UNIVERSITY FOR DEVELOPMENT STUDIES

ASSESSING THE EFFECTS OF SOCIO-CULTURAL FACTORS ON MATERNAL HEALTH CARE DELIVERY IN THE EAST MAMPRUSI DISTRICT OF NORTHERN GHANA

PAUL JAMANI FEIDIIB

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BY

PAUL JAMANI FEIDIIB(UDS/CHD/0138/13)

(B.A POPULATION AND FAMILY LIFE)

DISSERTATION SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH,SCHOOL OF ALLIED HEALTH SCIENCES, UNIVERSITY FOR DEVELOPMENT STUDIES, IN PARTIAL FULILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF PHILOSOPHY DEGREE IN COMMUNITY HEALTH AND DEVELOPMENT

FEBRUARY, 2017

DECLARATION

Student

I hereby declare that this dissertation is the result of my own original work and that no part of it has been presented for another degree in this University or elsewhere

Candidate's signature……. **Date**……..

Name: PAUL JAMANI FEIDIIB

Supervisors'

I hereby declare that the preparation and presentation of the dissertation was supervised in accordance with the guidelines on supervision of dissertation laid down by the University for Development Studies

Supervisor's signature:…… Date:……..

Name: DR. THOMAS BAVO AZONGO

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ABSTRACT

Socio-economic inequalities in basic maternal health interventions exist in Ghana, yet little is known about health-seeking of poor households. Further understanding of issues surrounding availability, affordability and quality of maternal health services among the poor is crucial to eliminating inequalities in maternal health coverage in Ghana especially in rural communities. The study was carried out to assess the effects of socio-cultural factors on maternal health care delivery in the East Mamprusi District of Northern Ghana. The main objective of the study was to assess the effects of socio-cultural factors on health seeking behavior of women during pregnancyand delivery. Analytical cross-sectional study design was used with multistage sampling technique to sample the respondents from the study area. The data obtained was basically through administered questionnaire and organized focus group discussion involving 308 women from the study area. Results from the study revealed that there was no significant relationship between parity and health seeking behavior of respondents as the findings indicated that all women would seek health care based on their own assessment of the health conditions they were battling with and whether treatment options were available. Further results from the study also revealed nausea, cessation of menstruation temporarily, weight gain and vomiting as signs of pregnancy. Availability of TBAs, poor road networks and lack of finance were major hindrance to women seeking health care in the study area. Based on the finding from the study, a number of recommendations were made to assist policy makers to improve health seeking behaviours of rural women including the need for spouse to be re-orientated concerning socio-cultural factors and its effects on maternal and child health.

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God richly bless you all

DEDICATION

This thesis is dedicated to the Almighty God and my family including my supervisor and all those who might find it helpful to them one day

TABLE OF CONTENTS

LISTS OF TABLES

LIST OF FIGURES

LISTS OF ACRONYMS

ANC	Antenatal Care
DHMT	District Health Management Team
GDHS	Ghana Health Service
GSS	Ghana Statistical Service
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Reduction
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
TBA	Traditional Birth Attendant
WHO	World HealthOrganization

DEFINITION OF KEY TERMS

Maternal Mortality: Female deaths due to complications of pregnancy, childbirth and puerperium

Skilled Birth Attendants: Providers with midwifery and obstetric skills, thus excluding trained birth attendants

Infant Mortality: Death of a child occurring under one year of age

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Women health seeking behaviour is a complex behavioral phenomenon (Magadi et al, 2003). Several researchers have tried to link the relationship between socio-cultural factors and health seeking behaviours of women especially in rural communities that the use of health services by women is related to availability, quality and cost of health services as well as the social structures, health beliefs and personal characteristics of the women (Magadi et al, 2003).

In 2005, about 600,000 women around the world died of birth-related conditions, making maternal death the leading cause of death among women of childbearing age in the world (WHO, 2005; Barbara and Gomez, 2004; Abubakari and Yahaya, 2014). Furthermore, 20 million women suffer acute health conditions related to pregnancy annually (Onah, et al., 2006; Abubakari and Yahaya, 2014). The prevalence of these health conditions and the capacity of these conditions to cause morbidity and mortality usually have a deep root in socio-economic characteristic of the community in which these women live with their husbands and family members (Onah, et al., 2006). Worldwide, maternal death can mean the loss of a productive member of the household, the dissolution of the family, and economic and social difficulty for the children (Onah, Ikeako and Iloabachie, 2006; Abubakari and Yahaya, 2014).

In developing countries socio-cultural factors on maternal health care delivery is an important root of women and young child mortality and reduced life span (UNDP, 2008; Abubakari and Yahaya, 2014). Factors at the village level like lack of access to health

professionals, lack of proper means of transportation to the nearest health facility, lack of availability of health services and infrastructure can contribute to maternal death especially in rural communities (Abubakari and Yahaya, 2014).

Many of the obstetric causes of maternal mortality (e.g. eclampsia, hemorrhage, and ruptured uterus) can be prevented with maternal care and adequate obstetrical services if health care are provided in the proper context for these women (Onah, et al., 2006; Adamson, 2006). Since most surgery rooms and other obstetrical services often are available only in hospitals, distance to the hospital or to the health provider has been considered an important factor of maternal mortality (Abubakari And Yahaya, 2014; Adamson, 2006). Another relevant factor related to the distance to the hospital is transport and transportation infrastructure (e.g., vehicles in the community, road conditions, and ambulance service) to help women reach specialized health services in time of need especially during labour (Onah, et al., 2006; Adamson, 2006). In those cases, counting the maternal death can depend on initiative and capacity of the family to report the death. Therefore, maternal deaths in remote regions lacking health care professionals are more likely to be underreported (WHO, 2000). It has been noted that health policies and programmes often perpetuate gender stereotypes and fail to consider socio-economic disparities and other differences among women, and may not fully take account of the lack of autonomy of women regarding their health seeking behaviour (Barbara and Gomez, 2004; Bawah, 2008; Berry, 2006). Women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women (Senah, 2003; Cannavan, 2008; Berry, 2006).

To date, most research on socio-cultural factors has concentrated on cultural causes and proximate factors as well as on service provision to women (Berry, 2006). Whilst the importance of socio-cultural factors underlying maternal mortality has been recognized in the health literature (e.g. Maine, 1992), there has been limited analytical work in this area (Senah, 2003; Adamson, 2006). Gender analysis suggests that socio-cultural factors is linked to a wide range of factors in women's lives, including the value women and their families and communities place on women's health, women's economic position, their access to education and information and their capacity to make autonomous decisions (Senah, 2003; Adamson, 2006).

The Beijing Platform for Action states that ".... relatively little is known about how social and economic factors affect the health of women and girls of all ages.... "(UN, 1995; p104; Adamson, 2006; Bazzano, Kirkwood, Tawiah et al., 2008) and proposes action to support and fund social, economic, political and cultural research on how gender-based inequalities affect women's health in the world (UN, 1995; p 109; Bazzano, Kirkwood, Tawiah et al., 2008). Access to health services is a complicated concept covering many different issues, including whether adequate facilities exist (e.g. adequate supplies and personnel, good quality of care), and also if women can reach the services given (e.g. cost, distance, information) (Bazzano, Kirkwood, Tawiah et al., 2008)

For developing countries like Ghana prevalence of socio-cultural factors on maternal health care delivery is one of the indicators of women health (Bawah, 2008). Factors influencing women health status may lead to policy formulation for the government in this country (Bland, 2001; Bawah, 2008; Bougangue, 2010). Combating the problem of poor health status is an ongoing process and frequent survey on the prevalence of the

socio-cultural factors on maternal health care delivery is a pre-requisite in this process (Senah, 2003; Cannavan, 2008) to aid in reducing maternal mortality

1.2 Problem statement and justification

Over a decade after the 2000 World Summit, maternal mortality still confronts Ghana and other developing countries (Bland, 2001). Ghana has an estimated maternal mortality ratio (MMR) of 350, while the number of maternal deaths stands at 2700 (WHO, 2013; Bland, 2001). The year 2015 was set as the deadline to achieve the eight millennium development goals (MDGs); however, Ghana did not achieve the MGD five, and goal two which specifies reducing maternal mortality ratio (MMR) by three quarters between 1990 and 2015 and achieving universal access to reproductive health by 2015 (WHO, 2000; Berry, 2006; Abubakari and Yahaya, 2014).

In Ghana, efforts to reduce maternal mortality have resulted in the institutionalization of policies and programs in the form of interventions, such as building of several maternal and child health clinics across the country, the institution of free antenatal care services, the development of safe motherhood protocol at all levels of health institutions and the establishment of National Health Insurance Scheme (NHIS), among others are ways to reduce maternal mortality (Berry, 2006; Carter, 2002; Bougangue, 2010). All these frantic effortsmade by government and other stakeholders in implementing these policies focus mainly on institutional causes of maternal deaths which are categorized into direct or in-direct obstetric causes (Carter, 2002; Abubakari and Yahaya,2014)

However, a number of social, economic, cultural and psychological factors have been identified as key components of maternal health, which interrelate with biological factors, to determine the health status of women (Senah, 2003; Cannavan, 2008).According to the

Ghana Statistical Service, in its 2008 Ghana Demographic and Health survey, over 95% of pregnant women attended antenatal clinic but only 27% had supervised delivery by skilled provider while 56% of women were delivered by a TBA and about 17% were delivered by a relative or no one in the Northern region (GSS, 2008). In the East Mamprusi District, available data indicates a low patronage of available health services (such as supervised deliveries and post-natal care) continue to persist even where financial and geographic access are deemed adequate (GHS, 2011; Yidana and Kuganab, 2014).

Institutional maternal mortality rate in the district is estimated to be 94 deaths per 100,000 (DHMT Report, 2014) which indicates an increase as compared to 47 deaths per 100,000 in 2013 (DHMT Report, 2013). However, the rate could be higher in the District since non-institutional cases are often not reported (Yidana and kuganab, 2014). Socio-cultural beliefs and practices such as male sex preference, administration of local substances to pregnant women, perception that the weak/coward delivers at the health facility, and the need to seek permission from one's family before visiting the health facility are believed to be associated with health seeking behavior of women (Senah, 2003; Abubakari and Yahaya, 2014, Sarkodie and Abubakari, 2014). This research therefore assesses the effects of socio-cultural factors that influence women's health seeking behavior during pregnancy and delivery and how they influence maternal mortality in the East Mamprusi district.

1.3 Research questions

Based on the stated specific objectives of this study, the following research questions were formulated to serve as a guide to the study. These research questions were carved to correspond with the specific objectives as indicated below;

I. What is the health care seekingbehavior of women during pregnancy and delivery in the East Mamprusi District?

II. What is the knowledge level of women about pregnancy-related complication in the East Mamprusi district?

III. What are thesocio-cultural factors influencing the health seeking behavior of pregnant women in the East Mamprusi district?

IV. What factors influences maternal death in the East Mamprusi district?

1.4 Objectives of the study

1.4.1 Main objective

The main objective of this study is to assess the effects of socio-cultural factors on health seeking behavior of women during pregnancy and delivery in the East Mamprusi District of Northern Ghana.

1.4.2 Specific objectives

The following are the specific objectives set for this research

1. To assess the health care seeking behavior of women during pregnancy and delivery in East Mamprusi District
2. To examine the knowledge of women about pregnancy-related complications in East Mamprusi district

3. To determine the socio-cultural factors influencing the health seeking behavior of pregnant women in East Mamprusis district
4. To examine the causes and determinants of maternal deaths in East Mamprusi district.

1.5Relevance of the study

In this part of Ghana and many other societies in Sub Saharan Africa, the wellbeing of women is considered very significant because of their vulnerability to diseases. Traditional system sometimes prevents women from freely accessing health care without their male consent. The findings of this study would be used in the Northern region of Ghana and beyond to create awareness by health workers on socio-cultural factors and its effects on how women generally seek health care. The study conducted in Ghana especially in the Northern Region would serve as a reference material for researchers interested in expanding the scope of the study to include other ecological areas in northern Ghana.

Governmental organizations such as Ministry of Health, Ghana Health Service and non-governmental organizations might find information emanating from this research useful in the design, planning and delivery of information on socio-cultural factors and its effects on access to health especially in rural areas where many people are still lacking basic amenities. Furthermore, the research output would guide health personnel in the district to properly target their services towards women in deprived communities in the district where these socio-cultural beliefs are still practiced.

With little or no information about the current state of wellbeing of women most especially pregnant women in this rapidly changing social and economic environment,

the outcome of this research is expected to raise awareness on the plight of the Ghanaian women in the rapidly changing social and economic environment. It is expected that the findings of this study will increase knowledge and add to literature in this academic field and open up issues affecting the wellbeing of women to trigger further research. Finally, this study would build literature on the maternal mortality situation in the district

1.6 Scope of the study

The purpose of conducting this research in the study area is to assess how women generally seek health care with specific reference to socio-cultural factors that people perceived are primitive. The research was delimited to provide only a few lists of socio-economic factors that are still affecting women health seeking behavior even in the face of religion and modernity. The results from the study can be used to generally assess how women seek health care elsewhere in Ghana and beyond with specific reference to where socio-economic factors still prevail. Findings from this research work would also be useful to health authorities to add a pool of knowledge in the research study area and to look at alternative ways of encouraging pregnant women to place health facilities on top of their lists in selecting health facilities as alternative place to others for delivery especially during labour.

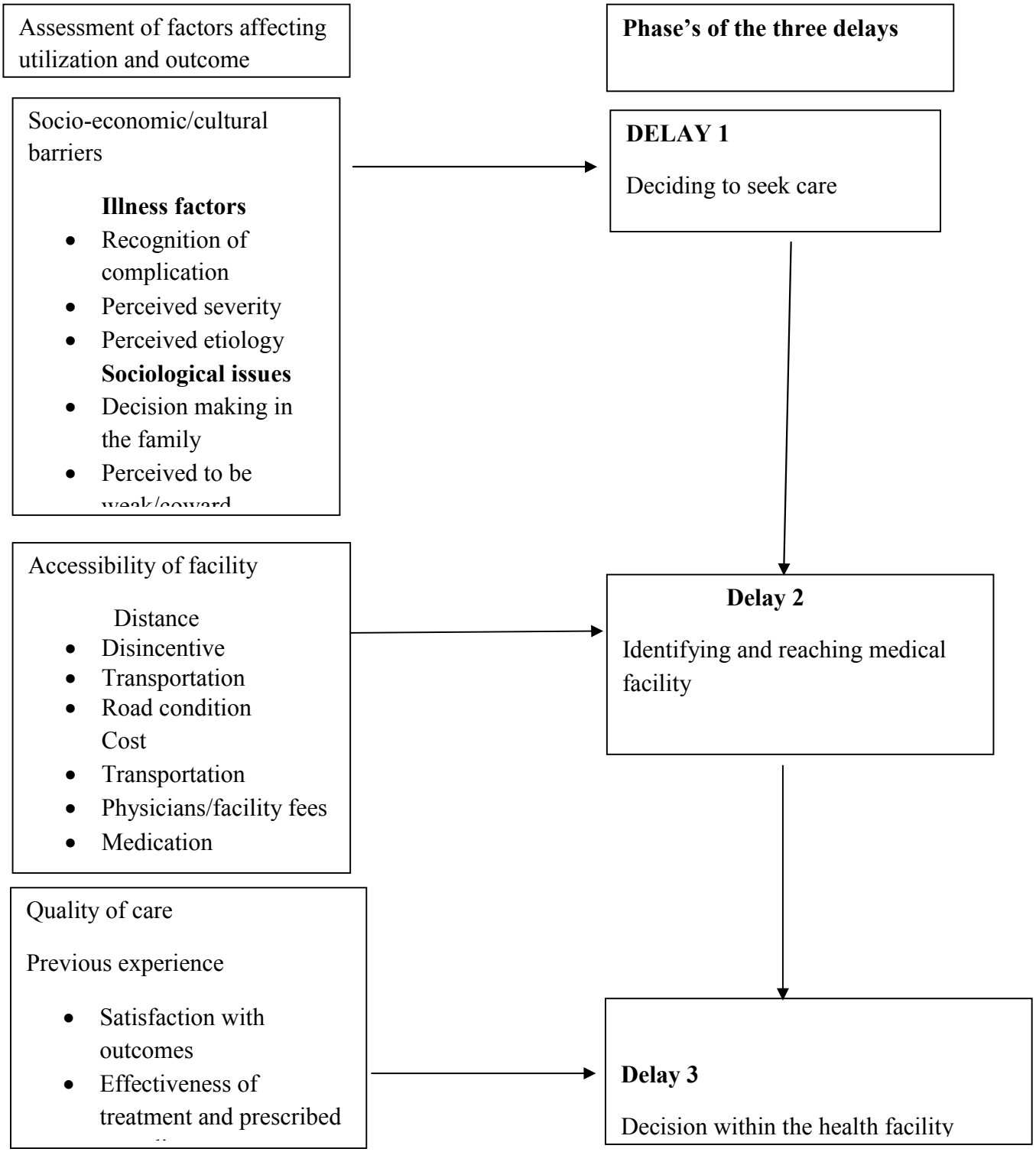
The research was delimited in scope to only effects of socio-cultural factors on maternal health care delivery in the East Mamprusi District of Northern Ghana. This delimitation of the study was done to manage the data collection considering the time and the resources of the researcher.

1.7 Conceptual framework

The theoretical framework for this study is based on the Delay Model. The Delay Model is one of the most cited conceptual frameworks used to explain socio-cultural factors responsible for maternal deaths (Thaddeus & Maine, 1990, 1994; Senah, 2003). Women who die in several instances through childbirth go through at least one of the delays stated in the model (Senah, 2003).

Immediate intervention is crucial in the management of obstetric emergencies especially for women (GSS, 2008). As noted by Nwokocha (2007) the ability of a health system to effect rapid intervention is mediated by socio-cultural factors. The "Three Phases of Delay" developed by Thaddeus and Maine (1990, 1994) in their article "Too Far to Walk: Maternal Mortality in Context" as shown in Figure 1.1 below, describes how socio-cultural factors interact to affect the use of health facilities by women during pregnancy, delivery and after delivery.Several researchers in maternal health explained delay in the recognition of a pregnancy by women as the first delay. Most experts emphasize that, where women fail to recognize the problem in time, decision to take action on where to seek care is also delayed. For this reason, Senah (2003) and WHO (2001) consider recognition of the problem as a key concern which causes a delay in accessing facilities. In fact, society plays an important role in the promotion of health or reduction in the incidence of maternal morbidity and mortality.

Figure 1.1: Delayed Model framework



Source: Adapted from Thaddeus & Maine, 1990

From the Figure shown in 1.1 above, several factors have been identified by the delay model in influencing women health seeking behavior. In fact, the key socio-economic factors identified include; illness factor, women status in the community, educational status and social factor. Delay as used in the Figure above emphasis the delay in taking decision about a health condition when sick or proven ill.

According to Thaddeus & Maine (1990), the delay in decision to take appropriate action when sick to some extent affect women health seeking behaviour. Even when the emergency situation has been appreciated, there is considerable delay in taking appropriate action. This may be due to ignorance about where to locate the appropriate facility or the lack of money to access the service of this facility (Senah, 2003). In the rural areas, especially where women are generally poorer, their dependence on their male counterparts becomes problematic in times of emergency when the men do not also have the resources or are absent at the time. According to GSS (2008) and Sarkodie and Abubakari (2014), women do not take decisions alone; other family members, members of the community, or traditional birth attendants may also fail to make timely decisions about the need to seek care delaying the decision to take action in time.

In some parts of the world, women are reluctant to seek care because they prefer to see female health care workers. In instances where female practitioners are not present in the health facility at the time of the arrival of the woman, personal likes and dislikes of the woman may prevent her from seeking medical care from male (WHO, 2001; Abubakari and Yahaya, 2014). As noted by GSS (2008), some Ghanaian women still rely on

community and family members, especially heads of families to determine the choice of health care during obstetric complications.

Another aspect of delay in seeking health care among women is the perceived unfaithfulness by men on the part of women during prolonged labour. In the event of obstructed labour, women are made to confess their alleged marital infidelity since it is believed that the ancestors or gods of the land can prevent successful delivery of the foetus, and that such a confession will lead to normal delivery of the foetus. In the Northern part of Ghana, a local herbal preparation, often of oxytocic derivation, is administered in obstructed labour. The local herbal preparation is known as Kalugotim which is reported to have caused many cases of ruptured uterus (Senah, 2003; Yunus et al, 2007; Abubakari and Yahaya, 2014). It enhances labour contractions without a corresponding dilatation of the uterus.

From the Figure, the second delay is the delay in arriving at a health facility. This happens when the decision to seek care has been made, but there is a further delay in arriving at the facility. The distance factor is complicated by lack of vehicles, bad roads and high transport fares. Therefore, when the decision to access the service of a health facility has been made, there is a further delay in arriving at the facility, which may be several kilometers away. Distance to a health facility and transportation problems were mentioned by 31% of Ghanaian women as reasons why they did not seek ANC (GSS, 2008). In many rural areas, a particular health facility may be located several kilometers to the next village or road junction where a vehicle may be found (Senah, 2003).

Delay within the health facility is described as the delay three, thus the final delay which hinders the smooth running of maternal health care services available to pregnant women.

The health facility that may be accessed in the community may be a private maternity home, an MCH clinic, a district or a regional hospital. Each of these facilities has its own problems which may delay quick intervention. For example, many private midwives have had no refresher courses since they graduated.

There are many private midwives who have no training in life saving skills and the use of special life-saving instruments and other modern obstetric techniques. In some other instances, the midwives, for financial reasons, delay referral, hoping that the pregnant woman may deliver spontaneously. Besides, most private maternity homes have no ambulances, and other necessary equipment and medical supplies to handle obstetric emergencies (Senah, 2003; GSS, 2005). Perhaps, a far greater danger is the large army of untrained midwives who operate with impunity, especially in the rural areas.

The Maternal and Child Health (MCH) Clinics, most of which operate within the officially stipulated working hours, are in no better condition than maternity homes; they are in no position to provide essential obstetric functions. In the district and regional hospitals also, there are no obstetricians, gynaecologists and anaesthetists. Others do not have ambulances, blood banks, adequate number or complete laparatomy set, modern autoclaves, emergency medical suppliers and regular supply of water and electricity, among others. Besides, their operating theatres are ill-equipped to handle many major surgical procedures.

