance of food by some pregnant women. On the other hand, others fail to eat some particular foods on grounds of health while others fail to consume prohibited foods due to traditional or cultural definitions spelt by the community in which they live.

Senah (2003) reported that dietary restrictions exist as one of the predominant practices for pregnant women in Ghana. Snails were tabooed during pregnancy according Senah (2003) and Chebere (1994 as cited in Fischer 2002). According to Chebere (1994 as cited in Fischer, 2002), the consumption of snails could lead to

delivering a baby with a defect on the mouth. In addition, honey was also considered unsafe for a pregnant woman since it could seal the birth passage (Fischer 2002). A similar aversion for snails was expressed by respondents during an ethnographic study of Chinese immigrants in Canada by Brathwaite and Williams (2004). The belief is that a pregnant woman who consumed snails will likely give birth to a child with the tongue sticking out. In addition, respondents listed lamb as food that is tabooed among pregnant women since women feared its consumption could lead to giving birth to a child with epilepsy as the pronunciation of epilepsy is the same as lamb in Chinese.

Furthermore, Senah (2003) expressed that eggs are believed to cause the child to be a thief when it grows while the snails on the other hand, is believed, will make the child drool. Additionally, pregnant Kassena and Nankana women of the Upper East Region of Ghana are restricted from eating meat and groundnut soup for fear that consumption of these will result in the birth of spirit children-children who are born with deformity at birth or unusual circumstances surrounding their birth and these children were usually killed at birth. It was also believed among the Akwapim that expectant mothers who buy eggs, pepper, tomatoes and garden eggs from the market risk causing severe rashes, infection and disability on the baby (Darko, 1992 as cited in Senah, 2003).

Demissie et al. (1998) in a cross sectional study from February to May 1995 revealed the reasons behind food taboos, the kinds of food pregnant women reject, the reasons behind the avoidance in eating the foods considered as taboos during pregnancy as well as its prevalence in Hadiya Zone in Ethiopia. The study noted that for women who held beliefs about food prohibitions, livestock foods were avoided by 90% of them while linseed was avoided throughout the pregnancy by a small number (16%) of women. Also, most women avoided foods such as milk and cheese. Additionally, banana (8.6%) and fatty meat (11.1%) were added to the stock of foods avoided by pregnant

women. Also, there were other foods that were recorded as popular amongst pregnant women such as “Teffinjera” 70%, “Shirowot” 67%, wheat bread 48% and kocho 35% (Demissie et al., 1998).

Among the reasons for the prohibition of some particular foods are the fear of discolouration of the foetus (20%), early expulsion of the foetus (9.7%) and the fear that eating nutritious foods will lead to increase in the size of the foetus resulting in difficult labour and delivery (51.0%) (Demissie et al., 1998). The reasons in support for prohibition of food- the fear of the increase in the size of the foetus by respondents in Demissie et al.’s (1998) study is in sync with Choudhry’s (1997) report where the women in an attempt to avoid difficult labour refuse to consume more food. The study revealed that there is deleterious result such as lack of food nutrients in terms of major protein that are needed by foetus for healthy growth of the baby when food prohibitions are adhered to. In addition, Choudhry (1997) disclosed the beliefs and practices surrounding maternal and child care of immigrant Indians as they are confronted with a new culture in Northern America.

Choudhry (1997) reported that Indians hold preferences for food during and after pregnancy such as the beliefs that there are cold and hot foods. The hot foods include milk, meat, eggs, fish, beans, eggplant, onion, garlic papaya, coffee, tea, ginger and chillies while cold foods include yogurt, buttermilk, coconut, wheat, green leafy vegetables, rice and bananas. Cold foods are presumed to prevent miscarriages while hot foods allow for easy delivery. Interestingly, the description about which food is cold and hot varies across the region of India. Beside these cold and hot foods that are beneficial to the body, others have been considered to be harmful to the pregnant woman and foetus and therefore avoided by pregnant women. Continuing, a similar study on hot and cold food restrictions during pregnancy was documented by Brathwaite and Williams (2004)

and Hoang et al. (2009). The practice is premised on the yin-yang principle of the Chinese where the body needs to keep a balance. Thus, a sick person or a woman who has delivered is believed to be in a cold state and must consume particular food to make the body warm (Brathwaite and Williams, 2004; Hoang et al., 2009; Kartchner and Callister, 2003).

Brathwaite and Williams (2004) conducted a study on hot and cold foods restrictions during pregnancy among the Chinese migrants in Canada. Foods such as meat and papaya are considered deleterious since they are perceived to cause abortions, deformity of the unborn baby, vomiting and skin infections (Nag, 1994 as cited in Choudhry, 1997). Notably, not only is consumption of some foods prohibited or encouraged but the practice of “eating down” is also a common practice among pregnant women in India (Choudhry, 1997, p. 535). Eating down refers to the practice of consuming less food during pregnancy. Chatterjee (1991 as cited in Choudhry, 1997) opined that eating down prevents difficulty in labour or delivery of large babies. Senah (2003) affirmed this stating that eating down could save a mother from foeto-pelvic disproportion. Nonetheless, Choudhry (1997) revealed that the practice of eating down is common among poor communities in India owing to their inability to feed family.

Furthermore, Brathwaite and Williams (2004) revealed the food given to a woman during pregnancy and postpartum period. The popular food during these periods is soup prepared with fermented pork feet and ginger. The soup when served during pregnancy keeps the baby healthy while after childbirth it serves to clean the womb of any leftovers of the placenta. Black root preserved with pork is also noted to aid the mother with milk production. Additionally, herbs are used to help in restoring the body to the period before pregnancy. Mo tshe Ring and Roche (2011) on the other hand expressed that no strict dietary practice is followed when a woman is pregnant. However,

several foods are prohibited after the woman delivers. Though meat without seasoning is considered good for the “bang ma”-the new mother- pork and goat meat are a prohibited foods (Mo tshe Ring and Roche, 2011, p. 50). Chilli, garlic, onion and salt are few of the foods that can harm the mother and child and so are avoided by the women after delivery. Food not prepared by close kin or someone who is not a relative is often avoided. The baby on the other hand is fed breast milk for a year when solid food can consistently be introduced and breastfeeding can continue till the seventh or tenth year before weaning so long as the mother does not get pregnant again. This practice is perpetuated by the belief that weaning a child at an early age is cruel.

Among Tibetans, strict dietary practices during pregnancy form part of their medical theory and proper dietary practice is very much emphasised despite the difficulty in getting fruits, vegetables, etc. Recommended foods for pregnant women during or after delivery includes bones and soup prepared from red meat stock (Adams et al., 2005). It is believed that the soup prepared from the red meat and bones will replenish the strength of the woman during or after delivery. Also, the local people’s belief in the medicinal properties of alcohol translates into their prescriptions for pregnant women where pregnant women are made to consume “chang” which is a locally prepared barley beer (Adams et al., 2005; 831). The amount of alcohol consumed could be few glasses in a week or several glasses in a day depending on each woman’s understanding of how much suits her as a healthy amount. This is believed to serve nutritional benefits as well as purify the system of the woman during pregnancy; a medical theory contrary to the western biomedical theory where a pregnant woman is dissuaded from consuming too much alcohol to prevent foetal alcohol syndrome (Adams et al., 2005).

On the contrary, in the case study research by Mo tshe Ring and Roche (2011), the women were offered tea and brown sugar and a restorative tonic made of honey, deer horn and brown sugar. Butter -“mar” is used for symbolic and spiritual purposes in the life of a new born baby (Adams et al., 2005, p. 831; Mo tshe Ring and Roche, 2011). Butter is smeared on the fontanel of the new born baby to shield the baby from being bothered by spirits. Additionally, butter is put on the tongue of the baby so that he or she would be endowed with good speech and astuteness. The practice involving the feeding of a new born baby with butter is also a way of establishing and defining the lineage bond of the baby with the household to ensure that the baby develops a good relationship- “rten ’brel” with the family. Depending on the type of nomadic community a child is born into, the butter is prepared with or without barley.

Therefore, for the farming nomadic community, a child is fed with butter and roasted barley flour referred to as “tsampa” whereas in a purely nomadic community only butter is given to the baby (Adams et al., 2005, p. 831). Though the western form of biomedical care preach strict infant breastfeeding in the first six months of the child to avoid infections, diarrhoea and contamination, the cultural understanding of safe delivery by Tibetans calls for the need to feed a baby with butter and barley flour and anything beside this could be seen by folks as inimical to the spiritual and social integration of the new born into the household or community. Considering the nature of sanitation often in rural community, this practice could pose health risk such as intestinal infections to the new born baby (ibid).

#### **2.2.5 Behavioural Restrictions/Other Practices**

Besides imposing dietary practices to ensure a good outcome of pregnancy, certain behavioural restrictions are established to protect the mother and the baby. These

behavioural restrictions and beliefs are peculiar to the society of the individual. For instance, Chebere (1994 as cited in Fischer, 2002) intimated that in Nakpala, Ghana, pregnant women are discouraged from climbing trees or sweeping the room at night, a belief which when flouted could lead to one sweeping away the soul of the baby.

Furthermore, Tibetans understanding of “safe delivery” is associated with the avoidance of certain conditions and places that can contaminate one’s spirit and are considered polluting. According to respondents, “grib” (pollution) occurs when one comes into contact with the faeces, garbage, blood of a woman menstruating, blood that comes during childbirth, death, blood from animals that have been killed for food, etc. Additionally, people who also come into direct contact with death and blood during childbirth such as doctors, nurses and midwives are seen as carriers of grib and their work is branded as “pollution work” ( Adams et al., 2005, p. 828). The contamination is not limited to only mortals instead it is believed that even deities can be susceptible to the “grib” and the fear of contact with grib and its ramifications can drive such benevolent spirits away. The fear of spiritual contamination is found in the implications of exposure to “grib”.

To them causes of sickness cannot be explained with biological or medical theories alone. Thus, it is believed that exposure to grib can cause spiritual, mental and physical weakness and sickness which often calls for special purification rites with juniper incense and prayers. Since the ramifications for exposure to grib are dire, Tibetans make efforts to avoid situations and places where pollution or exposure to grib can occur and to avoid benevolent or protective deities from fleeing from their household and community. In view of these fears, certain behaviours are adopted by Tibetan women during pregnancy and delivery to ensure that exposure to grib is minimal.

Pregnant women ensure that they do not contaminate themselves as well as contaminate others (Adams et al., 2005). A pregnant woman will prevent herself from being contaminated by not visiting places like home of butchers, slaughter houses, etc. In short, she must not visit places where dead person and animals are. Ensuring the latter-avoiding contaminating others, is done since blood during delivery is considered polluting and thus a woman delivering is considered as a source of grib and must prevent contaminating others in her household. Women in labour therefore deliver in 'tents', 'household storage spaces', 'animal barn /cowshed' or the confines of constructed fence made of objects or walls (Adams et al., 2005, p. 828). These ad hoc labour spaces are created away from the living space of the nomads and away from where benevolent deities are believed to inhabit to avoid the deities fleeing. Besides giving birth away from the living space, women in labour are adamant in receiving help from close relatives/husbands, in-laws or people who can be trusted to help for fear that they will be polluted by the blood of the childbirth. Furthermore, the objects used to cut the cord is not cleaned until after it has been used before it is cleaned and cleansed for exposure to grib (Adams et al., 2005).

A similar practice is found among the "Ma ma's" (birth assistants) of the participants in Mo tshe Ring and Roche's (2011, p. 52) study where tools used during delivery are not cleaned before use. These practices emanating from fear of grib as a folk belief breaches the biomedical theory of safe delivery. The tools for cutting the cord and labour spaces created or used are often dirty and can make the mother and the new-born baby vulnerable to intra-partum and postpartum infection. Moreover, 'warmth, heat, access to boiled water' as well as proper assistance and care during delivery are denied the child and new mother in their isolated makeshift delivery space (Adams et al., 2005, p. 829). In effect, with a perception of avoiding contaminating themselves and the

people around them-definition of Tibetan safe delivery- they rather expose the woman and baby to uncomfortable and risky health conditions.

Continuing, Mo tshé Ring and Roche (2011) hinted that to avoid grib, the relatives of the woman who has delivered keep away from the mother in a separate room since they believe that when they visit places like, toilet, tending flock, drawing water, etc, they can spread the contaminations from the places to the mother and infant upon contact. In cases where such places have been visited and the mother has to be seen, the individual waits shortly for some time in a separate room before contact with the mother is made.

Moreover, Brathwaite and Williams (2004) opined that several behavioural restrictions were imposed on pregnant woman in China. For instance, a pregnant woman is not allowed to frequent funeral grounds or attend occasions that are sad, desist from wearing black or white dresses, avoid carrying scissors on the bed, etc. Additionally, she must not pick items over the head. Also, since the number four sounds like death in Chinese, a woman must not have a house address that ends with the number four. Another behavioural practice among expectant mothers is to avoid donning the new baby in the clothes provided by the hospital. The belief is that wearing the clothes of another could transfer the character of the person who wore the clothes to the new baby. In view of that, mothers ensure that they go the hospital with new clothes for the baby.

An indispensable behavioural practice in the postpartum period is the support offered by the family. According to Brathwaite and Williams (2004), among the Chinese, a rest period of one month (referred to as zuoyuezi) is emphasised after delivery and the household chores are taken over by the mother in-law, biological mother or any close female member in the family to allow the woman rest (Brathwaite and Williams 2004, Hoang et al., 2009; Kartchner and Callister, 2003). Also, a woman is advised not to wash

her hair when taking a shower after birth which it is believed to prevent illness, avoid brushing the teeth, sexual abstinence, etc. The clothes of the mother and the other family members are cleaned separately while she is discouraged from using computer or watching television which could lead to developing early eye problem (Hoang et al. 2009; Kartchner and Callister, 2003).

A similar role of family support is recorded by Moyer et al. (2012) in his study of Kasena Nankan in Ghana. The role that females play in matters related to reproductive health in most rural communities which advance the health of women cannot be overemphasised (Tagoe-Darko and Gyasi, 2013; Moyer et al., 2012). According to Moyer et al. (2012), grandmothers played a vital role in ensuring the safety and wellbeing of pregnant females and their infants in the community. Mothers in-law of the females usually command respect in the household. They perform an indispensable role of supporting the women by providing new mothers with information on reproductive health. Besides, they are responsible for infant care which allows physical support in the form of bathing and massaging of the baby. This practice saves new mothers from being overwhelmed with the task in handling a new baby as well as allow for them to get familiar with the proper practices in taking care of the baby.

Tagoe-Darko and Gyasi (2013) intimated that among the Ga and Asante of Ghana, to ensure the health of a baby and the mother, particular traditional practices are taught during the postpartum period. Both the mother and the baby are put through massaging and treatment with hot water, shea butter, palm kernel oil, clay etc. The stage is characterised by the smearing of the body with clay, charcoal, and drinking traditional medicines from herbs, tree roots, barks, leaves, etc. to ensure the health of both the mother and the baby. The care of the mother and the baby is the sole preserve of elderly women in the family especially the grandmother who takes her through the values and

care of the baby and herself. In addition, the role of the traditional birth attendants in ensuring the health of the mother and the baby is indispensable. Also, different sizes and colours of beads are adorned on the ankles, arms and waist of the baby to monitor the growth of the child. In addition, to avoid malnutrition of the baby, contamination of the breast milk of the mother hygiene, sexual abstinence and breastfeeding is encouraged for a new mother.

Hoang et al. (2009) conducted a study of Asian migrants in Australia which offered insight on the essence of traditional practices and restrictions during pregnancy and postpartum period. It is advised that a new mother is not allowed to bath or wash her hair after a week and she is confined for thirty days and taken care of by family. The reason for this confinement has always been to keep the mother from getting polluted. According to Hoang et al. (2009), the thirty days confinement of women during the postpartum period served to keep a woman stable, allow her rest while the physical and emotional support which is offered by the extended family prevents postnatal depression. In addition, the precaution against picking heavy objects after birth protects a woman against vaginal prolapse. Also, the restriction against showering for a period after delivery served to protect the women in view of the fact that there is often no clean water in such areas and the use of the contaminated water right after delivery could cause vaginal infection.

### **2.2.6 Cord Management**

Ensuring the wellbeing of a child goes a long way to ensure the health of a mother. Cord management practices have been a prime focus in seeking the survival of the child in the first week of its arrival. The stump left after the umbilical cord of a baby has been cut is a vulnerable spot which requires proper management to prevent infections. Safeguarding

the survival of a new born baby involves proper care of its skin and cord stump. In order to speed the healing process, folks resort to the use of traditional remedies which usually are detrimental to the health of the baby. Several of these practices have been documented in studies in Africa.

In Ghana, Moyer et al. (2012) and Hill et al. (2008) reported of the bad cord management practices that lead to infection. A qualitative study by Moyer et al. (2012) on clean delivery among the Kasena Nankan people of Ghana revealed the unhealthy management of the cord stump of babies in the society. Shea butter, local herbs, red earth sand, local oil, ground shea nuts, juice from a local plant are just a few of the substances used in treating the cord of a baby among the indigenes. Respondents expressed that the use of these substances have faster healing properties. Additionally, they repel dirt as well as excessive moisture from entering into the stump. Among the indigenes, it is believed that when water enters the sore, it will swell up. Failure to use these recommended substances could lead to the sore getting swollen. A similar use of shea butter and alcohol in treatment of cord was documented among the rural people in Brong Ahafo of Ghana by Hill et al. (2008).

During the research, respondents expressed that the cord is tended with hot water to prevent the cord from getting dry. Respondents argued that the practice was indispensable as failure to apply shea butter or alcohol and drip water could cause distress to the baby, lead to spreading of the sore into the baby's stomach, sleeplessness, etc. Furthermore, Mullany et al. (2007) hinted of the use of cow dung for the treatment of the cord in Nepal. While Alam et al. (2008) advocated for the use of clean warm water, Dettol and soap for speeding cord healing, among Bangladesh new mothers, the use of mud, saliva, ash, mustard oil, ginger, chewed rice on the cord stump was discouraged.

These practices were all noted to be traditional practices aimed at the wellbeing of the baby. Unfortunately, they cause infection and can lead to the death of the baby.

### **2.2.7 Culture of Pain**

Fisher et al. (2006) mentioned that the fear of labour pain exists for women prior to labour. Pain during childbirth though may be considered universal (Robertson, 2001), Lasch (2000) opined that pain perception/experience is based on culture since there are variations in how people perceive labour pain which also defines the responses and how people deal with them. While some cultures conceive of pain as a necessary part of labour, other cultures have perceptions that contravenes to this belief. This therefore calls for measures to palliate the pain during such times. For instance, Robertson (2001) and Fisher et al., (2006) noted that Western societies often conceive pain as a needless preventable condition. Several reasons account for the diverse views on perception of labour pain. While, Nettelbladt et al. (1976) documented that intense pain could be associated with low education and bad perception about motherhood and pregnancy, according to Robertson (2001), women in some cultures believe that the support they have from other women during labour helps them through the transition of labour and childbirth.

Furthermore, Kabakian-Khasholian et al. (2000) contributed to the divergent views on labour pain and responses among women in Lebanon. Among women in the semi-rural region of Bekaa and Akkar, pain during labour was accepted by the women as a necessary part of the journey to motherhood. In view of that, women refused medication that will reduce the pain of labour but rather go through the natural birth unassisted. Women often considered natural delivery as a reflection of good pregnancy outcome. Similarly, Brathwaite and Williams (2004) commented that among Chinese

immigrants in Canada, the ability to go through the process of delivery without medication is cherished among the people. Besides, there is a belief that the use of medications to offset the pains of labour could harm the baby. Instead, women rely on the emotional support of family such as the mother or the husband and avoid the use of medication for delivery.

