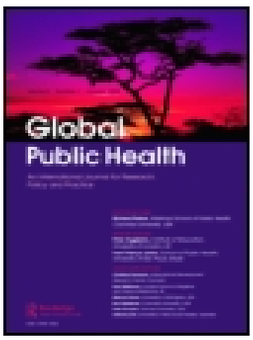

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Global Public Health

An International Journal for Research, Policy and Practice

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rgph20

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To cite this article: Ludovica Barbi , Momodou Cham , Elikem Ame-Bruce & Marzia Lazzerini (2020): Socio-cultural factors influencing the decision of women to seek care during pregnancy and delivery: A qualitative study in South Tongu District, Ghana, Global Public Health, DOI: 10.1080/17441692.2020.1839926

To link to this article: https://doi.org/10.1080/17441692.2020.1839926

Published online: 09 Nov 2020.

GLOBAL PUBLIC HEALTH
https://doi.org/10.1080/17441692.2020.1839926

Socio-cultural factors influencing the decision of women to seek care during pregnancy and delivery: A qualitative study in South Tongu District, Ghana

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ABSTRACT

Many low-income countries still encounter high mortality rates. The use of maternal health care services is known to be a key intervention in reducing maternal death. Despite investment in the healthcare sector, in 2015 Ghana did not meet the Millennium Development Goal 5 of reducing maternal mortality (MM). The Volta Region registered the highest rate of MM, the lowest percentage of antenatal care (ANC) coverage and the lowest percentage of skilled delivery. This is a qualitative study that used focus group discussions and key-informant interviews to explore the views on pregnancy among rural communities in the Volta Region, identify the barriers in accessing ANC and skilled attendance birth and collect views on how to improve the access to maternal care services.

Overall, the study argues that members of the community of the rural villages acknowledge the benefits of ANC and skilled delivery, and the potential risk related to home delivery. However, pregnant women in the Volta Region still encounter different kinds of obstacles that prevent them from seeking maternal health care. These obstacles are driven by social and economic constraints, and by the fact that women may still lack voice in the decision-making process, and by low males' participation.

Abbreviations: ANC: antenatal care; FGDs: focus group discussions; KIIs: key-informant interviews; MM: maternal mortality

ARTICLE HISTORY
Received 19 August 2019
Accepted 23 September 2020

KEYWORDS
Antenatal care; Skilled delivery; Socio-cultural factors; South Tongu; Ghana

Background

Many low-income countries still encounter high maternal mortality (MM) rates. The use of maternal healthcare services, including supervised delivery services, is one of the proven interventions that have the potential to reduce maternal death (Ganle et al., 2019). Over the last decade, improving maternal healthcare with the aim of boosting the proportion of women who receive services such as pre- and postnatal care, and skilled delivery has become a global priority (Ganle, 2014).

However, despite the focus on maternal health over the last decade, MM continues to be especially high in many Sub-Saharan countries. The MM ratio of Sub-Saharan countries in 2015 is reflective of this point: 542 per 100,000 live births compared to the 12 per 100,000 (live births) in higher-income countries (Ganle et al., 2019).

The difficulty to access skilled attendance during pregnancy and delivery is a recognised contributor to maternal deaths, particularly in less developed countries (Apanga & Awoonor-Williams,

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2018). Traditionally, three possible delays are recognised in accessing adequate care: (i) delay in the decision of seeking care; (ii) delay in reaching care; (iii) delay in receiving adequate health care (Thaddeus & Maine, 1994). The literature clearly indicates that while distance and costs are major obstacles in the decision to seek care, the way these two factors interact is not straightforward (Thaddeus & Maine, 1994). Moreover, previous studies have stressed the importance of further research to determine the other factors, besides money, that prevent women from accessing maternal healthcare services (Ganle et al., 2014). Indeed, socio-cultural determinants such as the extent of male involvement and the support provided by traditional birth attendants (TBAs), can affect the process of seeking care.