The Delays Model is used for this study because of its ability to help in identifying and explaining how the socio-cultural factors influence maternal health regarding the use of health facilities during pregnancy and delivery. Furthermore, the Delays Model will help to explain the type of delays that women experience during pregnancy and child birth.

The model considers knowledge about pregnancy and related complications, and the availability of health facilities as a crucial component of maternal health. It is as result of this that WHO (2001) split the *delay one* by Thaddeus and Maine (1990) into two, by taking out recognition of problem as a key issue. The model is specific to the influence of socio-cultural factors on the use of health facilities, which is the focus of this study.

1.8 Structure of this thesis

This research work is organized into six chapters. Chapter one contains the background of the study, problem statement, research questions, objectives of the research, relevance of the study, scope of the study, conceptual framework of the study and structure of this thesis. Chapter two of this research work examined the relevant literature pertaining to the topic with the methodology being the focus of chapter three comprising the introduction, study design, sample size and characteristics, sampling techniques, research variables, data collection and study instrument, quality control and research ethics.

Chapter four contains the analyzed data from the respondents with descriptive presentations in the forms of tables and graphs. Chapter five discusses the results whereas chapter six tackles the conclusions and recommendations.

CHAPTER TWO

REVIEW OF LITERATURE

2.1 Introduction

This chapter looks at the review of literature related to assessing the effects of socio-cultural factors on maternal health care delivery.

2.2 Health care seeking behavior of women during pregnancy and delivery

Healthcare seeking behavior has been defined as any action undertaken by individual who perceive he/she to have a health problem or to be ill for the purpose of an appropriate remedy (Ward et al, 1997; Berry, 2006).Health care seeking behavior for pregnant women is not an isolated event. Rather, it is an integral part of a pregnant woman's status in her family and community (Bougangue, 2010; Carter, 2002). It is a result of an evolving mix of her personal, familial, social, religious, and economic factors (Aktar, 2012; Berry, 2006). A pregnant woman's decision to seek a particular health care service is the composite result of her personal needs, social forces, the availability and qualifications of the care providers, and the location of the services (Aktar, 2012; Carter, 2002).

Some factors that might affect women's health care seeking behaviors during pregnancy and delivery are age at marriage, age at childbirth, level of education, work status, economic status, location of the residence to the health facility and husband's awareness on the condition of ill health (Aktar, 2012; Carter, 2002). According to Hellene & Paul (2004) pregnant women usually seek health care from traditional birth attendances

(TABs) because of proximity, clinics simple because of abuse during labour in hospitals and some from drugs stores if their conditions as perceived by them is not serious

Findings from a research conducted by Onah et al (2006) and Galadanci et al (2007) on certain behaviors of pregnant women during ill health in rural communities revealedthat poor utilization of ANC services, delivery at home, delivery by unskilled attendants, low utilization of maternal health services during pregnancy, cultural and decision to seek health care or not were identified as contributory factors to maternal mortality. In a survey conducted by Baud (2007) concerning pregnant women health seeking behaviours, it was revealed, that pregnant women decision to seek health care was often depended on whether they had previous miscarriages or still birth aside that they would feel relax to seek health care especially antenatal services especially in rural communities.

Available statistics at the global stage suggest that more than 60 million women deliver at home without skilled care, and about 530 000 die from pregnancy related complications, with 3 million babies coming out as stillbirth (Sines et al., 2006). Individual choice for location of childbirth especially pregnant women is embedded in society's conceptualization of the situation, often seen as a social process (Cannavan, 2008; Carter, 2002). Cultural diversity often leads to differences in the conceptualization of childbirth in parts of developing countries, creating a platform where expectant mothers feel reluctant to use health care facilities in times of pregnancy related complications (Carter, 2002).

Consequently, some expectant mothers have developed the penchant of observing normal home births, often surrounded by their families as a normative activity (Berry,

2006;Carter, 2002; Feleke, Mirkuzie, Fikru, 2013). In a traditionally oriented society, most newborns are delivered at home with the assistance of traditional birth attendants (GSS, 2003) of which majority of them are not trained (Feleke, Mirkuzie, Fikru, 2013). To encourage deliveries at health care settings, and to ease the economic burden of expectant mothers, the government of Ghana passed a policy in 2003 to improve access to health service for the poor and the vulnerable, by putting into place universal exemption from payment of user fees for all delivery care (Ansong-Tornui et al, 2007). However, many women still prefer home delivery, usually without the assistance of skilled attendance (Nketiah-Amponsah et al, 2009).

In most traditional societies, the moral status of a woman is raised when she delivers successfully at home (Bazzano, Kirkwood, Tawiah et al,2008). Pregnant women place of seeking healthcare in recent times has been the hospital where they perceived to always get the best care in terms of health but in recent times socio-economic factors couple with what women perceived as abuse and disrespect during child birth has affected women place of child birth (Ansong-Tornui et al, 2007)

In a land mark study conducted by Amos, Thomas & Kelle (2008) on general health seeking behavior of pregnant women the results indicated that several factors influence the decision of pregnant women in rural communities to seek early and proper health care. Factors such as long distance of travel to health facility, abuse and disrespect of pregnant women during labour, high cost of services related to medical care, availability of spiritual centres as alternative to health care and availability of self-medications were commonly identified as factors affecting women choice of place of birth.

Pregnant women decision to seek healthcare during labour has been influenced by many factors. Key among such factors has been the nursing care that they usually received whiles attending for ANC services (Feleke, Mirkuzie, Fikru, 2013). In a survey to ascertain where pregnant women would deliver if they have the option and the chance, it was realized that 40% of the pregnant women mentioned clinics with the reason they would be less abuse during labour whiles 60% of the pregnant women mentioned home because of culture, less abuse and they desire to save money and buy things for their babies and being surrounding by family members (Ansong-Tornui et al, 2007).

It has been recommended that, women below 20 years and those who have attained 35 years and above regularly attend ANC clinics for screening so that risk factors can be detected for the necessary interventions to be taken (Ansong-Tornui et al, 2007). It is argued by the WHO (2009) that these categories of women are at a higher risk of experiencing pregnancy-related complications because of their ages. According to WHO (2009) and the UNDP (2007) women in their extreme ages (below 20 and 35+) are more vulnerable to pregnancy complications, as compared to their counterparts and recommended that regular ANC services be sought

The frequency and timing of antenatal care visit and most importantly, the time associated with the first visit is relevant in detecting and preventing pregnancy related complications (Ansong-Tornui et al, 2007). Care is most effective if the visits start early during pregnancy and continues at regular intervals throughout the pregnancy (GSS, 2008; 2009). It has been recommended that a minimum of four antenatal care visits for women without complications and, at least, one during each trimester of pregnancy is good during pregnancy (Ansong-Tornui et al, 2007).

The time of initiation of ANC by pregnant women has been linked to early detection of pregnancy related complications and management by health workers (Feleke, Mirkuzie, Fikru, 2013). In a survey to know when pregnant women initiated ANC services in their last pregnancies in Uganda Kampala, it was revealed that 20% ofpregnant women initiated ANC services in the first trimester, 40% of the pregnant women never initiated ANC services before delivery whiles 40% of pregnant women claimed they initiated ANC services at the last period of the pregnancy (Neema-Stella, 2002)

In a study to compliment the work of health professionals on why pregnant women do not attend ANC services in Kenya, Nairobi, the data gathered revealed that 20% respondents stated that it was their own decision to attend ANC or not to attend, 5% stated that sometimes they feel too weak to go to hospital and if their ill health is not so serious, 35% respondents mentioned that it was their husbands and their own decision to go for ANC services, 30% respondents said their husband decided for them whiles 10% respondents said their in-laws (Ansong-Tornui et al, 2007).

Results from a survey carried out by Howden-Chapman, Cram & March (1998) in New Zealand concerning the health seeking behaviours of pregnant women revealed that there was no relationship between educational level and the choice of place of delivery of the pregnant women. However, a similar survey carried out by Jackson, Kelsall, Parr & Papa (1998) revealed that there was a relationship between the educational status of pregnant women and the choice of place of delivery.

Results from the study indicated that most of the pregnant women with tertiary education opted to deliver in the hospital as against pregnant women with inadequate education who opted for home delivery. Level of education is more likely to influence seeking

health care in times of need. A study conducted on socio-cultural determinants influencing maternal health care services in the East Gonja district of Ghana revealed a relationship between educational status and the commencement of ANC by women who gave birth in their last pregnancy (Sarkodie and Abubakari,2014).

Again, findings by GSS, GHS (2009) revealed that there is positive relationship between education and utilization of formal antenatal services. Results from a study which sought to find out the relationship between age of respondent and the number of times and when they attended ANC services during their last pregnancies was investigated by Jaffey (1991). The survey results revealed that primigravidae seek ANC services less and at later stage of the pregnancy as compare to multi-parity. Also, Thompson (1999) cross-sectional survey results revealed that pregnant women in Kenya attended ANC services twice in every week to the time of delivery.

In a similar research to assess the relationship between frequency of ANC services and age of pregnant women in Uganda who delivered during their last pregnancies revealed that they were no relationship between the frequency of ANC attendance and educational level (Neema-Stella, 2002). Choice of place for treatment during ill health of pregnant women in last pregnancies has been met with mixed feelings. Findingsprovided by Ansong-Tornui et al, (2007) revealed that most pregnant women sought for treatment at traditional birth attendant, most of the pregnant women said they resorted to self-medication or received treatment from relatives, whiles some indicated that they sought for treatment at chemical or drug shop with a good number going to the health professional for treatment.

There were other pregnant women who said they resorted to the herbalist during ill health in their last pregnancies for treatment. A report by Sarkodie and Abubakari (2014) on health seeking behavior of people in East Gonja district of northern Ghana found that educational status had a positive influence on the respondents' choice of location for treatment during ill-health in pregnancy. However, the study further proved that religion had no influence on this choice of treatment during ill health in pregnancy.

2.3 Knowledge of women about pregnancy-related complications

Maternal morbidly and mortality could be prevented significantly if women and their families recognize obstetric danger signs and promptly seek health care during pregnancy (Ansong-Tornui et al, 2007). The danger signs are not the actual obstetric complications, but symptoms that are easily identified by non-clinical personnel could assist pregnancy women receive prompt medical care (Feleke, Mirkuzie and Fikru, 2013). Knowledge of pregnantwomen concerningthe danger signs of obstetric complications is the essential first step in the appropriate and timely referral to essential obstetric care in health facilities (HPIEGO, 2004). Having the first and timely information of pregnancy especially during the early days could assist a woman to seek early medical care (Ansong-Tornui et al, 2007).

In a cross sectional survey to assess the knowledge of pregnant women on how they got to know that they were pregnant, Srinivasan and Mohanty (2008) reported that manyof the pregnant women said theygot to know that they were pregnant through laboratory tests requested when they were sick at the health facility whiles most said it was through experienced of previous pregnancies. In a related development, it was observed that knowledge of pregnant women who were admitted in a health facility most (40%)

mentioned that they got the information that they were pregnant from a health worker, 20% said they were informed by their relatives because that was actually their first time of getting pregnant and 40% stated their knowledge was informed by the experiences they had during previous pregnancies.

The commonest danger signs during pregnancy include severe vaginal bleeding, swollen hands/face and blurred vision, excessive vomiting, and severe abdominal pain (Abubakari and Yahaya, 2014; Adamson, 2006). Key danger signs during labor and childbirth include severe vaginal bleeding, prolonged labor, convulsions, retained placenta premature rupture of membrane, and malposition of the fetus (Thaddeus and Maine, 1994). Danger signs during the postpartum period include severe bleeding following childbirth, loss of consciousness after childbirth, and fever (Abubakari and Yahaya, 2014). Raising awareness of pregnant women on the danger signs would improve early detection of problems and reduce the delay in deciding to seek obstetric care (HPIEGO, 2004; Abubakari and Yahaya, 2014; Adamson, 2006).

Obstetric complications during pregnancy greatly add its quota to maternal mortality in many countries around the world (Barbara and Gomez, 2004). It has been noted that women around the world most especially in developing countries do not usually observed these danger signs in time hence leading to late seeking of medical care (Bawah, 2008). These complications, it must be noted, can sometimes be prevented if women have early warning signs and access to obstetric care (Yidana and issahaku, 2014), especially with regard to receiving proper antenatal education. Women who are educated about when to seek health care from medical professionals are more likely to seek health care in a timely manner during complications (Feleke et al, 2013).

According to Bougangue (2010) survey report on pregnant women sampled to examine their knowledge of critical period during pregnancy. It was revealed that almost all the sampled respondents considered the second-third trimester as the most critical period during pregnancy. Even the primigravidae who were also part of the study knew of certain signs and danger complications during pregnant which according to them needed to be handled by health professionals.

Knowledge of the danger signs of obstetric complications is an essential step in the recognition of complications and enables women to take appropriate action to access emergency care (WHO, 2006). To ensure safe and complication free pregnancy, women are entreated to undertake early antenatal care within the first trimester of pregnancy. This is crucial because it allows for early detection and management of complications, as well as detection of existing diseases and treatment, promotion of health and prevention of disease (WHO, 2006; Barbara et al, 2004).

Indeed, women who have no knowledge of one sign of pregnancy or the other are at a higher risk of developing pregnancy complications, or dying from such complications as compared to their counterparts who can identify at least two signs, because the former may not be able to detect pregnancy early for the necessary interventions to be carried out (Evjen-Olsen, 2008; Feleke, Mirkuzie, Fikru, 2013; Garenne, Mbaye, Bah, Correa, 1997). Greene and Margaret, (1999) report indicated that, there are instances where some pregnant women experience their menses during pregnant and intend to say that they are not pregnant. Under such situations, if stoppage of menses is the only sign of pregnancy known to her, she may not know that she is pregnant and, therefore, would not seek health care at the right time and hence, the risks of late antenatal care attendance would

be very high. Thus, where other signs of pregnancy are not known to them or are not immediately show up in pregnancy, they are likely to fail to recognize them.

Gebrehiwo et al (2011) found that a significant number of mothers in Ethiopia had no information on danger signs of pregnancy and negligence was the main reason for not having good awareness of danger signs of pregnancy. Meanwhile, Kuganab et al (2014) discovered in the Sissala West district of Ghana that knowledge of dangers of pregnancy was high among the respondents. Most women (79%) stated that there could be severe bleeding during pregnancy. According to Starrs (2006), knowledge of danger signs during pregnancy is low because they are not considered as being very serious dangers that can kill a woman or her unborn baby.

Most of the challenges pregnant women encounter are as a result of the imbalances in access to health services across the country such that ANC services are still not reaching the vulnerable and poor populations (Ghana Human Development Report, 2007). Close to 90% of qualified health service personnel are concentrated in the urban areas of the south (Bawah, 2008). About 1.9% of the total populations of women in Ghana die due to pregnancy-related complications (UNDP, 2007).

Results of a study conducted by Crawhall (1995) to ascertain pregnant women knowledge of pregnancy complications revealed that 88% of the pregnant women identified severe abdominal pain, oedema, vaginal bleeding and vomiting whiles 12% of the pregnant women mentioned foul smell from the vagina. Nausea, weight gain, cessation of menses and swollen feet were also common among the pregnant women. Findings from Chesaina (1991) report showed that there was no relationship between education and knowledge of pregnancy among pregnant women.

Generally, the first three months (the critical period) of pregnancy in the life of every woman must be handled with extra care to ensure that the pregnancy is carried to term without any serious medical complications (GSS, 2009). To handle pregnancy carefully demands knowledge of this period. Women who do not have knowledge about the critical period are less likely than their counterparts to seek antenatal care during the period. Also, they are less likely to handle pregnancy with special care during this period thus they stand the risk of pregnancy wastage, complications or pregnancy-related death. A study among mothers in Awutu-Senya district of the Central Religion of Ghana revealed inadequate knowledge of critical period during pregnancy among women at all levels of education, especially those with secondary education who were the majority (53.3%) of the interviewee in the study (Bougangue, 2010).

In a similar report available by GSS (2005) and the UNDP (2007) revealed that women with secondary education and above have adequate knowledge about pregnancy-related complications and seek antenatal care earlier than those below secondary level of education. On female education and maternal health, McAlister and Baskett (2006) maintain that education provides women with knowledge about pregnancy, and guides them to seek care which is in support of the findings of Magadi and Curtis (2003).

In a related study, Vlassoff et al. (2004) observed that improvements in education have potential transmission and prevention that translate into health. Definitely, where women lack knowledge about the seriousness of a medical condition, they may employ any means of solution based on their personal judgments or on advice by friends, relatives and community members (WHO, 2001; Senah, 2003). Some pregnant women in Ghana

rely on advice from relatives, friends and community members to choose place for medical care (GSS, 2009).

2.4 Socio-cultural factors influencing the health seeking behavior of pregnant women

Belief systems play a major role in the health care seeking behaviours of individuals (Shaikh and Hatcher, 2005). Indigenous beliefs and practices take shape around the cultural traits that are passed from one generation to the next (Haque, 2009; Hiluf & Fantahum, 2008). These practices are deeply rooted and embedded in most communities in Africa societies, and therefore they become part of the people's lifestyle (Hiluf & Fantahum, 2008). They are innate to such an extent that it is difficult to try to change these beliefs and practices, as people have adhered to them throughout their entire lives (Shaikh and Hatcher, 2005; Hiluf & Fantahum, 2008).

Employment which provides status and fulfilment encourages women to limit family size.

This kind of employment is mostly not available to uneducated women (Killewo et al., 2006). In India, there are high birth rates among the 94 percent of working women who are in the lowly paid insecure informal sector. Thus it is not just the fact of being employed that limits fertility, but the type and status of employment (Haque, 2009; Hiluf & Fantahum, 2008; Killewo et al., 2006).

In some cases, employment may be an important factor in women's decision to have an illicit abortion. Women in urban areas may have no household space for more children, and have employment patterns incompatible with pregnancy and motherhood. Even

women employed in the formal sector may have little job security and maternity leave and benefits schemes are very rare (Christian, 2009).

Women's workload may affect the intermediate factor of health status increasing risk of maternal death. Many women have a workload that consists of hard manual labour in agriculture, responsibilities for housekeeping and childcare and cooking, collecting firewood and fetching water which may result in chronic fatigue and other health problems (Haque, 2009; Evjen-Olsen, 2008). The last three months of pregnancy should be a time when the mother rests and gains weight. However, many women in developing countries continue with their full workload right up until the time of labour, and resume work shortly after giving birth (Haque, 2009; Evjen-Olsen, 2008). This can have an extremely detrimental effect on health.

For example, in the Gambia, where women are responsible for manual labour in the rice fields, they have been found to lose rather than gain weight during the last three months of pregnancy (Evjen-Olsen, 2008). Heavy workloads may also have an impact on nutrition (Cannavan, 2008; Haque, 2009). A study from Burkina Faso showed that during the rainy season when the heaviest work in the fields is done, women are sometimes too tired at the end of the day to prepare a proper meal, and the whole family is reported to lose weight at that time of year (Christian, 2009; Cannavan, 2008). There is need for an awareness of how women's employment and workload affects their overall health status, and can be particularly threatening to the health of women who are pregnant or breastfeeding (Barbara and Gomez, 2004; Carter, 2002).

Workloads are also linked to maternal outcomes through the time constraints they impose on women (Ansong-Tornui et al., 2007). Heavy workloads may mean that pregnant

women do not have the time to attend pre-natal care or spend time in hospital for delivery (Barbara and Gomez, 2004; Ansong-Tornui et al., 2007; Christian, 2009). In rural area, the seasonality of work patterns may exert an influence on maternal and infant outcomes. For example, a study in Zaire showed that 13 out of 20 maternal deaths occurred during the first five months of planting and harvest, when women were reluctant to go to hospital because of the need for their work in the fields (Ahmed, Adams, Chowdhury and Bhuiya, 2000).

Health service providers must ensure that their services are available at times when women can have access to them, and that waiting times in clinics are kept to a minimum (Adamson, 2006; Ahmed, Adams, Chowdhury and Bhuiya, 2000).In a study to assess how cultural practices and social support for pregnant women in New Mexico community affect pregnant women health seeking behaviour, Williams (2001) found that the understanding of cultural beliefs and practices resulted from ethnicity facilitated adaptation and change by the community in support of pregnancy, thus contributing to increased motivation in attending antenatal services. Indigenous practices and beliefs influence and underpin the behavior of women during pregnancy and childbirth (Hatcher, 2005). In addition, religion also has an impact on childbirth, thus leading women to believe that they have to follow and practice their religious rituals in order to preserve their pregnancy and give birth to healthy infants (Hoque and Hoque, 2011; Killewo et al., 2006).

Maternal morbidity and mortality are influenced by the socio-economic context of the health care system, and the cultural and biological realities of the woman seeking health care (WHO, 1999). This complex interaction between the individual and the socio-

cultural environment means that even when skilled care is available, women may not seek it or receive it because of their socio-economic status (Killewo et al., 2006). Among the indirect causes of maternal deaths are taboos associated with pregnancy and child birth, traditional midwifery system, age of the woman, delays and the nature of the health facilities perceived by the woman to be good or bad (WHO, 1999; WHO, 2001).

Abubakari and Yahaya (2014) reported that certain beliefs prevented most women from attending ANC, such as the claim that ANC leads to the unborn child growing big and making delivery difficult during labour. In a focus group discussion organized for pregnant women in Uganda, over 76% of the women participants claimed that those who attended ANC were often told by the nurses to take eggs, fish, meat, and so on. They claimed that when a pregnant woman eats these, she turns to experience difficulties during labour because the unborn child grows bigger. Additionally, women who eat eggs and fish are regarded as bad women by Dagomba culture (Abubakari and Yahaya,2014).

Such women cannot be good housewives who can take care of the family, as remarked by one of the respondents. “It is believed that women who are used to eating eggs and fish can use the meager family money meant for cooking to buy and eat eggs at the expense of the whole family” (Abubakari and Yahaya, 2014). It is also believed that women who are used to eating eggs can steal eggs from the hencoop when the men are away on their farms and used it secretly to prepare food without the husband knowledge (Killewo et al., 2006). This can deplete the family wealth. For these reasons, women are discouraged from eating eggs. To avoid being asked by the doctors to eat eggs, some pregnant women would not attend ANC (Magadi & Curtis, 2003). Issah, Musah & Iddrisu (1999) research report revealed that aged women seem to patronize herbal

treatment when they are pregnant as compare to the younger ones who seek hospitals treatment.