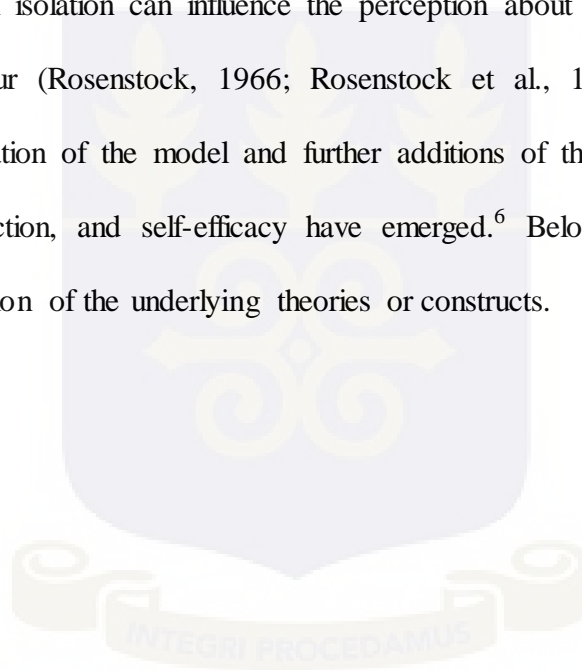
Continuing, Kartchner and Callister (2003) stated that among the Chinese, the pains of labour are not the “defining moment of motherhood” (p. 103). It is only considered an essential part of childbirth. In view of this, most women in the urban setting give birth without having to consider palliating the pain through medication unlike in the Western culture where medication during childbirth is rife (Robertson, 2001). Conversely, a different picture existed among women in urban Beirut who felt that suffering was a dispensable part of labour and often requested for epidural to reduce the pains of labour (Kabakian-Khasholian et al., 2000). While Nettlebladt et al.’s (1976) study of women in Southern Sweden revealed that the presence of husbands in labour ward did not remove the pain, Fisher et al. (2006) advocated that overcoming the fear of labour pain would be mitigated when there is improved relationship with health workers as well as support of family. In all, the pain experience during labour and people’s response to it can be considered to be more cultural than medical.

### **2.3.1 Theoretical Framework**

The study adopted the Health Belief Model (HBM) and social facts concept as the underlying conceptual frameworks for the research. The Health Belief Model highlights a set of intrapersonal factors that influence health perception about a disease which determine the health behaviour of an individual (Rosenstock, 1966; Rosenstock et al., 1988). The original Health Belief Model was based on health behaviours that are

influenced by health perceptions and the available interventions that would reduce the occurrence of it.

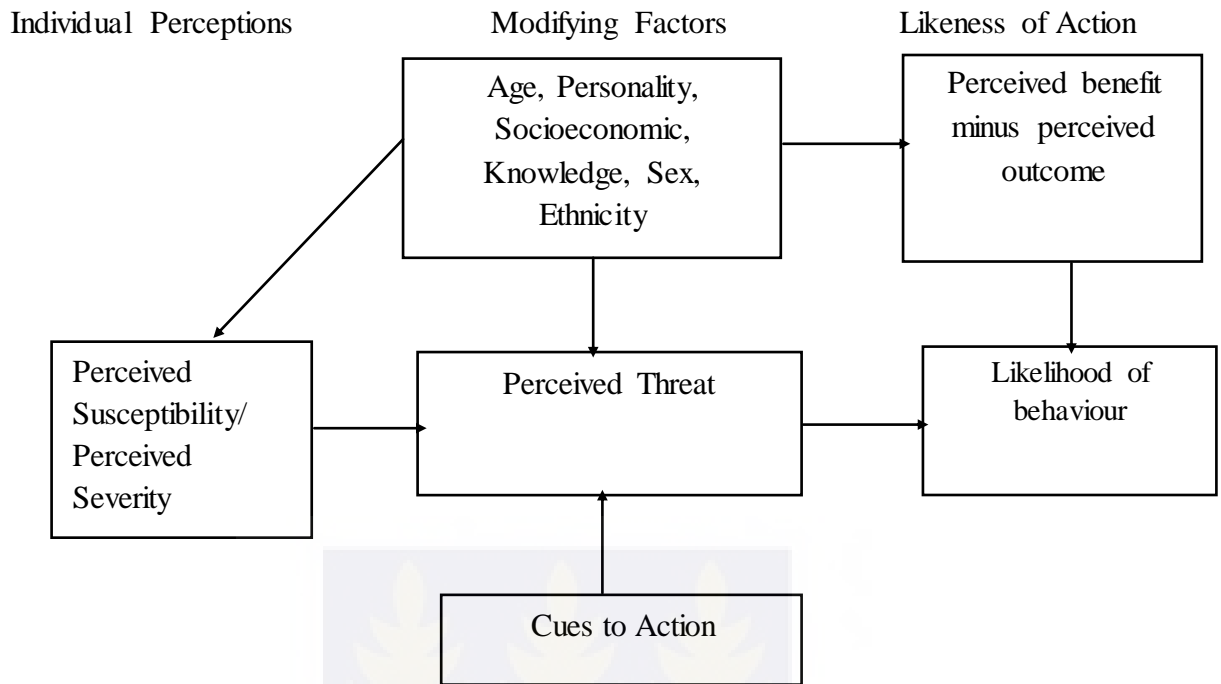
Central to this theory is the argument that people are not passive in their choice of health behaviour neither do these perceptions occur to them as random thoughts. Instead, the perceptions that influence health behaviour are determined by intrapersonal factors. The model is a popular theory developed in the 1950s by a group of social psychologist working with the US Public Health Services namely; Hochbaum, Rosenstock and Kegels. The original construct or model has four tenets and each of these tenets simultaneously or in isolation can influence the perception about a disease and determine the health behaviour (Rosenstock, 1966; Rosenstock et al., 1988). There have been subsequent modification of the model and further additions of the construct of modifying factors, cues to action, and self-efficacy have emerged.<sup>6</sup> Below is a construct of the model and explanation of the underlying theories or constructs.



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<sup>6</sup> <http://www.jblearning.com/samples/0763743836/chapter%204.pdf>

**Figure 1: Health Belief Model (HBM)**



**Source:** <http://www.jblearning.com/samples/0763743836/chapter%204.pdf>

**Table 1: Health Belief Model Construct Chart**

Perceived Susceptibility	An individual's assessment of his or her chances of getting a disease or not
Perceived Seriousness	An individual's judgment as to the severity of the disease
Perceived benefits	An individual's conclusions as to whether the new behaviour is better than what he or she is already doing
Perceived Barriers:	An individual's opinions as to what will stop him or her from adopting the new behaviour
Modifying variables:	An individual's personal factors that affect whether the new behaviour is adopted
Cues to action:	Those factors that will start a person on the way to changing behaviour
Self-Efficacy:	Personal belief in one's own ability to do something

**Source:** <http://www.jblearning.com/samples/0763743836/chapter%204.pdf>

Explaining the perceived susceptibility as a concept, it refers to the perceived probability of acquiring a disease and subsequent change in behaviour. It is assumed that an individual is likely to adopt a healthy lifestyle when he or she figures that the risk of

contracting a disease is high while the reverse holds when the individual perceives that the risk of contracting the disease is low.

The perceived seriousness as a construct also explains the belief a person has about the severity of the disease which will lead to a change in behaviour. While this belief largely stem from medical information or medical knowledge about the disease, it could also be as a result of weighing the impact or the challenges the existence of a disease will pose to an individual's health and life in entirety. This may or may not lead to a change in behaviour. In a situation where the perceived susceptibility meets with the perceived seriousness of the disease, it produces a serious threat and a higher likelihood of change in behaviour than when they exist in isolation.

Furthermore, perceived benefit explains when an individual considers the expediency of adopting a particular lifestyle in line with the idea that it will reduce the risk of developing a malady. Therefore, a person is likely to adopt a healthy lifestyle when it is perceived to decrease a development of a disease. Perceived barriers, on the other hand, explains when the individual's change in behaviour is dependent on the assessment of the perceived difficulties in adopting a new healthy lifestyle. Hence, a change in behaviour is strongly determined by what an individual has to overcome when a new lifestyle must be adopted. The challenges must not outweigh the benefits that accrue to the change in health behaviour. In this case, when a person is able to identify the challenges and barriers in adopting a healthy lifestyle it becomes easier to surmount.

Besides these named traditional constructs of the Health Belief Model, added constructs referred to as cues to action, self-efficacy, and modifying factors also influence health behaviours. Cues to action are the events, people, mass media etc. whose activities or advice influence an individual to change health behaviour while self-

efficacy explicates when a change in health behaviour is spurred by belief in one's ability to adopt a new lifestyle.

The final addition, modifying factors are the factors that can enhance or diminish the four major constructs. Culture, level of education, past experience, skills, etc. are a few of the modifying factors that influence a person's behaviour. Thus, though an individual may be aware of the seriousness of the disease as well as the susceptibility-perceived threat-but religious orientation could rule out these perceptions which will prevent a change in health behaviour. It could also on the other hand motivate the individual to change behaviour.

### **2.3.2 Adopting Cultural Construct as a Theory**

The Health Belief Model is used to interpret and predict the health behaviour of an individual by considering a set of beliefs or perceptions of a person that determines and dictates individuals' response to diseases in our daily choice of seeking health and fitness. An understanding of the reason for the health seeking behaviour of the individual is a step toward finding interventions and key solutions to the problem of maternal health. Since negative health behaviour is an inhibition towards a healthy lifestyle, knowledge of the source or the reason for such behaviour is key. For this study, to better understand the health behaviour of the individuals in the community in addressing maternal health issues and friendliness to policies and interventions, cultural beliefs as a modifying construct served as the explanatory factor to the health seeking behaviour of the indigenes. Obviously, the contribution of the individual influences and defines the outcome of many health situations. Also, for every health condition, depending on how a person perceives and responds to it, it could become life threatening.

Admittedly, personal perceptions about health of a woman during pregnancy, childbirth and postpartum period are not achieved in a vacuum, neither are the decisions about healthy lifestyle made passively. Also, an individual will not adopt a healthy behaviour only because it may be beneficial to them. Instead, health seeking behaviours are situated in the sociocultural context of the society. The health and wellbeing of an individual hinges on their sociocultural understanding of the etiology of the disease which in the long run affects the kind of treatment sought. In this case, cultural beliefs and practices served as the lens in judging the health situation and subsequent response.

### **2.3.3 Social Facts**

Social facts concept was propounded by Emile Durkheim one of the fathers of Sociology. Social facts concept was considered the subject matter of sociology-social phenomenon that must be studied empirically (Durkheim, 1982). According to Durkheim (1982) social facts have characteristics that cannot be reduced to psychology or biology. It is beyond the biological individual since it endures overtime. In addition, it subjects the individual and consciousness to the social (Cosser and Merton, 1971). Social facts therefore are the social structures and cultural norms and values that are external to the individual but have coercive powers over the individual. This definition brings out the distinction of the material and immaterial social facts. The material social facts are the visible structures that are observable such as architecture, technology, etc. The immaterial on the other hand include the abstract yet powerful morals, social current, language, norms, values, etc. and these are what Durkheim focused on. Therefore, though the manner of acting, thinking and feeling are external of the individual but they are vested with coercive power and independent of ones will (Durkheim, 1982).

In relating immaterial social facts to my study, it can be argued that though traditional beliefs and practices about pregnancy, childbirth and postpartum period are external of the individual yet they exert power on that individual to succumb to them. They control the conduct and tendencies of the individual during pregnancy, childbirth and postpartum period. Their coerciveness becomes visible when an attempt is made to violate them. Thus, traditional beliefs and practise of the society may not be tangible but over time people have been socialised to internalise them which constrains the individual in the society. Therefore, social facts are what influences people's decision and determines health seeking behaviour during pregnancy, childbirth and postpartum period. Additionally, they determine the social meanings attached to pregnancy and childbirth. Clearly, the practices and beliefs associated with the period are independent of the individuals of the society yet it coerces them to conform. Therefore, decisions about pregnancy, childbirth and postpartum period are determined by the society and every action or decision an individual makes is influenced by these practices that are external though coercive.

#### **2.4.1 Conclusion**

In summary, the literature review shows maternal health is not devoid of cultural undertones but that there are dietary practices, behavioural restrictions and social meanings that are attached to pregnancy childbirth and postpartum period. Furthermore, the modifying factor of cultural practices of the Health Belief Model served to explain the context from which individuals perceive a health situation. Thus, to understand how an individual adopted a change in behaviour towards an achievement of health outcome during pregnancy and childbirth the modifying factor of cultural beliefs and practices of the Health Belief Model was used to illustrate this argument. Moreover, the social facts

concept explained the context in which though these beliefs and practices are external yet coercive of the individual in the society to affirm that the individual is not independent of the larger society but subject to its rules and regulations at every stage of life including pregnancy, childbirth and postpartum period.

With the aim of understanding the phenomenon of pregnancy and postpartum period experiences from the perspective of the indigenes, the use of qualitative study design for similar studies for the literature reviewed is laudable unlike the use of quantitative approach where food taboos are quantified and represented in figures and percentages. Also, the literature reviewed in most part treated childbirth and the stages of life in isolation and failed to highlight how childbirth finds expression in the stages of life of an individual in the Asante community in one study. Hence, the present study highlighted the importance of childbirth and what role it plays in the lifetime of Asante folks in Ghana in one study. Continuing, the harmful contributions made by traditional practices were satisfactorily highlighted in the literature but as to what practices enhance maternal health were shrouded in most of the research. Thus, this study explored the traditional beliefs and practices that enhance maternal health in rural or peri-urban setting of the Sekyere South District of Ghana.

## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1 Introduction

This part of the research presents the description of the methodology used in collecting and analysing the data. Kothari (2004) explains research methodology as the methods/ techniques, the logic behind the methods in the context of the research study and the justification of the appropriateness of the method to yield reliable results or conclusions in a study. Choosing the appropriate research method is key to minimising errors in achieving reliable conclusion.

For this study, the following sub-topics represent the research methodology used by the researcher to conduct the study: area of study, study population, research design, sampling techniques, sample size and selection, data source, data collection procedures, data management and handling. Additionally, quality control, problems encountered on the field as well as the ethical considerations was captured in this section of the study.

#### 3.2.1 Study Area

This study was conducted in the Sekyere South District formerly Afigya Sekyere District in the Ashanti Region. The main objective was to explore the traditional beliefs and practices about pregnancy and childbirth in the district. The area was chosen for the study due to its location in the Ashanti region- the region that recorded high maternal death ratio as high as 315 per 100,000 live births compared to all other regions in the country<sup>4</sup> as well as its feature as a hub of people with rich socio-cultural background and historical culture. Historically, the famous Okomfo Anokye, one of the famous spiritual leaders of the Asante Kingdom was the chief of Agona Asante. It is through him that the

popular “Sikadwa Kofi” the Golden Stool of Asante Kingdom was conjured from the sky to be used as a symbol of unity among the Asante (Kwadwo, 2002).

The District is one of the thirty administrative districts in the Ashanti Region and was established in 2008 by Legislative Instrument 1898. It has a total land area of 584 square kilometres. This represents about 2.4% of the total landmass of Ashanti Region. Geographically, it is located in the north-central part of the Ashanti Region. It is thirty-four (34) kilometres drive away from the capital of the region, Kumasi. It shares boundaries with five other districts namely; Ejura Sekyere Odumase to the north, Sekyere West District to the east, Sekyere East District and Kwabere to the south and Offinso to the west. The district is sub-divided into four sub-districts namely Agona, Jamasi, Kona and Wiomoase. Agona Ashanti is the district capital. There are also forty-eight communities in the district (District Health Directorate, 2013).

The vegetation of the district is mainly rain forest teeming with tropical woods of different species among which are Odum, Wawa, Mahogany, and Sapele. The district has moist-semi-deciduous vegetation. The vegetative cover is dictated by the soil type and human activities. The vegetation supports crops such as cocoa, coffee, plantain, banana, citrus, cassava, cocoyam and maize. Greater part of the district falls within a dissected plateau with heights between 800m to 1200m above sea level. The northern part of the district is dotted with the Mampong Escarpment that stretches from Jamasi and Boanim. It happens to be the only high land in the area. Some aquatic bodies like the rivers Oyon, Offin and river Abankro serve as water sources and irrigation for farmers and inhabitants along their paths. The district is made up of developed town centres with satellite villages reduced to scattered farming hamlets. These areas are characterised by migrant farmers who work in the farms of the local inhabitants.

Furthermore, 48.0% of the labour force falls within economically active age for the total population. The economy of the district which is mainly agrarian claims about 78.7% of the total labour force, both directly and indirectly. Also, commerce absorbs 4.8% with services and industry (small scale) - which includes local industries like basket weaving and soap making- taking their share of 9.4% and 7.1% respectively. It is known to harbour the shrine of the famous Okomfo Anokye as well as draws tourists to the district in the area of kente weaving and craft carvings at Kona, Jamasi and Bepoase. The district has a total of 257 government and privately established schools such as basic schools, Junior High Schools, Senior High Schools, Vocational and Technical Institution. It has a religious composition of Christians, Muslims and religious traditional believers. The only sects in the district are the Allisuna and the Tigyani. The Christians are the majority with the religious traditional believers in the minority.

The total population of Sekyere district was estimated at 94,009 with 44,691(47.5%) males and 49,318(52.5%) females in 2012(GSS, 2010 as cited in the District Profile, 2013). Clearly, the number of the female population in the district outnumbers the number of male population in the district. As at 2010, the rural-urban composition of the district was made up of 53.3% urban communities and 46.7% rural communities (District Profile, 2013) with varied range of ethnic groups of diverse social strata. The Asante's who are the indigenes of the district are in the majority constituting about 73.1% of the total population. The Brongs 1.5%, Akuapims 1.6%, Ewes 5.0%, and about 18.8% from tribes in the Northern, Upper-East and Upper-West regions make up the rest of the population in the district.

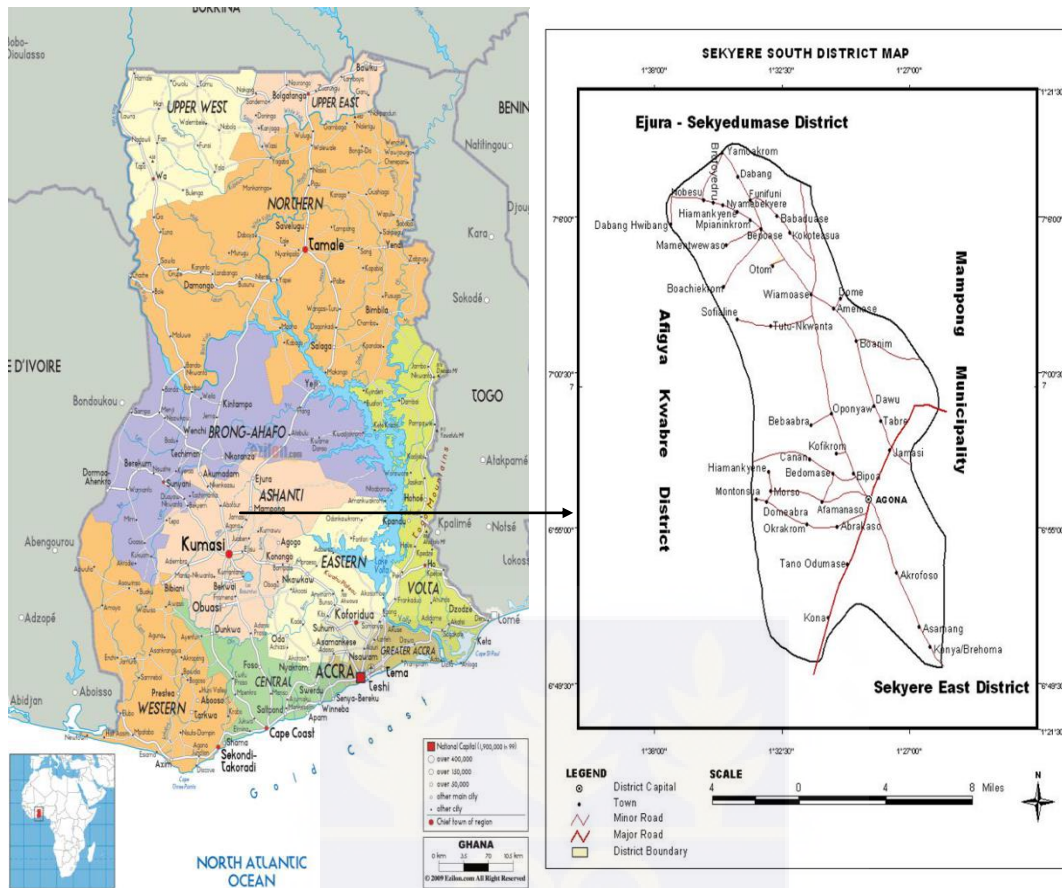


Figure 2: Map of Ghana

Map of Sekyere South District

### 3.2.2 District Health Report

The Sekyere South District’s Health Directorate annual report provided in 2013 revealed the following information:

The district has nine (9) health facilities composed of three (3) hospitals, five (5) health centres and one (1) maternity. This composition can further be divided into five (5) government hospitals and four (4) facilities by Christian health institutions popularly referred to as Christian Health Association of Ghana (CHAG). The total number of health workers or staff was two hundred and fifty-seven (257) made up of six (6) medical officers, sixteen (16) trained traditional birth attendants, two (2) pharmacists and twenty-one (21) midwives. The number of deliveries by skilled attendants for the year was estimated at two thousand nine hundred and seventy one (2,971) while the number of

deliveries by traditional birth attendants was estimated at one hundred (100). The district recorded two (2) maternal deaths while still birth was recorded at sixty-eight (68). The district has as its set target to lobby for more midwives to cater for the increasing number of maternal and child health cases in the district as well as reduce high still birth incidence in the district.