Ghana is one of the most developed countries in Sub-Saharan Africa and has made considerable investment to its healthcare sector. In spite of this, the country has not made sufficient progress in reducing its MM rate(s). Whilst MM in Ghana dropped from 760 to 380 per 100,000 live births between 1990 and 2013, the country still did not meet the Millennium Development Goal 5 of reducing its rate of MM below 190 per 100,000 by the year 2015 (United Nations (UN) in Ghana (2016). MDG 5: Improve Maternal Health:, n.d.). Specifically, the Volta Region, in the Southern part of the country, recorded the highest MM ratio (Ghana Health Service (GHS) (2015). 2014 Annual Report, n.d.). According to the Ghana Maternal Health Survey 2017, the Volta Region has the lowest percentages for both maternal antenatal care (ANC) provided by a skilled provider (95.6%) and percentage of women who had more than 4 ANC visits (83.5%). Moreover, it has the second lowest percentage for delivery with a skilled provider (62.4%) and for women who delivered in a health facility (62.8%) second only to the Northern Region (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF, n.d.).

Socio-cultural determinants as an obstacle to maternal care access are well-documented factors in the Ghanaian context (Dapaah & Nachinaab, 2019; Ditekemena et al., 2012). Furthermore, even though maternal and new-born healthcare services are provided for free in Ghana since 2003, barriers at the institutional level still persist. Indeed, the study of (Ganle et al., 2014) found that there is an unequal distribution of skilled healthcare services and women experience intimidation in healthcare facilities, unfriendly health personnel, lack of privacy and poor quality of care.

Despite different studies focused on addressing barriers to access maternal care in the broader context of Ghana (Aboagye & Agyemang, 2013; Dickson et al., 2018; Doku et al., 2012; Sipsma et al., 2014), there has been less interest in the differences within Ghana, and no specific study was conducted in the Volta Region. As such, in the literature, the views of women living in rural villages in the Volta Region, remain largely unknown (Apanga & Awoonor-Williams, 2018). For this reason, even though some of the obstacles encountered in accessing maternal healthcare are similar across the country, there is still some degree of variation in community-level variables that require the examination of the local cultural context of the Volta Region (Stephenson et al., 2006). A better understanding of the perception and views in the Volta Region on barriers to access maternal care may inform policymakers on how to reduce care-seeking delays and may potentially reduce MM in the region.

The objective of this study is to explore the views on pregnancy among rural communities in the Volta Region, identify the perceived barriers in seeking ANC and skilled attendance at birth, and collect views and suggestions from the members of local communities about ways to improve access to maternal care services.

Methods

Study design and setting

This is a qualitative study, and in reporting and conducting it, the Standards for Reporting Qualitative Research (SRQR) were used (O'Brien et al., 2014). SRQR is a list of 21 items that are

considered essential for a complete and transparent report of qualitative data. Qualitative exploration was done using focus group discussions (FGDs), and key-informant interviews (KIIs).

The study was undertaken in the South Tongu District, located in the southern part of the Volta Region, during June and July 2017. The district has a population of 87,950, of which 76,640 (87%) live in rural areas; most are farmers, traders or working in fish-related activities (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International., n.d.). In terms of facilities, in the district there are two public district hospitals, two private district hospitals, four public health centres, and one public family planning facility.

Sample size and sampling procedures

Three rural communities Sokpoe, Sogakope and Fievie were selected based on their distances from the hospital where the researcher was collecting data. The study included both female and male persons. Inclusion criteria for the FDGs were as follows: pregnant women, women that had been pregnant within the previous two years; men with a pregnant partner (either married or unmarried) or, who had been pregnant in the previous two years.

We adopted a mix of two different sampling techniques (purposive sampling and convenience sampling). At the first stage, we recruited the population of interest via gatekeepers being mostly staff of the nearby health facilities, chiefs and elders. We acknowledge that this recruitment process may have introduced some bias in the selection of participants. Therefore, we allowed any men and women who expressed the desire in taking part in the research to also be added, provided that they met the inclusion criteria. No participant dropped out of the study.

We used the principle of saturation to determine the sample size. Saturation is the gold standard to determine the purposive convenience sample in health science research (Guest et al., 2006). This method is based on the principle behind Guest's gold standard, where no new data were gathered beyond 12 interviews.