A study conducted by McAlister & Baskett (2006) to assess socio-cultural factors affecting pregnant women choice of place of birth in Thailand revealed that pregnant women had no knowledge of socio-cultural factors affecting pregnant women choice of place of birth and was constantly going to hospital to deliver. Similarly, in a study to assess social factors influencing pregnancy and child birth in Nigeria, it was discovered that community norms, beliefs and personal likes and dislikes of pregnant woman, availability of TBAs and long distance to health facility were the most dominant factor affecting child birth (Moses et al., 1994; Narayan,1999; Nnamdi, Mojekwu, Ibekwe, 2012).

In a descriptive study to assess the variables for choice of place of delivery for pregnant women in Southern part of Ethiopia, Nyarko (2006) revealed that most of the women identified factors affecting women choice of place of delivery to include; inadequate income of pregnant women to pay health care bills, feeling of privacy and being surrounded by family members and friends during labour at home, fear of operations, fear repeated vaginal examination, level of educational status of women, parity of women, age of the mothers at pregnancy and history of antenatal follow up.

Kwapong (2008) noted that some harmful traditional practices and dietary rules influence pregnant women in Ghana. Food related superstition, taboos and restrictions on women of childbearing age, pregnant women and lactating mothers, and the traditional practice of serving the best part of the meal to male members of the household worsens the already vulnerable health situation of the majority of women (GDHS, 2003). Statistics

indicate that approximately 65% of pregnant women and 45% of non-pregnant women in Ghana are malnourished (GDHS, 2003).

According to Adamson (2006), the view that childbirth demonstrates courage and power of women is common in societies where women command much less power than men in the public domain. Carter (2002) found that pregnant women in Benin would rather suffer days of obstructed labour than ask for help during childbirth and risk being seen as weak. Awonodomo (2013) noted that many people believe in superstition and witchcraft. These religious beliefs make some of these women go to a priest for prayers or rituals when they are sick and/or during pregnancy for protection.

They only seek medical assistance when these prayers fail at that time the condition may be too late for health workers to manage. In rural communities, if a person is sick or not getting pregnant, they attribute it to witchcraft, the lesser gods or their ancestors. Their belief in witchcraft and ancestors makes them consult fetish priests, pastors and Mallams for prayers rather than going to a professional medical doctor for checks and a cure (Onah, Ikeako, Iloabachie, 2006). During pregnancy, women in the rural communities prefer going to priests to pray for protection from witchcraft, instead of going to the clinics *(*Awonodomo, 2013)

Consistent with previous findings at the village level, health facilities play an important role in the reduction of maternal death. Reducing travel time to a hospital is an important strategy to reduce maternal mortality (GDHS, 2003). Furthermore, the number of doctors and clinics in the community are an important factor to reduce maternal mortality. Economic factors like female wage and literacy also are relevant (Evjen-Olsen, 2008).

Risk factors like diseases, climatic events and poverty have an effect on maternal mortality. Diseases like malaria and tuberculosis incidence are important indirect causes of maternal mortality. Climatic events like cyclones also increase maternal mortality(Evjen-Olsen, 2008). These points out the importance of providing support to pregnant women in communities that are affected by climatic events and the high incidence of malaria and tuberculosis.

The reduction of poverty is an important factor to reduce maternal mortality (Evjen-Olsen, 2008). It has been observed that communes with higher number of individuals below the poverty line have higher levels of maternal mortality (Evjen-Olsen, 2008). It has also been observed that female wages and literacy are key determinants of maternal death (Evjen-Olsen, 2008). These factors may increase the opportunity cost of morbidity and can provide females more resources to access healthcare.

2.5Causes and determinants of maternal deaths

In order to effectively reduce maternal mortality, it would seem important for health care system managers and implementors to understand these socio economic factors and recognise that they may well be in fact a function of the inappropriateness of care that is on offer (Wuni, 2009). Health managers must help create initiatives to overcome these factors, for example through the opening of antenatal waiting shelters for high risk women (Wuni, 2009; Yunus, Bomfe, Sulemana, 2007; Ujah, Aisien, Mutihir et al., 2005). Even where abortion is legally available, women may still use a traditional abortionist by preference for reasons of the extra privacy they afford, indicating a need to increase the sensitivity of legal abortion services to women's needs (Yunus, Bomfe, Sulemana, 2007; Ujah, Aisien, Mutihir et al., 2005).

Poor quality of antenatal care and screening may discourage women from attending these facilities. Failure to successfully screen and detect anaemia, blood pressure, protenuria has very serious consequences on women health (Ujah, Aisien, Mutihir et al., 2005). These deficiencies added to women's experience of health personnel with indifferent attitudes, and time and money constraints, can destroy women's faith in the usefulness of antenatal care (Ujah, Aisien, Mutihir et al., 2005). Financing options such as insurance should be explored as a means of allowing rural households to make direct financial contributions to the cost of their health care without placing financial barriers to obtaining care at the time of illness.

Health insurance schemes for rural populations in Africa may be feasible where there is a willingness/ability in the community to pay, and where schemes can rely on the community for local management rather than requiring a management structure similar to that of a western insurance system (Sarkodie and Abubakari, 2014).

The plan is to charge a fee of very moderate rate for women or for each newly married woman for pre-marriage examinations, MCH health cards, five pre-natal check-ups, delivery and four post-natal visits. This could go a very long way to enhance women health.

Any fees received could to be divided up between the country MCH facility, community health centres and village doctors or birth attendants, with five percent retained to pay for insurance compensation (Stanton, 2004; Sarkodie and Abubakari, 2014). It has also been noted that if an insurance policy is implemented in the community with very low take up rates meant that this MCH insurance system could not be implemented. Fees for pre- and

post-natal examinations couldbe revised to make it attractive for womento come for deliveries.

Perceptions of poor quality of care may be what most hampers the efficiency and financial viability of rural health schemes (Sarkodie and Abubakari, 2014). Education is a distant factor which offers the possibility of affecting the magnitude of maternal mortality in a number of different ways (Hoque and Hoque, 2011; Mpembeni et al., 2007). One is the well known effect of education in lowering fertility. If women get pregnant less and bear fewer children, they are less at risk of maternal death (Nyarko, 2006). Women's social status, self-image and decision making powers may all be increased through education, which may be key in reducing their risk of maternal death, resulting from early marriage and pregnancy or lack of information about health services (Killewo et al., 2006; McAlister & Baskett, 2006; Mpembeni et al., 2007).

There is a need to consider issues relating to teenage pregnancy of girls who are in education.The psychosocial pressures on young pregnant women can be great, endangering their health through the increased likelihood of illicit abortion, or inadequate access to health care. Family pressure often forces pregnant teenagers to drop out of school. Adolescents may seek unskilled abortions in order to avoid expulsion from school on the grounds of pregnancy. Some schools in Africa and Asia expel pregnant teenagers as a matter of policy (Mpembeni et al., 2007; Nnamdi, Mojekwu, Ibekwe, 2012). A study in Nigeria showed that 52 percent of pregnant adolescents were expelled from school.

Educated women may have more understanding of the physiology of reproduction and be less disposed to accept the complications and risks of pregnancy as inevitable, than illiterate or uneducated women (Carter, 2002).

Education has been described as a medication against fatalism. Fatalism can take the form of a belief, such as exists in many Southern African cultures, that health problems are a punishment for an individual lack of adherence to a set of behavioural rules, related to spiritual well-being (Hoque and Hoque, 2011; Nyarko, 2006).Maternal death may be seen as an act of God (Carter, 2002). Educated women may also be less likely to accept dangerous practices aimed at alleviating complications in pregnancy (Carter, 2002). Amongst the Hausa people of Nigeria, for example, *girishi* cuts are a traditional surgical operation to treat obstructed labour by cutting the vagina with an unsterilized blade (Carter, 2002). Whilst it is commonly performed on uneducated women, educated women rarely accept the practice (Carter, 2002).

Uneducated women are less likely to seek the help of professional health services because they are probably less aware of what is available, and probably find the culture of health services more alienating and frightening (Carter, 2002). Areas with low female literacy rates are also often areas where the fewest births are attended by trained personnel (Onah, Ikeako, Iloabachie, 2006). Education is also significant in the way that it influences women's patterns of paid employment outside the home (Hoque and Hoque, 2011; Onah, Ikeako, Iloabachie, 2006). It is also noted that Prevention of Maternal Mortality Network, based at Columbia University, identified social distance as a barrier to access to services for many of the groups interviewed in projects amongst rural communities in West Africa. Social distance is described by the study as consisting of differences in language, behaviour and expectations between the consumers of health care and its providers (Onah, Ikeako, Iloabachie, 2006).

Ethnic and linguistic diversity also can be the cause of social distance, impeding access to services (Rahman, 2000; Sarkodie and Abubakari, 2014). Even when providers and users/consumers are of the same ethnic group, there can be social distance barriers caused by differences in education, experience and socio-economic status. Hospital staff may ridicule the traditions and practices of a community and impose unfamiliar food, supine position for delivery, and culturally inappropriate hospital dress, all of which may influence women in deciding to give birth in more sympathetic environments outside of health services (Nyarko, 2006; Price, 2001; Rahman, 2000).

The Columbia research found that these problems were particularly acute for minority ethnic groups. For example, Malian women, who are required by their culture to wear long black gowns, complained about being told these were dirty and that they must wear short white hospital gowns for delivery (Rahman, 2000; Sarkodie and Abubakari, 2014). Unfamiliar hospital food can intensify the strangeness of the hospital environment for some women.

However if, as in Ilorin, a woman is required to bring her own food to hospital this can create a further setback in getting to a hospital when complications set in (Onah, Ikeako, Iloabachie, 2006). For reasons such as these, women in Accra said that they preferred to go to facilities in areas where their own ethnic group is in the majority, even if they are not the nearest (Onah, Ikeako, Iloabachie, 2006; Nyarko, 2006; Rahman, 2000).

According to Price (2001) the most immediate maternal complications during child birth include; retained placenta, general tiredness and exhaustion, perineal tears, haemorrhage and death.

Maternal complications can also arise during or in the post-partum period which may be procedural such; as caesarian or instrument birth, puerperal infection, mastitis, breast engorgement, depression, psychosis and death (Price,2001; Rahman, 2000; Rani, & Bonu, 2003; Sarkodie and Abubakari, 2014). In Kenya, maternal health is recognized by the Kenya's Constitution as a fundamental right hence the goal to have a country where every pregnancy is wanted, every birth is safe, every newborn is healthy and no mother dies while giving life (Sarkodie and Abubakari, 2014; Senah and Kodjo, 2003; Shah and Say, 2007).

A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO, 2004, 2010). Maternal deaths may arise from direct or indirect causes. Direct maternal deaths are deaths resulting from obstetric complications of the pregnant state, from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above (Shah and Say, 2007).

Indirect maternal deaths are from pre-existing diseases or from a disease that developed during the pregnancy which was not due to a direct obstetric cause, but was aggravated by the physiologic effects of pregnancy (WHO, 2008; Shah and Say, 2007). Any complication or disease developed during pregnancy and childbirth could be described as maternal morbidity (Shah and Say, 2007). These pregnancy-related health problems include severe anaemia, infertility, and damage to the uterus and reproductive tract sustained during childbirth (WHO, 2014). Pregnancy and its related complications are issues of both biology and culture ((WHO, 2014). Studies show that socio-cultural factors

also contribute to the state of maternal health (Senah, 2003; WHO, 2014). As noted by Campbell and Graham (2006) majority of the maternal deaths occur after child birth mostly within 24 hours. About a quarter of this occurs during pregnancy and about 15% take place at the time of delivery (Campbell and Graham,2006).

The commonest cause of maternal mortality is haemorrhage, representing 24% of the cases. It is the leading cause of maternal deaths in Ghana (GSS, 2008; WHO, 2008). Haemorrhage is a swift and severe loss of blood before, during and after delivery. It is considered a direct cause of maternal death because it is directly associated with pregnancy and childbirth (WHO, 2008; WHO, 2014). Sepsis, a very severe infection*s the second most frequent cause of* maternal death (Senah, 2003). It can be eliminated if aseptic techniques are respected and if early signs of infection are recognized and treated in a timely manner (Senah, 2003)

The third cause, eclampsia, emerges as pre-eclampsia, a common hypertensive disorder, which can be detected during pregnancy (Senah, 2003). Although pre-eclampsia cannot be completely cured before the delivery, administering drugs such as magnesium sulfate can lower a woman's risk of developing convulsions (eclampsia), which can be fatal. Another frequent cause of maternal death is obstructed labour, which occurs when the fetus' head is too big compared with the mother's pelvis or if the baby is abnormally positioned (Shaikh and Hatcher, 2005; Ujah, Aisien, Mutihir et al., 2005; Williams, 2001) Whereas in many developed countries almost all pregnant women receive antenatal and postnatal care and are attended to by a midwife and/doctor at childbirth, available data show that less than two thirds receive similar services in developing countries (Williams, 2001). Many pregnant women in developing countries do not receive the care they need

either because there are no services where they live, or they cannot afford the services because they are too expensive or getting the services is too costly (Williams, 2001; Yidana and Issahaku, 2014; Yunus, Bomfe, Sulemana, 2007). Some women do not use services because they do not like how care is provided or because the health services are not delivering high-quality care (Thomas, Pauline & Bridget, 1999). As noted by Christian (2009), the common risk factors related to maternal mortality includes maternal age, parity, and birth interval.

In a case-control study to analyze risk factors for maternal mortality in three leading hospitals in Dakar, Senegal, Garenne et al. (1997) identified the major causes of death as puerperal sepsis and other infections, haemorrhage, eclampsia, ruptured uterus, and anaemia. The results from the case-control study found the major risk factors connected with health system failure as medical equipment failure, late referral, lack of antenatal visit, and lack of available personnel at time of admission (WHO, 2014)

Several studies on risk factors identified many socio-demographic factors to have association with maternal mortality (Yunus, Bomfe and Sulemana, 2007). Examples of socio-demographic factors often cited include first pregnancy, pregnancy of high birth order, rainy season, being unmarried and low level of education (Yunus, Bomfe, and Sulemana, 2007.In a study by Abe and Omo-Aghoja (2008) to ascertain the major causes of maternal deaths, the study found risk factors such as low literacy, high poverty levels, parity and non-utilization of maternity services as being associated with maternal mortality.

Feminists have drawn attention to the fact that the bulk of reproductive work is carried out by women, in child-bearing, child-rearing and the care of adults (Sarkodie and

Abubakari, 2014; Shah and Say, 2007). Maternal mortality is perhaps the ultimate reminder that it is women who shoulder the costs of this reproductive work, in this case through their premature death. Levels of maternal mortality are indicative of how states have chosen to intervene or not in reducing the costs of reproduction to women's lives (Shaikh and Hatcher, 2005). Health policy may exhibit strong gender bias in terms of where resources are allocated and whether providing effective services which are accessible to women is seen as a priority (Sarkodie and Abubakari, 2014; Shah and Say, 2007)

Health policies and programmes often perpetuate gender stereotypes and fail to consider socioeconomic disparities and other differences among women, and may not fully take account of the lack of autonomy of women regarding their health (Shaikh and Hatcher, 2005). Women's health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women. For decades, in the field of women's health, there has been a focus on fertility regulation, creating a narrow conceptualization of women's health as bounded by the ages 15 to 45 and the reproductive system (Shaikh and Hatcher, 2005).The current interest in maternal health and maternal mortality marks a widening of this understanding of women's health and a recognition that, in the context of Maternal and Child Health programmes, mothers have in the past been neglected in favour of measures to improve infant and child (Sarkodie and Abubakari, 2014; Shah and Say, 2007)

Therefore, the participation of women themselves, as well as families and communities, is essential for the success of safe motherhood initiatives (Shaikh and Hatcher, 2005; Shah and Say, 2007). Women's groups and NGOs can lobby for changes to improve the

provision for women's health, as well as for women's rights and legal changes to improve women's status. Community-based research can be carried out by groups and NGOs in order to determine women's own perceptions of problems relating to safe motherhood (Shah and Say, 2007)

Women's groups can also play an important role in educating women about how their bodies work and reproductive health issues, as well as providing information to the community about what services are available and where (WHO, 2014). Another aspect of this education and communication work may be raising the awareness of men and the rest of the community of maternal death risks (WHO, 2008). However, the need for maternal education may well have been overestimated in the past, as many women are well aware of the danger signs of the onset of obstetric complications (Shah and Say, 2007).It can be for other reasons than not recognizing risks that they do not seek medical help. Women's organisations can tackle these issues by exploring community strategies to overcome cost and transport difficulties, and by initiating dialogue with health service providers over quality of care improvements (Shah and Say, 2007; Senah, 2003; Sines, Uzma, Steve and Heidi, 2006)

Although the immediate effects of women's groups and organisations may not always be obvious, or measurable in the way that medical interventions are, their potential importance in addressing maternal mortality, particularly in relation to the social, cultural, political and legal factors outlined above, should not be overlooked (WHO, 2008; Sines, Uzma, Steve and Heidi, 2006).Maternity waiting homes (MWH) are lodgings close to hospitals where women can stay prior to giving birth (Sines, et al., 2006; Senah, 2003). Research suggests that maternity waiting homes may provide a very

effective strategy to overcome problems of poor access to hospitals in rural areas where distance is a major obstacle to reducing maternal mortality.

A study in rural Zimbabwe found that for women with antenatal risk factors, there was a significant 50 percent reduction in the risk of perinatal death for the women who stayed at the MWH compared to women who came from home during labour (Ujah, Aisien, Mutihir et al., 2005).

It may be that women who use MWHs are of a higher socioeconomic status than those who stay at home because poorer women find it more difficult to take time away from work at home. Despite this, the study suggests that women of lower socioeconomic status are also at less risk of a perinatal death (though not as much) if they stay in a MWH. MWHs are most effective if distance is the only factor preventing access to health services (Senah and Kodjo, 2003; Ujah, Aisien, Mutihir et al., 2005). For their effectiveness, it is also necessary that a high proportion of women attend ante-natal clinics so that those women with antenatal risk factors can be identified for referral to the MWH (Sines, et al., 2006). The effectiveness of MWHs in reducing maternal deaths must also be impeded by the fact that a proportion of women not identifiable as high risk will nevertheless develop obstetric complications (Ujah, Aisien, Mutihir et al., 2005)

Part of the attraction of MWHs as a safe motherhood strategy is that they require no high technology and rely mostly on human resources already present in many communities (Ujah, Aisien, Mutihir et al., 2005). But MWHs rely on their connections to effective hospital care and treatment for those women developing complications, and also on being connected to the community so that women are prepared to use them.Several examples of MWHs in Latin America show how the accessibility of MWHs is at its best when they

are culturally sensitive and viewed as a community service (Ujah, Aisien, Mutihir et al., 2005). In Cuba, community groups such as the Women's Federation, local political organisations and agricultural unions participated in the management of MWHs and in making these facilities comfortable and acceptable to pregnant women (Ujah, Aisien, Mutihir et al., 2005). The construction, maintenance, funding and food supplies, and care-work for the MWHs are contributed to by the community.

The idea of an MWH must have credibility in the community it is intended to serve, because women and their families may not be easily convinced to move away from home before their delivery due date (Ujah, Aisien, Mutihir et al., 2005). In societies where women are in purdah, or seclusion, MWHs may be considered unacceptable, so cultural compatibility needs to be taken into account when planning such facilities (Ujah, Aisien, Mutihir et al., 2005). Maternal mortality ratios are highest in Africa with figures of up to 1000 per 100,000reported in rural areas of several countries, and ratios of over 500 in some cities (WHO, 1991). In Western, Central and Eastern Africa, the risks of pregnancy are generally higher than in Northern and Southern Africa (WHO, 1991). High maternal mortality in Africa is compounded by high fertility. Maternal mortality in Southern Asia is very high, though not quite as high as in Africa (WHO, 1991). The dense population of South Asia accounts for nearly half the world's maternal deaths as compared to 29 percent of its births (WHO, 1991). Asia is the region with the greatest disparity in maternal mortality ratios between countries (Cannavan, 2008).

Ratios in East Asia are quite low (Cannavan, 2008). Hong Kong, Singapore and Japan have maternal mortality ratios of seven, ten and 18 per 100,000 live births respectively, which compare favourably with the lowest ratios in Europe (WHO and UNICEF, 1996).

China, by contrast, has a maternal mortality ratio of 95 deaths per 100, 000 (WHO and UNICEF, 1996).

Excluding parts of the Caribbean, risks of pregnancy in Latin America are lower than inAfrica and most of Asia (Cannavan, 2008). However, data on Latin America is largely based on civil registration and tends to underestimate the problem perhaps by as much as 60 percent (Evjen-Olsen, 2008). The average for the region is estimated to be 200 per 100,000 live births, a high proportion of which are abortion-related deaths (Evjen-Olsen, 2008). According to WHO estimates, in South America, 41 women per 1000 aged 15-49 undergo unsafe abortions, and there is one maternal death per 1000 abortions, representing almost a quarter of the region's maternal mortality (Bougangue, 2010).

In Western and Northern Europe, maternal mortality ratios are in most cases around 10 per 100 000 live births. Scandinavia, however, has ratios of around five per 100,000 (Bougangue, 2010). Low maternal mortality ratios and low fertility in Europe means that the region has relatively few maternal deaths (Garenne, Mbaye, Bah, Correa, 1997). Ratios in Southern and Eastern Europe are slightly higher at around 30 per 100,000. Romania is an exceptional case as maternal mortality peaked in 1989 with 169 deaths per 100,000 live births, a figure which fell to 83 per 100,000 after the prohibitions on abortion were revoked in 1989 (Garenne, et al., 1997). Russia and Poland have worsening maternal mortality, reflecting growing reproductive health problems in these countries (Garenne, etal., 1997). Australia, Canada, Japan, New Zealand and the United States all have ratios similar to those in Europe (Garenne, et al., 1997).

The measurement of maternal mortality is beset with problems of data collection andaccuracy. Most figures probably underestimate the magnitude of the problem.