**Table 2:** Summary of District Health Report

Description	Category	Number	
District Population	Males	44,691	94,009
	Females	49,318	
Medical Officers	Medical Doctors	6	
	Medical Assistants	9	
Midwives	Midwives	21	
Nurses	Enrolled Nurses	54	
	Student Registered Nurses	68	
	Community Health Nurses	59	
TBA's		16	
Deliveries	Skilled Attendants	2971	
	TBAs	100	
Mortality	Maternal	2	
	Still Birth	68	
Institutions	Hospital	5	
	Health Centre	4	

Source: District Health Directorate (2013)

### 3.3 Study Population

For this research, the study population composed of all traditional birth attendants, elderly women, medical officers, midwives, women who have ever been pregnant and men who have ever been parents in the district.

### 3.4 Research Design

The research design entails the logical structure of the research enquiry that a researcher undertakes (Kothari, 2004). It is the guide or framework within which the research was

handled in terms of the outline for the collection of data, measurement as well as the analysis of data. The research was principally qualitative in nature. In view of this, data collection followed a sequence of an in-depth-interview, focus group discussion and a key informant interview.

The use of a qualitative design for the study was informed by the advantages that come with qualitative study as well as the appropriateness of the design for the problem or topic of research. For instance, the use of qualitative methodologies allowed for the exploration and discovery of deeper levels of meaning on the problem under investigation (Bryman, 2012; Osuala, 2005). Besides, it engendered a flexible atmosphere that encouraged the researcher to comprehend, explain and interpret the issues from the perspective of the participants/ indigenes on the traditional beliefs and practices about pregnancy, childbirth and postpartum period (Bryman, 2012; Osuala, 2005).

### **3.5.1 Sampling the Respondents**

For every study, there is a general population from which a part or number of the population must be picked. This is in view of the fact that all the units of the population under study cannot be interviewed. Thus, there was a need to select a part of the population from the general population for the study. However, in sampling, the objective is to get characteristics that are representative of the general population. For this study therefore, two categories of respondents were created.

The first category consisted of respondents who do not fall in the group of the key informants but fall within the defined study population. The characteristic of the first category comprised parents, pregnant women in the society and elderly people. On the other hand, the second category of respondents was those who were considered key

informants in the study. Key informants are the people who by their experience, position and role in the society had much knowledge about the topic being studied such as traditional birth attendants, medical officers, midwives, and herbalist (Lori and Boyle, 2011; Kothari, 2004; Kumekpor, 2002; Osuala, 2005). I considered this group the second category of respondents because their interview was shaped by the response I had from the first group of respondents. For this study, a multistage sampling technique, purposive sampling and snowball sampling were used.

### **3.5.2 Sample Size**

Determining the sample size can be a delicate process and careful consideration was given to factors such as monetary and limited personal resource, homogeneity of the population, the sampling technique used and time available to the researcher since it was an academic research subject to deadline for submission. Also, issue of precision was considered (Osuala, 2005). It was selected from the population universe for the study. Considering that the study was a qualitative study with a homogenous population with respect to the people practicing the same culture across the district, the sampling size was guided by saturation principle. In view of that, the sample size for both categories were determined by the rule that interviews will be terminated when information on the problem under study keep on repeating itself. For each group therefore, the sample size was guided by the absence of new information on the beliefs and practices about pregnancy, childbirth and postpartum period in the district.

A total of twenty-seven (27) respondents were sampled for the first category of respondents. Conversely, eight (8) key informants were purposively sampled as the second category of respondents. The eight (8) key informants were made up of three (3) traditional birth attendants, three (3) midwives and two (2) doctors- an obstetric and

gynaecologist and a medical doctor (general). In all, a total of thirty-five (35) respondents were interviewed for the study.

### **3.5.3 Sampling Community Members**

In sampling the respondents in the community, a multi stage sampling was used to sample interviewees for the first category of respondents- respondents who have ever been parents, pregnant women and elderly women. At the first stage of sampling, the four (4) sub-districts were sampled - Agona, Jamasi, Kona, and Wiamoase with the aid of demarcation provided by the District Health Directorate (2013).

At the second stage of sampling, a simple random sample was used to sample one sub-district -Agona Ashanti from the four (4) sub-districts. At the third stage of sampling, Agona Ashanti and Akrofonso were sampled from the sub-district of Agona Ashanti. A single suburb/area was also selected. Finally, purposive sampling was used in identifying eligible respondents in the homes in the communities. This type of sampling technique guaranteed a less scattered population for interview in terms of proximity, reduced cost and travel time. Also, considering the limited time and resource available to the researcher, the multi-stage cluster sampling came in handy. This technique is notably helpful usually in areas with widely dispersed population in a large area (Bryman, 2012).

### **3.5.4 Sampling Key Informants**

During the sampling of the key informants, snowball sampling and purposive sampling technique were used in sampling the units to be interviewed. The following groups of people were sampled through the purposive sampling technique; traditional birth attendants, midwives and medical doctors (an obstetric and gynaecologist and the medical doctor). The purposive sample was used for sampling key informants because

they have indispensable information and knowledge about the research problem as well as exhibit characteristics that are not evenly distributed in the population (Bryman, 2012; Kumekpor, 2002). Besides using the purposive sampling in selecting the traditional birth attendants, the snowball sampling technique was useful in locating them. Therefore, while the respondent in the community mentioned and aided in their location, the first traditional birth attendant I contacted led me to the specific location of other colleagues in the profession.

### **3.6 Data Source**

The study employed both primary and secondary sources of data. The secondary data helped the researcher to gain prior information and understanding of cultural beliefs and practices about pregnancy, childbirth and postpartum period in other countries and Ghana before field work commenced. It influenced the decision on the right design, informed the researcher of the diverse approaches to the study as well as provided insight for the field work. Thus, some decisions about the research were influenced by my reading of external materials. The secondary form of data were obtained from books, journal, articles, annual progress reports, news articles, website briefs and newspapers among others.

Conversely, the primary source of data were the data that were gathered through the in-depth interviews, key informant interviews and the focus group discussion during the actual field work in the Sekyere South District of Ashanti Region. Therefore, the interviews, pictures taken, and the field notes on the field constitute the bulk of the primary data. The data collection for the second category of respondents was conducted in January 2014 while that of the key informants' interview was conducted in March 2015.

### **3.7.1 Methods of Data Collection**

Key to achieving great data for analysis is a careful consideration of the methods of data collection. The type of study design influences and dictates the method used for collecting information. Since the research conducted was principally a qualitative study, the main methods for collecting data followed a logical sequence of in-depth interview, focus group discussion, and key informant interviews. Based on the information after each interview, a guide is provided as to what questions to ask in the subsequent interviews or discussion.

Apart from one medical doctor who requested to have his interview in English, the local language Asante Twi was used throughout all the interviews. All the interviews were also tape recorded after the consent to tape record interviews were granted by the respondents. Additionally, notes and pictures were taken to complement the data that were recorded.

### **3.7.2 In-depth Interview**

In-depth interview involved the use of questions which allowed the respondents the liberty to express themselves in their natural environment about the research topic as well as the posing of follow up questions to further elicit information or response from the participants. Considering that the research design was principally qualitative study, the best method of data collection was the interview where questions were posed by the researcher for oral-verbal responses from the participants in the study. It was a personal face-to-face interview initiated by the researcher where most questions were posed and issues were probed by the researcher. These face-to-face encounters between the

researcher and the informant(s) were directed towards understanding informants' perspective on their lives, experiences or situations as expressed in their own words.

In-depth Interview allowed for further probing on traditional beliefs and practices about pregnancy, childbirth and postpartum periods. These were semi-structured interviews which were conducted based on themes of the research topic. It allowed flexibility of exploring and probing further a topic where necessary. The interview did not follow a strict chain of questions in a particular manner or outline for all the participants (Bryman, 2012; Kumekpor, 2002). In-depth interviews were conducted for twenty two (22) respondents but with varying time frames. The shortest time frame for interview spanned thirty minutes and the highest at an hour and thirty minutes.

### **3.7.3 Focus Group Discussion (F.G.D)**

Focus group discussion was organised to elicit information from the respondents. Focus Group Discussion was the qualitative method of data collection that employs in-depth interview to elicit information from a group of people with homogenous background, experiences or characters to discuss the topic of interest for a study (Kumekpor, 2002). The major differences between the in-depth interview and the focus group discussion stem from the large size of the respondents for the focus group discussion as well as the use of a moderator who controls and guides the direction and pace of the interview (Bryman, 2012; Kumekpor, 2002).

For this study, only one focus group discussion was conducted. The group was composed of five (5) participants- who were all females and were also parents. The researcher expected to have a group with a larger number but was constrained by the turn up of the participants. Most of the respondents could not turn up because they were engaged in various tasks. However, this did not affect the progress of the discussion

since the number of people who turned up was enough for a fruitful discussion. Kumekpor (2002) affirmed that the range of the group for a focus group could be between a minimum of five (5) and a maximum of fifteen (15) people while Bryman (2012) pointed out that at least a minimum of four (4) people would suffice. Admittedly, larger groups could engender diverse ideas on the research topic (Bryman, 2012) but staying within the proposed range of number prevented crowding and eased the moderation. The focus group discussion was chosen to explore the beliefs and cultural practices about pregnancy and childbirth.

The focus group discussion was characterised by questions that allowed the respondents to discuss at length issues related to the topic though the discussion skirted around themes about cultural practices associated with pregnancy and childbirth. Hence, the dominant thematic issues about cultural practices and beliefs surrounding pregnancy, childbirth and postpartum period were discussed. Besides encouraging respondents to express their opinions, diverse and counter-opinions were stimulated which served as rich data on the topic. With the consent of the group, the focus group discussion was tape recorded. Notes were taken alongside the tape recording to complement the data as well as important themes and ideas that emerged along the discussion as it progressed. The discussion spanned an hour and thirty minutes.

#### **3.7.4 Key Informant Interview (KII)**

The key informant interview was the method used to collect data from the second category of respondents. This qualitative method of data collection involved the researcher conducting a face-to-face or one-on-one in-depth interview to elicit information from respondents who are believed to have significant knowledge or experience about the topic of research. Credited as experts with knowledge about the

topic, participants/interviewees provided insight as well as recommendations where necessary on traditional beliefs and practices about pregnancy, childbirth and postpartum period.

For this study, eight (8) key informant interviews were conducted to obtain rich information concerning traditional beliefs and practices on pregnancy childbirth and postpartum period. Through the key informants, the traditional beliefs and practices that were a challenge to the biomedical model of health delivery as well as the health of the pregnant women and the baby were brought to light. The characteristic composition of the key informant interview was; one (1) obstetric and gynaecologist, one (1) medical doctor (general), three (3) midwives and three (3) traditional birth attendants. The interviews were tape recorded and transcribed later. The interview of the medical doctor (general) was in English while the rest of the interviews were in the local language-Asante Twi. These key informant interviews shed light on information gathered from the initial interviews of the first category of respondents. Each of the respondents was interviewed independently.

**Table 3:** Summary of Data Collection Methods and Sample Size composition

<b>Methods of Data Collection</b>	<b>Category of Target Population</b>	<b>Number of People</b>
In-depth Interview	Elderly women, pregnant women,	22
Focus Group Discussion	Women who have ever been parents and Elderly women	5
Key Informant Interview	Traditional Birth Attendant/ Herbalists	3
	Medical Doctors	2
	Midwives	3
Subtotal		8
Total Sample Size (n)		35

Source: Author's construct

### **3.8 Data Collection Instruments**

The data collection instrument for the study was an interview discussion guide. For this research, the interview guide was used for the data collection for all the respondents including respondents during the in-depth interview, focus group discussion and the key informant interview. The interview guide as data collection instrument was made up of open ended semi-structured questions on specific themes about traditional beliefs and practices on pregnancy, childbirth and postpartum period in the study area. Conducting interviews for this research using an interview guide did not follow a regular or strict outline/ pattern for all of the respondents. This allowed for the respondents to express themselves freely on the topic of discussion. In addition, it allowed for follow up questions to be asked which also ensured probing into issues for deeper understanding of respondents' comments during the interview.

### **3.9 Data Management and Analysis**

The data from the in-depth interview were transcribed and typed in word and cleaned before analysis. The data from the note-taking were integrated in the interviews data. Recording and transcribing interviews ensured that the opinions and contributions were thoroughly and repeatedly examined. Also, it prevented the tendency of glossing over the views of the interviewee as well as made up for the inadequacies of our memories during and after the interview (Bryman, 2012). The large amounts of raw data collected on the field were categorised into small manageable themes. Direct quotes were utilised where necessary in order not to lose the original meanings. The in-depth interviews were content analysed and integrated into the findings during analysis and report writing.

### **3.10 Quality control**

In order to obtain reliable data and avoid collecting redundant data, the questions were translated into the local language - Asante Twi. A pilot study was done to ascertain if there will be no change in meaning of the sentences as a result of the direct translation of the research questions from English to the local language in the course of the interview. Besides ensuring that there is no change in meaning in the course of translating the questions from English to the local language, the pilot study allowed for a trial of how the questions were properly presented or posed to elicit the best response from the informants. The data was collected by the researcher in person on the field and so familiarity with the issues and themes that emerged facilitated the understanding in conducting a good analysis.

### **3.11 Ethical Considerations**

Ethical principles are important for every research that is conducted on any population. The basic tenets include avoiding causing harm to interviewees, avoiding deception, avoiding invasion of privacy and ensuring that there is an informed consent prior to the interview (Bryman, 2012).

Before the interview was conducted in the Sekyere South District, a letter of introduction from the Department of Sociology, University of Ghana, was served the Sekyere South District Health Directorate to seek permission to conduct the study in the district. Furthermore, owing to the fact that all the interviews of the medical doctors and midwives took place at the hospital premises, permission was sought from Hospital Administrators and Matrons in charge for the day both at the Seventh-day Adventist Hospital at Asamang and the Seventh-day Adventist Hospital at Wiamoase to allow for the professionals or respondents in question to be interviewed.

All the respondents' consent was sought prior to the commencement of the interview. Hence, interviews were conducted only for individuals who voluntarily agreed and gave their consent to be interviewed. This principle held true during the key informant interview as well as for participants of the focus group discussion. For this study, the identity as well as the information provided by the respondents or participants was guarded with confidentiality.

Respondents who were willing to participate in the interview were briefed on the purpose of the study and objectives of the work were carefully explained to them. Consent was sought before interviews were tape recorded and all interviewees approved. The respondents were briefed on the liberty to withdraw from the interview whenever they feel they are uncomfortable with the direction of the interview, content of the interview or for any reason beside that which is stated. In view of this, two respondents withdrew in the course of their interview on grounds of time schedule but it did not affect the data gathered for those individuals. At the end of the study, no harm was caused to any of the participants.

### **3.12 Problems Encountered on the Field**

Some of the challenges encountered on the field included recruiting focus group participants. As a result of the busy schedules of respondents in the community especially considering the fact that most of the interviews were conducted during peak farming season, it was difficult getting people to agree to join the group for the focus group discussion. The issue of seasonal factor as a potential challenge could serve as lesson for planning fieldwork especially for researchers who seek to conduct research in the area and environs in the future. Thus, the research schedule or time plan must be drawn taking cognisance of such challenges. Also, securing the consent and booking

appointment for interview with the key informant was difficult due to the nature of their task as well as the venue for the interview.

Additionally, the challenge of having to conduct the interview in the local language Asante Twi was a challenge considering the fact that some of the terms in the local language and the English language do not render themselves easily for translation. However, every attempt was made to conquer the challenge of language translation at every level at which interviews were conducted.



## CHAPTER FOUR

### ASANTE COMMUNITY IN RETROSPECT

#### 4.1 Introduction

The Asante are a subgroup of the Akan ethnic group in Ghana West Africa. The Akyem, Kwahu, Sefwi, Fante, Brong, Akwamu, Assin, Wassa and Denkyira are all subgroups who together with the Asante belong to the larger Akan group (Agyekum 2006; Kwadwo, 2002; Nunkunya, 2001). They are further divided into matrilineal clans of the Akan ethnic group. These groups include the Asakyiri, Aduana, Bretuo, Asona, Ekuona, Agona, Asinie and the Oyokoɔ clan who are heirs to the Asante throne. The etymology of the name “Asantefoɔ” could be traced to the group’s battle with the people of Denkyira and their subsequent liberation from the tyrannical rule of the kingdom which resulted in them been referred to later as ‘Esantifoɔ (people of war) which was later adulterated to Asantefoɔ (Kwadwo, iv, p. 2002). Asante twi is the language spoken by the people. They occupy the forest belt areas of Ghana.

#### 4.2 Political Organisation

The Asante existed as independent states. During the reign of King Osei Tutu I, the independent states came together to form the Asante Kingdom in the later part of the seventeenth century (Kwadwo, 2002). Among the group, the higher political power is wielded by the *Asantehene* who is the King of the Asante, who rules concurrently with the Queen mother *Asantehemaa*. The seat is passed on to only royal members of the people of the Oyokoɔ clan. He rules the Asante Kingdom with the help of paramount and sub-chiefs and a conclave of elders drawn across the matriclan of the Asante. As the political head of the Asante, the *Asantehene* together with the Queen mother, paramount chiefs, sub-chiefs and elders in the Asante communities execute the administrative tasks

of the group. The smaller towns and villages in the kingdom are usually ruled by the clan that was the founder of the village or town. However, individuals who trace their lineage through the matri- clan are the only potential heirs to ascend the throne (Kwadwo, 2002; Nukunya, 1992). In the past, the role of military officers of the kingdom such as the *adontenhene*, *Ankobeahene*, *Kyidomhene*, etc. in protecting the community and waging war against enemy groups was indispensable.

### 4.3 Family

The family referred to as “Abusua” has a structure that epitomises the larger society. Asante are a matrilineal group of people whose inheritance and succession is through the mother’s line (Johnson, 1970; Nukunya, 1992). Matrilineal descent provides the key to understanding the social organisation, and the nuances in how members relate to each other. In view of matrilineal descent rule, the children of a male and his brothers children among the Asante’s belong to the family of their wives. On the other hand, his mother, children of his sisters, maternal uncle and aunts are the ones considered as family. In spite of this rule of matilineage, the patri-filiation is very much recognised among the Asante since a child inherits his personality from the father. Beside accepting paternity of the child and naming the child, a father plays an important role in the life of his children by seeing to their moral and social upbringing (Nukunya, 1992).