A total of 77 community members took part in the study (Table 1). Of these, 67 participated in a total of 6 focus group discussions (FGDs)- two in each rural community, while 10 were involved in KIIs. Each focus group was constituted by approximately 10 participants. Due to the different distances between the rural villages and healthcare facilities in the study, women in the FGDs were stratified bearing this aspect in mind. Distance is one of the most influential factors in a person's decision to seek care and thus, the decision to stratify the participants was important. Table 2 shows the socio-demographic characteristics of the total number of women (62) that took part in the FDGs. The mean age of the male participants in the FDGs was 26. Key informants were selected among those with the greatest influence in the health aspect of the communities (i.e. chiefs, elders, assemblymen and assemblywomen, headmasters of the schools, and community health workers) (Table 3).

Data collection

We carried out the interviews using a semi-structured interview guide (Appendix 1 and 2). Two different open-ended thematic topic guides were used: one to conduct KIIs (Appendix 1), and the second to conduct the FGDs (Appendix 2). The aim of the second questionnaire was to explore more in-depth the issues described by women in FGDs. We designed both questionnaires after

Table 1. Study sample.

	Women	Men	Total
Focus group participants	62	5	67
Key informants	4	6	10
Total	66	11	77

Table 2. Women demographic and pregnancy characteristics of the study sample. ANC: antenatal care.

Total number of women	62	
Mean age of women (SD)	24.6 (4.03)	
Mean number of children per woman (SD)	2.55 (1.64)	
Pregnancy characteristics	Yes (%)	No (%)
Planned pregnancy	12 (19.35)	50 (80.65)
Use of ANC	49 (79.03)	13 (20.97)
Supported by partner/husband	25 (40.32)	37 (59.68)
Married	21 (33.87)	41 (66.13)
Independent decision to seek maternal healthcare (if 'No': someone else decided)	45 (72.58)	17 (27.42)
Sex preference for child	36 (58.06)	26 (41.94)

Table 3. Key informants.

	Women	Men	Total
Headmaster		2	2
Assemblyman		1	1
Chief		1	1
Elder		2	2
TBA	1		1
Nurse	3		3
Total			10

reviewing existing literature on delay in accessing maternal care. They were conceived with a flexible structure with mostly open-ended questions that enabled to explore any possible unexpected but relevant issues that arose. We pre-tested the instruments with a small group of nurses working at the Richard Novati Hospital (former Comboni Hospital), the local District Hospital. This helped to rephrase questions that were unclear and adapt more understandable and appropriate concepts. The interviews were conducted by an independent researcher in the three villages. We conducted FGDs and interviews mostly in English, which is the official language of Ghana. A translator was present, in case of need to translate few sentences in and from the local language (Ewe). We recorded all the interviews and FGDs with a voice recorder and later transcribed. Field notes were also taken. The average length of the FGD was two hours and the one of KII was half-hour.

Data analysis

The analysis process consisted of two stages. First, the interviews were recorded and transcribed; later, the transcripts were coded for themes using thematic analysis. This method helped identify and analyse patterns of answers (Braun & Clarke, 2006). After reviewing the literature and the thematic guides of the interviews, a list of 'core codes' was created. In a second time, two authors independently coded for 'emergent codes' by re-reading the transcripts to assign open codes to relevant concepts and perceptions. 'Core codes' and 'emergent codes' were later combined into categories to form major themes. Discrepancies were solved through discussion.

Ethical considerations

King's College London ethical board approved the research. The Richard Novati Catholic Hospital approved the study as an operational research to enhance the quality of maternal care offered. The hospital already has a mandate under Policy objective 7 of the National Catholic health Service to 'Promote Research in all areas of the national Catholic Health service'. So local permission was obtained from the IRB of the hospital and District Health Management Team.

The hospital usually partners with local and internal university students to carry out such operational research. This is done for local studies which have been approved by international

University Ethics Committees. National Approval would have been sought from the Ghana Health service ERC if the study was going to be extensive and beyond the district.