Because of these problems, it is difficult to accurately discern trends in maternal mortality rates (Haque, 2009; Hiluf & Fantahum, 2008). Although poverty is linked with high maternal mortality, it has also been noted that there exists great variation in the maternal mortality ratio even between countries with low GDP (Magadi & Curtis, 2003). For example, a woman's lifetime risk of a maternal death is 1 in 230 in Sri Lanka, as compared with 1 in 13 in the Gambia and 1 in 10 in Nepal even though these countries have similar levels of GDP (Hiluf & Fantahum, 2008; McAlister & Baskett, 2006)

Indonesia is considered to have achieved much in economic development, and yet the maternal mortality ratio is high at 650 per 100,000 (Magadi & Curtis, 2003; McAlister & Baskett, 2006). This shows that there are substantial differences between countries in their ability to translate economic development into improved maternal health

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the research methodology that was used to conduct the research work. The chapter comprises the introduction, profile of the study area, study design, sample size and characteristics, sampling techniques, research variables, data collection, study instrument, quality control and research ethics.

3.2Profile of study area

The study was conducted in the East Mamprusi district. East Mamprusi district is located in the North-Eastern part of the Northern Region. The district capital is Gambaga. The district shares common borders with the following: Binduri and Bawku West to the North, Bunkpurugu-Yunyoo to the East, Karaga to the South, and West Mamprusi to the West. The District has an estimated total population of 129,000. Average household size is 7.7 and almost half of married women (48%) are in polygamous unions.Educational status of women and girls is very low with 78% of them being illiterate, and one in 6 pregnancies occurs in girls aged 15-19 years.

The major ethnic group in the District is the Mamprusi who speak Mampruli. Other ethnic groups found in the eastern part of the District are the Bimobas and the Konkombas; these are the dominant ethnic groups. Minority groups found in the area include the Mossi, Talensi, Hausa, Fulani, Frafra and Chokosi. The land is rocky with highlands and Sahel savannah vegetation. Shea trees are wildly grown and other trees such as dawada. Cashew also thrives well. The district has long dry months with severe

heat around February to April resulting to high cases of cerebro-spinal meningitis. Outbreaks are usually experienced during these periods.

The districts also have a lot of hard to reach communities due to the rocky nature and rivers and streams. The district has a fairly good drainage system. There are five urban settlements with population of 5,000 and above. These settlements include: Gambaga, Nalerigu, Sakogu, Langbinsi, and Gbintiri. The people in these urban settlements constitute about 30% of the total population of the District. Seventy percent of the people are thus rural dwellers.

Since all the major social and economic infrastructure and services are located in the urban areas, majority of the people are either deprived totally of utilizing these facilities or have limited access to them. Throughout the district, settlement patterns are largely dispersed. This is more so with the rural communities. A number of compounds made up of usually round huts roofed with thatch and owned by a number of households are scattered over large farmlands. This pattern in the rural areas sometimes poses a problem of distinguishing one community from another in some cases.

Most of the people especially in the rural areas live in circular structures roofed with thatch. These are usually built in circular groups to form a compound. Compound houses in most rural communities found in the western part of the District are mostly nucleated; scattered compounds are mostly associated with the Konkombas and other communities in the eastern part of the District. The scattered nature of the settlements in the eastern part of the District makes accessibility to communities quite difficult. Most of the roads linking such places are only footpaths or roads in very bad conditions.

The major road across the District from the East to the West is however motorable throughout the year. The scattered nature of the settlements especially in the eastern part of the District implies that there should be greater investments in the provision of socio-economic infrastructure like roads and boreholes. Another implication of the scattered nature of settlements on the provision of water facilities for instance is that boreholes with pump for separate settlements are more feasible and cost effective than mechanized boreholes usually sited in small towns.

The three-tier functional settlements hierarchy growth centers is based on the functions and socio-economic services provided. The higher the number of socio-economic infrastructure and services, the more important the settlement is regarded as a major, minor, or rural service centre. Based on these socio-economic services, and also on the size of the population of the settlements, the following emerged as the major settlements in the district: Gambaga, Nalerigu, and Langbinsi; other settlements that follow are Gbintiri, and sakogu. Socio-economic infrastructure and serves are concentrated in the Northern half of the District. Settlements in the southern and central parts of the district do not have easy access to these facilities and in some cases have very limited access to the major service centres.

The urban population that constitutes only 30% of the total population has easy access to socio- economic infrastructure and services concentrated mainly in the major service centres. Majority (70%) of the people are Moslems. The rest are made of Christian and Traditional Faith Practitioners. Thepeople are mostly subsistent farmers who cultivate food and some cash crops such as groundnuts, maize, millet, vegetables and animal

rearing. The district is one of the poorest districts in the region. Many youth, especially young girls migrate to Kumasi and Accra to work as head porters (*Kayaye*).

This practice has serious implications for HIV/AIDS, STI, and teenage pregnancy among others. The district has five sub-districts for the provision of health services. These are: Gambaga, Nalerigu, Sakogu, Langbinsi, and Gbintiri; five and two health facilities are provided by the Ghana Health Service and Christian Health Association of Ghana, respectively. The district also has six functional CHPS (Community-based Health Planning and Services) compounds providing 24/7 health services. The Baptist Medical Centre in Nalerigu serves as the District Hospital.

The district is more accessible to most communities in the West Mamprusi, Karaga and Bunkpurugu-Yunyoo districts. These communities use health services from the East Mamprusi District which has resulted in over coverage of set targets, especially in the Reproductive and Child Health activities. This also has implications for under estimating resources for health service delivery. This also results in over or under achievements in set targets. The district is a meningitis epidemic zone and cases are recorded throughout the year. The most challenging period of the epidemic is always within the first quarter of every year.

3.3Study design

Analytical cross-sectional study design was used for the study to assess the effects of socio-cultural factors that influence women's health seeking behavior during pregnancy and delivery and how they influence maternal mortality in the East Mampurusi district. Analytical cross sectional study is usually conducted to estimate the prevalence of the outcome of interest for a given population, commonly for the purposes of public health

planning. Data can also be collected on individual characteristics, including exposure to risk factors, alongside information about the outcome. In this way cross-sectional studies provide a 'snapshot' of the outcome and the characteristics associated with it, at a specific point in time.

In this study, the researcher solicited information from each respondent once, within a specified period of time for the research and analysis was made after the data collection. The study was both quantitative and qualitative (integrated method) in nature. The data collected was based on socio-demographic characteristics of respondents, health seeking behavior of women during pregnancy, labour and delivery, respondents' level of knowledge on pregnancy complications, socio-cultural factors affecting health care seeking behavior of women during pregnancy, labour and delivery and causes and determinants of maternal mortality.

3.4Sample size and characteristics

The target population included women in fertility age from the district. This target population comprised all women who had given birth and live permanently in the East Mampurusi district irrespective of the period of child birth. According to the DHMT (2014) annual report, the total women in their fertility age population was 31882. These respondents who formed that study population were drawn from this number during the period for the study.

Three hundred and eight (308) participants who were used as study respondents from the study area were carefully selected and interviewed using well defined criteria. The criteria for selection of respondents from the study area included

- ✓ Women in whom a viable outcome was expected

- ✓ A lactating woman
- ✓ Only women were used in the study to eliminate the influence of male experiences

In the exclusion criteria, the following criteria were also set

- ✓ Women who have come as a visit to the study area
- ✓ Women who were health workers
- ✓ Women who were teachers
- ✓ TBAs in the community

The district has a total population of women in the fertility age (WIFA) as 31882 representing 23.5% (DHMT, 2014). Thus; the study population was estimated and sampled using the formula below:

$\square = \frac{\square^2 \square \square}{\square^2}$(Fisher et al, 1998)

.

Where:

n=the desired sample size (when the population is greater than 10,000)

z= the standard normal deviation, usually set at 1.96 which corresponds to 95% confidence level

p= the proportion of the target population estimated to have particular characteristic

q=1.0 – p

d- Degree of accuracy desired, usually set at 0.05

Given that 23.5% of the women population in district is within the fertility age group then the sample size was estimated to be;

$\square = \frac{1.96^2(0.24)(0.76)}{0.05^2} = 280$

n= 280

In order to cater for participants' non-response and drop out, a margin of 10% of 280 (approximately 28 participants) was calculated and added to the above estimated sample size. This resulted in a total sample size of (28 +280) or 308 participants.

3.5 Sampling technique

The sampling procedure used for the study was multistage. This method involved the drawing of a sequence of samples from already selected samples, so that only the last sample of subjects is studied. Indeed, East Mampurusi district was purposively chosen for the study because of its demographic characteristics such as high poverty rate, high fertility rate, adherence to religious and socio-cultural practices which largely affect health delivery in the district (District Annual Report, 2006)

According to the DHMT Report (2013), the district is clustered into five sub-districts and out of these, three (including Gambaga, Gbintiri and Sakogu) were selected using simple random sampling technique by labeling and balloting. The choice of the technique was based on the fact that the sub-districts, each of which had unique characteristics, had an equal chance of being selected for the study.

A similar sampling technique was adopted in the selection of two communities each from the various sub-districts chosen for the study. From Gambaga sub-district, the 2/3 communities selected were Gbangu "A" and Gbangu "C"; the 2/5 communities selected from Gbintiri sub-district were Mozio and Jablajo " B" while Dabari and Gadantinga were the 2/6 communities selected from the Sakogu sub-district. Probability Proportional to size was used to allot respondents to each community. As a result of the above procedure, the systematic sampling technique was then used to select houses for the

study; hence the first house was selected by taking a spin from any relevant landmark. Every third house was considered.

In the chosen house, the simple random sampling technique was further used to select a respondent if there were more than one eligible household to respond to the quantitative data (questionnaire). Purposive sampling was then used to select respondents in two communities (Gbangu" A" and Mozio) for a focus group discussion.

These communities werepurposively selected for the group discussion because of their cultural diversities that could potentially impact on the health care seeking behavior of women during pregnancy, labour and delivery. The focus group involved three groups of respondents which comprised mothers-in-law, women in their reproductive ages (these included those who gave birth before and those currently pregnant), and opinion leaders.

Table 3.1: Distribution of sample size according to sub-district

COMMUNITY	POPULATION	WIFA POPULATION	PERCENTAGE (%)	SAMPLE SIZE
GBANGU "A"	1382	298	28	86
GBANGU " C"	1558	339	32	98
GADANTINGA	635	143	13	40
DABARI	388	86	8	25
MOZIO	305	86	8	25
JABLAJO "B"	412	116	11	34
TOTAL	4680	1068	100.0	308

Source: DHMT, 2014.

3.6Research variables

A woman who delivers in a health facility is dependent on several variables. The study considered availability of health facility, availability of good medication and absent of abuse and disrespect during delivery as dependent variables. The independent variables in this study were socio demographic characteristics like age of women, religious status of women, educational level, marital status, parity, and women occupation. It is also good to mention that attitude of health workers, inadequate medication at health facility, distance to health facility and nature of road were considered.

3.7 Data collection and study instruments

The data for the research was obtained from both primary and secondary sources. Through the use of questionnaire and interview guides, the primary data was obtained from respondents whilst some information on the secondary sources was obtained from the DHMT, district assembly, GHS, GSS, published journal articles, published theses and the internet. The integrated method of data collection was used for the study to give detailed and accurate information of the issues under study.

The main instrument for the data collection was structured questionnaire. The questionnaire was designed in such a way that it contained both opened and closed ended questions based on themes from the specific objectives of the study. Structured questionnaire was used for the focus group discussion among the key informants. The focus group guide contained questions on health seeking behavior of women during pregnancy and delivery, knowledge of woman on pregnancy related complications socio-cultural factors affecting the health seeking behaviors of pregnant women and causes and determinants of maternal deaths.

Structured research tools were administered personally by the researchers. Even though some respondents could have answered the questionnaire themselves, the researchers still found it very relevant to administer the research tools to the respondents for the sake of uniformity and accuracy of responses. Face to face interview was used to collect the data from the respondents.

Focus group discussion (FGD) was used as a tool for data collection among some selected women in the study area. It was used as a tool to explore how women feel about socio-cultural factors and health seeking behaviours of women. In all, 10 women were carefully selected for two different focus group discussion. The group members did not know each other and was homogenous in terms of gender and fulfilled inclusion criteria. Before the FGDs, the moderator introduced all participants, explained the general purpose of the study and topic of the discussions. The participants were informed about the language to use and permission to use any language or clear any information before answering a question.

Informed verbal consent was obtained from all individuals participating in the discussion. Then, participants' conversations were transcribed verbatim and translated.The actual data collection stated on the 10th of June and ended on 16th July, 2015. The FGD was held on 16th July, 2015. The field assistants and the researcherwere directly involved in the focus group discussion in order to ensure uniformity and consistency in the questioning and interpretation of the survey data.

In order to ensure that accurate information was obtained from women who had no formal education and those with difficulty in reading and writing, the researcher spoke through an interpreter who understood adequately the various languages spoken in the

communities where the focus groups were conducted. Three research assistants were recruited and trained. They were given training on the techniques involved in data collection, the purpose of the research, and ethics of research and interpretation of the questions in the questionnaire.

3.8 Quality control

The research tool was always cross-checked after administering to ensure that all questions applicable to the respondents were answered correctly and appropriately recorded or ticked. After the data collection exercise from the field, the questionnaires were put in secured places for entry into a computer software package for analysis. Research tools that were coded and entered into the computer software for analysis were put in secured places for the sake of cross-checks.

3.9 Data analysis and presentation method

Completed questionnaires were sorted out, collated and cleaned. Also, strict procedures and steps were followed to code and develop a frame of analysis for the actual analysis to be done.Data collected from the field were edited by screening for content validity and consistencies in the questions and the responses provided. The focus group discussion was conducted in Mampruli and Likpaklpaln through an interpreter and views of respondents recorded using a tape recorder. The focus group discussions conducted with the Key informants were later transcribed from the local languages into English before using it for analysis. Templates for the questionnaires were developed after data collection using the Statistical Product for Service Solutions (SPSS version 21.0) and word excel 2013

Responses generated from the open-ended questions were tallied to check the frequency of particular responses making it possible to code the responses to these open-ended questions. The analysis of the data was in two categories, comprising the background characteristics of respondents, health seeking behavior, respondent's knowledge on complications, socio-cultural factors and causes and determinants of maternal deaths.

The quantitative data were analyzed using descriptive statistics. The qualitative data were analyzed manually and responses grouped into themes based on study objectives.

3.10 Study limitations

First of all, the findings of this study may be limited by recall bias. Indeed, women may be able to recall clearly more on issues relating to complications and health seeking behaviors when given a shorter period usually two weeks but the study did not place emphasis on time for recall thus could be affected by selection bias. Also, the study was conducted in three sub-districts of the East Mampurusi district. These parts of the district are culturally and linguistically different from other parts or areas of the district, hence the results may not be generalizable. Finally, there were limited time and resources constraints which could otherwise have extended the coverage of the study. Nonetheless, these limitations did not influence the interpretation of the findings nor inference to the entire population.

3.11 Dissemination of findings

Once the project is completed, the researcher seek to share the findings with skilled birth attendants, stakeholders and policy makers in maternity care through stakeholders meetings, professional conferences, media programs and publications in health related journals for public access.

3.12 Ethical considerations

Ethical clearance was taken from the University for Development Studies Graduate School Ethics Control Board; informed permission was also sought from the District Director of Health Services, the District Chief Executive. Proper community entry was carried out, respecting all community structures and protocols. This enabled the lead researcher to explain the purpose of the study to them, since socio-cultural and maternal mortality issues are very sensitive within the traditional setup.Verbal informed consent was obtained from the community elders, and women, chiefs and opinion leaders. Confidentiality was assured to respondents

CHAPTER FOUR

RESULTS

4.1 Introduction

The primary data collected from the respondents was carefully cleaned before the analysis was performed on them. Analysis of the data was done using descriptive statistical methods such as pie charts, tables and bar charts. In all, 308 women were recruited for the study from the study area. From the results, the average age of the respondents was 18.96 years. The minimum age was 15 years and maximum age was 44 years at the time of conducting the research from the study area. The analysis of the data was done according to the specific objectives of the study putting each major heading in bold.The chi-square test was used to find any association between categorical variables. All statistical tests were performed using two-sided tests at the 0.05 level of significance. P values less than 0.05 was considered significant.

4.2 Socio-demographic background of respondents

The socio-demographic background of the respondents is shown in Table 4.1 below under the following headings; age, marital status, educational level, religion, ethnicity and occupation. All these variables are carefully presented in the composite Table below.From Table 4.1, half of the respondents 50.6% reported their ages to be between (25-34) years, 39% respondents said they were between the ages of (15-24) years and 10.4% respondents were between the age of (35-44)years at the time of conducting the research work from the study area. The research revealed that 85.6% of the respondents were married with only 5.2% respondents being single or in a consent relationship. A

significant number representing 9% claimed that they were separated, divorced and widowed.

A significant proportion 57.8% of the women had no formal education, 30.5% respondents had JHS qualification, 8.4% respondents had SHS qualification and only 3.2% women had tertiary education. Additionally, 18.5% respondents were practicing Christian faith, 53.6% respondents were practicing Islam faith with 27.9% respondents being traditionalist believers. Furthermore, 40.6% respondents claimed they were from the Mamprusis ethnic background, 21.6% respondents were Moar, 9.1% women were Kusasis, 19.4% women were Likpakpaln and 5.6% respondents were from other ethnic groups like Mossis, Dagombas and Frafras.Additionally, majority of the respondents accounted for 65.6% were housewives, whilst 24.4% respondents were trading. Only few (5.8%) respondents were salaried workers.

Analyses revealed that 59% respondents had 1-2 children, 11% respondents had 3-4 children while 30% respondents claimed they had above 4 children at the time of conducting the research from the study area. There was no significant relationship between parity and health seeking behavior of respondents as the findings indicated that all women would seek health care based on their own assessment of the health conditions they were battling with and whether treatment options were available in some areas in which they were living.

Table 4.1: Socio-demographic characteristics of respondents

VARIABLE	FREQUENCY	PERCENT
Age		
15-24 yrs	120	39.0
25-34 yrs	156	50.6
35-44 yrs	32	10.4
TOTAL	**308**	**100**
Marital status		
Married	264	85.7
Single	16	5.2
Separated	**14**	**4.5**
Divorced	10	3.2
Widowed	4	1.3
TOTAL	**308**	**100**
Educational level		
No formal education	180	57.8
JHS	92	30.5
SHS	26	8.4
Tertiary	10	3.2
TOTAL	**308**	**100**
Religion		
Christians	57	18.5
Islam	160	53.6
Traditional	91	27.9
TOTAL	**308**	**100**
Ethnicity		
Mamprusi	130	40.6
Moar	69	21.6
Kusaal	29	9.1
Likpakpaln	62	19.4
Others	18	5.6
TOTAL	**308**	**100**
Occupation		
Unemployed	13.	4.2
Traders	75	24.4
House wife	202	65.6
Salaried workers	18	5.8
TOTAL	**308**	**100**

Source: Field data, 2015

4.3 Health seeking behavior of women during pregnancy and delivery

Women health seeking behavior varies depending on a number of factors. Accordingly, long distance to health facility, lack of proper means of transport to health facilities, bad road networks linking women place of residents to health facility and availability of TBAs in the same locality with women have been observed to influence women health seeking behavior. Women health seeking behavior sometimes also is linked to how properly they were treated in a previous visit to a health centre couple with self-medications options in the community. Similarly, it has been noted that women may seek health care in a place depending on how severe they perceived their health conditions to be.

Table 4.2: Health seeking behaviour

Variable	Frequency (308)	Percent (%)
Number of Pregnancy		
One	65	21.1
Two	117	38.0
Three	35	11.4
More than three	91	29.5
Last place of ANC visit		
TBAs	98	31.8
Health centre	17	5.5
CHPS compound	178	57.8
Herbalist	15	4.9
Had wastage	83	26.9
Time of initiating ANC		
First trimester	93	30.2
Pregnancy complications	64	20.8
Third trimester	107	34.7
Neutral	44	14.3
Frequency of ANC visits		
Once	90	29.2
Twice	94	30.5
Three times	19	6.2
Four times	16	5.2
More than four times	46	14.9
Never	43	14.0

Source: Field survey, 2015

The study explored to know how many times mothers became pregnantbefore their last delivery. It was revealed that, 38.0% respondents who formed part of the study became

pregnant for two times, 11.4% respondents became pregnant for three times, 29.5% respondents became pregnant for more than three times whiles 21.1% respondents became pregnant for the first time.Also, data gathered from the respondents revealed that 73.1% respondents never had wastage or stillbirth whiles 26.9% respondents said they had stillbirth at the time of conducting the research. Among the respondents who ever experienced wastage of pregnancy, 31.3% respondents sought ANC services before the miscarriage whiles 68.7% respondents said contrary. However, when asked for reasons why they never sought for ANC services before experiencing pregnancy wastage/ stillbirth, 31.6% respondents stated high cost of services, 29.8% respondents indicated long distance to health facility, 22.8% respondents who took part in the survey mentioned that they consulted the traditional birth attendant for herbal medication whereas 15.8% respondents stated that they resorted to self-medication and perceived treatment at that time to be good for them.

As shown in Table 4.2 above, it was revealed by the research that 31.8% respondents sought ANC services from Traditional birth attendance, 5.5% respondents stated health centre, and 57.8% respondent's mentioned CHPS compound whiles 4.9% respondents mentioned herbalist

Time of initiating ANC services is very good for women especially during pregnancy where a foetus is so much desired. Results from the research further indicates in the same Table 4.2 that, 30.2% respondents stated that they reported to the health facility for the first time of their pregnancy within the first three months, 20.8% respondents said they went to health facility when they were experiencing pregnancy complications, 34.7% respondents said when their pregnancy was getting to term, 14.3% respondents could not

recall when they reported to the health facility. Just initiating ANC services and not actually going to access it is not enough for a pregnant woman.

Additionally, in assessing the frequency of ANC attendance by respondents in their last pregnancy, the data gathered from the survey as shown in the same table 4.2 above revealed that, 29.2% respondents went to ANC once, 30.5% respondents attended ANC twice, 6.2% respondents went three times, 5.2% respondents attended ANC four times whiles 14.9% respondents utilized ANC services more than four times with 14.0% never attending ANCAmong women who never sought ANC services at all during their last pregnancy, it was revealed that almost all indicated that they realized they were pregnant at a very late period and fear they might have been shouted up by nurses for coming to health facility with late pregnancy.