Furthermore, there is an emphasis on the extended family system and members often come together to perform social activities and usually share a common residence. The head of the family – *abusuapanin* is the older male in the family but it must be mentioned that he does not make decisions alone. Instead, decisions are made simultaneously with the adult female, *Obaapanin*, who is also responsible for affairs of the females in the family (Kwadwo, 2002; Nukunya, 1992).

#### **4.4 Education**

Parents are the primary people to see to educating their children. Nukunya (1992) mentioned that the father was responsible for the moral upbringing of a child. Hospitality, respect, honesty are few of the values that are instilled in the lives of young people. Through proverbs, storytelling, folktales, taboo, etc., young generation are taught the values of society (Johnson, 1970). All adults in the community could punish a child for wrongdoing. The values of motherhood and motherliness are taught a woman at an early age (Sarpong, 1974). The practice of raising children was considered a communal responsibility since the belief that a child belongs to the society and the aftermath of its upbringing would be borne by all was held strongly (Nukunya, 1992).

#### **4.5 Economic Activity**

As a result of the geographical location of the Asante in the forest belt of Ghana, farming serves as the major occupation that the indigenes subsist on. It is an occupation that has no gender restriction since it is practiced by both males and females in the community. Families produce enough food to feed themselves. Before the introduction of cocoa, kola trees and palm trees were the commercial products among the group. Usually, parents teach their children their vocations as a kind of family trade or they are sent out to train with a professional as apprentice. Male children acquired skills such as goldsmithing, blacksmithing, weaving of baskets, kente weaving, wood carving, metal-casting, palm wine tapping, drumming, and hunting through apprenticeship or as a form of vocation passed down from the father (Johnson, 1970; Kwadwo, 2002; Nukunya, 1992). The women on the other hand were also involved in farming and craftsmanship such as pottery (Johnson, 1970) as well as sale of mushrooms, vegetables and food crops.

Priest and Priestesses are also occupations among the group. While some may solely be involved in divination there are others who are herbalist and traditional birth attendants who attend to issues related to reproductive health in the community. Traditional birth attendants function as an integral part of the group since time immemorial.

#### **4.6 Religious Activities**

The religious characteristics of the Asante encompasses beliefs and practices related to supernatural such as life after death, magic, witchcraft, divination, sorcery, etc. The Asante worship deities/gods who are believed to inhabit natural objects such as rivers, rocks, trees, etc. The goddess of the earth referred to as *AsaaseYaa* is known to be benevolent and it is worshipped by the group. In honour of such deities/gods, some days are considered sacred and farming on such days are prohibited. Accordingly, among the farming community, the land is not cultivated on Thursday which explains the name of the earth goddess, *AsaaseYaa* (Kwadwo, 2002; Nukunya, 1992). The belief in life after death is also held among the people. Ancestors are dead relatives whose spirit have crossed over to the spiritual world to protect, reward and punish wrongdoers. This position is not credited to any individual but won on merit of leading an honest life and dying a natural death. Death related to accidents, leprosy, suicide, lunacy, childbirth, etc. strip an individual of the honour (Nukunya, 1992).

Occasional festivals such as Akwasidae, Afahye, Odwira are held to honour the gods and ancestors. As a religious practice, divination is done to foretell an auspicious future, explain a mystery of an occurrence such as sickness, death, etc. In view of that, some families consult a diviner to foretell the future of a new born or its death (Boaduo, 2011). Also, witches are believed to be people who can use their supernatural powers to benefit or harm others and it stems from jealousy, loathing, envy or sheer pride in malevolence.

Its accusation is often among relatives and people one closely interacts with (Nukunya, 1992; Sarpong, 1974).

#### **4.7 Rites of Passage: Puberty/Marriage/Funeral**

Rites of passage exist among the Asante community and most people in the society aspire to experience and go through all the rites of passage as members. Three significant rites of passage are known to be organized to mark the stages of life and these include puberty rite, marriage ceremony and funeral ceremony. It must be noted however that for each rite of passage, there are latent as well as manifest objective of emphasising fertility. Each rite of passage clearly seeks to stress the need for one to procreate and the rites are performed in respect of this. Invariably, fertility is inextricably interwoven with these rituals.

To begin with, puberty rite is a rite of passage for young girls in the community which marked the transition from childhood to adulthood. It is a ceremony that must be performed before a woman is married off. During the ceremony, she is made to eat the sacred food of mashed yam and boiled eggs and hold the hands of a boy and a girl in the process to signify that someday she will give birth to both sexes. Her first morsel of the food is fed her by a woman who has never lost a child in her life (Kwadwo, 2002). In addition, she is made to swallow boiled egg in whole as part of the puberty rite to wish her easy birth like that of a chicken. When one is able to swallow without difficulty and not bite into it, it is deemed a sign of easy labour and fertility in the future (Kwadwo, 2002; Sarpong, 1974). When a young woman is able to go through the ritual she is considered matured for marriage. Evidently, this rite of passage organised for young girls in the community puts emphasis on procreation or fertility of a woman hence the many rituals that affirm it.

#### 4.8 Marriage

Marriage is an important activity among the Asante and getting pregnant before the required ceremony is performed could call for severe sanctions such as shaming or banishment in the past. Asante are polygynous group of people. A man can therefore marry two or more women at the same time provided he can take care of them. Several forms of marriage exist among the group. These include betrothal marriage (asiwa), widowhood inheritance, concubinage (mpena aware), replacement marriage (ayete) and debt substitution marriage (awowa aware) (Kwadwo, 2002). People from the same matrilineal clan irrespective of where you come from are not allowed to marry since they are believed to belong to the same ancestor. As noted earlier, the ceremony finds expression in childbirth.

For instance, the notion of pregnancy and childbirth being the target and objective of marriage resonates in Sarpong's (1974) study of the Asante and the institution of marriage. Since pregnancy or procreation serves as a basis for most sexual activities, Sarpong (1974) mentioned that "bride wealth ratifies marriage...and may have to be followed by conception of a child or even its actual birth before marriage can be said to have been established" ( p. 83). Similarly, most of the ethnic groups in Ghana are very much modelled after the idea that procreation is prime in marriage if the group is to continue to exist (Senah, 2003).

Actually, not only is procreation very much encouraged among the people of Asante but prolific procreation. Sarpong (1974 as cited in Senah, 2003, p. 50) opined that in offering prayers for the newly married, the Asante appeal to God, the gods and their ancestral spirits to bless the bride with the womb of an elephant". As a result, family planning was not popular among the group. Women who are able to give birth to their tenth child were honoured by their husbands with "Badudwan". In addition, the state

exempts such women from participating in communal labour. This incentive became necessary after the Asante lost their population to war in their early battles with neighbouring states (Kwadwo, 2002).

Women who seek to give birth could also consult diviners and traditional birth attendants and once there is conception the diviners are consulted to fortify the pregnancy and protect the mother (Boaduo, 2011). Bark of trees, leaves and roots are prepared for the woman as medicine to protect the child and the mother (Sarpong, 1974). All members of the family are responsible for a baby's upbringing when it is born. Another mother could express milk for a baby if the mother cannot produce enough milk to feed it. Also, in the absence of a mother, a baby that is crying can be cooled down with the breast of another woman and a child who has lost the mother could be taken care of by the family (Nukunya, 1992) all in an effort to see to the survival of a child which is considered a social asset of the community. Pregnancy and childbirth are therefore deemed one of the important tasks and activities that the society finds essential as a community especially in marriage.

#### **4.9 Funerals**

Funerals have for centuries been an important event among this group of people and having a befitting and honourable burial has always been a good reason for the people in these communities to emphasise on the value of giving birth. Besides, it is asserted that failure to perform the rite could mean the person will not be able to cross over to the land of the dead referred to as "*asamando*" (Kwadwo, 2002, p. 62). As opined by Sarpong (1974), the type of funeral organised for the dead is dependent on factors such as age, status, manner of death, etc.

In the past, when a woman dies during labour, she was not prepared for proper burial. Instead, she is buried immediately without much ado since it is not considered a natural death. There is not much talk about it and it is believed the woman did not fight with valour and lost the battle. This kind of death was treated equally like the death of an individual who committed suicide (Forster, 2013; Sarpong, 1974; van der Geest, 2000). This is often called “atofowuo” in rephrase “ɔtofoɔwuo”; literally, “*the death of a lowlife*”. Such death is a taboo and bad omen in the community. Forster (2013) confirms that when a woman dies during pregnancy or childbirth, she is not mourned and the typical Akan mourning cloth such as “kuntunkuni, brisi, kobene, and adinkra” is not worn (p. 281). Instead, white cloth which is symbolic of victory is worn to shame the death and express that the death of the deceased was a loss that was not felt.

In like manner, a baby who dies at birth or is stillborn is also treated with contempt and not given an honourable befitting burial. A dead baby is put into the traditional pot locally referred to as “kukuo” and buried with immediate effect. This kind of death and burial was referred to in the past as “kukuba” literally “pot-baby”- the term couched after the object that a baby is laid in when it is buried. A child who is born with the aid of herbalist or a medicine man or believed to recur at birth is given a particular name and mutilated as a sign to shame it and to terminate its torturing of the parents (Boaduo, 2011). The mother who has lost a child is made to treat the child’s death with contempt by wearing a white dress and served a heavy and good meal (Kwadwo, 2002).

Moreover, the belief that some families suffer from “awomawu” (one who incurs persistent and or recurrent stillbirth) could even become a subject of interest for investigation during marriage between families. Families do this to avoid their relatives marrying from such unfortunate families and suffering similar fate. Families who are aware of such bad omens in their families consult diviners and medicine men to purge

them and in some cases the relatives relocate to avoid the spirit which it is believed to be dwelling in the vicinity to stop following them (Boaduo, 2011).

To de Witte (2003) and Kwadwo (2002), strict adherence to funeral rites for maternal and child death has faded out because of the manner in which funerals of today are organised. Though Arhin (1994) corroborated that funerals in the past have transformed yet the essential rites remain. Up until now a dead baby is not mourned like an adult. A woman who dies while pregnant or during labour is also not mourned.

In another vein, though funerals have turned into politics of reputation where the living more than the dead are honoured in that it has become an occasion for families to flaunt their wealth, affirm its prestige and to celebrate its excellence (de Witte, 2003), it comes back to the point that one who has children and has taken care of them looks forward to a grand and ostentatious funeral. It is an event that though the dead do not witness yet most aged adults look forward to in their quest for social prestige. According to de Witte (2003, p. 533), “reciprocity is the basic principle governing the organisation of funerals within the family. Children organise a fitting funeral for their dead parent in recognition of the care they received from him or her during his or her lifetime”. The coffin by tradition is bought by the children of the dead (Kwadwo, 2002; Sarpong, 1974) and therefore not having any child could lead to one not having a befitting burial no matter your status in the society. Funeral therefore may be a rite of passage held for the dead but the role that fertility or childbirth plays during the ceremony cannot be over emphasised.

#### **4.10 Childlessness**

Considering the importance and values that people attach to pregnancy and childbirth, childlessness and infertility among the Asante can be a source of worry. It

could be considered as one of the social tragedies to befall any individual. Asante's concern for childlessness is obvious judging by the manner in which it is handled. Women who are childless are likened to a chicken which does not pass urine. According to Sarpong (1974, p. 99), having one's own children is one of "the greatest blessing of a Ghanaian woman" and in the past a childless woman who wished to have children of her own was given a wooden doll (referred to as "Akuaba" in twi) to carry at her back which symbolically, it is believed to bring fertility to the woman. In the event of the death of the woman, she is buried with the wooden fertility doll when she dies without ever producing a child (Sarpong, 1974).

Indisputably, individuals in these communities who renege on this culture and value of society suffer societal sanctions. "Obonini" meaning "barren woman" is the usual term for a woman who has remained childless in the community. Women are often blamed and sanctioned for childlessness in these communities. Though women are often blamed when there is a failure to produce children in a union, however, the men have also never been left off the hook. On the part of men, childlessness could come as a very big blow and could result in marriage being dissolved by the family (Kwadwo, 2002).

Furthermore, a name such as "krawa" which refers to his impotence is imputed on him. "Aban agye ne tuo" (to have one's gun ceased by an authority), "ɔɔ benada" (one who farms on a Tuesday) are just a few of the mocking statements that are made about men who remain childless in the community. The statement "Aban agye ne tuo" portrays that a man who goes hunting must be able to bring some game home on his trip and in this case the failure of the man to reproduce children is personified to represent the fact that his hunting will not be successful because his weapon for hunting has been supposedly ceased by an authority. "ɔɔ benada" on the other hand is said to spite a man

because farming on Tuesday in these communities is forbidden since most Tuesdays are sacred days. For a man to be described as farming on a sacred day is ironical which means that he cannot reproduce at all.

The sanction of a woman with no child is no less of a sanction compared to the man if not worse in such setting. A woman can only be considered a woman when she is believed to have ever taken seed to the extent that some women just wish to have miscarriage as consolation. Sarpong (1974) confirmed this stating that "...to be childless is socially disastrous; but if it is known that a childless woman was once under conception but through miscarriage or child death cannot now boast of a child, the shame that she would have felt is very much mitigated" (Sarpong, 1974, p. 85). Her in-laws could also make life unbearable for her. Childlessness could also lead to the dissolution of the marriage or the man going in for an additional wife (Kwadwo, 2002). Some of the sanctions could be as subtle as gossiping and insinuations from in-laws or open sneer, insults or witchcraft accusations (Kwadwo, 2002). Obviously, childbirth is very much emphasised in this community.

#### **4.11 Conclusion**

Presently, the Asante community just like most cultures has undergone transformations emanating from the introduction of Christianity, formal education, colonialism, etc. Almost all the institutions of the Asante have had a fair share of social and cultural transformations. For instance, though marriage remains an activity championed by the family and the kingmakers, it has experienced a change from polygynous marriage to the monogamous marriage with some traditional marriage ceremonies disappearing. The introduction of formal education, Christianity and urbanisation has caused puberty rite and early marriage of women to fall out of favour

also with gender roles been challenged. Urbanisation and its attending challenges have led to nucleation of family as against the extended family system (Kwadwo, 2002; Nukunya, 1992). That notwithstanding, it must be stated however that some of the cultural practices have stood a test of time.



## CHAPTER FIVE

### PRESENTATION, INTERPRETATION AND DISCUSSION OF FINDINGS

#### 5.1 Introduction

This part of the thesis presents the research interpretation and discussion of findings at the end of the data collection. In attempting an interpretation and discussion of findings, the socio-demographic data of respondents will be discussed. The socio-demographic information of the interviewees for the study will be presented as sex, age, marital status, major occupation, religion, educational background and ethnic group.

##### 5.2.1 Sex

For this study, out of the total respondents of thirty-five (35) there were thirty (30) females and five (5) males. This data is in sync with the district demographic report which presents a population where there are more females than males in the district. Despite the initial inclusion of males in the target group, most of the male respondents were reticent to be enumerated for interview giving reasons that maternal health issues are better dealt with by women.

##### 5.2.2 Age of Respondents

Determining the ages for the young people was much easier compared to the old people. This could be explained in light of the fact that most of the old people do not have accurate dates of their age. In view of this, for most of the adults who were interviewed, references were made to historical events to enable the researcher determine their ages. Also, for some other people, divulging their age was difficult for them since issues of age seems to be shrouded in secrecy especially among women in the local community. At the end of the interview, the age category of the respondents ranged

between eighteen years (18) to thirty-nine (39) years, forty years (40) to fifty-nine (59) years and sixty (60) years and above. Out of the three age group category, fourteen (14) of them were between the ages of eighteen and thirty-nine, eight (8) of them were between the ages of forty and sixty years while thirteen (13) respondents fell into the age category of sixty years(60) and above. Regardless of age, each of the respondents had knowledge of the beliefs and practices about pregnancy, childbirth and the postpartum period.

### **5.2.3 Marital Status**

Three categories were outlined which suited the respondents in terms of their marital status. These categories were, married, single and widowed. Out of the thirty five (35) respondents for the study, fourteen (14) of them were married, eleven (11) of them were single while ten (10) of them were widowed. It must be noted that marriage is very much valued among the Asante. Nonetheless, a union without a child fails in most respect to be recognised by the society and the family because emphasis is placed on childbirth in marriage.

### **5.2.4 Major Occupation**

Several of the respondents in the study were noted to be engaged in diverse occupations as daily life activity and upkeep. The respondents who were interviewed as key informants were clearly defined by their tasks since there were three (3) midwives, one (1) obstetric and gynaecologist, one (1) medical doctor and three (3) traditional birth attendants.

Furthermore, the occupations documented for the other respondents who were interviewed in the first category beside the key informants were ten (10) farmers, one

(1) biochemist, seven (7) traders, three (3) teachers, one (1) nurse, one (1) carpenter, one (1) mason, one (1) chemical seller and two (2) hair dressers. The information on major occupation of the respondents revealed that there were more farmers than the other occupations. This data is in line with information on the district where 78.7% are in the agrarian sector as most of the respondents are farmers (District Profile, 2013). Other professions which were equally represented indicate a transformation in the economic activities of the Asante which was characterised by farming. The occupation of the respondents did not in any way alter their ascription to the traditional beliefs and practices about pregnancy, childbirth and postpartum period. For each of them, these practices were acknowledged as necessary part of the culture that must be retained.

#### **5.2.5 Religion of Respondent**

Five categories were created as religious group or affiliation for the purpose of this study. These categories were Christianity, Islam, Traditional religion, none and other. Twenty eight (28) of the respondents responded in the affirmative as Christians while three (3) of them did not belong to any religion at all. All of the key informants were Christians. This is consistent with the history of the influence of Christianity among the Asante who historically were documented as traditionalists. Additionally, though a comparison of religious orientation and tendency to believe in traditional beliefs and practices was not an objective in this study, however almost all the respondents in the first category had a belief in spirituality that required the help of herbalists. Also, dietary practices were influenced solely by cultural prohibitions despite the existence of dietary restrictions among some Christian denominations.

### **5.2.6 Educational Background**

The categories for the educational background included primary education, Junior High School, Senior High School, Tertiary and Vocational education. Seven (7) of the respondents completed junior high school, four (4) of them completed the Senior High School, eleven (11) of them completed the tertiary education while thirteen (13) of them had no formal education. Out of the eleven (11) who had tertiary education, five of them were key informants who were formal health workers with the remaining six (6) of the respondents who were not health workers. All the traditional birth attendants had no education. Clearly, seventeen (17) of the respondents have had formal education. Education among Asante has experienced transformation to include increase in formal education. Also, despite the fact that most of the first category of respondents had formal education, it did not influence their perspective or rejection of the beliefs and practices on pregnancy, childbirth and the postpartum period since their responses indicate their support.

### **5.2.7 Ethnic group**

The targeted ethnic group for the purpose of this study was the indigenes in the district who formed the majority of the ethnic group in the area. The Sekyere South District, located in the Ashanti region has the Asante as the main ethnic group in the area. This detail has been clearly and specifically illuminated in the profile report of the Sekyere South District. Hence, the first category of group that was created for the purpose of the in-depth interview had respondents who were basically Asante because information about cultural beliefs and practices about pregnancy and childbirth and postpartum period was to be sought solely from this targeted ethnic group in the district. In all, twenty seven (27) of the respondents for this category of respondents for the study

were Asante. On the contrary, no specific targeted ethnic group was purposively sampled for interviews for the group of key informants.

Three (3) of the traditional birth attendants interviewed were Asante, as well as the two (2) medical doctors. Out of the three (3) midwives interviewed, all of them also belonged to the Asante ethnic group.



## CHAPTER SIX

### SOCIAL MEANINGS ATTACHED TO PREGNANCY AND CHILDBIRTH

#### 6.1 Introduction

The phenomenon of pregnancy and childbirth goes beyond the biological understanding and activity of giving birth and it is sated with values and meanings peculiar to the people and their culture. For this study, despite the universality of pregnancy and childbirth, findings revealed that though pregnancy and childbirth are acceptably biological events, nonetheless they connote a plethora of symbolic and social meanings that only the indigenes subscribe to. Several of these ideas that were expressed by the respondents have been coalesced into three thematic areas of procreation, honour/prestige and childlessness.