Moreover, single participant permission was obtained from each community. At the beginning of the interviews, we explained both the aims of the study and the use of the data to each participant. It was clarified to each one of them his/her right to drop out from the study at any time he/she wanted. Due to illiteracy obstacles, oral informed consent was considered adequate. This was obtained and recorded from each participant before the start of the FGDs and KIIs. Interviews' recordings were safely stored to ensure that only the researchers had access to them. Finally, anonymity was ensured by removing from transcripts all the names and other personal details that could identify participants.

Results

As reported in Table 4, four major global themes related to pregnancy and access to maternal services emerged: (1) pregnancy and the role of God; (2) the importance of ANC and skilled delivery; (3) obstacles to seek care during pregnancy and delivery; (4) the role of the male partners. Suggestions for improvement were grouped under one additional separate global theme.

Pregnancy and the role of God

Several participants made comments regarding the role of God in relation to pregnancy (Table 4). For example, Adjua (23-year-old) stated: 'It's the work of God, a gift from God to get pregnant' adding that God will take care of the pregnancy throughout the whole period. God seemed to play a role also in relation to the sex of the new-born. Many participants stated, 'I had no preferences', 'anything God gives me'. While others did have a preference for the sex of the new-born, they also explained that they did not have choice but to just accept whatever God would give them.

The importance of ANC and institutional delivery

ANC is important

Most women perceived pregnancy as a condition requiring health care, highlighting the importance to seek care during pregnancy. Indeed, most of the participants acknowledged the importance of attending ANC explaining that pregnant women should not simply stay at home. As part of this, participants explained that it is good practice to do some check-ups during the pregnancy, recognising the role and the experience of the health workers in monitoring the health of the baby. One participant reported:

> It is important to seek care during pregnancy because sometimes the baby inside is something you don't see but the health workers, they have much experience to look after the kid so if you don't come and you are in the house, when something happens you may not notice, so it is good that you come so if something bad is happening that child can be taken care of. (Efua, 26-year-old)

Furthermore, participants reported that ANC is useful to detect malformations that the baby might have. Moreover, women were aware of the importance of attending ANC to check the position of the baby in the womb. Participants also knew that there could be problems with the presentation of the baby at the time of the delivery and caesarean section may be required. Elikem (21-year-old) stated: 'I think it is important because if there are some complications and the presentation of the baby is not good, the health team can take you to the theatre'. Overall, participants were aware of the importance of attending ANC during pregnancy, highlighting the most important reasons.

Table 4. Code phrases, basic themes and global themes.

Code phrases	Basic themes	Global themes
- The work of God - Whatever God the creator has given me - Anything God gives me	1. God has a role in pregnancy	1. Pregnancy and the role of God
- It is important to seek care during pregnancy - Abnormalities will be detected - Baby might not be well in the womb - Delivering at home is not hygienic - Risk of complications for the mother and the baby	1. ANC is important 2. Skilled attendance at birth is important	2. The importance of ANC and institutional delivery
- Financial problems - Distance and transportation problems and cost - Accessories they are required to bring for the delivery are too expensive - Gender roles in the society - Use of home-remedies instead of medications because of the lack of money	1. Geographical distance and transportation 2. Financial problems 3. Cultural practices and beliefs	3. Obstacles to seek maternal care
- My partner did not accept any responsibilities of the pregnancy - My partner gave me money - My husband helped me cooking - My husband helped me in washing but did not give money	1. Responsibilities that men take during the pregnancy 2. Responsabilities that men do not take during the pregnancy	4. The role of the male partners during pregnancy
- It is very good to encourage male involvement - We are encouraging them to bring their partners - Education goes deep in the heart so that they come to the hospital	1. Increase women's empowerment 2. Increase male involvement during pregnancy 3. Improve coverage and effectiveness of health education	5. Suggestions to increase access to maternal care

Skilled attendance at delivery is important

Women were also very conscious of the benefits of delivering at the hospital, such as the availability of better equipment and the possibility to prevent/treat infections. As Kofi (56-year-old) stated

> delivering at home is not that hygienic as delivering at the hospital, because (in the hospital) they use sterilized material to help the woman to not get any infection but at home, you know, a woman can come from a farm and no washing the hands and then it starts delivery so to that woman anything can happen; yes, there are so many complications, you know, during the labour, at times they force the woman to push, push and using their hands and the woman can get an infection and normally it is solved at the clinic.