A chi square analysis was performed to assess place of ANC services and age of respondents. It was revealed that, 35.0% respondent's age 15-24 years patronized the services of the traditional birth attendant, 5.8% respondents from health centre, 56.7% respondents made used of the CHPS compound with 2.5% respondents seeking health service from herbalist. Respondents age 25-34 years, 26.3% respondents went for ANC services at the Traditional birth attendant, 5.8% respondents used the health centre, 62.2% respondents from CHPS compound with 5.8% respondents utilizing ANC services from the herbalist. The study however, established a significant relationship between age and place of seeking ANC among respondents during their last pregnancy (Chi-square value=38.260; p=0.000).

Also, from the results obtained 31.7% respondents aged between 15-24 years started ANC services within the first month of pregnancy, 30.8% respondents of that same age

category started within the first three months, 19.2% respondents started ANC services when they experienced complications whiles 6.7% and 11.7% respondents respectively initiated ANC services when their pregnancies were getting to term and most respondents could not tell when they started ANC services. Again, 23.7% respondents aged 25-34 years started ANC services within the first month, 30.1% respondents of that aged category started ANC services within the first three months, 25.0% respondents started ANC when they had complications whiles 7.1% respondents started ANC services when their pregnancies got to term with 14.1% respondents not able to tell exactly when they started ANC services. This results however, only established a significant relationship between age and when respondents decided to seek ANC services (Chi-square=0.0051; P=0.000).

Analyses also revealed that, 35.4% respondents said that the decision to seek ANC services depends on their own powers, 11.0% women said they together with their husbands decided whether she should go for ANC services or not, 27.6% respondents mentioned that only the husband was responsible for deciding whether the women should be allowed to go for ANC services while 26.0% respondents said their mother-in-laws were responsible for them to go to seek ANC services at any place.

It was observed that the role played by the husband and the mother in laws in relation to ANC services were mainly providing money to the women. Ideally the man is responsible for providing money to the women to take transport to the nearest health facility but sometimes, the man cannot provide and hehas to fall on the woman to rely on the mother in law for assistance. In the unlikely event, both don't have, it means the woman would not be able to go for ANC services that day or that week.

Results also revealed that respondents who attended ANC services identified reasons for attending ANC as; 15.9% stated that they attended ANC services so that health professionals would detect and treat diseases that were disturbing them, 23.4% said that they went for ANC services for health professionals to monitor the Progress of their pregnancy, 33.1% indicated that they went for ANC services for proper medication for themselves and their unborn baby, 7.1% said that they attended ANC services in other to prepare themselves for safe delivery and 13.3% of mothers were advised by Nurses to attend ANC services whiles 7.1% mentioned due to spouse's decision to attend ANC services.

. Religion and preferred choice of treatment during ill health in pregnancy was examined in the study to ascertain their relationship. The results that emanated from such analysis showed no significance between woman's religion and preferred choice of treatment (Chi square=4.456; p=0.963).

A cross tabulationbetween respondent's level of Education and place of ANC attendance was explored to establish their relationship and the results showed that,34.8% respondents who had no formal education sought ANC services from traditional birth attendance, 3.9% respondents sought ANC services from health centre whiles 56.2% respondents said they seek ANC services from CHPS compound with 5.1% respondents from herbalist. However, 34.0% respondents who had Basic education sought ANC services from traditional birth attendance, 5.3% respondents sought ANC services from health centre whiles 57.4% respondents said they seek ANC services from CHPS compound with 3.2% respondents from herbalist.

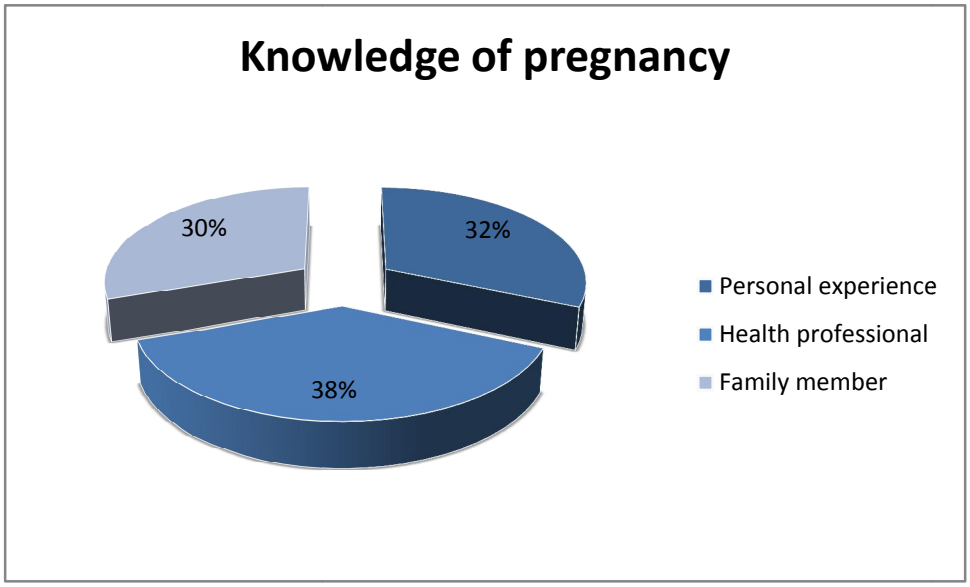
15.4% respondents with SHS education sought ANC services from traditional birth attendance, 7.7% respondents sought ANC services from health centre, 65.4% respondents attended ANC services at CHPS compound. Respondents who had tertiary education revealed that they attended ANC services at the health centre and at the CHPS compound representing 30.0% and 70% respectively. The findings from the research revealed a significant relationship between the variables (Chi-square value=37.260; p=0.000).

4.4 Knowledge about pregnancy and related complications

Good knowledge about pregnancy and related complications concerning women is associated with confidence in adoption of safe practices leading to low complications of pregnancy. Hence, prevention of these complications is essential to improve the quality and health status of women and the community. From Figure 4.1 shown below, 38% women admitted that during their last pregnancy, they were informed of their pregnancy by health workers, 32% respondents stated that they were informed of their pregnancy by their personal experiences while 30% respondents stated that it was their family members that informed them of their pregnancies. Early knowledge of pregnancy of women would be a good sign as they could initiate timely ANC services. Analyses also revealed that, a large of the respondents (43%) mentioned nausea as a sign of pregnancy, 21% respondents mentioned cessation of menstruation temporarily, 19% respondents mentioned weight gain while 17% respondents identified vomiting. It was obvious that all the respondents could mention at least one sign of pregnancy. Having the knowledge of when a woman could deliver would put the woman on a better position to prepare

adequately before delivery. The duration of pregnancy was assessed to examine women knowledge of how long a woman would have to carry a normal pregnancy. From the analyses, majority of the respondents (79%) respondents mentioned that a normal pregnancy would last for nine months while 21% respondents mentioned seven months.

Figure 4.1: Knowledge of pregnancy



Source: Field Survey, 2015

Table 4.3: Critical period during pregnancy

Variable	Frequency (308)	Percent (%)
First trimester	190	61.7
Second trimester	99	32.1
Third trimester	19	6.2
Danger signs		
Oedema	92	30
Severe headache	10	3
vaginal bleeding	15	5
Fever	37	12
severe abdominal pain	116	38
Convulsion	15	5
foul smelling discharge/fluid from vagina	11	4
Vomiting	12	4

Source: Field Survey, 2015

From Table 4.3, majority of the women mentioned that the most critical period during pregnancy was the first trimester, 32.1% respondents stated the second trimester while 6.2% respondents mentioned that the most critical period of pregnancy was the third trimester. Assessing women knowledge of what theyperceived to be the most critical period during pregnancy would assist them to make a better decision to protect themselves and their unborn babies.Examining what women would use to determine critical period during pregnancy could be a better way to assist them make informed choice about their foetus and themselves.The research explored to know why respondents

considered that period as critical.From the responses gathered, 65.9% respondents mentioned that the period was critical because the foetus was considered to be growing at that time while 34.1% respondents stated that the foetus was maturingat that time. Almost all (90%) of the women admitted that during the period they identified as being critical, they sought health care from health workers while 10% respondents mentioned that they sought heath care from the herbalist.

Pregnancy is a prerequisite of maternal death. Therefore, factors that influence the incidence of pregnancy will also influence levels of maternal mortality. Once a woman is pregnant, pregnancy complications may develop which need to be prevented or effectively treated in order to reduce maternal mortality. If pregnancy complications are not successfully treated, then maternal death may be the final outcome.The health status of a woman may affect the likelihood that she will develop complications during pregnancy and also her ability to survive these complications. Health status is itself affected by a range of factors, both distant and intermediate. Anaemia is a health status factor which is influenced by other factors, for example it may be the result of a lack of money to buy food, or its persistence may be the result of a lack of access to health services which can correct anaemia.

Viewing women's health across the life cycle, it is clear that the health status of pregnant women is affected by their experience earlier in life. Particularly significant is the nutrition of girl children. For example, where girl children are undernourished, sometimes due to gender bias in food allocation, their growth may be stunted leading to the likelihood of complications in pregnancy.From Table 4.3, most respondents identified severe abdominal pain of the woman as a danger sign of pregnancy while 30%

respondents mentioned oedema. The rest identified by women as danger signs are shown below in Table 4.3

An analysis of variance (ANOVA) was done to establish any significant differences among respondent's knowledge on pregnancy. Overall, the respondents had good knowledge concerning pregnancy and its related complications. There was a significant difference in knowledge score among respondents in different age category. It was indicated that respondents aged 30 and above had good knowledge concerning the pregnancy more than those who were aged below 30 years (ANOVA, P=0.005). This could suggest that respondents who were 30 years and above were better informed on the pregnancy possible from previous experiences than those who were aged between below 30 years. There was no significant difference in knowledge score for respondents in different occupation and education and knowledge on pregnancy complications (ANOVA, P=0.1223).

4.5 Socio-cultural factors influencing health seeking behaviours of pregnant women

The study identified several social, cultural, economic, and morbidity factors such as age of mother, perceived cultural belief, likes and dislikes of place of birth, gender of household head, residence, type of house, parents' education as the determinants of factors influencing women health seeking behaviour. It was revealed that religion has no bearing on women place of health seeking behavior.Maternal mortality in developing countries is one of the main public health issues that not only concern the health of the women, but also the health of the newborn (Donnay 2000). Maternal death is usually associated with both a poor health environment and a serious lack of health resources (e.g., medicines, health care professionals and health care infrastructure)

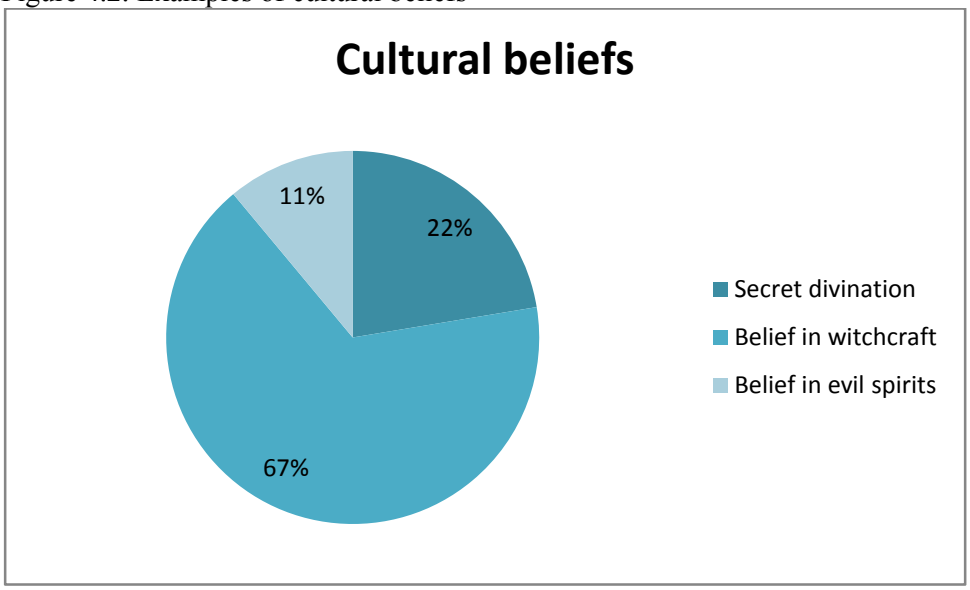
Most of the researchers that study the determinants of maternal mortality at the individual level evaluate the direct or indirect causes of maternal mortality. For example, Ahmed et al. (1999) found that in Zambia among the most common obstetric causes of maternal death are abortion, toxemia, and puerperal sepsis. Some of the indirect causes of maternal death that are more prevalent are anemia, HIV, malaria and tuberculosis; these diseases are closely associated with poverty. The pattern of fertility is also important in explaining maternal mortality (Boherma,1987). There is evidence that indicates that multiple pregnancies affect not only the health of the mother, but also the health of the infant (Ozumba and Igwegbe, 1992). According to WHO (2005) maternal death is directly related to the number of pregnancies and deliveries.

This is supported by many descriptive studies that have found that the number of deliveries is related to maternal death (Alauddin, 1986; Walker et al., 1986). Using a logistic regression and controlling for other factors, Chowdhury et al. (2007) found that more than six pregnancies increase the likelihood of maternal death. However, Okonofua et al. (1992) found that multiple pregnancies are not a significant determinant of maternal death. Maternal mortality has been linked with poor nutrition (Rush, 2000; Loudon, 2000). Malnutrition has been associated with anemia which is one of the main causes of maternal death (Bravin et al., 2001).

Results from the study revealed that majority of the respondents (95%) stated that there were cultural beliefs affecting women choice of place of delivery and health seeking behavior while a relatively smaller number (5%) mentioned that there are no cultural factors affecting women health seeking behaviour.Knowing what type of cultural beliefs exist in a given geographical location could inform policy makers on what type of steps

could be taken to improve women health seeking behavior. The study identified few cultural beliefs that motivated women not to seek health care especially in health facilities. From Figure 4.2 shown below, 67% respondents gave secret divination of women in secret diviners, 11% respondents mentioned belief in evil spirits and 22% respondents mentioned belief in witchcraft.These few examples of cultural beliefs in the community affected women health seeking behavour.

Figure 4.2: Examples of cultural beliefs



Source: Field survey, 2015

Sometimes in the community, women were given local treatment before being sent to the hospital for treatment. The results from the studyrevealed that87% women mentioned that women in the study area were sometimes given local treatment before taken to a health centre depending on the severity of the complaint while 13% respondents stated that women were not given local treatment before taken to the health centre. In theirview, women were first sent to hospital after which local treatment could follow depending on the advice of the elderly.The study also identified two local medicines that in times of ill health women were treated with before being sent to the hospital. From Table

4.4indicated below, 42% respondents mentioned that "tuaaga", a local concoction was normally given to women in times of ill health while 58% respondents stated "puumagu" also a local medicine for women in times of ill health.

Table 4.4: Examples of local treatment

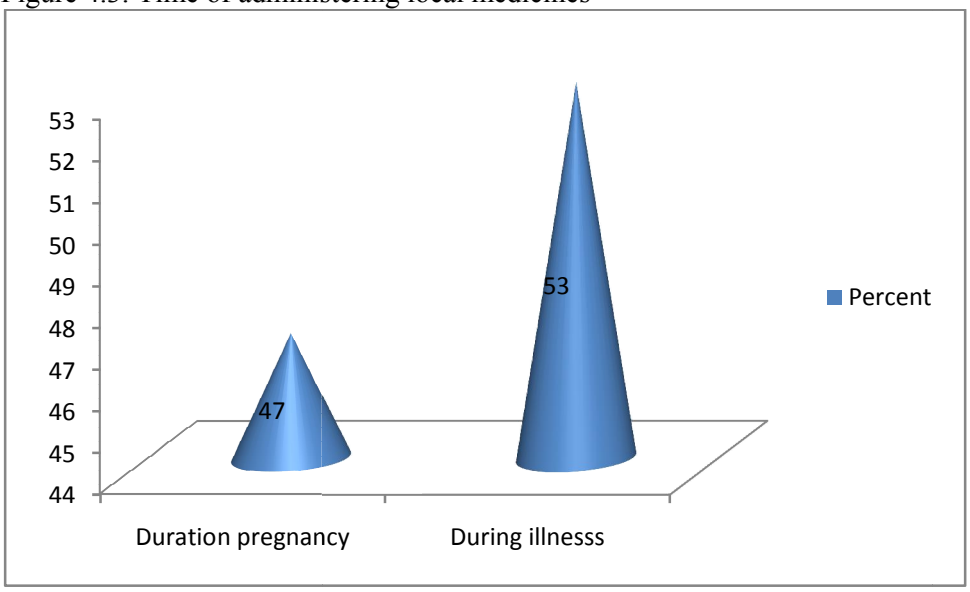
VARIABLE	PERCENT	PERCENT
Herbs (tuaaga)	128	42
Local medicine (puumagu)	180	58
TOTAL	**308**	**100**

Source: Field survey, 2015

Results from the study as shown in Figure 4.3revealed that, 53% respondents mentioned that the time of administering those local medicines to women is during ill health while 47% respondents stated that during pregnancy. All the respondents (100%) again indicated that women could take the local medicines even without any pregnancy. They further stated that the purpose of the local medicine is to treat a condition. Majority of the women (68%) admitted that women who were given local medicines were allowed to go to the health centres to seek better health most especially ANC services while 32% respondents mentioned that women who were treated using local treatment were in most cases not allow to immediately go to the health centre for treatment most especially ANC but have to stay a little bit longer in the house for the local medicine to take effect. Analyses also showed that, most respondents (71%) identified lack of proper means of transport to carry women most especially pregnant women to health centres as one of the reasons for the late report of women to health centre to seek health care, 3% respondents mentioned in some extreme cases women would have to allow their husbands to first

consult a diviner while 26% respondents stated that they do have to get permission from their husbands before going to the hospital in time.

Figure 4.3: Time of administering local medicines



Source: Field survey, 2015

From Table 4.5 shown below, 68% respondents mentioned that successful previous home delivery by pregnant women do compel them to deliver at home as against health facility delivery, 3% respondents mentioned lack of finance to pay certain medical bills at the health facility and 29% respondents stated husbands do not in most cases allowed their wives to go to hospital early before labour sets in. It was observed through the study that 90.6% respondents mentioned that they were reasons why pregnant women/mothers are not allowed to go and deliver in the health facilities in this area whiles 9.4% respondents mentioned that they were no reasons. Some of the reasons the majority identified were; fear of caesarian section, demonstration of courage, the need to attain permission from husband/relatives to deliver at the health facility, previous birth at home was successful, financial problems and the cultural setting.

Others also identified poor road network, poor attitude of health workers and effectiveness of TBAs in the community. Distance and transport issues in rural areas are a highly significant factor affecting women's access to health services, especially emergency care. Even if women do attempt to get to hospital for treatment, they may arrive too late for their lives to be saved because of poor roads and a lack of adequate transportation. Delays may also occur in referral from one health facility to another. A woman in a remote rural area must leave her family behind, and have a large amount of money to spend on transport if she is to reach a hospital which can deal with obstetric complications. If she is accompanied by a friend or relative, this person must also find the time and resources to stay near the hospital during the time of treatment. If she dies in hospital or on route, then transporting the body back home is both difficult and expensive. It may also be distressing to die far away from family and friends.

Again, the research findings indicate that 38.9%respondents stated that pregnant women who were in labour in the community needed a consultation and divination at the soothsayer's house before sending the person to the health facility for delivery, 46.7% said when the TBA is finding it difficult to deliver the pregnant women (long labour) whereas 14.4% indicated that when finally, the husband/relative agrees that the pregnant woman be sent to the clinic/hospital for delivery.

The results also revealed that the health seeking behaviours of pregnant women in the community were influenced negatively or positively by certain factors as 4.9% respondents stated lack of support and companionship shown to pregnant women/mothers by husband/relatives when they are to go to a health facility, 31.5% respondents mentioned financial constraints as a factor, 4.5% respondents said poor nature of

roads/unavailability of transport to the facility at the time of need, 11.5% respondents perceived unprofessional nature of health workers, 20.5% respondents said health facilities are far to reach by pregnant women, 5.5% respondents stated the need to ask for permission from their husband or relatives for attaining to the health facility, 11.0% respondents perceived effectiveness of the TBAs in the community whereas 10.7% respondents stated strong smell at the health facility thus, not being helpful to their health.

Table 4.5: Reasons for home delivery

Variable	Frequency (308)	Percent (%)
Previous home delivery	208	68
Lack of finance	10	3
Permission from husband	90	29

Source: Field survey, 2015

4.6 Causes and determinants of maternal deaths

The maternal mortality rate correctly refers to the number of maternal deaths in a period (usually a year) per 100,000 women of reproductive age (usually defined as aged 15-44 or 15-49). This indicator takes into account both the risk of becoming pregnant and the risk of dying for reasons related to maternal complications during pregnancy. There is a range of other definitions and measures of maternal mortality which aim to overcome some of the problems associated with these common measures. This research tried to identify few causes of maternal deaths.

Strong physical effort can also increase health risks to both the pregnant woman and the fetus (Bonzini, 2007; Mozurkewich, 2000). Contractions and reduction of blood flow to the placenta, which can lead to preterm and spontaneous abortion, have been linked to

hard work (Bonzini, 2007; Ronda et al., 2009). Agricultural work, specifically, has been linked with preterm delivery (Savitz et al., 1996; Nguyen, 2006; Ronda, et al., 2009). Furthermore, Carrera (2007) suggested that labor overburden can lead to complications that cause maternal death. Cerón-Mireles et al. (2002) found that the number of hours a pregnant woman spent standing at work is related to preeclampsia and eclampsia, two of the leading causes of obstetric complications

Factors at the village level like access to health professionals, transportation availability, and infrastructure can contribute to maternal death. Many of the obstetric causes of maternal mortality (e.g., eclampsia, hemorrhage, and ruptured uterus) can be prevented with maternal care and adequate obstetrical services. Since most surgery rooms and other obstetrical services often are available only in hospitals, distance to the hospital or to the health provider has been considered an important factor of maternal mortality (Maine et al., 1996).

Another relevant factor related to the distance to the hospital is transport and transportation infrastructure (e.g., vehicles in the community, road conditions, and ambulance service) to help women reach specialized health services. In the case of an obstetric emergency, minimizing the time to the health provider is considered one of the more important strategies to reduce maternal mortality. childbirth (Shiffman, 2000), percentage of women receiving prenatal care (Sloan et al., 2001) and access to treatment for pregnancy complications reduce maternal mortality (Bulatao and Ross, 2003). Robinson and Wharrad (2001) found that the number of physicians decreases maternal mortality rates.