#### 6.2 Procreation

Among respondents, pregnancy and childbirth means perpetuation of the lineage and an emphasis on procreation. Owing to the fear that failure to procreate will lead to the groups extinction, “*yɛn ase behye*” meaning “we will be extinct” was the popular phrase used by respondents in support of procreation. Despite the transformation that society has undergone, emphasis on procreation in marriage through childbirth is encouraged among the Asante. Statements such as; “*awoɔ na ede enipa ba efie*” meaning “it is pregnancy and childbirth that brings people home”, “*yede awoɔ edua efie*”, “*yede awoɔ na ekyekyere ekuro*”- “childbirth is used to establish settlement” were just a few of the comments backing procreation. A respondent explicitly stressed the importance of preventing extinction through procreation by intimating that:

*“Pregnancy and childbirth are phenomena akin to the life of a plantain sucker. It is believed that when a young plantain sucker is planted, it yields and reproduces several other suckers as it grows. When a matured plant is harvested, the next grown plant replaces the harvested sucker as the parent sucker which is also*

*tended until it is harvested and the cycle goes on. This will be the only vivid description and comparison that I can offer to explain our peoples' belief that the birth of one child replaces one dead person in the society and the continuous process of ensuring that there are people in the family and the community at large" (Nuro, 2013).*

Essentially, a female child is preferred over a male child in this cultural setting owing to the emphasis on procreation and the matrilineal orientation of the Asante. Thus, in response to questions concerning the sex preference among the respondents, all the arguments were conclusively in favour of a female child which is in line with Nukunya (1992) and Sarpong's (1974) report that female is the preferred sex among the Asante.

Besides, unlike Choudhry's (1997) study where females are considered a liability to the family due to marriage, Asante's preference for female child is better understood in terms of marriage where the asset of children is acquired in the union. Due to the matrilineage kinship system of Asante's, respondents affirmed that children born to the couple are considered property of the woman's family. During the focus group discussion, an old lady exclaimed; “ *eba enyini wɔ nese fie nanso ɔnkahɔ*” to wit “*a child may be raised (or grow) in the father's compound but will eventually leave.*” This means that, no matter who takes care of the children, by tradition they belong to the family of the woman in marriage. Therefore, the cultural preference for female is closely associated with the Asantes's advocacy for procreation to ensure continuity in society.

Continuing, the preference for female child according to respondents is for the reason that females are helpful in household chores and often are adept at taking care of home and hearth properly as noted by Kwadwo (2002), Nukunya (1992) and Sarpong (1974). An old lady during the focus group interview expressed:

*“Consider yourself (pointing at me) as you sit here, if you give birth only to a son and you have male siblings, they will give their children to their wives' family and since you did not give birth to a female child, your mother's line will be extinct. I had a lot of children but they were all males. I was lucky to have had female children later who have also given birth. Now consider this, where would I be in my old age if I did not have her (pointing to a lady cooking close-by,*

pauses and throws her hands in the air as if in despair) ...*and who would have taken care of me?*” (Old lady, 2013.fgd)

Moreover, another reason given by respondents in support of preference for female child pertains to property inheritance. Despite the transformation in inheritance due to intestate succession law, some rules of matrilineal descent which calls for the retention of family property through the mother’s line still lingers. For instance, where there are no females with male children in the family, in a situation where there should be an heir to the throne in a royal family, the family is likely to lose the stool to the next closest kin with a female who has a male child. Additionally, other properties could equally be lost in the same manner. This challenge of a family losing property to another family was expressed by one of the respondents as she bemoaned:

*“In my family for instance, my paternal grandmother gave birth to only one female who later died. As a result, the house that my father built was given to my grandmother’s sister’s daughter to live in with her children (she pouts her lips as a sign of her disappointment and dissatisfaction). If only she had given birth to another female child of her own (she makes a sad face) she would have had children in the house from her line to take over that property and live in it. It is still alright to give birth to a male child though. If you give birth to a male child as a first born and you take care of him well his children can become your family. The fact is, female children allow for property to be kept in the family while they also reproduce so that when you die, people can say that she had so and so number of children in her line”*(Nuro, 2013).

Evidently, though procreation is encouraged among the Asante, it does not explain all the reasons for their preference of female children. Instead, the need to also have the family retain its property and the indispensable services of a female child in household chores are reasons in support of the preference for a female child. In summary, the respondents expressed that pregnancy and childbirth are biological phenomena that have cultural meanings such as encouraging procreation, ensuring continuity of the family line, preference for female children in view of matrilineal

kinship orientation that underscores inheritance and succession through the mother's line, etc.

### 6.3 Honour and Prestige

The Asante's emphasis on procreation is not an end in itself according to respondents. The act of procreating among the Asante's comes with its perks. "Awoɔ ye?"- "there are benefits in giving birth or having children"- was the popular chorus in support of procreation by most of the respondents. Several proverbs and sayings were used by the respondents to confirm the persistent belief in the importance of childbirth to individuals and society. For instance, most of the respondents used several terms to express how having a child is valuable than having any wealth or valuables of life; "εba sene ade" "εba" referring to a child and "sene ade" "better than valuables" to wit "having a child is above acquisition of valuables/treasures". This proverb depicts that among the Asante, there is the belief that there is wealth in people. This notion of wealth in people resonate in a study by Chapman (2006) and Kartchner and Callister (2003) that children are assets to parents and the family considering the benefits they bring to them. These social benefits for this study include honour, prestige, economic benefits, security, etc.

To begin with, a respondent touted the honour associated with having a child in this society when he expressed;

*"Giving birth as a man in this society is very important and having one is an honour and prestige. For instance, if you are ever asked if you have children and your response is not in the affirmative, people perceive you to be irresponsible and it is a sign that you lead a loose life with women"* (Akwasi, 2013).

Another also added;

*"When you give birth in our society, most people respect you compared to the one who has not given birth. People may or may not know the real reasons behind someone's delay in giving birth yet one who has given birth is very much*

*respected. Additionally, it is also viewed as maturity. Once you give birth you are considered matured*” (Ama, 2013).

Besides ensuring that older generations are replaced and properties are retained in the matrilineal family, procreation among the Asante, confers honour on the individual and the family. Therefore, a female or a male who has a child in the community according to the respondents is considered matured and responsible in every sense of the word.

Continuing, the value of prolific procreation was also expressed by respondents. The practice of giving birth to large family size according to respondents is a source of pride for people who have large family and are able to take care of them. To others, large family size could be a game of chance to ensure that in the event of the death of any of the children some will survive or prosper. After all, they will also say, “*yennom ahina baako mu nsuo*” which means “one cannot afford to drink from one pot” which could break. Therefore, there should be more children to secure the future. In support of this view, one young female respondent expressed;

*“Having a large family is pride (abodin) and I can boast of such large number. In fact, it is good to give birth to a lot of children but due to hardship it is also advisable to keep small family size. Nonetheless, I have ten kids.”* She added; “*if for no reason at all I know that if five do not do well or survive in life, at least five of them will do well. I feel secured this way*” (Fobi, 2013).

True to her words, her prolific procreation was the talk of the town at her funeral when she died a year and half later after the interview. While she considered financial condition as the determinant of family size, another also refuted;

*“Sometimes considering having money as a factor before deciding on the family size does not matter to others. Instead, the reverse is also true. I know a man who says that he wants to give birth to a lot of children as a farmer so that he can get enough hands on the farm. Besides, he wants to pride himself with the number of children he has given birth to. He has nine kids presently. It is prestige and pride for him now. When he gets into a quarrel with people on the street, he refers to the number of children he has as his source of pride. For instance, he says ‘you can’t talk to me anyhow because I have nine kids/children’”* (Brefo, 2013).

Actually, having large family size is considered great wealth and honour especially for those respondents from farming communities. Children are considered great asset and social wealth to the family and the society in these communities since their help comes in handy on the farm. The larger the family size, the better since they help during the farming season. One respondent affirmed this when she expressed:

*“As for me, I think keeping a large family is alright. If there are more people in the house, it is economically good. For instance, in this season of farming you will get a lot of hands to work on the farm and it saves you a lot of money from hiring labourers. So for me, I will give birth to a lot more children to enable my husband and I have more hands on the farm ” (Ataa, 2013).*

Furthermore, it is also believed that the larger the family size, the more likely one will have support especially during occasions such as funerals. A family with large size in terms of numbers is a force to reckon with in these communities and it is symbolic of or has the social meaning of strong defence. The belief is that there is strength in numbers and having a large family will mean a pool of contributions in organising social events. Families that are large and united are feared and respected in these communities. Hence, beside the aim of replacing dead generation and ensuring continuity of the family, prolific procreation gives one guarantee of support in numbers.

Conversely, others offered arguments that were not in favour of prolific procreation, which is a deviation from cultural belief influenced by social transformation, education and economic changes (Nukunya, 1992). According to a respondent;

*“The practice of giving birth to a lot of children was very popular and valued in the past. This value was very much cherished in that a woman who is able to give birth to the tenth child in the past was offered a ram called “badu dwan” (Ram in honour of a tenth child) in the olden days to honour her. Prolific procreation is the reason for the existences of local names such as “Mansa” (a female born after two female siblings in succession), “Nsia” (nsia means six, and a sixth born), “Manson” (“nson” means seven and “eba” means baby- “manson” means seventh born), Badu (tenth born) that are commonplace among Asante. Presently, giving birth to a large number of children is not economically expedient. Besides your friends are likely to make fun of you because you have a lot of children” (Pomaa, 2013).*

Furthermore, another vital reason in support of childbirth among the Asante is the fact that children are security and support for the future. There exists an obvious system of obligatory reciprocity where parents who catered for their children benefit from them when they get old. According to a respondent:

*“Yen npaninfoɔ ebuu be bi se, se yehwe wo ma wose fifiri a na wonso woahwe amma yense atutu. Awoɔ ho mfasoɔ bi ne se wonyini a womma behwe woɔ. Mete ho yi anka enye nkadaa yi a anka mereye no den? Mani afira, menhunu adee. Se empo obi ben me koraa a me nhunu no. Se obi amoa me a me ntumi endware anaa mentumi enkɔ baabiso so. Se medidi o medware o gye se Mansa. Se anka manwo no a anaa se manhwe no a, na anka saa emere yi merefa hene? Me ntumi enkɔ se obi emfa ne ba enfem me. Enti awoɔ de ehia”* (Old lady, 2013 fgd).

This means that;

*“Our elders have a proverb that when a child is tended to grow teeth it must reciprocate by caring for the parents till they lose their teeth. The benefit of giving birth is for your children to take care of you when you are old. As I sit here, how will I survive without the help of my children? I’ve lost my sight, I can’t see. I am unable to see even when the person is close. I cannot shower or go to the toilet without assistance. Whether I will eat or take a bath, it depends on Mansa. If I had not given birth or taken care of them how would I have survived such crisis? I couldn’t also ask someone to lend me her child. So, having a child is very important* (Old lady, 2013 fgd).

Another respondent in support added that:

*“When you are in a family and you don’t give birth it is bad. It is not good because it brings a lot of struggles and hardship especially in your old age. You will find it difficult to foot your medical bills, accommodation, food, and clothes. But when you give birth and you take care of the children, when they grow up and you are old they will take care of you”* (Nuro, 2013).

Obviously, in a community and a country where there are no homes for the retired or aged, having children to see to your welfare becomes an indispensable decision in the present towards a secured future. Even in the present, children are considered to support their parents by running errands. In support of this view, “yēsoma nipa na yēsoma sika”

“one can only send a child and not money” was the proverb that was chanted by most of the respondents. Agreeably, having a child is a buffer and social security for the future of adults who take care of their children. This was also documented by Kartchner and Callister (2003) who reported that having children is a necessary cushion for the future since the children grow up to take care of their aged parents.

Finally, Asante’s understanding of childbirth is properly understood in light of the organisation of one of the most important social event among them- funerals. Giving birth and having a befitting funeral is impressed upon the minds of most of the respondents. One respondent therefore narrated an account of a funeral held for a retired midwife who had no child:

*“I know of a woman who was a midwife who died in this area (points to the direction of the house). Even before she died, she lived a miserable life always bemoaning her state of never ever having a child. She was never happy until the day she passed away. Her funeral was not properly organised despite all her pension pay. If she had had a single child alive at the time of her death she would have been given a more honourable and befitting funeral ceremony and burial than what we witnessed here” (Akos, 2013).*

Another also added:

*“If you are on this earth and you have no child you will not be fortunate to receive an honourable burial by the family. When you give birth and you die, your children will organise a brass band at your funeral and the whole town will hear about how well your funeral was organised” (Fobi, 2013).*

Understandably, having children among the Asante is a guarantee for an individual to receive the honour of pomp and befitting burial when one passes away. This belief of giving birth and having a befitting burial is consistent with de Witte’s (2003) study of the Akans and funerals in Ghana.

#### **6.4 Childlessness**

It is evident that with the many reasons expressed in support of childbirth, bareness is abhorred in this society. Despite the cultural transformation in most societies owing to

colonialism, formal education, urbanisation, etc. the findings of the study corroborated Sarpong's (1974) report on the abhorrence of childlessness among the Asante. A respondent related that:

*“Pregnancy and childbirth are very important phenomena since they are what lead to procreation and prevent extinction of life. When an individual has no children especially in marriage, it can be distressing! Though a woman who has had a child out of wedlock may suffer shame in the society but that cannot be compared to one who does not have children in a union. The one with a child is esteemed. Our people expect a woman to give birth in the first few months of marriage. The couple do not feel happy when childbirth delays. Also, you feel uncomfortable walking on the street since you are tempted to believe that people are gossiping about you which they truly do. In fact, people in this community stress on having children more than marriage” (Ama, 2013).*

Thus, though marriage may be recognised among the group but the lack of children for a period of time will call for societal pressure. Furthermore, owing to the emphasis on procreation in the community, it doesn't come as a surprise when a young lady is pressured to marry and have children. Accordingly, a respondent remarked;

*“If you are a woman between the ages of twenty and thirty you are always advised to not just marry but to give birth and when you fail to do that, your mother and the family start putting pressure on you. Some may be direct while others will be nonverbal cues that can make life unbearable sometimes” (Yaa, 2013).*

Obviously, despite the years of social transformation among the Asante, the notion of childbirth having influence on marriage as expressed by Sarpong (1974) and Kwadwo (2002) persists. This is also corroborated by Fischer (2002) who expressed that in Ghana, couples are likely to be put under pressure when they are unable to give birth in the first year of their marriage.

Several moral as well as spiritual reasons are still assigned to the failure of an individual from getting pregnant in these communities and many of these are replete in their narrations:

*“When someone does not have a child in this community, people believe the person to be the cause of his or her own misfortune. People tell you that you are a witch and have eaten up your children. Also, it is added that you have*

*exhausted your ovaries and destroyed your womb through abortion. People see you as hopeless while others also believe that you have cemented your womb with coal tar. Some also speculate that there is a disease that is preventing you from giving birth and children and neighbours avoid eating your food. When people are conversing about children, you are often not expected to make comments concerning children. One could be sneered at -‘what do you know about children?’ when the comment does not go down well for someone. In fact, if you do not have a child, you cannot chide someone else’s. These and many other reasons are what make some barren women say they would be glad to even have a miscarriage so that people will know they have ever been pregnant. Regardless of your status or achievement in life, giving birth seems to be the only means for a woman to affirm her identity in our community” (Pomaa, 2013).*

Additionally, wild stories are told about them and the reasons for their failure to give birth:

*“There was a woman in this town. When she got pregnant and gave birth to the child, she used to lock the child up in the room. The baby will cry all day and this happened several times until the baby died. The woman never had a child afterwards, she became barren. She was only lucky to have had money which she used to raise her siblings’ kids. Other than that, she would not have had any assistance during her old age. In spite of this, I will always say that even if the back of your hand tastes good it can never be like your palms” (Old woman, 2013 fgd).*

Another also added;

*“We women are often blamed for barrenness and the in-laws will think you aborted when you were young. I also think sometimes it is the cause of the men because their semen cannot fertilise a woman. It could also be a spiritual issue for instance when you are bewitched. In that case, you can seek the help of a pastor, herbalist or fetish priest/priestess to save your face. This is necessary because when someone is childless in this community she is more or less not counted among the lot because she is seen as not making any contribution to society. When she gets into an argument or a fight with someone, they could sneer at her that ‘have you bought paracetamol before?’ In fact, people gossip and look down on individuals in the community who do not have children” (Mansah, 2013).*

In this account, paracetamol (a pain relief) is considered as one of the cheapest drug any parent can buy for an ailing child and to question a barren woman’s ability to purchase it is just to spite her and mock her of her unlucky fate. It is not about the fact that she cannot afford, rather, she has never known what it means to have an ailing child much less to buy the cheapest medicine because she has no reason to. This belief substantiates

Fortes' (1960 as cited in Senah, 2003) statements about people's response to childless women since half a century after this study, the practice of vilifying childless people in the community has not changed. The advent and advancement in science and technology was believed to have minimised the myth and mystery behind infertility and bareness yet the findings attest to the fact that it has done little to assuage the inconvenience victims experience concerning this social belief. Also, the view that giving birth to one's own children will be of much benefit than fostering another's child is strongly held among the group.

In summary, several other discrete unfair treatments meted-out especially to women in these communities keep the women unhappy. Life in such communities without a child is distressing. Also, the phenomena of pregnancy and childbirth among the Asante go beyond biological conception and delivery. Instead, it means a fulfilment of societal values of procreation, affirming ones social identity, honour and security for the future. All these were advanced in the wake of globalisation, social and cultural transformation of society.

To place this result in the context of the theoretical framework, it is evident that most of these social meanings attached to pregnancy and childbirth are premised on the cultural values of the people- social facts. Though childbirth may duly be a biological process, the influence of cultural values in terms of the prominence given to sex preference, prolific procreation, honour and prestige cannot be overemphasised. Understandably, these values are external of the individual but individuals are compelled to adhere to them and flouting them attract social sanctions. An obvious example is the emphasis on childbirth, failure of which leads to one being branded as a witch. Not only are the values external to the individuals and coercive but they also persist overtime.

Obviously, this is achieved through socialisation of members to believe in these cultural values which is evident in their constant reference to old age proverbs.



## CHAPTER SEVEN

### PREGNANCY, CHILDBIRTH AND POSTPARTUM BELIEFS/ PRACTICES

#### 7.1 Introduction

This chapter is a continuation of the data analysis. Among the themes to be discussed are the belief and practices associated with pregnancy and childbirth, beliefs and practices surrounding the postpartum period as well as the janus-faced beliefs and practices in the community.

##### 7.2.1 Beliefs and practices associated with pregnancy and childbirth

The social meanings attached to pregnancy and childbirth by respondents attest to the importance people accord to pregnancy in these communities and an obvious need to ensure that a woman and the foetus are healthy through pregnancy until delivery. In light of this, the need to facilitate pregnancy or conception as well as ensure a good outcome for pregnancy and childbirth is notably of prime importance.

Several beliefs and practices as well as taboos are therefore observed by pregnant women in the community to ensure safe delivery. Among such beliefs mentioned by the participants, in keeping with the notion of ensuring the safety of the baby and the woman are what has been categorized into themes of traditional birth attendants, spirituality, dietary restrictions and behavioural restrictions.

##### 7.2.2 Traditional Birth Attendant (s)/ Herbalist

In an effort to satisfy the aforementioned cultural values and mitigate the social sanctions that childless individuals, especially the women in these communities contend with, some people employ varying modes of services beside the biomedical model of health service to facilitate conception. For instance, some women confessed that they

sought the services and assistance of traditional birth attendant/herbalist, pastors, priests and priestesses to be able to conceive. These people are often responsible for the pregnancy until birth and their instructions are binding on the individual as long as one remains a client to them. A female respondent narrated:

*“I went for herbs from a woman of God. She is called Adwoa Ago. She is from this town. When I went to see her she gave me the herbs. I prepared ‘ab eduro’ (a local soup prepared from palm nut) with the herbs and drank it. When I went to consult her, she took nothing from me. She only told me to come and thank her after I have delivered safely. The baby and I are not three months yet. When the baby is three months old, I will go and thank her” (Ataa, 2013).*

Clearly, despite the primacy of the biomedical model over the orthodox healing services, in these communities, the services of local healers and diviners in matters like pregnancy and childbirth is still in vogue. In the past, these people served as the sole “caretakers” of pregnant women as opined by Sarpong (1974) but with the advent of biomedical health care, most of the women obviously combine the herbal treatment and the antenatal attendance. This practice is corroborated by Tagoe-Darko and Gyasi (2013) and Fischer (2002).

Among the local people interviewed for this study, there was a general belief that a woman who gets pregnant must consult a traditional birth attendant who would ensure that the mother and the foetus are taken care of till delivery. A similar notion was reported by Sarpong (1974) that the first step for every woman who conceives is to fortify the pregnancy by consulting a herbalist or diviner. Traditional birth attendants are usually elderly females who live in local communities. They are known and accepted in the community by the indigenes. They are actually held in high esteem by their clients. Among the Asante, traditional birth attendants have played a vital role in the lives of women in the community since time immemorial and their services come in handy. Though some are restricted in the treatment of only pregnancy related issues and delivering of babies others, on the other hand, deal with ailments and conditions such as

fibroid, barrenness, goitre, hernia, epilepsy, drunkenness, family planning etc.

Recruitment as traditional birth attendants are through diverse forms. While others are handed the skill as a family trade others claim to have been taught the skill by spirits or dwarfs:

*“I will be ninety years next year and I’ve practiced as a traditional birth attendant since I married as a young lady. I married a fetish priest and I was once called by the spirits. They instructed me to follow them with a cutlass and I was led into the forest. I was directed to harvest roots, leaves, tree barks, etc. I returned to the house with lots of herbs and my basket filled to the brim. I was later directed by the spirits as to what ailment each of these herbs are to be used to treat especially pregnancy and childbirth issues and from then, I became a traditional birth attendant. I am able to treat all sorts of ailment besides aiding many women to conceive” (TBA, 2013).*

They prepare herbs/concoctions for women who seek to conceive as well as women who are pregnant. They attract clients from different walks of life. Pregnant women who seek the services of traditional birth attendants could remain under their care from the third month (first trimester) until the child is weaned. According to one of the traditional birth attendants, before a concoction is prepared, clients who consult her are requested to provide an amount of three Ghana cedis (less than a dollar) together with a presentation of half an egg and kenkey (“asikyiredokono” a local food made with corn and sugar). Once these are provided, the treatment commences. It is believed that failure to heed to instructions and the flouting of it upon consultation could imperil the mother and the child and lead to disastrous consequences.

Such instructions range from behavioural to dietary restrictions. One traditional birth attendant admitted to allowing her clients to combine the biomedical health service treatment with her herbs. The herbs are used by ingestion, enema, rubbing on the belly, massaging on the body, etc. A respondent confirmed that her traditional birth attendant’s predictions were as accurate as the treatment of the midwife at the hospital. The purpose of the medicine is usually for easy birth, strengthening the baby, and protecting the child

from malevolent spirits that could harm it. One of the respondents testified of their services:

*“There are very good herbalist and traditional birth attendants I know who offer herbal treatment to pregnant women. When one takes the medicine, it gives the mother strength. It also protects the child from diseases in the womb, make the child develop strong and healthy bones as well as make the child walk quickly when they are born. I know of my sister’s child who went for the herbs and the children are very strong, healthy and walk quickly. As a result, her cousin (pointing to a pregnant woman) is also being treated by the same traditional birth attendant. In fact, when I watch how agile these kids are, I sometimes wish I were young enough to give birth again. I would have gone to see the same old woman”* (Dansowaa, 2013).

Continuing, one of the most sought after herbal treatment is what most people refer to as “awomereaduro”. This popular treatment according to the traditional birth attendants and respondents is the use of herbs for pain management and easy childbirth during labour. They are prepared by traditional birth attendants and ingested by a pregnant woman when the labour sets in. Others go through the treatment from the first trimester until they deliver. The herbs could also be taken with or without soup, like rubbing it on the belly, brewed for daily consumption or through enema. The fear of pain by mothers and attempt to palliate the pain is consistent with the study of Fisher et al. A respondent related her encounter as follows:

*“I believe in the potency of herbs that are taken to allow for easy birth. When I was in labour and went to the hospital, there was a girl I met at the clinic who had been in labour for a long time. She asked permission from the nurses to go to the house. When she returned, she was able to deliver her child easily. She later confided in me that she went in for “awomereaduro” to speed up her delivery of the baby”* (Linda, 2013)

Most of the female respondents opined that, the use of such concoction and herbs is not only for the purpose of palliating the pain of labour and having easy birth but also to speed up labour process to avoid staying at the hospital facility for a long time when in labour. Staying at the facility will attract high charges or bills and the use of herbs at this stage is indispensable.

Usually, the treatment ends in the third month after delivery where you are allowed to go through the final ritual referred to as “asubo”. This final ritual occurs when the client consults the traditional birth attendant so that she is relieved of all restrictions. She thus sets one free from the rules so that one can live a normal life. When one fails to go through the final ritual, it could spell dire consequences when any of the taboos are broken. The items presented at this stage are not specified by the traditional birth attendant but they range from cash to pieces of cloth, perfume, etc. The services of traditional birth attendants in the rural areas come in handy in a situation where a pregnant woman cannot get to the facility on time. The 2013 report from the District Health Directorate indicated that most the traditional birth attendants had licence to operate and are given occasional training.



**Figure 3:** Prepared herbs/ medicine ready for distribution

### 7.2.3 Dietary practices during pregnancy

A good dietary practice by a pregnant woman is one of the important steps of ensuring that a woman fortifies the treasure she is carrying. Several foods were tabooed during pregnancy according to respondents. This corroborates Senah's (2003) report that dietary restrictions exist as one of the commonly tabooed practices in the Ghanaian community for pregnant women. Dietary restrictions could be permanent or temporary-after delivery of the baby. Some of the dietary restrictions are generally imposed by the community while some of them are personal to the individuals. The personal taboos often are observed upon the recommendation of the traditional birth attendant or the herbalist from whom herbs and assistance were sought. According to the respondents, some foods were commonly known to be considered as taboo or forbidden for consumption by a pregnant woman. These are ripe plantain, roasted plantain, okra, snails, and "kahuro" (meat from hide/ skin).

Ripe plantain was mentioned by all the respondents as food that was forbidden or not safe for consumption by a pregnant woman. When questioned for the reasons behind it been considered forbidden for pregnant women, respondents expressed that eating ripe plantain could lead to a condition referred to locally as "enkyempan". This condition, it was further explained, makes a pregnant woman experience false labour. Any pregnant woman who goes through this condition, it is supposed, is likely to push the baby out before its time is due. Also it is believed that it could also cause the womb to burst because of the incessant feeling of wanting to push.



**Figure 4:** Ripe Plantain

Furthermore, roasted plantain was also mentioned as one of the foods that a pregnant woman must avoid. It was believed to cause the baby to have chapped or dry skin after it has been delivered. Therefore, a woman who wishes to have a baby with a beautiful oily skin is advised to stay away from roasted plantain. One of the respondents related:

*“When I was pregnant, my mother told me not to ever eat roasted plantain. When I asked her why I should not eat it, she told me that it will cause my baby’s skin to appear dry. I therefore did not taste of that food until I delivered.”*(Ataa, 2013)



**Figure 5:** Roasted Plantain

Additionally, okra and snails were also considered as taboo and must not be consumed by a pregnant woman. According to respondents, when a woman who is pregnant uses okra and snails to prepare food, it will cause the child to drool when it is delivered. Drooling among toddlers could be a symptom of cerebral palsy (locally known as *gyemigyemii*) and women in fear of that avoid any food believed to cause a baby to drool.



**Figure 6:** Snails



**Figure 7:** Okra

Meat from hide (referred to as “kahuro” among indigenes) is often a delicacy among these people. However, pregnant women are restricted from eating them since it is believed that it could cause the navel of the baby to harden.



**Figure 8:** Hide (Kahuro)

Furthermore, some women mentioned that they were forbidden to eat pawpaw, kenkey and hot pepper, “asikyiredokono” (kenkey with sugar) as well as food prepared from flour. Oranges were also avoided because they are known to cause haemorrhage. These were not common/general dietary restrictions. Instead they were tabooed upon the instruction of the traditional birth attendants, priest or priestess.

*“Every herbalists or traditional birth attendant has her own rules. In my case, the traditional birth attendant I received treatment from (she had actually initially denied the use of herbs) advised me not to eat bread or any food that contains flour. You know, the flour foods can cause constipation which would lead to painful and difficult labour. Her instructions on avoiding the consumption of flour foods when followed will enable the pregnant woman to push easily when in labour” (Ama, 2013).*



**Figure 9:** Oranges

Continuing, it is worthy to note that some of the women practice eating down. Eating down is the practice whereby a pregnant woman refuses to consume much food usually with the excuse that the foetus will become big and will likely cause difficulty in labour. This belief is in sync with the study by Choudhry (1997) that eating down is

prevalent among pregnant women in India. Also, the reasons given for this practice was in line with Chatterjee (1991 as cited in Choudhry, 1997) and Senah's (2003) study that eating down will prevent difficulty in labour. In summary, dietary restrictions are practiced by people in the community with the belief that it will ensure a good outcome of pregnancy and delivery.

#### **7.2.4 Behavioural Restrictions during pregnancy**

Besides the fact that a pregnant woman is not allowed to eat some particular foods, some behaviours and activities which are likely to cause harm to the mother and the baby are also forbidden. For instance, a pregnant woman is advised not to fight. This is to avoid causing harm to the foetus in the course of the fight with someone. It is believed that some people out of jealousy would intentionally pick a fight with someone known to be pregnant and avoiding a rebuttal or any confrontation is advised.

Another behavioural restriction for a woman who is pregnant is to avoid donning red and black apparels. Among the Asante, red and black are known to be colours for mourning. Therefore, it is considered a bad omen for a pregnant woman to be found draped in such colours. A respondent recounted her version of how she was advised not to wear red and black colours when pregnant since it was a bad omen:

*“My mother visited us one evening and was petrified to see me preparing to go to bed in a red night gown. She advised me to go and remove the dress and further cautioned me about wearing mournful colours such as red and black. You know, in our community these colours are worn during funeral occasions and my wearing it when pregnant according to her is a bad omen. So I did not wear that attire or any other similar colour again until I delivered” (Ama, 2013).*

This behavioural restriction is similar to Brathwaite and Williams' (2004) documentation of the Chinese immigrants in Canada who do not allow pregnant women to wear black. Another restriction on the dressing is the fact that a pregnant woman must avoid wearing clothes that are tight on her body. In actual fact, this is to enable the mother and the child

to feel comfortable and not constricted. Also, it was mentioned that in the past, it was forbidden for a woman to buy clothes and items in preparation for the child lest you lose the child. This practice was understandable in the past in view of the fact that there were no scan machines to ascertain the sex of the child. Presently, such practices are discouraged and have faded out since women who attend ante-natal clinic are given list of items to be produce when visiting the hospital during delivery.

Furthermore, a pregnant woman who wants to have easy birth must not allow a child whose mother had difficulty in labour giving birth to, to walk or jump over the legs. Children whose mothers had difficult labour giving birth to them are noted to carry that omen and could transfer it to another pregnant woman and cause the pregnant woman to also go through a similar painful labour.

Conversely, a child who was born with ease could be invited to eat from the same dish with a pregnant woman with a similar motive that the luck of easy labour which that child carries will be transferred to the pregnant woman. A woman in a focus group discussion gave an account of her experience:

*“When I was pregnant with my fourth child, I knew of a neighbour’s child whose mother gave birth to her easily and so I used to invite her to eat with me. Unlike my third child, I suffered a lot when I gave birth to her and I used to avoid her so that she does not jump across my outstretched legs and cause me to go through the same experience I had when I was delivering her”* (Mansa, 2013 fgd).

When it comes to household chores, it is performed depending on her strength. She is advised to be active and up and doing so that she can give birth easily. In some instances, she is exempted from sweeping the compound and any other tasks that involves too much bending over. A woman in her final trimester is encouraged to pound fufu which it is believed would push the baby down and prevent breech birth. Most female respondents affirmed that it had worked for them in one or two of their labours. Also, she is advised in her ninth month to prepare herbal medicine with new leaves of cocoa and

use it as enema. This practice was said to give the baby a beautiful skin and remove any bad body odour on the skin of the baby after delivery.

### **7.2.5 Spirituality Surrounding Pregnancy and Childbirth**

With the belief that children are assets or social wealth that attract the attention of people who do not have such good fortune, it makes the unborn child and the mother vulnerable target of malevolent people who could bewitch them according to respondents. These spirits could harm the unborn child as well as the mother in diverse ways which manifest before or after it is born. Therefore, it is this fear of malevolent act of envious people and spirits that pregnant women in the community make every effort to avert and guard against. This is a belief equally shared by respondents in Chapman's (2006) study where pregnant women have anxieties about the safety of their unborn child in respect of the fact that envious neighbours or rivals can bewitch the baby and mother. Sarpong (1974) also opined that, pregnant women protect their children by observing particular taboos as well as using mystical medicines that are believed to ward off "spirits, witches, magicians and sorcerers and other evil powers from harming her or the child" (p. 85).

To begin with, a pregnant woman is advised not to eat outside. This taboo is believed to protect the unborn child from being infected with "asram" (a local disease that causes a baby to convulse and have diarrhoea). A child who gets this disease could be unhealthy for a long time and may result in its death if not properly treated. It is one of the most dreaded diseases by pregnant women and new mothers in the community. It is believed that some people in the community have bad medicine and spirit which is used to infect children with the "asram" even before it is born. Usually, these people have the antidote to the disease and so they deliberately pass it on to a child through

several medium though not direct but spiritual. When the baby is infected, such mothers will consult them for their healing services. In view of that, eating outside makes one an easy target for people with such bad spirit especially those who want to harm babies. In a situation where you cannot avoid buying food outside, it is advised to bring the food to the house to eat and not to put it in your palms and eat outside. Besides spiritually passing the disease through food, it is also believed that people who expose themselves are easy prey for spirits and malicious people. It is therefore advised that pregnant women do not expose their calf but to wear clothes that covers them well. One mother taking care of her newly born granddaughter recounted her advice to her child:

*“It is not the best to go out half naked when you are pregnant. I used to talk to and fight my daughter about this when she was pregnant. It is not good to expose your shoulders. I used to fight my daughter over wrapping cloth over her chest and exposing herself. If you want to cover yourself lightly you can do so indoors. These people can pass the disease to the child easily when they see your calf or your breast. I advised her not to stray to the area of a woman who is noted to spread the disease “asram”. I feared she could bewitch her and the child and infect the baby with the disease but since she was cautious and always covered up, she and the baby are healthy and safe. Such infected babies will always give you problems when they are born. The child will get sick all the time and you will have to spend money all the time on drugs” (Linda’s mother, 2013).*

Furthermore, a pregnant woman is also advised to be secretive about her pregnancy at the onset. This is thought to draw attention to the woman. This is affirmed by Sarpong (1974) who expressed that it is tabooed to boast or show early signs of pregnancy. If she is loquacious, it is believed that she can be the target of people with evil eyes. She can miscarry if she blabs about the pregnancy before she fortifies herself and the baby with a pastor a priest or herbalist. In an attempt to be discreet and secretive about the pregnancy, some women mentioned that they wore big dresses that will not make their bulging stomachs visible or conspicuous. These dresses usually referred to as “maternity” by the local people are used to conceal their pregnancy from the prying eyes of malicious spirits and envious people in the community who are believed to have the

power to bewitch a pregnant woman. It is also to prevent people from knowing how far along the pregnancy is. The ability to read the size of a pregnant woman's belly will make it easy for the spirits to determine the time of delivery to cause difficult labour or delayed delivery. A similar practice of secrecy was expressed by respondents according to Adams et al. (2005) where Tibetan women wear more clothes to conceal their pregnancy from envious neighbours and rivals to prevent them from knowing of their condition. Moreover, a pregnant woman must not be rude. It is believed that malicious people with evil spirit could tempt a pregnant woman just to get her to fall into their trap and harm the unborn child. One must therefore guard her speech in times like these.

*“When someone is pregnant it is a time to be careful and mindful of your speech. A spirit can test you and if you offend the person they can harm you. When you cast insinuations and speak rudely or evil of someone you can be pregnant for more than ten months. When someone tells you ‘you will give birth for us to see’ in an exchange, such people could cause you to suffer and have difficult and delayed labour for days or even be pregnant beyond the usual nine months. It is a common phenomenon so pregnant women are advised to be mindful, decent and respectful in their speech. There are spirits all over who are particularly envious of people who are pregnant because of the thing they carry” (Brefo, 2013).*

Another spiritual belief surrounding childbirth is the understanding that when one overtly expresses pain when in labour, she could be bewitched to experience prolong labour or the baby will be stillborn. In view of that, when women are in labour, they refuse to call attention to themselves by expressing signs of labour and pain. Others narrated that at the sign of labour they pack their things and notify the most trusted neighbour usually the mother or the husband who escorts her to the clinic. Others also mentioned that they sneak out and notify a neighbour to secretly follow up later with the items needed for the delivery at the clinic. Beside this, respondents mentioned that they do not hurry to the facility because some of the pains may just be the onset. Refusing to be stoic will only mean hurrying to the facility and staying there for a long time. Not only is it harrowing to stay at the clinic but prolong stay will attract high hospital charges. Nonetheless,

having to draw attention to oneself when in labour understandably could lead to losing the child according to one respondent:

*“When you are in labour you do not announce it and call attention to yourself. Remain strong and stoic. One of my children did that and when she delivered she lost the baby. I was going to farm that day when I asked her if she was alright and she responded in the affirmative. When I returned from farm I met a lot of people in my compound on account of my daughter screaming for help in labour. I hired a taxi and took her to the hospital. We suffered a lot yet she lost the baby. As for me I have given birth before and I do not call attention to myself when I am in labour neither do I rush to the health facility too early. In fact, if you do, you may spend three days or even weeks at the facility. I often wait for the mucus plug to come before I rush to the facility. I know my timing very well. After all when you rush to the hospital early you will only stay there for a long time and come home after paying high bills” (Linda’s mother, 2013).*

Clearly, stoicism at the onset of labour is very much encouraged as a measure against calling attention to oneself, avoiding malevolent spirits from causing harm to the baby as well as avoiding the payment of high hospital bills. In summary, pregnancy and childbirth are never devoid of spiritual connotations and beliefs considering the fact that childbirth and pregnancy are social wealth that attract the attention of benevolent and malevolent people alike.

### **7.3 Stillbirth/Maternal death**

The safe delivery of a child and a healthy mother has always been the drive behind the institution of taboos and when this is achieved, it is a season of joy. Childbirth is considered a battle that a woman has to fight and win. This is affirmed by Sarpong (1974) “...pregnancy and childbirth are regarded as warfare, not because the child is not wanted but because they are known to result in death” (p. 85). In view of that, a woman who gives birth safe and healthy is accorded respect. When a woman delivers safely in the community, they often express, “woawo afa ne ho afa ne ba” which means “she has delivered herself and her baby”. She is pelted with the usual traditional greeting - “afirimu” or “wotirinkwa”. “Afrimu” literally means “to come out of” (the battle).