The literature consistently has found that factors like maternal health services, fertility controls, good nutrition, and women's education reduces maternal mortality. Results from the study revealed as shown in Table 4.6 below that late initiation of ANC by women has always resulted in pregnancy complications which women often report late to health centres for checkups and 23% identified lack of untreated mosquito net exposing pregnant women to mosquitoes leading to malaria. The rest of the causes as identified by women are shown in the Table below.

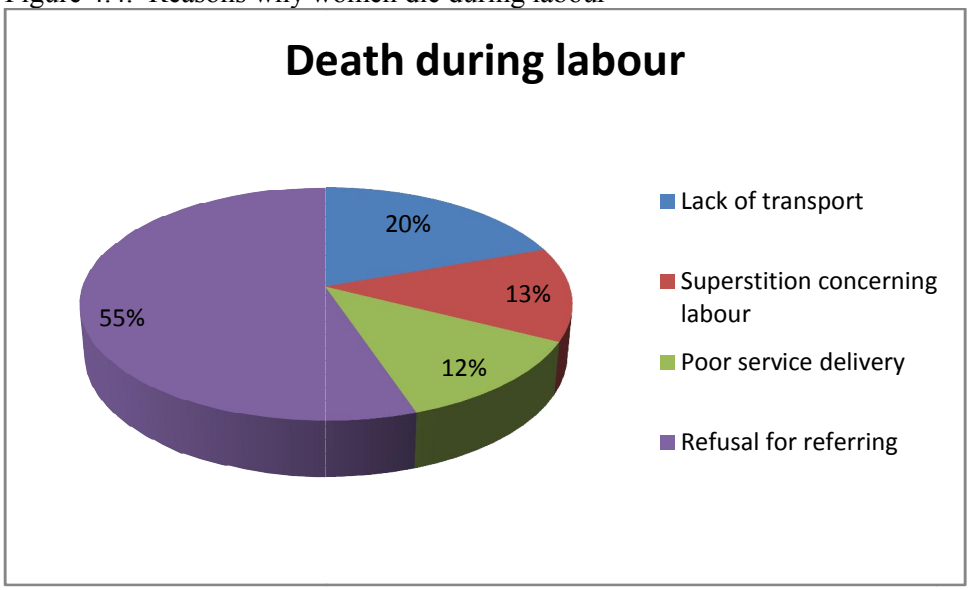
Table 4.6: Death during pregnancy

VARIABLE	FREQUENCY	PERCENT
Lack of good nutrition	20	6
Untreated malaria	70	23
Unsafe abortion	10	3
Use of local medicine	28	9
Late initiation of ANC	150	49
Late recognition of pregnancy complications	30	10
TOTAL	308	100

Source: Field survey, 2015

From Figure 4.4 shown below, 55% respondents mentioned that women refusal to be referred to the nearest health centre for treatment normally results in death sometimes, 12% respondents mentioned poor service delivery at health centres by health workers, 13% respondents mentioned superstitions surrounding labour while 20% respondents stated lack of proper transport to carry women to health centres for treatment early

Figure 4.4: Reasons why women die during labour



Source: Field survey, 2015

Results from the study revealed that more than half of the respondents representing 52% as shown in Table 4.7 below mentioned that bleeding after delivery was a major cause of death of women mostly after delivery, 19% respondents mentioned delayed placenta while 29% respondents stated superstitions

Table 4.7: Death few days/weeks after delivery

VARIABLE	FREQUENCY	PERCENT
Bleeding after delivery	160	52
Delayed placenta	59	19
Superstitions	89	29
TOTAL	308	100

Source: Field survey, 2015

Results from the study as shown in Figure 4.5 below revealed that 65% respondents mentioned that good nutrition to pregnant women, 9% respondents mentioned regular ANC visits by women during pregnancy and 26% respondents mentioned provision of good road would reduce if not eliminate death of women during pregnancy, labour and after delivery. Whilst in the international debate on maternal mortality, certain strategies are favoured for more research, it is necessary to keep in mind where the focus of strategies is in the field. For example, pre-natal care is now less emphasized in international circles because it does not help to save a woman's life when complications set in, and there is more interest in emergency obstetric care services.

It is also important to mention that abortion-related deaths are included in some sources of data and not in others. The exact cause of a woman's death may be difficult to define and it may not be known that a woman was pregnant at death. Often the cause of death is classified wrongly in order to avoid social embarrassment for the families of unmarried women, or to cover up an illegal abortion. Hospitals may under-report maternal deaths in order to avoid blame for patient mismanagement or inappropriate treatment.

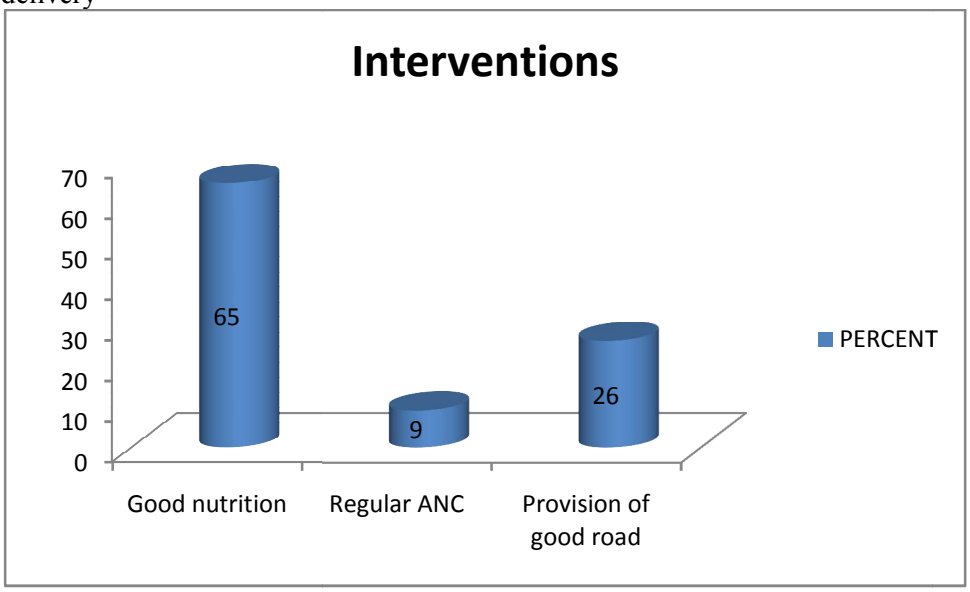
Findings from the study did not reveal any known abuse of a woman leading to death during pregnancy or after delivery. There is an increasing recognition of the significance of violence to women's health with, for example, a new WHO programme on the prevention and management of the health consequences of violence against women WHO, 2013). In order to decrease morbidity and mortality among women victims of abuse, the programme evaluated the effectiveness of existing interventions to prevent and deal with violence against women; work to improve the capacity of health workers at all levels to identify and respond appropriately to victims of physical and sexual abuse and support the formulation by national governments of policies and protocols to address the issue.

Also from the results gathered from the study areas, no respondent mentioned of a case where a woman had to confess during prolong labour. Accusations of marital infidelity may crop up at the time of delivery, for in many African societies, prolonged labour is ascribed to marital infidelity during pregnancy or at some other time. The woman may be given no assistance with the delivery until she confesses to the infidelity and the name of the man involved. The result of this may be stillbirth and sepsis leading to death. If she survives, the long term risks include ectopic pregnancy, infertility, chronic pelvic inflammatory disease, and vesico-vaginal festiculae.

Problems of measuring maternal mortality frequently arise in the literature. In developing countries most women receive delivery assistance from traditional birth assistance, traditional healers or family members (Fikeree et al., 2004; Herrera-Torres et al., 2006), which makes it difficult for health professionals and authorities to record the occurrence and the causes of the death. Maternal deaths where health professionals are absent can

result in underreporting (Graham, 2002). The accuracy of the measurement of maternal mortality cases depends on the available of healthcare specialists (e.g., doctors, nurses, midwives, and nurse's aids) and the accessibility to healthcare facilities. For example, certain causes of maternal death require high technical skills to identify them (Horron, 2005).

Figure 4.5: Ways of preventing pregnant women from dying during pregnancy, delivery and after delivery



Source: Field survey, 2015

CHAPTER FIVE

DISCUSSION

5.1Health care seeking behavior of women during pregnancy and delivery

Health is the bedrock upon which all human societies exist. Thus, the health status of a populace plays an imperative role in the wellbeing of people within a topology and social space. Many people throughout the world and in particular Ghana conceptualize health and health care as the absence of physical pain and as such, those indicators primarily constitute health from a one-dimensional positivistic space (Ansong-Tornui et al, 2007). There is no one determined way policy to address the issue of maternal mortality especially in communities where people are still conservative to culture and traditions. Preventative measures are important but there are no reliable predictors of maternal death. Therefore, making access to emergency obstetric services available to all women is central to reducing maternal mortality. Here, attention is required both to supply (coverage and quality of service provision) as well as demand issues, which have thus far received limited attention.

The dichotomy between supply and demand is often not helpful. Supply-side issues, particularly quality of care, feedback into decisions to seek health care in emergencies. In order to ensure access, health service managers need to be aware of women factors. e.g. distance to facilities, which restrict access mostly women to health care. Results from the research revealed that 31.8% respondents sought ANC services from Traditional birth attendance, 5.5% respondents stated health centre, and 57.8% respondent's mentioned CHPS compound whiles 4.9% respondents mentioned herbalist. This finding from the research agrees with the report by Hellene & Paul (2004) that pregnant women usually

seek health care from traditional birth attendance because of proximity, from clinics simple because of abuse during labour in hospitals and some from drugs stores if their conditions as perceived by them is not serious.

However, the finding is at variance with the work of Nguad, (1998) that pregnant women place of seeking healthcare has traditionally been the hospital where they perceived to always get the best care in terms of health. . Results from the research further indicates that 30.2% respondents stated that they reported to the health facility for the first time of their pregnancy within the first three months, 20.8% respondents said they went to health facility when they were experiencing pregnancy complications, 34.7% respondents said when their pregnancy was getting to term, 14.3% respondents could not recall when they reported at the hospital. Again this finding from the research seems to be similar to the findings presented by Neema-Stella (2002) that (20%) of pregnant women in Uganda, Kampala initiated ANC services in the first trimester, 40% of the pregnant women never initiated ANC services before delivery whiles 40% of the pregnant women claimed they initiated ANC services at the last period of the pregnancy. In rural communities it has been noted that economic and geographic factors have been identified to play a major role in women health seeking behaviour. In several studies pointing to why women deliver at home instead of at the health facility, it has been observed that most of them complained that they do not have the needed resources to get all the materials that would be demanded of them in health facilities. In fact, it has also been discovered that economic and long distances to health facilities especially in rural communities prevented women from going to the health centre to deliver.

The main problem is that many midwives looked upon delivery from the point of view of medical intervention, while the women giving birth saw it as a social and cultural event (Ujah, Aisien, Mutihir et al., 2005; Stanton, 2004; Ujah, Aisien, Mutihir et al., 2005). The Zarma ethnic groups, 62 percent of the population of Niger, have a tradition of a woman giving birth to her first child in her parent's home. Women who live in the city may therefore return to villages for delivery even though this means access to health facilities will be more difficult.

Other Zarma traditions include delivering in a squatting position, not pushing for fear of after pains, not crying out during delivery, and burying the placenta to ward off evil spirits (Stanton, 2004; Ujah, Aisien, Mutihir et al., 2005). Midwives have little tolerance for these beliefs. The research cites incidents of women who insisted on delivering squatting at the health centre, being made to clean the floor of the health centre themselves immediately after delivery (Ujah, Aisien, Mutihir et al., 2005).

It is important for midwives to be trained more appropriately to deal with pregnancy and delivery in traditional settings. User groups of maternal health services should also be set up to promote dialogue between women and midwives (Williams, 2001; Wuni, 2009;).

The availability of female health professionals may have a big influence over whether women use services. In Egypt, for example, the widely held view that women should not be seen by males except for close relatives after puberty means that some women will not accept treatment from male physicians (Yidana and Issahaku, 2014; Wuni, 2009). Women may need permission from their male guardian to seek care even in emergencies. Even when they do seek care, the doctor-patient relationship may be less effective through discomfort at talking to a man. In Islamic northern Cameroon, men are not

allowed to touch other men's wives without authorization, even for medical purposes. Women say that they would rather die than seek unauthorized care in their husbands absence (ibid) (Wuni, 2009).

In northern Nigeria too, both men and women are opposed to female patients being treated by male physicians (Wuni, 2009). Increasing the supply of female health professionals can help address this problem. However, an access problem may persist because female physicians may prefer to remain in urban areas, or not be assigned to rural areas where they will be isolated from family protection (Yidana and Issahaku, 2014; Yunus, Bomfe, Sulemana, 2007). In Ghana, however, older males are perceived as being more competent than younger or female doctors, and for Ghanaian women, male doctors do not represent a barrier to care (Yunus, Bomfe, Sulemana, 2007).

Generally, findings from the research provide understanding of health seeking behavior of pregnant women with particular socio-demographic characteristics. Hence, policy makers will be able to effectively address issue of health promotion that will be geared towards more preventive health seeking behaviour rather than that of curative care in rural communities. It is important to note that policy makers can target a particular group of people with the right information using the right approach to get the needed results. Identifying the right approach to spread health information to people most especially pregnant women could yield the needed results as compare to the traditional way of just organizing health talk for all women in a community.

Campaigns towards positive health seeking behaviour for pregnant women even in places where health facilities are inadequate or non-existence and pregnant women have to travel long distance before accessing health care would go a long way to change the long

held way of seeking health care. The study findings indicated that, 29.2% respondents stated that during their last pregnancy they went for ANC services once, 30.5% respondents attended ANC twice in a month, 6.2% respondents went three times in a month, 5.2% respondents said they went four times in a month whiles 14.9% respondents attended ANC more than four times in a month with 14.0% never attending ANC during their last pregnancy. The average attended of ANC by the respondents was at twice in the month. This finding from the study, is at variance with the finding of Thompson (1999) that pregnant women in Kenya attended ANC services twice in every week to the time of delivery. It is important to state that some factors known to be directly affecting the utilization of ante-natal services especially for pregnant women in rural communities include; long distance to health facilities, cost of services at the health centres, socio-economic and cultural barriers and quality of care of services provided, including service provider attitude (GHS, 2007).

Ante-natal services are important part of preventive and promotive health care mostly for pregnant women in Ante-natal clinics. Ante-natal care has been observed to have beneficial impact on pregnancy and birth outcomes through early diagnosis and treatment of complication as well as promoting the health of the pregnant women. Although pregnant women are supposed to always initiate ANC services early, sometimes late initiation of ANC services by women is always due to both socio-cultural factors prevailing in their area. ANC services effectively being utilized by pregnant women create the opportunity, for service providers to establish contact with the pregnant women to identify and mange current and potential health risks and problems during pregnancy.

Ante natal services also create the opportunity for the woman and her care providers to establish a delivery plan based on the needs of women, resources and circumstances. In addition, ANC provides the opportunity for screening and detecting of conditions such as breast cancer, HIV and sexually transmitted infections (STIs) and other reproductive issues. For effective ANC, it is ideal that services are initiated early in pregnancy and adequate number of visits made for the women to enjoy the full package of services delivered.Furthermore, findings from the study revealed that 35.4% respondents stated that it was their own decision to attend ANC or not to attend, 11.0% respondents mentioned that both couples took the decision, 27.6% respondents said their husband decided for them whiles 26.0% respondents said their in-laws. This finding from the study disagrees with the work by Obel (1995) where most (40%) of pregnant women who seek for ANC services during their last pregnancy mentioned it was their husbands and their own decision to go for ANC services whiles 20% respondents stated that it was their own decision to attend ANC or not to attend.

Education and place of ANC attendance was explored to establish their relationship and the results showed that,34.8% respondents who had no formal education sought ANC services from traditional birth attendance, 3.9% respondents sought ANC services from health centre whiles 56.2% respondents said they seek ANC services from CHPS compound with 5.1% respondents from herbalist. However, 34.0% respondents who had Basic education sought ANC services from traditional birth attendance, 5.3% respondents sought ANC services from health centre whiles 57.4% respondents said they seek ANC services from CHPS compound with 3.2% respondents from herbalist.

Analyses also revealed that, 15.4% respondents with SHS education sought ANC services from traditional birth attendance, 7.7% respondents sought ANC services from health centre, 65.4% respondents attended ANC services at CHPS compound. Respondents who had tertiary education revealed that they attended ANC services at the health centre and at the CHPS compound representing 30.0% and 70.0% respectively. This finding from the study agrees with the research conducted by Jackson, Kelsall, Parr & Papa (1998) which revealed that there was a relationship between the educational status of pregnant women and the choice of place of health care. Results from the study indicated that most of the pregnant women with tertiary education opted to deliver in the hospital as against pregnant women with inadequate education who opted for home delivery.

The study also tried to establish the relationship between age and place of seeking ANC services during last pregnancy. It was realized that 35.0% respondent's age 15-24 years sought ANC services from traditional birth attendance with 2.5% respondents seeking health service from herbalist as against 26.3% respondents aged 25-34 years who sought ANC services from Traditional birth attendance with 5.8% respondents seeking ANC services from herbalist.

However, 46.9% respondents aged 35-44 years sought ANC services from Traditional birth attendance whiles 7.4% respondents resorted to herbalist. This finding from the study complement the research carried out by Issah, et al., (1999) research report that the aged pregnant women in Nigeria, in the Northern States seem to patronize herbal treatment when they were ill as compared to younger pregnant women. This is evident as 5.8% pregnant women aged 25-34 years and 35-44 years sought ANC services from

herbal homes. It was clear from the results that even after seeking ANC services from either the traditional birth attendant or the herbalist, respondents still went to the health facility for treatment.

Also, from the results obtained 31.7% respondents aged between 15-24 years started ANC services within the first month of pregnancy, 30.8% respondents of that same age category started within the first three months, 19.2% respondents started ANC services when they experienced complications whiles 6.7% and 11.7% respondents respectively initiated ANC services when their pregnancies were getting to term and most respondents could not tell when they started ANC services.

Again, 23.7% respondents aged 25-34 years started ANC services within the first month, 30.1% respondents of that aged category started ANC services within the first three months, 25.0% respondents started ANC when they had complications whiles 7.1% respondents started ANC services when their pregnancies got to term with 14.1% respondents not able to tell exactly when they started ANC services. It was also revealed by the study that twenty-two percent respondents aged 35-44 years started ANC services within the first three months, 28.1% respondents within the first three months, 6.2% respondents started ANC services when they experienced pregnancy complications, 18.8% respondents started when their pregnancies were getting to term whiles 25.0% respondents could not remember exactly when they started ANC services.

This result is at variance with the finding made by Jaffey (1991) results that primigravidae seek ANC services less and at later stage of the pregnancy as compare to multi-parity. Results also revealed that respondents who attended ANC services identified reasons for attending ANC as; 15.9% stated that they attended ANC services so

that health professionals would detect and treat diseases that were disturbing them, 23.4% said that they went for ANC services for health professionals to monitor the Progress of their pregnancy, 33.1% indicated that they went for ANC services for proper medication for themselves and their unborn baby, 7.1% said that they attended ANC services in other to prepare themselves for safe delivery and 13.3% of mothers were advised by Nurses to attend ANC services whiles 7.1% mentioned due to spouse's decision to attend ANC services.

Understanding ways by which socio-cultural conditions affect health care among pregnant women would enable policy makers to identify the most effective interventions for improving population health. Poor health may lead to socio-cultural and economic deprivation because it impacts on people's chances of education and employment and their access to housing and other goods and services. The relationship between socioeconomic conditions and health operates in both directions but primarily it is deprivation that leads to poor health rather than vice versa.Knowledge of health risks is, by itself, not enough to change pregnant women behaviour. Socioeconomic status affects health mainly through family income, housing, work conditions and unemployment. Disintegration of social networks, which is more likely to occur in areas of socio-economic deprivation, has detrimental effects on health that potentially spread to involve all members of society. Conventions of family and social life, such as social support, promote health.

5.2Knowledge of women about pregnancy-related complications

Health care seeking behaviour can be explained as people visiting a health practitioner or health consultant such as doctor, nurse, pharmacist or healer for health care and/ or health

advice. According to the Theory of Reasoned Action (TRA) in which attitudes and subjective norms, both constitute the building blocks of this theory. The determinant of intention and attitude toward health seeking behaviour, is a function of beliefs and knowledge concerning the consequences of performing the behaviour and evaluation of each of these consequences as either positive or negative as perceived by the individual (Abubakari and Yahaya, 2014; Bazzano, Kirkwood, Tawiah et al., 2008).

Health promotion campaign globally have long been premised on the idea that providing knowledge about causes of ill health and choices available for treatment, will go a long way towards promoting a change in individual behaviour, towards more beneficial health seeking behavior (Bazzano, Kirkwood, Tawiah et al., 2008). However, there is growing recognition, in both developed and developing countries, that providing education and knowledge at the individual level is not sufficient in itself to promote a change in behavior especially among pregnant women in rural areas in Ghana.Studies have focus almost exclusively on the individual as a purposive and decisive agent, and elsewhere there is a growing concern that factors promoting 'good' health seeking behaviours are not rooted solely in the individual but the broader family relations, community norms and the location of health facility (Bazzano, Kirkwood, Tawiah et al., 2008). They also have a more dynamic, collective, interactive element. And in many cases these interactive elements are so silence that people don't even recognize them or consider them as so important. Researchershave long been interested in what facilitates the use of health services by women in areas where traditions and cultures and male dominant is still prominence, and what influences people to behave differently in relation to their health seeking behaviours.

These studies demonstrate that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables including, sex, age, the social status of women, the type of illness, access to services and perceived quality of the service (Tipping and Segall, 1995) and in most cases, the behavior of health workers. In mapping out the factors behind such patterns, there are barriers or determinants which lie between patients and services. These tend to fall under the divisions of geographical, social, economic, cultural and organizational factors.

According to Abubakari and Yahaya (2014) good knowledge of a health condition is associated with confidence in adoption of safe practice among most pregnant women especially in rural communities leading to low neglect of certain ill conditions they perceived as not being complete. Studies have revealed that the overall knowledge, attitude, and practice of women about preventive measures of pregnancy related complications is inadequate and suggested that health workers intensified their campaign on preventive measures of maternal death among women in rural communities to serve as a guide to prevent women from spreading false information among themselves especially among those who are traditionally conservative to change. In relations to knowledge of women and ill health, good attitude have demonstrated that there is always a strong correlation between a person attitude and the health seeking behavior of the person.