Despite the many taboos observed in ensuring that the child and the mother are safe, there have been several incidence of the loss of the child, mother or sometimes both and special funeral rites are organised to mark the demise. Albeit Akans and that Asante are noted for their attachment to and love for the organisation of funerals as social events (de Witte, 2003), regardless of this belief which resonates in the social meanings attached to pregnancy, the death of a woman during deliver as well as the death of a baby is still not met with acceptance. It is still a taboo or bad omen. Asante's aversion for maternal death and stillbirth is clearly expressed in the manner in which the death of a woman or child at birth is treated or handled. A woman who dies during birth or stillbirth is treated with contempt.

Though some of the rituals where a woman is buried immediately and a child is buried in a pot have faded out but the death of a mother and a child is still considered a grave loss in the community.

*“The death of a child or a woman during childbirth is painful. It does not bring a good name to the family the woman comes from and the child as well. The child through whom the mother died gets a tag. People in the community point accusing fingers at such children as the cause of the death of their mother. The death of a baby is painful. However, the death of a mother is much more abhorred than that of a child. They often advise that, “Ahina no emboeε a wobetumi akɔ nsuo bio” (meaning that if the pot is not broken one can draw water again). People sometimes think that a child who dies at birth would have been troublesome in the future and therefore its loss must not be grieved. Tradition therefore demands that when the baby dies they prepare heavy food for you to eat and you are advised not to entertain the pain or the loss. Instead, to spite it so that it does not happen again” (Brefo, 2013).*

When questioned what such deaths are attributed to, informants enumerated several reasons for such deaths. People believe that children are social wealth and a mother who attracts the envy of rivals or enemies could be bewitched and killed. Also, it is believed that a woman who goes in for someone else's husband may be cursed not to give birth but to experience recurring child death or killed during labour to teach her a

lesson by the aggrieved rival. Yet, others also purported that women who often lose their children at birth may be having what they locally referred to as “*nsuhyew*”- a hot fluid that cooks the baby in the womb of the woman. Such women are therefore advised to see a herbalist for help. This notion was also expressed by Fischer (2002) in her study of childbirth in Komenda Ghana. Children born to women with history of still birth are considered to be spirits who enjoy torturing their parents by reincarnating, a belief consistent with Boaduo (2011) and Ogunjuyigbe’s (2004) study of Ghana and Nigeria respectively. Presently, they may not be mutilated, but avoidance of such occurrences of recurrent stillbirth are what drive women to consult traditional birth attendants and spiritualist.

In summary, the spiritual beliefs surrounding the death of a mother or a child during labour clearly attest to the fact that for centuries Asante abhorred maternal death and stillbirth and much of these beliefs and practices remain in order to secure the lives and health of a pregnant woman and the child.

#### **7.4.1 Beliefs and Practices Associated with Postpartum Period**

Postpartum period is also an important stage where care must be taken to ensure that the new mother and the child are tended and kept alive and healthy. In that respect, some beliefs and practices are known to be held to ensure that the baby and the new mother (*obaatan*) are kept out of danger. These include dietary practices, spiritual beliefs and behavioural practices.

#### **7.4.2 Dietary Practices during the postpartum period**

Ensuring that a mother eats a balanced meal and nursed to regain strength after labour is of prime importance during the postpartum period. Among the Asante,

informants noted that a mother needs to be well nourished in order to be able to feed the baby. The mother's diet in the first few months is given much attention. She is fed at least three square meals day. Traditional diets that are believed to aid mother in expressing breast milk are encouraged. Rice is believed to dry the milk of the mother and is therefore not encouraged as a regular meal for a new mother. Fruits such as mango and pineapple are also discouraged since it is believed, when consumed by the mother, can cause the baby to suffer diarrhoea.



**Figure 10:** Pineapples and Mangoes

The usual heavy meal that is served a mother is fufu(pounded cassava mixed with plantain or cocoyam) and palm nut soup. The soup is prepared with local herbs known to heal the wounds in the womb of the woman. Some of the herbs include “nnwaduaba” and “kwaatema” which when prepared as palm nut soup are known to help the mother produce a lot of milk for the baby. Additionally, mashed kenkey and groundnut, mashed plantain or mashed cocoyam with groundnuts is also encouraged to aid the mother in producing more milk for the baby. A baby is fed exclusively on breast milk until it is six

months old before solid food is introduced. The practice of sleeping in the same room and bed with the baby is encouraged to allow easy breastfeeding and bonding.

The food given to the baby includes corn dough made into porridge mixed with dry herrings, fresh eggs or honey. In some cases, “whintea” (a local spice), ginger and a little bit of pepper puree is put in the porridge. Though solid food is given to the baby, breast feeding continues until the second or fourth year of the birth of the child. This practice is corroborated by Tagoe-Darko and Gyasi (2013), Chapman (2006) and Adams et al.’s (2005) studies where breast feeding is encouraged.



**Figure 11:** Palm nut fruit

#### **7.4.3 Behavioural Practices**

Some behavioural practices which also mark the postpartum period are geared toward the safety and health of the mother. Also, they are done as a matter of tradition. For instance, a woman who delivers is expected to don white apparel and have white as the dominant colour that is used for at least forty days. . In the Ghanaian community, white is a sign of victory, triumph, joy, purity (Sarpong, 1974). Considering that childbirth is still believed to be warfare (Sarpong, 1974), to come out unscathed after

delivery is a sign of victory which calls for its celebration. It is therefore only appropriate that a woman who went to fight a battle as it is so believed and has delivered safely with a healthy baby expresses her triumph symbolically by donning a colour that signifies victory. Before a mother and a new baby arrive, a separate room is prepared and swept clean in anticipation for the new member of the family. The clothes of the mother and child are washed every morning separate from the rest of the family to avoid contamination. This practice is in line with the practice of protecting the mother and the baby from contamination among the respondents of Mottish Ring and Roche (2011) and Kartchner and Callister (2003).

Among the Asante, tradition demands that a woman who gives birth is pampered and taken care of by a female relative and the people around her. She is nursed to health by an elderly woman who baths the baby every morning and evening. The role of old women in the family in seeing to the health and wellbeing of a pregnant woman is laudable and worth mentioning. The first point of call for instructions and guidance for a woman who is pregnant until delivery is the old woman in the house or the mother. Thus, they usually quote “abrewa ewo efie a eye”, meaning, the presence of an old woman at home is indispensable. She advises the new mother on what to do and what not to do. They believe their years in experience in childbirth are a rich source of wisdom they can glean from. The role of these old women is key from the beginning of the pregnancy till the child is born and tended. This role played by women is highlighted by Moyer et al. (2012) and Tagoe-Darko and Gyasi (2013) in their study of delivery practices in some communities in Ghana as well as Kartchner and Callister (2003) and Hoang et al. (2009). The relative is often a grandmother or the biological mother of the woman and the role of these women during childbirth is essential. In the absence of all these people, the mother-

in-law of the woman or any elderly female in the family could also assume this arduous and important task.

Services provided by the visiting relative include teaching the new mother how to take care of the baby and herself, washing of clothes, bathing the baby, cleaning and cooking, etc. This is to allow for the woman to rest and regain strength to take over in due time. This service lasts a period of forty days or three months, after which it is assumed the woman would be able to resume the task of taking care of herself and the baby without much difficulty. A respondent related this:

*“Since I had never given birth before, when I got pregnant I used to ask my mother which side of the bed and side of my body I must sleep and she advised me on the posture I must assume. For instance, she used to tell me not to lie face down when I am sleeping instead, I must lie on my side. Presently, she is the one taking care of me and my baby” (Linda, 2013).*

The mother also added;

*“If you are a mother or an old woman at home and you notice and are informed of a child’s pregnancy, you have to talk to her and teach her to keep herself well. Additionally, you can send her to see a herbalist for herbs. Actually, there are people with bad omen and bad medicine on them who can harm a pregnant woman and her child. It therefore behoves on the mother to go out there and get herbs to give to the pregnant mother so that nothing happens to her and the baby when she delivers. This sort of protection must continue after delivery until they are both safe from any danger whatsoever. In addition, you must help take care of the baby until she is able to take over and has learnt to take care of the child” (Linda’s mother, 2013).*



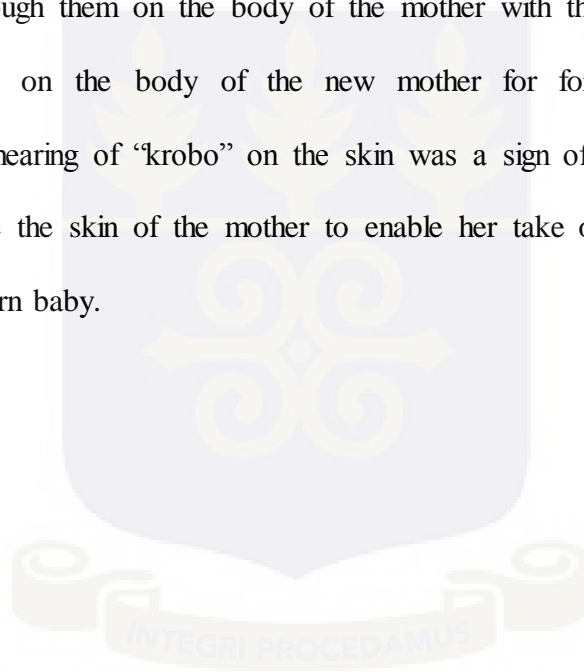
**Figure 12:** An elderly woman carrying a baby

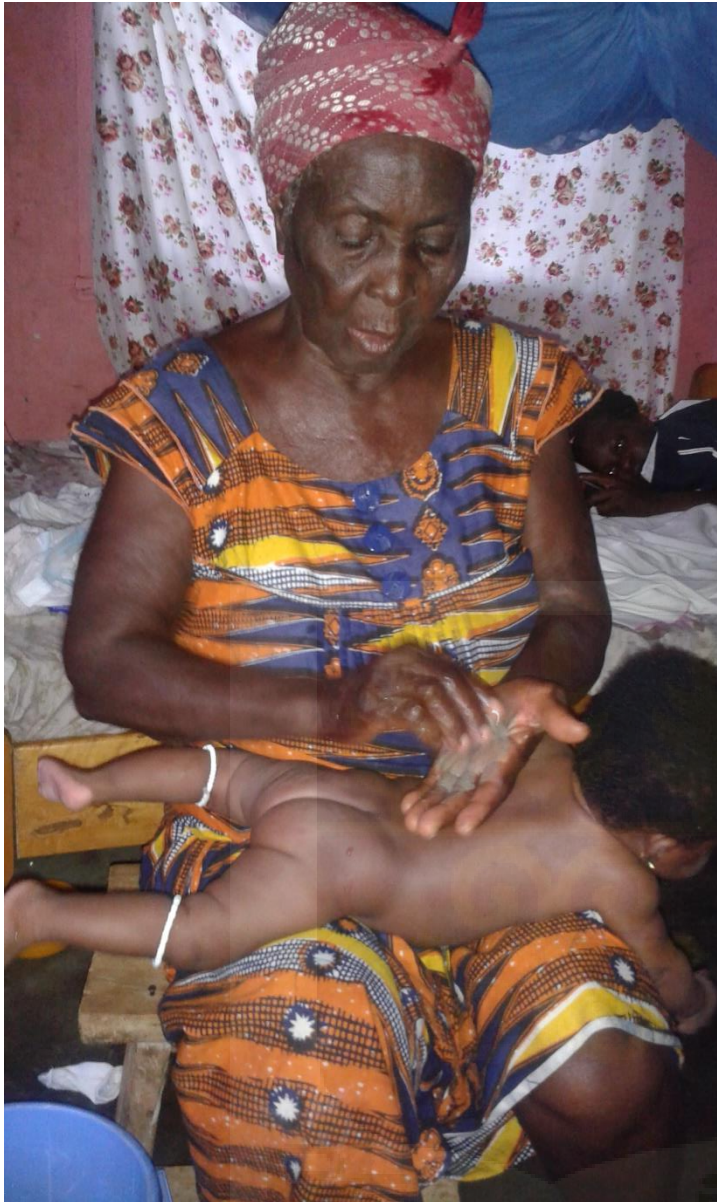
In addition, the usual use of the plural “we” to refer to a new mother and the person taking care of her in statements instead of “she” to refer to the new mother alone means the one taking care of the child and the new mother are together responsible for the child’s survival. Since a child is believed to be a gift to the community, the birth of it is the responsibility of all and calls for the support of the community. The belief that a child is not only the responsibility of the parents but the family is corroborated by Nukunya (1992). Unlike the West where there is baby shower prior to the birth of the child, in these communities the woman is bathed with gifts and support that comes in the form of fetching water, firewood, food, clothing, etc. only after the woman has delivered.

Furthermore, a new mother is made to take a hot shower twice everyday-one in the morning and the other in the evening. This is unlike yin-yang principle of the Chinese where a woman does not bath in the first week of birth as expressed by

Brathwaite and Williams (2004), Hoang et al. (2009) and Kartchner and Callister (2003). Among the Asante, taking a bath with hot water, it is believed, would not allow for the breast milk to dry up. Also, it relaxes the nerves and gives the mother energy to take care of the baby. Additionally, she is encouraged to sit on hot water as a way of healing her wounds after delivery.

According to informants, camphor, salt and gravel are put in a bucket or basin for a woman to sit on. In the past, the body of the woman is smeared in “krobo”; clay mixed with spices such as “whintea”, “pɛpɛ”, “nketenkete” which have square and spiral patterns drawn through them on the body of the mother with the use of a broom stick. This was smeared on the body of the new mother for forty days. According to respondents, the smearing of “krobo” on the skin was a sign of victory. The substances and spices massage the skin of the mother to enable her take over the arduous task of caring for a new born baby.





**Figure 13:** An old lady attending to a baby

Also, a woman who gives birth but cannot afford corset is made to tie her belly with a piece of cloth to help speed up the shrinking of the belly after delivery.

Moreover, a mother is advised not to stay outside shelter or room with or without the baby till dusk. Instead, she is to retire to her room or will risk contracting a disease known locally as “bosubosu”. “Bosubosu” is believed to affect a mother who stays out late. When a mother stays out late and dew falls on them, the child would suffer diarrhoea. Also, abstinence from early sexual relations is encouraged.



**Figure 14:** A young mother bathing a baby

Infant care is an equally important aspect of the postpartum period and added task for the female taking care of the mother. A baby is bathed with leaves and hot water at least twice a day. This is done to strengthen the baby. It is cautioned that the head of the baby is not bathed on the day it was born. The baby is thrown three times into the air and caught after bathing. This is to make it fearless. Afterwards, the baby is smeared and massaged with clay and shea butter. The clay is mixed with the faeces of grasscutter which is believed to make the baby grow fat or big quickly and to have strong bones to start walking quickly.

A line is drawn from the forehead to the end of the nose with a broomstick and clay to make the baby develop a beautiful, straight and pointed nose. In addition, dots of clay are made on the side of the ears to raise them up. It is believed that the sides of the ears were dented when the baby was pulled out by the traditional birth attendant or midwife during delivery. This smearing of the body with clay is done for a period of forty days. The treatment of a child and the mother with hot water and clay is corroborated by the study conducted by Tagoe-Darko and Gyasi (2013).

Continuing, the baby is adorned with beads on the arms and legs/ankles and waist which are used to monitor its weight and growth. It is worthy to note that only the female child is given waist beads when born. The colours of the beads are also symbolic. The white beads which are used in the first three months are indicative of victory. Subsequently, gold or yellow beads are put on the baby's arms and legs so that the baby will be wealthy in the future.

Male children are circumcised and named on the eighth day of birth. The umbilical cord is also treated with hot water and usually with concoctions prepared by the traditional birth attendant or by the family. In order to get the cord to fall off early, several concoctions are used including toothpaste, palm kernel oil and chalk, salt mixed with chalk, "ekau" and spittle. Once the cord comes off, the stump is continuously treated with hot water and the concoction until the wound heals. One of the respondents admitted thus:

*"To get the umbilical cord to fall off early, hot water, chalk and salt were used to treat it. At the hospital I was given methylated spirit to put on it every time but I believe it is painful since the baby cried whenever it was applied on its hanging umbilical cord. So I went in for chalk mixed with salt. The salt and the chalk are not painful yet potent and more effective than the methylated spirit"* (Linda, 2013).

This form of cord treatment is corroborated by a study of Hill et al. (2008) of the Brongs of Ghana where hot water and shea butter are used in the treatment of cord stump. Several of such practices of the treatment of cord with substances were documented by Moyer et al. (2012), Mullany et al. (2007) and Alam et al. (2008).

The cord that falls off is buried under a cocoyam or a plantain sucker. Since childbirth is compared to a thriving plantain and its suckers, it is tended to grow and harvested for the child to eat. It is assumed that the severed cord when planted under a plantain sucker teaches the child and it is a sign of good wish for it to also grow up and procreate.



**Figure 15:** A baby dressed in beads

Thus, the essence of procreation to society is symbolically taught the young child. In addition, it is believed that when it is buried, it is symbolic of planting the individual's soul in the locality-a sign that one is a child of that soil and should always return home. Finally, the mother is advised to occasionally change the child's sleeping position on the bed which will help shape the head of the baby.

#### 7.4.4 Spirituality Surrounding Postpartum period

There are spiritual beliefs that influence and dictate the care given to the mother and child during the postpartum period. It is believed that a mother and baby are targets of malevolent spirits since they are vulnerable. In view of that, certain measures are put in place to ward off any malicious spirit that may try to harm the baby and the mother.

To begin with, the door post of the new mother is adorned with bunch of leaves of a plant belonging to the Kalanchoe group (air plant) - bryophyllum. The bryophyllum leaf referred to as “Tanmeawu” in the local parlance is believed to ward off malevolent spirits that may visit the new mother and the child. As the name of the plant connotes “wo tan me a wobewu” it means literally that “if you hate me you will die”. According to folks, the plant has the potency to make the powers of a witch or a wizard less effective when going through the doorway to the room of a new mother. This is believed to also fight the dreaded “asram” disease that affects babies. Besides, the nature of these air plants to reproduce themselves without necessarily rooting them in soil it is believed, will bring blessings and reproduction to the woman –a sign of goodwill for further reproduction.

Another practice put in place to protect the baby is when the baby and the mother are made to sleep together with the mother sleeping at the edge of the bed and the baby close to the wall. It is believed that the mother’s spirit is stronger than the child and any spirit wanting to attack the child would have to go through the mother first.



**Figure 16:** A door with bryophyllum leaves at the top right corner

Furthermore, parts of a chameleon and bryophyllum leaves are put in a cloth and tied to the arm of the baby to protect it from spirits that might want to harm it. It is believed that when an evil spirit or person tries to harm the baby, just like the chameleon which is able to change its skin and blend in with the environment, the baby will transform its nature which will make it difficult for the spirit to make the baby out. Thus, the chameleon parts together with the bryophyllum leaves ward off evil spirits from the baby. It is also advised that a baby must not be given to strangers at night and whenever it has to be taken from someone, the mother must whisper to it; “do not go to strangers”. It is believed that spirits transformed in human form come as strangers and

lurk around homes where there are children and whispering to the child not to go to strangers protects it from been harmed by one. Some mothers expressed that they are also given herbs tied into a cloth with chilli pepper by their herbalists which when kept in the room will drive away the spirits of people with evil intentions when they visit the new mother and child.



**Figure 17:** A baby wearing amulet on the left arm

To put the study within the context of the theoretical framework, the health belief model functions as an ideal theory to explain the health behaviour of folks in dealing with maternal and neonatal health in the community. This is because it is obvious that the treatment and handling of pregnancy, childbirth and postpartum period are determined by the cultural beliefs and practices of the people. Though there are biomedical systems of addressing the health issues during these periods but findings of the study attest to the fact that the culture of the indigenes serves as the lens and dictates the health seeking behaviour of the respondents. Obviously, though there is a known primacy of the biomedical services over the traditional but a thriving combination of both methods is enabled because these practices have coercive powers, transcends the biological individual and are integrated in the community to persist overtime.