Results from the research revealed that 30% pregnant women knowledge of their pregnancies was informed by health professional, 38% respondents said they were notified by family/community members, and 32% respondents mentioned personal experience. This finding from the study is in line with the report presented by Srinivas and Mohanty (2008) that 35% of pregnant women got the information that they were

pregnant from a health worker when they visited the health facility, 25% said they were informed by their relatives because that was actually their first time of getting pregnant and 40% of the pregnant women stated their knowledge was informed by the experiences they had during previous pregnancies. It is important to emphasis that having the first hand information of pregnancy could be a better way of encouraging women to start attending ANC services at health facilities since most women do present pregnancy complications during ANC visits at late pregnancy.

From the results also, majority of the women mentioned that the most critical period during pregnancy was the first trimester, 32.1% respondents stated the second trimester while 6.2% respondents mentioned that the most critical period of pregnancy was the third trimester.This finding from the study completely disagree with the findings presented by Sundaram & Kaunram (2003) report that almost all the pregnant women sampled for a cross-sectional survey considered the second-third trimester as the most critical period during pregnancy. It is also good to state here that respondents by their own assessment defined critical period as the period during which the developing baby is needed to be taken care of by the mother.Nonetheless, those not having knowledge about the critical period are at a higher risk of developing complications and dying from maternal causes since they do not know about the dangers involved in the period to recognize them as problems and take prompt decision to seek care as the proponents of the Delays Model maintain.

Again, this current study revealed that there was significant association between level of education and when the critical period is, during pregnancy. This finding is in line with other findings which revealed that women with secondary education and above have

adequate knowledge about pregnancy-related complications and seek antenatal care earlier than those below secondary level of education (GSS, 2005; UNDP, 2007). This finding however, disagrees with Bougangue (2010) results that majority (53.3%) of women especially those with secondary education and all other levels of education showed inadequate knowledge of critical period during pregnancy. Results from the study also confirmed the fact that respondents were able to identify one form of danger sign of pregnancy. Most (38%) respondents identified severe abdominal pain as a danger sign during pregnancy whiles 30% respondents mentioned oedema.

This is not surprising as these danger signs were constantly being discussed in the study area. From the respondents, it was discovered that 82.5% respondents have experienced either abdominal pain or oedema whiles 17.5% respondents said contrary. The finding indicates that, there was a significant association between education and knowledge of signs of pregnancy which is at variance with the early finding by Chesaina (1991) that there was no relationship between education and knowledge of signs of pregnancy.When sought to know what measures were taken to treat or manage the conditions, 23% indicated they resorted to herbal medicines since that was available and cheap. Whiles a relatively smaller 10% said they went to see a health professional. In the focus group discussion, some of the mothers said they resorted to herbalists and spiritual men in order to protect the pregnancy and to ensure successful delivery, since previous pregnancies which were not given spiritual protection failed. According to the mothers, seeking antenatal care services at early stage would expose the pregnancy to the society, which is likely to attract evil spiritual eyes to attack and destroy the pregnancy. The mothers in the discussion also stated that, people with spiritual eyes could see things for themselves but

need confirmation from the pregnant women and close relatives to take action. This findings agrees with Senah (2003) and Arhin (2001) that until pregnancy becomes visible, it remains secrete in Ghanaian society, and that it is traditionally immodest to show early signs of pregnancy until it becomes visible. Under this condition, early identification of risk factors and complications through screening will not be possible.

The study found some women who had good knowledge about critical period during pregnancy but never sought medical care in their last pregnancy. This category of women justified their act with spiritual reasons.

"I experienced two miscarriages, I had to visit the spiritualist through the effort of my husband's uncle and the spiritualist found nothing wrong with my womb. What the spiritualist informed me was that I would become pregnant again but I should immediately perform certain rituals, he instructed me to do" (27 year mother of one child from Gadantiga)

Thaddeus and Maine (1990), on the Three Delays Model contend that people may have knowledge about a medical condition, its implications as well as the appropriate place to seek care but may delay or not seek care at all because of cultural factors or system of belief in the society.

5.3Socio-cultural factors influencing the health seeking behavior of pregnant women

Pregnant women health seeking behaviour is continuously interfacing social, cultural, psychological, religious and political experiences and so the biomedical theorizing is a simplistic perspective on the subject matter as health is perceived to be the absence of illness and the psychosocial well-being of an individual (Ansong-Tornui et al, 2007). It is a known fact that socio-economic status affects a woman's chances of dying a maternal

death by working through the intermediate factors. Mortality is almost always higher among the poor and disadvantaged than among the wealthy, and this is also true of maternal mortality. Gender analysis suggests that it is equally important to consider the demand-side factors relating to the utilization of health services. The links between socioeconomic status, health behaviour and access to health services need to be better understood. Stating very clear that it is good to assess how women's positions in households and communities relate to their abilities to seek adequate health care for themselves, thereby preventing maternal death.

Analysis of gender relations in a given context is crucial to understanding the processes by which such decisions are made and specifically the limitations on women's capacity to control reproductive decision making and to seek health care for themselves. This, in turn, has implications for strategy. Where, for example, it is recognised that women's decision making capacity is limited by household and community power relations, maternal education to increase women's awareness of the need to seek intervention will clearly be insufficient to increase their use of services. It may be useful to view women's vulnerability to maternal death and capacity to access health care without any hindrance.

Results from the study revealed that 95% respondents indicated that they were cultural/local beliefs suggesting why a pregnant woman dies during or after child birth whiles 5% respondents said they were no cultural/local beliefs at the time of conducting the research at the study area.

This finding from the study confirms the work done by Shaikh and Hatcher (2005) that indigenous beliefs and practices take shape around the cultural traits that are passed from one generation to the next. These practices are deeply rooted and embedded in these

societies, and therefore they become part of the people's lifestyle. They are innate to such an extent that it is difficult to try to change these beliefs and practices, as people have adhered to them throughout their entire lives.Pregnant women especially in rural areas with the study area not excluded casually perceive health primarily from the perspective of physical illnesses much so that in the absence of certain physiological indicator they perceive of themselves to be healthy, and so they will address matters relating to its care based on their socio-cultural attitude and valuation.

The degree to which women have control over their own sexuality and reproductive decision making is affected by a range of factors, including: pressures to bear many children (high fertility), related to economic and social security as well as gender identity; son preference (often related to property and inheritance rights biased against women); and age at marriage. The personal and power relationships which exist within the family between husbands and wives are clearly important too, as are the cultural beliefs and practices surrounding sexuality which underpin these relationships, often limiting women's sexual autonomy. High fertilityis associated with high levels of maternal mortality, both because more pregnancies mean more chances of pregnancy related deaths, and because the risks of pregnancy and childbirth increase after the third child. And yet in many developing countries there is still a strong pressure on women to bear many children despite the risks. There are a number of reasons for this.

Gender identities, that is, what it means to be a man or a woman in a particular society, are shaped and defined by patterns and expectations of reproductive behaviour. For women in many parts of the world, the surest route to social and economic security is to bear many children, preferably sons. Fear of infertility, of divorce or of polygamous

marriage also acts as pressures on women to bear more children.Where male children are accorded more importance than females, women may go on bearing more children in order to have a boy, or more boys. Property and inheritance laws which limit the rights of females can reinforce son preference. In India, the equal rights of sons and daughters to inherit are enshrined in the Constitution but in practice this is often ignored.Interpretations of religious teaching may also contribute to son preference. In Orthodox

Hinduism, only a son can perform the funeral rites for his father, so a Hindu with no sons risks being reborn as a lower form of life.

The practice of dowry, where a family must hand over wealth with the marriage of their daughter to her new family, makes having daughters an economic burden, whilst sons are an asset because it is known that their work will benefit the family. New technology for determining the sex of foetuses can reinforce son preference and have an impact on female mortality, both in terms of the male/female ratio of births, and an increase in maternal mortality.The World Health Organization's (WHO) (2005) stated that "Poverty and social exclusion of pregnant women in rural areas are the greatest threats to their well-being and health seeking behavious. Elderly pregnant women are especially disadvantaged due to their marginal position in the society from proper health care. Findings from Bangladesh and Vietnam, by Ahmed, Tomson, Petzold, & Kabir (2005) conducted a research to elicit information on the health-seeking behaviour of pregnant women in rural communities.

It was discovered that socio-economic indicators were the single most pervasive determinant of health-seeking behaviour among the study population, overriding age,

religion and sex, and in case of health-care expenditure, and types of illness. It was discovered that no major differences in health-seeking behaviour between elderly people and younger adults. On average about 35% of those who reported having been ill during the previous 15 days in both age groups chose self-care/self-treatment; for both age groups the most commonly consulted type of provider was a paraprofessional such as a village doctor, a medical assistant or a community health worker. Patients' level of education affected whether they avoided self-care/self-treatment and drugstore sales people and instead those formal allopathic practitioners.

This finding supports the finding from the research which revealed 53.5% respondents mentioned local medicine (black in colour) taken with porridge to reduce stomach pains locally known as pumaagu whiles 46.5% respondents identified concoction prepared with herbs taken to treat odema (tuaaga). And the overwhelming 87.01% respondents who said they were treatment in the community which was administered to pregnant mothers/women. It is important to mention that throughout the research period, none ofthe women mentioned that they have ever been beaten by their husbands. The threat of violence may also be a dimension of women's sexual and reproductivedecision-making, linking to maternal deaths through increasing the likelihood of unwanted pregnancies. Rape, including marital rape, is also an issue often overlooked and yet relevant. Very little is known about girls and young women who become pregnant as a result of sexual violence and incest in the study, though they would clearly be at risk of maternal death.

The issue of violence needs to be firmly placed on the international health agenda. Safe

motherhood initiatives which remain limited to the notion of reproductive health, are in danger of ignoring the importance of women's emotional and physical well-being, which are connected to issues beyond that of their reproductive anatomy.

Gender violence may be amongst the most significant causes of morbidity and mental distress among women.Again, 38.9%respondents stated that pregnant women who were in labour in the community needed a consultation and divination at the soothsayer's house before sending the person to hospital for delivery, 46.7% said when the TBA is finding it difficult to deliver the pregnant women (long labour) whereas 14.4% indicated that when finally, the husband/relative agrees that the pregnant woman be sent to the clinic/hospital for delivery. This finding supports the study done by Hatcher (2005) that indigenous practice and beliefs influence and underpin the behavior of women during pregnancy and childbirth.

It was observed through the study that 90.6% respondents mentioned that they were reasons why pregnant women/mothers are not allowed to go and deliver in the health facilities in this area whiles 9.4% respondents mentioned that they were no reasons. Some of the reasons the majority identified were; fear of caesarian section, demonstration of courage, the need to attain permission from husband/relatives to deliver at the health facility, previous birth at home was successful, financial problems and the cultural setting.

This finding supports the study done by WHO (1999) which identified maternal morbidity and mortality as being influenced by the socio-economic context of the health care system, and the cultural and biological realities of the pregnant woman seeking health care in their geographical setting. And the finding by Carter (2002) that pregnant

women in Benin would rather suffer days of obstructed labour than ask for help during childbirth and risk being seen as weak.

It is important to know that services as mediated by women their degree of physical and sexual, economic, social and political autonomy are too some extend not always assessed. For example, women's vulnerability to maternal death may be increased by poor health or physical violence and abuse, which are manifestations of their lack of physical and economic autonomy. Their capacity to seek health care may be limited by restrictions on mobility for both economic e.g. lack of independent resources to access transport) and social (norms which limit women's freedom of movement) reasons. The results also revealed that the health seeking behaviours of pregnant women in the community were influenced negatively or positively by certain factors as 4.9% respondents stated lack of support and companionship shown to pregnant women/mothers by husband/relatives when they are to go to a health facility, 31.5% respondents mentioned financial constraints as a factor, 4.5% respondents said poor nature of roads/unavailability of transport to the facility at the time of need, 11.5% respondents perceived unprofessional nature of health workers, 20.5% respondents said health facilities are far to reach by pregnant women, 5.5% respondents stated the need to ask for permission from their husband or relatives for attaining to the health facility, 11.0% respondents perceived effectiveness of the TBAs in the community whereas 10.7% respondents stated strong smell at the health facility thus, not being helpful to their health.

There is often a tendency for studies to focus specifically on the act of seeking 'health care' as defined officially in a particular context. Although data are also gathered on self care, visits to more traditional healers and unofficial medical channels, these are often

seen largely as something which should be prevented, with the emphasis on encouraging people to opt first for the official channels of health care (Ahmed, et al, 2001).Despite the fact that the decisions to seek health care take place in a complex web of relationships, delays in seeking care for maternal health problems can be fatal. They can occur at the level of the individual and household, in the community, or because of referral andtransport problems, as well as in medical facilities themselves. Gender analysis can offer insights into the process by which the decision is made whether or not to seek health care services for pregnancy and childbirth.

More attention needs to be paid to the factors that influence the value that women place on their personal well-being and those that influence their ability to seek healthcare for themselves. The amounts of time, money, information and authority for decision making women have at their disposal are key. The value women place on their own health can be influenced by a number of factors such as informational barriers and low self esteem.

Lack of information or knowledge can mean that women are unaware of the gravity of their own condition. Some health conditions may be so common in a community, and women may have suffered the symptoms for so long, that they are not even recognised as problems that need medical care, such as chronic reproductive tract infections. Some conditions, such as sexually transmitted diseases, may be hidden because they are thought to be shameful. Pregnancy can be another condition which is not perceived as requiring care, or which women do not want to admit to in early stages. Low self esteem reinforces fatalism about health conditions including maternal illness.

Women may not regard their own pain and discomfort as worthy of complaint until it is so debilitating that it may be too late. Hesitancy to seek care after domestic violence may

also be attributable to women's lack of self-esteem or embarrassment. The nature of the problem of maternal mortality may make effective political support and commitment to the issue more difficult to sustain, because maternal deaths are the result of a complex range of factors and because this is not a field which can be remedied with a silver bullet there is no vaccine or pill that will make births safe. Despite the recent international focus on the issue of maternal mortality, most governments have not made maternal health a priority, even where formal MCH programmes exist Government and private sector policies affect the status of women's health and their access to maternal and family planning services. People point out that this is true both in the presence and the absence of policies that are designed to protect the rights and promote the health and nutrition of women.

For example, policies which limit women's access to family planning and maternal health services to certain groups, e.g. married women only, are likely to contribute to higher maternal mortality rates. Thus, the efficacy of safe motherhood initiatives will be partly determined by the policy environment in which they are implemented. Strong country commitment is recognised as one of the main factors behind programme success, and a lack of commitment can undermine efforts to strengthen safe motherhood programmes, as a review of activities in Francophone Africa found.When appraising the maternal health situation in a country, questions need to be posed about which policies impact on women's reproductive health, whether or not there are regulations or legislation to support policy implementation, and whether there exists national level support for policies relating to safe motherhood.

The level of political commitment to safe motherhood can be gauged by looking at whether key figures in the health ministry are involved in formulating policy in this area and, whether the Gender ministry is involved. The creation of a safe motherhood position or committee within the health ministry may help build commitment and establish programme procedures and standards at aim up improving health care. As the Beijing Platform for Action proposes, ministerial and interministerial mechanisms for monitoring the implementation of women's health policy and programme reforms should be established, and women's health concerns should be mainstreamed in all relevant government agencies and programmes. There may be scope for gender ministries to establish links with women's organizations concerned with safe motherhood and related issues such as violence against women.

5.4Causes and determinants of maternal deaths

Socio-economically structured inequities in health coverage play a significant role in gaps in maternal health coverage, globally and in Ghana Further improvements in maternal health indicators are therefore highly dependent on increasing coverage among the poorest and most disadvantaged segments of society especially in rural communities where health facilities are mostly lacking. Socio-cultural and economic resourcefulness are useful predictors of receiving ANC and delivery care among pregnant women.

In light of the state of research in this field, the analysis opens another avenue for reflection. The research attempted to enhance the understanding of mother's knowledge on the causes and determinants of maternal deaths. With the use of expanded understanding of the mothers in rural areas, the research showed that socio-economic circumstances are important predictors of maternal health-seeking behaviour alongside

other known factors such as age and geographic location of available and functioning health care facilities.

It is vital to state that the health-seeking behaviour of pregnant women is a discreet dimension. The interventions that can potentially increase the proportion of women accessing any ANC services may be different from those encouraging early and regular ANC services among ANC users in rural communities.Decisions to seek medical care are often made not by a woman on her own, but by her husband, or other family (e.g. mothers-in law) and community members. Health education campaigns need to recognize this and ensure that decision makers are educated about women's health needs and when health care should be sought. Examples of efforts to educate the wider decision making community include a project in Papua New Guinea which provides community health classes in female reproductive anatomy and health to all married men, and a project educating mothers-in-law in Nepal on proper care during pregnancy and childbirth. However, it is equally important to develop women's own decision making authority over access to healthcare. Women's access to information about health and available services can be improved in a variety of ways.

Embarrassment and lack of self-esteem as reasons for not seeking care can partly be addressed by creating a more sensitive and sympathetic culture of health services. However, many women and families may already be aware of the danger signs of obstetric complications, and still not seek help automatically. Reasons for this can be to do with community perceptions of poor quality of care as well as costs women's autonomy in deciding to seek care can be hampered by their economic dependence and the prohibitive costs of emergency intervention. Some women may have no or limited

cash available in times of emergency unless they are given it by their husbands. This can cause delays in seeking care.

If the husband lacks funds, he may ask for contributions from other relatives or the community. If the community is asked for help, community leaders may make a decision which overrides the husband's wishes. Women's autonomy can differ according to their age and seniority within the family. For example, pregnant teenagers may be dependent on the decisions of older members of the extended family for economic reasons.Results from the study revealed that late initiation of ANC by women has always resulted in pregnancy complications which women often report late to health centres for checkups and 23% identified lack of untreated mosquito net exposing pregnant women to mosquitoes leading to malaria the reason for the death of some women during pregnancy. In terms of resource allocation, women's health care is often channeled through maternal and child health services (MCH).

These services are usually limited to aspects of reproductive health and do not cover women's many other health needs. They may also be unavailable or irrelevant to vulnerable groups such as young unmarried women, women seeking abortion, women suffering reproductive tract infections and infertility, and women who are past childbearing age. In the past MCH services have been criticized for putting too much focus on the child, and efforts may have been made to put the M back into MCH to cater for the woman folk.

However, motherhood represents only a part of women's lives and health needs. A more holistic approach to women's general and reproductive health needs may be necessary to create the kind of quality of care in health services necessary to increase women's

accessto health care. One of the main issues in provision relating to maternal health has been the balance of resources between family planning, prenatal care and emergency and essential obstetric care. Essential obstetric care refers to all interventions needed to manage problem pregnancies and complications, some but not all of which will be emergencies. To reduce maternal deaths, essential obstetric care including quality emergency obstetric care, is vital. Prenatal care, education and screening have their parts to play, but on their own are insufficient to stop maternal deaths because most life-threatening obstetric complications cannot be accurately predicted or prevented. However, a focus on emergency treatment must not overlook quality of care or the fact that for most women community-based services is what is most often needed.

Further findings from the study indicated that, 16.2% respondents said difficult delivery was the reason for the death of some women during labour, 9.7% respondents stated financial difficulties, 8.4% respondents mentioned lack of transport/poor road networks,17.5% respondents indicated refusing referral by some pregnant women as the reason for the death during labour,16.9% respondents mentioned existing complication whereas 8.8% respondents stated superstition surrounding labour as the cause of death.

The above factors stated by respondents as causes of maternal deaths are basically the same factors that prevent utilization of antenatal services. The study therefore confirmed that socio- cultural factors and anything that prevents or impedes utilization of antenatal services are likely to cause maternal death (Harrison. 2009; Yobo, 2009; UNFPA, 2007). Widespread coverage of maternal and child health care services cannot combat maternal death unless quality of care is improved and maintained. When women and communities

perceive that quality of care is low, they may well decide not to use services even if they are at risk.

Inadequate health care systems in developing countries with poor quality of care can contribute to maternal mortality rather than help reduce it. Failures in the health service delivery system include: the lack of minimal life-saving equipment at the first level of referral, lack of equipment, personnel and know-how even in referral hospitals, and inappropriate patient management. People describe how studies of health care systems may classify some failures of services as patient factors for which the health care system is not responsible. Examples of such factors would be delays before patients present themselves at hospital, or patients.

If a woman knows of someone who spent time, money and effort to reach health facilities and still died, while another woman had complications at home but survived, she may decide, or it may be decided for her, that the risks of not seeking help are worth the savings. An essential aspect of quality of care is that health services should be more socially accountable. To assess the degree of accountability attention may be paid to whether women or their families or friends complain if they receive poor care, and to what channels exist for complaints and review of treatment received. There is need for action to equip those most affected by maternal mortality, poor women (and men), to actively participate in demanding changes.

Again, this finding supports the findings made by Thomas, Pauline & Bridget (1999) that many pregnant women in developing countries do not receive the care they need either because there are no services where they live, or they cannot afford the services because they are too expensive or reaching them is too costly. Some women do not use services

because they do not like how care is provided or because the health services are not delivering high-quality care.

Available results from the DHMT (2014) indicated that maternal death was four (4) representing 94 deaths per 100,000. This possible was necessitated by the fact that pregnant women do choose traditional and folk medicine or providers in a variety of contexts which have potentially profound impacts on their health seeking behavior leading to serious and unmanaged pregnancy complications leading to death. This seems to agree with the findings made by Senah (2003) that pregnant women who die in several instances through childbirth go through at least one of the delay*s* in the model. Efforts should be made to raise community awareness regarding the importance of seeking health care from trained personnel and the availability of services. Seeking maternal healthcare should not be a dehumanizing experience, and women should be treated with respect and compassion by health personnel.

Unfortunately, this is often far from the case in developing country health care systems. Cultural beliefs and preferences relating to childbirth and pregnancy can be particularly strong and resistant to change. Cultural practices and beliefs should be evaluated to determine if they are medically significant and, if they have beneficial or benign effects, then efforts should be made to incorporate them into health care delivery systems. Although physical convenience and financial accessibility are of great importance, cultural appropriateness and perceived quality of care may be even more so important in health care system.

Thus, cultural misunderstandings or lack of sensitivity among health professionals can lead to a breakdown in communications between women and health workers which is not

conducive to high quality of healthcare. Some traditional values and practices may be beneficial to reproductive health, even if that is not their aim. In some societies, social norms prescribe that only physiologically mature girls can marry, so early marriage is discouraged, and traditions such as the fattening house are part of customs for brides to be in good physical condition on marriage. Norms against a woman having a baby after she becomes a grandmother, diminish the amount of pregnancies to older women who are more at risk of maternal death.

Breastfeeding suppresses ovulation and therefore helps increase birth spacing, ultimately reducing the number of children a woman has. Traditions of post-partum sexual abstinence would have a similar effect. There is much regional variation among these kinds of customs, but their erosion may have particular importance for maternal and child health as well as family planning. There is now growing recognition of the need to be more sensitive to the realities of health care seeking behavior especially among pregnant women in rural communities. For example, in Nepal there is a large and growing sector of non-qualified allopathic providers engaged in the traffic of modern pharmaceuticals. They provide an accessible means of reaching Western medicines to a wider range of the population especially among rural people, yet lack formal medical training.

There is therefore the accompanying problem of bad, unregulated prescriptive practices. Incorporating these unqualified providers into more formal training may therefore be beneficial. The situation is not different from the study area where availability to health facilities remains virtually inadequate and most women reported to have been receiving drugs from drug peddlers (DHMT, 2013 Report; Ahmed, 2000).

It is also important to state that sometimes policy implementation may also affect maternal health directly or indirectly. At present only a tiny proportion of health budgets is allocated to maternal and child health care, within which child health and family planning get the lion's share of resources compared to maternal health. The large share of resources allocated to family planning programmes compared to other aspects of maternal health care may be disproportionate. It's good that proper and pragmatic advocacy groups for women rise up and call for a drastic reallocation of national resources in developing countries with a large share for the health sector, and a substantial allocation within the health budget for the health care of women, of which maternal health care is one component.

In the context of economic crisis and structural adjustment, many developing country governments can no longer afford to provide health care for all free of charge. This has meant increased reliance on the private sector, cost sharing, and the introduction of user fees which are likely to hit the poor hardest in the absence of effective exemption schemes. Given women's absolute and relative poverty and lack of control over household income in many developing countries, it seems likely that women's demand for health care will be more affected by rising costs than men's. For example in Senegal, where communities are involved in financing and managing primary health care, changes in utilisation in response to rising costs affected the very poor more than the moderately poor, and women more than men.

In Benin, women admitted to maternity wards are known to leave hospitals in the night to avoid paying fees which they cannot afford, exposing them to risk of complications. In Nigeria, research has found that the introduction of user fees has discouraged some

women from seeking maternity care. A study in Zaria showed that between 1983, when charges were levied, and 1988, the number of hospital deliveries fell by 46 percent and maternal deaths increased by 56 percent. In China, women are known to have been turned away from hospitals where they needed treatment, for reasons of cost.

Research is needed into how the introduction of user fees affects women's decisions to seek prenatal care and other medical help during pregnancy, delivery and the puerperium. Insurance schemes or other funding methods such as credit systems may be considered (WHO, 2008).Although poor budget constraint as explained early may affect health care of women, it is also good to incorporate other unqualified personnel noted for distributing drug to rural people because according to Uzma et al (1999) incorporating unqualified TBAs into training programmes for maternal health would go a long way to improve the health status of pregnant women in rural communities where these people are mostly patronised.

Thus increasingly health care seeking behaviour studies are coming to the conclusion that traditional and unqualified practitioners need to be recognized as 'the main providers of care' (Rahman, 2000) in relation to some health problems in developing countries. It is important to state that developing country maternal health services are also prone to shortages of trained personnel and lack of equipment, drugs and supplies including blood banks. Just as serious is the problem of inappropriate action taken by health staff when treating patients. Because evidence from hospital-based studies show that delays in diagnosis and treatment, with decisions to operate taken too late, are relatively common in developing country facilities often with fatal consequences most especially for women.

The incidence of poor quality care feeds back into women's and household's decision making about whether to seek medical help when pregnancy complications set in.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

In this chapter, a brief summary of finding has been made, following which conclusions have been succinctly presented and recommendations made in line with findings.

6.2 Summary of findings

Analysis of social and economic determinants of health behaviours of pregnant women and health outcomes has progressed from a limited descriptive approach to focusing on identifying determinants which may be amenable to intervention. Half (50.6%) of the respondents were between the ages of 25-34 years whiles 85.7% of respondents were married. Muslims constituted the majority of the respondents (53.6%), 57.8% of the respondents were having no formal education and 31.8% respondents sought ANC services from Traditional birth attendance, 5.5% respondents stated health centre, and 57.8% respondent's mentioned CHPS compound whiles 4.9% respondents mentioned herbalist.

Most (39.6%) of the respondents stated they prefer to deliver in the hospital/ health centre, 25.0% respondents stated Clinic/CHPS compound, 18.8% respondents said they prefer to deliver at Traditional birth attendant,14.9% respondents prefer to deliver in the home whiles 1.6% respondents prefer to deliver in herbalist home. Results further indicated that 30.2% respondent's knowledge of their pregnancies was informed by health professional, 38.3% respondents said they were notified by their family/community members, 1.4% respondents mentioned personal experience whiles 10.0% respondents indicated that they did not know until their menstruation stopped.

For decades, in the field of women's health, there has been a focus on fertility regulation, creating a narrow conceptualization of women's health as bounded by the ages 15 to 49 and the reproductive system. The current interest in maternal health and maternal mortality marks a widening of this understanding of women's health and recognition that, in the context of Maternal and Child Health programmes, mothers have in the past been neglected in favour of measures to improve infant and child health.

However, the current focus on reproductive health still means that many other aspects of women's health and well-being, particularly the health problems of adolescents and ageing women, as well as the non-maternal, non-reproductive health needs of women during their reproductive years, tend to be neglected. It is useful to consider the entire life cycle when addressing the causes and consequences of women's poor health. This allows for a focus on the particular problems which affect females at different stages of the life cycle, and recognizes cumulative effects and lifetime problems, in the context of a holistic view of women's health.

Feminists have drawn attention to the fact that the bulk of reproductive work is carried out by women, in child-bearing, child-rearing and the care of adults. Maternal mortality is perhaps the ultimate reminder that it is women who shoulder the costs of this reproductive work, in this case through their premature death. Levels of maternal mortality are indicative of how states have chosen to intervene or not in reducing the costs of reproduction to women's lives. Health policy may exhibit strong gender bias in terms of where resources are allocated and whether providing effective services which are accessible to women is seen as a priority.

6.3 Conclusions

Health care seeking behaviour in Northern Ghana is an important policy issue especially among pregnant women in rural communities. It is encouraged, especially in light of preventative care that is cheaper than curative care as well as less costly on the government's health budget. Ultimately, the ability of the healthcare sector to deliver effective and high quality services in an equitable way is highly dependent on addressing adequately the social, cultural and economic context in which ill health and disability arise among pregnant women in rural communities of Ghana. Coverage of basic maternal health interventions and utilization of private providers are lower among rural poor women.

Further understanding of issues surrounding availability, affordability and quality of maternal health services among the poor is crucial to eliminating inequalities in maternal health coverage. Most of the respondents (30.2%) knowledge of their pregnancies was informed by health professional, 38.3% respondents said they were notified by family/community members, 1.4% respondents mentioned personal experience whiles 10.0% respondents indicated that they never knew until their menstruation stopped. Majority (87.01%) of the respondents said they were treatment giving to pregnant mothers/women at home or in the community.

Furthermore, results from the focus group discussion in the study area revealed that smell of medicines or strong scent of chemicals within the hospital environment, financial constraints,and availability of TBAs in the community and or busy assisting their husbands in the farms influenced pregnant women health seeking behavior. Pregnant women in the study area indicated that they wereafraid to be operated upon,being able to

endure painful labour, sudden labour, seeking for permission from their husbands, pregnant woman who is sent to the health facility to deliver may have cheated on the husband and refused to confess the act were identified as reasons why pregnant women do not deliver in the hospital.

Further discussion with the pregnant women revealed that Oedema, anemia, malaria, abdominal pains, vomiting, and blurred vision were diseases experienced by pregnant women. Respondents again indicated that evil spirits do transferred sickness to pregnant woman which eventual leads to death during delivery or after delivery. Unsafe abortion, pregnant women refusing to be transferred, superstitions and late initiation of ANC were very common among pregnant women in the study place.

Addressing maternal deaths involves a two stage process: firstly, strengthening women's choice over reproductive decision-making, and secondly, ensuring that once a woman is pregnant, she has access to appropriate care, including emergency intervention where necessary. Approaches linked to this first stage are family planning interventions, which attempt to reduce the number of maternal deaths by reducing the number of pregnancies. However, family planning should not be seen as the sole answer to the problem of maternal mortality because it cannot help reduce the risk of death once a woman has become pregnant.

It is therefore useful to consider maternal mortality in the context of the second stage, with particular focus on women's health in pregnancy. It is now accepted that preventative measures (maternal education, pre-natal care etc.) are not enough to reduce maternal mortality. Attempts to identify those women who are most at risk and refer them to hospital for delivery cannot eliminate maternal deaths because many apparently high

risk. Women will have no problems, whilst women who are not seen as being at risk can still rapidly develop unforeseen complications. Therefore effective treatment of obstetric complications by means of essential and emergency obstetric care is vital ways of reducing maternal mortality among pregnant women.

Health seeking behaviour is not just a one off isolated event. It is part and parcel of a person's, a family's or a community's identity, which is the result of an evolving mix of social, personal, cultural and experiential factors. The process of responding to 'illness' or seeking care involves multiple steps, and can rarely be translated into a simple one off choice or act, or be explained by a single model of health seeking behaviour.

A pregnant woman's decision to attend a particular health care facility is the composite result of personal need, husband need, social forces, the actions of health care providers, the location of services, the unofficial practices of doctors, the financial issues, and in some contexts has very little to do with physical facilities at a particular service point.

6.4 Recommendations

Based on the findings of the study, the following recommendations have been drawn to assist policy makers, individuals and government organizations that are interested in helping to curb maternal mortality especially in rural communities. It would also serve as guide to non-governmental organizations interested in reducing maternal mortality.

- ✓ Health workers should be committed to work in the study area
- ✓ Spouse should be re-orientated concerning socio-cultural factors and its effects on maternal and child health
- ✓ More so, the media should be mobilized to focus on campaign aimed at improving and promoting strategies for improving maternal and child health

- ✓ Organizations such as Planned Parenthood Association should intensify education on sexual and reproductive rights in the study area especially among the youth on dangers of unsafe abortions
- ✓ Traditional leaders should be encouraged to disregard certain superstitions to enable pregnant women seek health care early
- ✓ Health workers and Traditional Birth Attendants' from the study area should always do early referral of pregnant women to hospitals before pregnancy complications become too difficult to manage
- ✓ Religious leaders should intensify the need for early ANC initiations by pregnant women in the study area
- ✓ Pregnant women in the study area should form associations to assist them access loan from banks to improve their income
- ✓ Workshops should be organized in the study area to enlighten pregnant women on the critical period during pregnancy
- ✓ Availability of more health centres from the study area will improve health seeking behavior of the people leaving in the study area especially among pregnant women
- ✓ Activities of drug peddlers in the study area should be monitored to prevent pregnant women from buying medications from them

6.5 Directions for future research

The duration of the research and financial constraint did not allow the researcher to conduct a detailed study in some relevant areas of maternal health. Thus, the research recommends further study in the following areas:

1. In view of the influence of the socio-cultural environment, further study could be carried out on tradition, nutrition and maternal health.

2. A comprehensive study could also be conducted to look at knowledge about pregnancy and the use of health facilities.

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APPENDIX

UNIVERSITY FOR DEVELOPMENT STUDIES

DEPARTMENT OF COMMUNITY HEALTH AND DVELOPMENT

CONSENT FORM FOR RESPONDENTS

TOPIC: Assessment of Socio-Cultural Factors that influence maternal health delivery in the East Mamprusi District of Northern Ghana

Introduction

The purpose of this study is to assess the effects of socio-cultural factors that influence women's health seeking behavior during pregnancy and delivery and how they influence maternal mortality in the East Mamprusi district. The study is solely for academic purpose and for this reason, you are assured of confidentiality and anonymity with regards to any information you provide. Please you are required to sign/thumb print below if you agree to be a respondent.

Sign …… Date…….

SECTION A: BACKGROUND INFORMATION

1. How old are you now (Years)

2. What is your marital status?

a) Married

b) Single

c) Divorced

d) Windowed

e) Separated

3. What is your level of education?

a) No formal education

b) Basic education

c) Secondary education

d) Tertiary education

4. What type of work do you mainly do?

a) Government employee

b) House wife

c) Trading

d) Unemployed

e) Any other (specify)……..

5. What is your religion?

a) Christian

b) Moslem

c) Traditional worship

d) Any other (specify)……..

6. Which ethnic group do you belong?

a) Mampruli

b) Moar

c) Kusal

d) Lukpakpaln

e) Others

SECTION B: Health seeking behavior of women during pregnancy and delivery

7. How many times have you been pregnant?

a) One

b) Two

c) Three

d) More than three

8. How many children do you have?

a) One

b) Two

c) Three

d) More than three

9. Have you ever experienced pregnancy wastage or stillbirth?

a) Yes

b) No (if No, skip to 13)

10. If yes to (8) above, how many times.

a) One

b) Two

c)Three

d) More than three

11. Did you seek antenatal care before the pregnancy wastage or still birth?

a) Yes

b) No (if No, answer 12)

12. If No to (11) why?

a) High cost of services

b) Long distance to health facility

c) Consulted the herbalist/spiritualist

d) Self medication

13. Where did you seek for Antenatal care services in your last pregnancy?

a)Traditional Birth Attendant

b) Hospital

c) Maternity home/clinic

d) Herbalist spiritualist

14. In your last pregnancy when did you report to a healthcare provider for the first time?

a) Within the first month

b) Within the first three months

c) When I experienced complications

d).When the pregnancy was getting to term

e) Don't know

15. How many times did you attend antenatal clinic in your last pregnancy before delivery?

a) Once

b) Twice

c) Three times

d) Four times

e) More than four times

f) Never

16. Who decided for you to commence Antenatal care services?

a) Self decision

b) Both couples decided

c) Husband decided

d) Mother-in-law /mother

e) Others

17. What are some of the reasons for attending antenatal services at the health centre? (Please,Tick as many)

a) ANC to detect and treat diseases

b) ANC to monitor Progress of pregnancy

c) ANC for medication

d) ANC Prepared me for safe delivery

e) Nurse's advice to attend ANC

f) Spouse's decision to attend ANC

18. Where is/was your choice of location for treatment during ill health in pregnancy?

a) Traditional birth attendant

b) Self/relation for treatment

c) Chemical/drug shop

d) Health professional

e) Herbal centers

19. Where was your preferred place of delivery during labour?

a) Hospital

b) Maternity home/clinic

c) Herbalist/spiritualist center

d Home

e) Others

20. Where do you plan delivering in your next pregnancy during labour?

a) Hospital

b) Maternity home/clinic

c) Herbalist/spiritualist center

d) Home

d) Others.

21. What are some of the factors that prevent pregnant women from going to health facilities (hospital, clinics) before, during and after delivery?

……

……

22. Do you have spiritual centers/herbalists which/who treat pregnant women in this area?

a) Yes

b) No (if No, skip to 25)

23. If yes to (22) above, did you go there for treatment in your last pregnancy?

a) Yes

b) No

24. If yes to (23) above, how often did you visit the spiritual healing centre?

a) Regularly

b) Not regularly

Section C: Knowledge about pregnancy and related complications

25. How did you get to know that you were pregnant?

a) Informed by health professional

b) Informed by family/community member

c) Personal experience

d) Don't know

26. What are some of the signs of pregnancy? (Tick as many)

a) Nausea

b) Cessation of menses

c) Weight gain

d) Vomiting

27. What is the normal term for pregnancy?

a) seven months

b) eight months

c) nine months

d) ten months

e) don't know

28. When is the critical period during pregnancy?

a) During the first three months

b) From the forth and to the sixth months

c) From seventh month and above

d) Don't know

29. Why is this period in (28) above critical? (Please tick as many)

a) The foetus is delicate and not yet developed

b) The foetus is fully matured

c) Spiritual reasons

d) Don't know

30. How did you handle your last pregnancy during this critical period?

a) Consulted a health professional

b) Sought care from herbalists/spiritualists

c) Self care by using orthodox and herbal medicine

31. What are some of the danger signs of pregnancy complications? (Please tick as many)

a) Oedema

b) Severe headache/blurred vision

c) Vaginal bleeding

d) Fever

d) Severe abdominal pain

e) Convulsion

f) Foul smelling discharge/fluid from vagina

g) Vomiting

32. Did you experience any of these complications in your last pregnancy?

a) Yes

b) No

33. If yes to (32), what did you do?

a) I used herbs

b) I consulted a health professional

c) I consulted a spiritualist/herbalist

SECTIONC: SOCIO-CULTURAL FACTORS INFLUENCING HEALTH SEEKING BEHAVIOURs OF PREGNANT WOMEN

34. Are there some local/cultural beliefs why a pregnant woman dies during or after child birth in this area?

a) Yes

b) No (if No, skip to 39)

35. If yes to question (37), mention these local/cultural beliefs:

a)……

……

b)……

c)……

……

36. Do pregnant mothers/women receive any local treatment at home in this community?

a) Yes

b) No

37. If yes to (36) above, mention any two (2) of the local treatments that are given to the pregnant mothers/ women at home.

1…….

2……..

38. How long do pregnant mothers/women receive local treatment at home before attending to a health facility for service?

a) Days (mention number)

b) Weeks (mention number)

c) Months (mention number)

39. Are pregnant women/mothers who receive local treatment allowed to attend health facilities (hospital, clinics) for antenatal services?

a) Yes

b) No

40. If No to question 39 above, why?…….....

41. Are pregnant mothers/women first sent to the health facility to deliver when they are in labour or later when they are not able to deliver in time?

a) First

b) Later

42. If later to question 41 why?……

43. Are there some reasons why pregnant women/mothers are not allowed to go and deliver in the health facilities in this area?

a) Yes ( )

b) No ( ) (if No, skip to 45)

44. If yes to question 43 above, why? .....

45. In what ways are pregnant women in this community protected from becoming ill?.....

.....

46. What available information is in this community/district that helps prevent women from dying during pregnancy, labour and after delivery?

.....

.....

47. What family planning methods are accepted and in use in this community/district? (tick as many)

a) Condom

b) Birth control pill\

c) Implanon

d) Others

48. Has your husband ever followed you to a health care provider/health facility to deliver?

a) Yes

b) No

49. If No to question 48 above, why?

……

……

……

SECTION D; CAUSES AND DETERMINANTS OF MATERNAL DEATHS

50. Are you aware of any woman who died of any pregnancy related complication in this household within the last three years (2012) up to last year (2014)?

a) Yes

b) No (if no,skip to question 53)

51. If yes when did it occur?

a) This year

b) Last year

c) Last two years

d) Last three years. Where did she die?

a) Hospital

b) Health centre

c) Clinic/CHPS compound

d) Traditional birth attendant

e) Herbalist/spiritualist home

53. Why do some women die during pregnancy?

……

……

……

54. Some women also die during labour, what are the reasons?

……

……

……

……

55. Some women also deliver and after a few days/weeks, they die, what are some of the reasons?

……

……

……

56. What are some of the things that can be done to prevent women from dying during pregnancy, delivery and after delivery?

.....

.....

THANK YOU FOR YOUR CO-OPERATION

APPENDIX II

UNIVERSITY FOR DEVELOPMENT STUDIES

DEPARTMENT OF COMMUNITY HEALTH AND DEVELOPMENT

FOCUS GROUP DISCUSSION GUIDE

SECTION A:

HEALTH SEEKNG BEHAVIOUR OF WOMEN DURING PREGNANCY, LABOUR AND AFTER DELIVERY

1. When does a pregnant woman attend antenatal clinics?

2. Why is it important for pregnant women to attend antenatal?

3. Why is it that some women refuse to attend antenatal, if you know about any of such cases?

4. What are some of the reasons why pregnant women are not allowed to go and deliver in the health facilities in this community/district?

5. What are some of the things that discourage pregnant women from going to health facilities (hospitals/clinics) before, during and after delivery?

6. When women are in labour in this community who assists them to deliver?

7. If Traditional Birth Attendants, are they, or is s/he trained or untrained?

8. What is the perception of the skills of the Traditional Birth Attendants in this community?

9. What are some of the reasons why some women deliver at home?

SECTION B

KNOWLEDGE OF WOMEN ON PREGNANCY RELATED COMPLICATIONS

10. When a woman is pregnant, what are the common diseases that she suffers from in this community?

11. What are the signs and symptoms that a pregnant woman complains of in relation to your named diseases above?

12. When a woman has complications during delivery, what do you do in this community?

13. When is the critical period during pregnancy? (Probe for why the period is critical and how they handled their pregnancies during the critical period)

K**SECTION C**

SOCIO-CULTURAL FACTORS THAT INFLUENCE HEALTH CARE SEEKING BEHAVIOUR OF WOMEN DURING PREGNANCY, LABOUR AND AFTER DELIVERING

14. Are there any beliefs concerning the kind of food a pregnant woman should eat in this community?

15. During pregnancy what are the foods a pregnant woman is allowed to eat?

16. During pregnancy, what are the avoidable foods a pregnant woman is prevented from eating?

17. Why should a pregnant woman be prevented from eating such foods mentioned above?20. Are there cultural reasons why some pregnancies cannot be sent to the health facility/antenatal?

18. What are some of the local/cultural beliefs why a pregnant woman dies during or after child birth in this community/ district?

19. When a woman is pregnant, do they consult soothsayers on the pregnancy?

20. If yes for above question why do they do that?

SECTION D; CAUSES OF MATERNAL MORTALITY

21. Why do some women die during pregnancy?

22. Some women also die during labour, what are the reasons?

23. Some women also deliver and after a few days /weeks, they die; what are some of the reasons?

24. What are some of the things that can be done to prevent women from dying during pregnancy, delivery and after delivery?

THANK YOU FOR YOUR CO-OPERATION