### **7.5 Janus-faced beliefs and practices**

Seeking a good outcome during pregnancy and childbirth is often the prime motive of most communities and folks have resorted to traditional beliefs and practices. Though the biomedical model has come to stay, some traditional practices remain and are pursued by indigenes in some of the localities. These practices are sanctioned by the community as helpful for the health and safety of a woman and a baby from conception through pregnancy and parturition. However, a critical look at these practices and beliefs reveal facts that leave much to be desired in that they are janus-faced. Much as folks want to believe that some of the practices enhance maternal health, they could also be inimical to the health of a woman and child.

To begin with, the social meanings attached to childbirth and the social sanctions that are meted out to childless individuals in these communities, especially when women are blamed for childlessness, has psychological effect on victims in such communities.

Despite the safe avenues for treating childlessness, findings of the study revealed that, people are compelled to resort to herbalists, priest, etc. whose services are cheaper and easily accessible to truncate the societal pressure. Unfortunately, the preparation of the herbs which obviously are not brewed under hygienic conditions could pose health risks when consumed. This concern was raised during an interview with an Obstetric and Gynaecologist;

*“As a specialist, I condemn the use of such traditional herbs from herbalists. It is not advisable for a woman or pregnant woman to combine both traditional herbs and medicine given to them at the hospital. This is because no research has been conducted to ascertain the constituent chemical elements or components of the herbs that are doled out to clients by traditional birth attendants/herbalists. One cannot determine the far reaching health impact on the foetus or the woman when herbs are used” (Obstetric and Gynaecologist, 2015).*

Moreover, since the dosages are based on their discretion, as to what quantities they prescribe are safer for consumption is another contentious issue. Also, for people who have allergies to any unknown chemical components in the herbs, the use of it could trigger fatal reactions and lead to haemorrhage noted to be one of the leading causes of death in the Ashanti Region. In the case of pregnant women, the use of herbs for easy birth in light of the above mentioned conditions could lead to rupture of the womb or precipitous labour which can also lead to haemorrhage. In addition, the concoctions could pose inimical threat on the life of the baby since it could cause early expulsion of foetus and premature birth as well as foetal distress. In view of this, the use of herbs for pain management was discouraged by one of the midwives in an interview:

*“I do have knowledge that some of the women use herbs for several reasons such as easing labour. Actually, if there truly were any herbs that were potent enough to take care of labour pains and ease labour, it would really make our workload lighter and easier for us. It must be noted that people have different experiences when it comes to labour and for me, I do not encourage the use of herbs which are offered by traditional birth attendants and herbalist. People who have history of the use of herbs usually have precipitous labour and haemorrhage” (Midwife, 2015).*

Continuing, though overeating during pregnancy could lead to foeto-pelvic disproportion (Senah, 2003) however, the dietary restrictions put on the consumption of foods like snails, pineapples, oranges mangoes, etc. during and after parturition could equally be fatal since it deprives the mother from minerals and vitamins such as protein, vitamin C, vitamin A, etc. that are needed for the nourishment, fortification and growth and health of the mother and the foetus. These could pose health risks such as anaemia. Also, culture of pain/stoicism and the secrecy surrounding labour where a mother is advised to be stoic and endure pain without attracting attention could cost the life of the mother and the child. When a woman delays reporting to the facility, it could aggravate any health risk that may occur unexpectedly. Though the practice of sitting on water could help heal vaginal tears that occur during labour, the addition of gravel to the water as a mechanism to speed up the healing process introduces infections to the wounds of the woman. Furthermore, the application of concoctions on the umbilical cord to enhance the rate at which the cord will fall off beside the use of methylated spirit which fights infections is a bad cord management practice that can result in cord sepsis. Finally, the smearing of the vulnerable skin of the baby with faeces of grasscutter could cause skin infections.

Contrary to the enumerated health risks associated with traditional beliefs and practices in the community, there are inherent advantages that ensure the health of the mother and the baby. Therefore, despite the existence of traditional beliefs and practices that are inimical to the health and life of a woman and the child, there are others which contribute to their health and stability. To begin with, the traditional practice of expressing contempt and tabooing the death of a pregnant woman as well as the death of a baby encourages proper care of a woman during pregnancy. Considering the respect for childbirth coupled with the fear also that a family will be tagged with recurrent child or maternal death, conscious efforts are made to avert and reduce maternal and neonatal

morbidity and death. It is a responsibility of the society that a baby survives. Thus, it is a culture that is receptive to maternal and child health. It is a tradition that emphasises the health of a woman from conception through pregnancy to parturition and beyond. In addition, despite the emphasis on female child preference, the male child is never neglected but protected and cared for unlike other cultures where the neonate may be killed for example female infanticide as reported by Kartchner and Callister (2003). These beliefs and aversion for maternal and neonatal death are moves to reduce their occurrence. Hence, pregnant women, family and all other stakeholders and the society at large are compelled by tradition to ensure safe delivery of the baby and seek the health of the mother and facilitate a good outcome of pregnancy.

Furthermore, the behavioural injunction on a woman to avoid altercation with people as well as avoid fist fight in public protects the woman from injuring herself and the baby. Also, the practice of discouraging the pregnant woman from eating outside for fear of spiritual forces is to save the mother from eating contaminated food. Additionally, it encourages her to be wary of her diet and to prepare her own food for the proper growth of the foetus. Besides, soap and water may not be readily available outside for one to wash the hands before eating and exposure to dust outside warrants the washing of hands before eating. This belief therefore keeps pregnant women in check.

In addition, though kenkey and hot pepper, roasted plantain, etc. are foods consumed in these communities, the cravings for such foods by a pregnant woman may not be healthy since they only contain carbohydrate or iron and cannot substitute a balanced meal needed by a pregnant woman for foetal growth and development. “Bosubosu”, a behavioural restriction on a new mother from staying out late protects mother and child from the dreaded tropical disease malaria whose etiology is the exposure to mosquitoes. This is because mosquitoes are rampant during the late and

early hours of the day in the tropics. Besides, temperatures drop at dusk and the weather could be too chilly. Considering the vulnerability of babies and new mothers to harsh conditions like mosquitoes and the cold night air, such beliefs discourage the mother from staying out late so that she retires to the safety of the shed or room to avoid exposure to these insects and the late night cold. Therefore, the risk of the mother and child contracting malaria is mitigated. In addition, the practice of discouraging childlessness through social sanctions is a social barometer against unscrupulous abortion and maternal or neonatal death resulting from such activities.

Continuing, the obligatory support offered by the extended family and other females in the community is a form of social capital. A succinct definition of social capital could be the benefits people derive from a group for being part of that social network or circle. Social capital in this case is a rare resource or asset that an individual falls on in such circumstances for belonging to the extended family. As a result of the obligatory role and unspoken rule of having to provide and care for every woman who gives birth in the family, a new mother is always assured of help from the family in the extended kin group at such crucial times. Therefore, people draw on the social relationships in the community and survive by dint of the support offered by benign family and females in the community. For instance, both the tangible and intangible support that comes in the form of gifts, counsel, babysitting, cooking, washing, janitorial services, etc. exist as indispensable social resource or asset for women inherent in the extended family among the indigenes. Notably, this form of social support acts as a safety net to say the least, for poor women in the family during such vulnerable times. Last but not least, the physical and emotional support one gleans from this social support could also be a panacea to postnatal depression.

## CHAPTER EIGHT

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### 8.1 Introduction

Maternal morbidity and mortality have over the years existed as militating factors to national development. Though maternal morbidity and mortality exist as a global menace, a much gloomier picture of the situation is presented by the sub-Saharan region where maternal morbidity and mortality persist. Over the years, several policies and frameworks like the Safe Motherhood project and the Millennium Development Goal 5 (Waage et al., 2010; Wilmoth et al., 2012) have been drafted and implemented all in an attempt to combat the menace. Sadly, despite the attempt by international bodies, governments and agencies, for decades the hurdles remain.

Admittedly, attaining maternal health involves recognising the contributions of other elements such as cultural factors. Pregnancy is a universal phenomenon but with the differences in its handling in communities with diverse beliefs and practices it requires a corresponding approach in viewing the challenges that pertain to maternal health. In view of this, the need to make a grassroots attempt at understanding the problem by probing the traditional beliefs and practices and their role in militating or enhancing maternal morbidity and mortality cannot be overemphasised.

This chapter presents a summary of the study with regards to the objectives, methodology, major findings and conclusion based on the findings. Several recommendations have also been made based on the findings. The study examined the traditional beliefs and cultural practices and maternal health in the Sekyere South District of Ghana. The specific objectives of the study were;

- To examine the social meanings attached to the phenomenon of pregnancy and childbirth in the socio-cultural setting of the respondents.
- To explore the beliefs and practices associated with pregnancy and childbirth.
- To explore the beliefs and practices associated with postpartum period.
- To interrogate the practices which promote/enhance maternal health in the society.

## **8.2 Methodology**

The study made use of a qualitative design or approach which allowed for exploration of the research topic for deeper meaning and understanding of the problem. The techniques employed in this respect included in-depth interview, key informants interview, focus group discussion with the use of interview guide for data collection. A total of thirty-five respondents were interviewed. The qualitative data was manually analysed and was also content analysed. Also, the research was guided by the Health Belief Model and Durkheim's social facts. The modifying factor of culture as a health belief model was used to interpret or explain and predict the health behaviour by considering a set of beliefs or perceptions that determined and dictated response to maternal health issues. In this case, culture featured prominently as the drive for health-seeking behaviour. In addition, Durkheim's social facts explained the reasons for the persistence of values or social meanings pertaining to pregnancy and childbirth.

## **8.3 Major Findings**

The study revealed that pregnancy and childbirth as biological occurrence were not independent of varying cultural beliefs and values among the people. Among such values is the belief that fear of extinction of the group leads to emphasis on childbirth. In line

with this, the female child who the matrilineal descent rule places the responsibility of procreating for the family is the preferred sex. In addition, having a child is a definition of womanhood and maturity as an individual in the society. Also, in a society where there are no social welfare systems and home for the aged, childbirth exist as the avenue to escape the uncertainties of the economies of these communities. Besides, prolific procreation was very much encouraged considering that large numbers is an honour and prestige.

However, the adherence to these cultural beliefs and values in the community make women vulnerable in their drive to fulfil these societal obligations. This is because the fear of been branded a witch, dissolution of marriage or accusations of loose life in the past as societal sanctions make most women seek remedies that put them in vulnerable position. These may not be limited to but include consulting untrained traditional birth attendants, drinking herbs that are believed to facilitate conception, etc. Thus, it compels women to resort to dangerous approaches in an effort to fulfil the social requirement of procreating.

Moreover, the study revealed that there are dietary and behavioural restrictions that are practised in the community during pregnancy and childbirth. Foods such as ripe plantain, okra and snails were considered unsafe for consumption by pregnant women. Certain behavioural practices such as covering up of the body, concealing the pregnancy with clothes were advised to protect the pregnant woman from harm. In addition, a pregnant woman was advised not to eat outside to prevent being infected with a local disease “asram”. Other practices such as eating with a child whose mothers had easy birth to allow a pregnant woman have a similar birth was encouraged. Also, the practice of enduring pain and being stoic by concealing pain before going to the facility is advised to avoid attracting the prying eyes of evil spirits that might want to harm the

baby. Stoicism was also a check against hurrying to the facility and staying at the facility for a long time. The use of herbs (*awomereaduro*) to palliate labour pains and allow for easy birth has always been one of the major reasons for the use of the services of traditional birth attendants in the community.

Continuing, the study revealed that there are several practices that are instituted to ensure the health of a mother and the survival of the neonate. For instance, the mother and the child are taken care of by an elderly female from the extended family. It could be the mother, grandmother, mother-in-law, etc. The postnatal care spans a period of one month within which several activities are put in place to see to it that they are both properly cared for. The janitorial service, cooking, bathing of the baby, etc. are taken care of by the adult female. Among the array of practices are massaging of the mother and the baby with warm water, treatment of the cord of the baby with substances such as chalk and salt, spittle, etc. The baby is fed exclusively on breast milk until the sixth month where food can be introduced. In view of that, the mother is encouraged to take nutritious foods that will enable her produce milk for the child. Foods such as palm nut soup and fufu are encouraged. Fruits such as pineapple, mango were tabooed. Other behavioural practices such as staying out late were discouraged to protect the mother and child from tropical diseases such as mosquitoes. Kalanchoe plant is also placed on the door to scare away people with bad spirit.

Finally, the study revealed that traditional beliefs and practices exist in the community as a way of ensuring a good outcome of pregnancy, safety and survival of the mother and child after delivery. These practices have existed beyond time and have been passed on from generations. Indeed, some of the practices pose threat to the health of the mother and the child. The dietary restrictions deprive the mother of minerals and nutrients needed for the growth and development of the foetus. Besides, stoicism

entertained by some women before visiting the health facility can lead to complications or death due to delay to the facility. Also, the use of herbs to facilitate birth and reduce pain in labour can lead to the rupture of the uterus, haemorrhage, and other health complications that plaque the region.

Conversely, several practices held by the indigenes serve to protect the mother and the child and ensure excellent care and good health. To begin with, the social meanings attached to pregnancy allow for the encouragement of proper care of pregnant women in the community from conception through to postpartum period. For instance, since fostering is not upheld, proper care is taken to ensure a good outcome of pregnancy and childbirth. Also, cultural practices and beliefs that were held in contempt for maternal and neonatal death were a major feat in the battle for the lives of women in the community. Besides, the other social meanings attached to pregnancy make childbirth and care a priority for the community.

In addition, the care of the mother in the postpartum period, as a social capital, is inherent in the extended family system and women draw on it to ensure the survival and health of the mother and the child. Unlike other communities where nannies are hired and other benefits exit, in this case the extended family exists to provide such help. The material and immaterial support made available by the family and other females in the community provide emotional and physical support for the mother which goes a long way to prevent postnatal depression.

#### **8.4 Conclusion**

Based on the findings, it is realised that despite the primacy of the biomedical model, traditional beliefs and practices form an integral part of the health seeking behaviour of indigenes in the community. In view of that, the beliefs and practices serve

as the lens through which most health challenges are addressed. The findings of the study revealed that the beliefs and practices held by people during pregnancy and childbirth as well as postpartum periods are janus-faced in that they were enabling and constraining at the same time. For instance, dietary practices such as eating down could save a mother from foeto-pelvic disproportion. However, it could also lead to deprivation of the mother of balanced meals and vitamins for foetal growth and development.

In addition, the benefits that a mother gains from tapping into the social relationship of the extended family to cater for the new mother and the baby cannot be overemphasised. In all, traditional practices could serve to harm a pregnant woman in the society while on the other hand they may provide avenues for enhancing the survival and health of the woman and a child.

### **8.5 Recommendations**

Based on the findings, the following recommendations have been made.

- It is obvious that despite the advocacy for the adoption of healthy cord management practice and good nutritional practices, folks still employ unsafe measures in cord treatment as well as fail to appreciate the benefit of good dietary practices during pregnancy and postpartum period. Therefore, the education against improper management of cord, harmful behavioural and dietary practices that have deleterious impact on the health of the mother must be intensified during the antenatal visits.
- Women must be encouraged by health personnel to continue patronising the services of the biomedical system of health such as visiting the antenatal clinic during pregnancy and delivery. In line with that, the rapport built by the traditional birth attendants with their clients must be harnessed into the modern

delivery system beside a healthy reconciliation of the biomedical health care and the traditional form of health care.

- Stoicism, a behavioural practice encouraged among the indigenes is not in sync with the biomedical health care policy towards maternal health. This is because delay to the health facility and the failure to reveal signs of discomfort and pain at the onset of labour could aggravate any health risk unknown to the woman. The health insurance benefits that motivate pregnant women to visit the hospital if strengthened would discourage women who are scared away by the cost of health care by remaining stoic with the aim of offsetting the high cost of staying at the facility. In addition, the use of herbs from traditional birth attendants to palliate labour pains and truncate prolong hours of labour and delayed delivery at the facility will equally be mitigated.
- It is also recommended that cultural competence is emphasized among health workers to ensure that patients are comfortable at the facility and to also motivate them to confide in health workers. Whenever health professionals are informed about the cultural context in which they operate, their approach to clients will be guided by the need to address the cultural beliefs with tact and professionalism.
- Considering the indispensable help offered by traditional birth attendants, their training should be intensified with emphasis on hygienic practices during delivery. Their capacity to operate must be enhanced and in support, the District Health Directorate must encourage the use of gloves, antiseptics, etc. that allow for safe practice. Also strict licensing policies must be established to foster easy regulation of their activities.

In summary, meeting the health need of women during pregnancy and child birth is an “ethical duty” of every society (Sherrat, 2000, p.235). With Ghana’s constitution

enshrined with a clause that defines the right to life as an inalienable right, government, individuals, and citizens are enjoined to preserve the lives of women in the country because the death of a woman goes beyond the loss of an individual-it means the loss of primary care givers of children and productive force of the economy.





**Figure 18:** Delivery bed at the labour ward/Theatre

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**Appendix: Interview Guide**

This Questionnaire is intended to collect data for research on **Cultural practices and beliefs on Maternal Health in the Sekyere South District of Ghana**. The data will be used for academic purposes only. Anonymity will be ensured and confidentiality will be kept.

**SECTION A: SOCIO-DEMOGRAPHICS**

1. Sex

(i) Male  (ii) Female

2. Age

(i) 18-39  (ii) 40-59  60 and above

3. What is your marital status?

(i) Single (ii) Married (iii) Widowed

4. What is your major occupation?

5. Which religious group do you belong to?

(i) Christianity (ii) Islam (iii) Traditional (iv) None (v) Other.....

6. What is your level of education?

(i) Primary (ii) Junior High School (iii) Senior High School (iv) Tertiary (v) Vocational

Training

7. Which ethnic group do you belong to? .....

**SECTION B: INTERVIEW GUIDE FOR RESPONDENTS**

1. How is motherhood status considered in the society? Why?
2. Is childbirth upheld in this community?
3. What is the preferred sex of a child in this community?
4. What do women do traditionally to stay healthy when pregnant?
5. What preparations are made during pregnancy to ensure the well-being of the mother and baby? Why?
6. What kinds of beliefs and practices regarding pregnancy and childbirth are you familiar with?
7. Are there any foods that are appropriate or inappropriate for you according to your religion or custom during pregnancy? Why?
8. What are the beliefs and restrictions concerning drugs/medication during pregnancy in the community?
9. What behavioural changes or restrictions do women need to follow during pregnancy? Why?
10. Where do most women deliver their babies? Why?
11. Are there any foods that are appropriate or inappropriate for you according to your religion or customs during postpartum period?
12. What other activities does a woman involve in to stay healthy after delivery?
13. Does the family or community help in practical ways when one delivers?
14. Could you tell me your opinion on whether these practices regarding pregnancy and childbirth should be sustained? Why?

**SECTION C: INTERVIEW GUIDE-TRADITIONAL BIRTH ATTENDANT (TBA)/ HERBALIST**

1. How long have you been a traditional birth attendant in this village?
2. Could you tell me how you became a traditional birth attendant? From whom do you get these skills and since when?
3. How many years of experience do you have as a Traditional Birth Attendant?
4. How many deliveries do you conduct per year?
5. What do you think are the reasons for your acceptance in the community?
6. Which categories of people mostly seek your services?
7. What are the types of services you normally provide to the mothers during pregnancy, delivery and postpartum?
8. How do mothers pay for the services you offer to them?
9. What kinds of beliefs and practices regarding pregnancy and childbirth are you familiar with?
10. What kind of relationship do you have with the formal health system workers in the district?
11. What challenges do you normally face in your work as a traditional birth attendant? Any other questions or comments?

**SECTION D: INTERVIEW GUIDE FOR DOCTOR/MIDWIFE**

1. What cultural practices and beliefs have you encountered regarding pregnancy and childbirth?
2. What cultural practices and beliefs have you encountered regarding and postpartum period?

3. What is your perception about dietary and behavioural restrictions in this community
4. How do you think about role of a traditional birth attendant in this rural community? Why?
5. Any other questions or comments?