The majority of women recognised that complications might occur at different levels during the delivery. Indeed, participants highlighted that in case something goes wrong with the baby and you are delivering at the hospital, the nurses can take care of the problem on time. For example, a woman explained that if the baby is in distress, in the case you are at the hospital, they can put him/her on oxygen. Furthermore, participants were aware of other complications that can occur during the delivery. They pointed out that it is good practice to deliver at the hospital not only for the safety of the new-born but also for their own. A woman explained that during her fist pregnancy, the umbilical cord was caught around the neck of the baby and because she was at the hospital, that the doctor could detect and proceed accordingly while it would have not been the case, if

she was to deliver at home. Moreover, some women explained that because in certain instances there might be excessive bleeding during the delivery, it is safer to deliver at the hospital compared to do so at home where you can bleed to death. They pointed out that if you are at the hospital in case of excessive bleeding of the mother, it is possible to get a blood transfusion.

Obstacles to seek maternal care

Geographical distance and transportation

After having explored whether participants were aware of the importance to seek care during pregnancy, the obstacles encountered in the process have been explored. One of the first problem highlighted was the geographical distance from the nearest hospital. Pregnant women who live in remote villages encounter obstacles in travelling to the hospital because they have difficulties in accessing vehicles. Most of the people in the villages included in the study, do not have a car and therefore to move they rely on walking or public transports which are mainly motorbikes. It is, therefore, very hard for a pregnant woman who lives in a remote village to access the nearest clinic/hospital. When women were asked whether they had accessed institutional delivery, 87% confirmed. However, when women were stratified by village, those who were living farther from the nearest health service, accessed institutional delivery significantly less than the others. Indeed, all women from Sogakope, which is approximately 1 km away from the nearest health service, delivered at the health facility compared to none of Fievie which is 5.5 km away. Moreover, 91.6% of women from Sokpoe which is 2.2 km away delivered at the health facility.

Financial problems

Geographical distance and the availability of transportation are not the only problems when it comes to accessing maternal healthcare. Some participants acknowledged that the problem does not only lie in transportation per se but also the fact that they cannot afford transportation to reach the hospital. Indeed, approximately 80% of the interviewed women of this study identified financial restraints as the main obstacle to seek maternal healthcare.

Moreover, some women asserted that they delivered at home because of 'precipitate labour'. Esi (22-year-old) explained

> I attended ANC but I didn't give birth at the hospital because the labour was very fast, it was just pain in the abdomen and by the time I realized I was in labour the head of the baby was already coming out.

Other participants also pointed out that they went into labour very fast so they could not reach the hospital on time. However, key informants clearly suggested that often behind the wording 'precipitate labour', a problem of transportation, or a financial issue, is usually masked.

Cultural practices and beliefs

Although, during focus groups, women did not necessarily explicitly report cultural obstacles in seeking care, key informants recognised that traditions and gender roles could result in motivations for deterring pregnant women from seeking ANC. Some women when asked if they were the ones that decided to seek care, stated that it was rather their mother or auntie who suggesting them to do so. This could point out to a potential lack of empowerment of women in deciding themselves.

When it was asked to key informants (community health nurse, traditional birth attendants, assembly woman and head master) which types of women do not attend ANC and deliver at home, most of the responses were those who are old and teenagers as well as multi parity explaining that teenagers feel shy to come to the ANC, the elderly as well.

Another important cultural obstacle detected was related to a series of items that women have to bring along with them when delivering in a facility, and the associated cost, often not affordable. For instance, tradition wants women to wear a new white dress after the delivery because as explained by Mawuli (60-year-old) 'the colour white represents the victory of life against death, most women

wear the white for about 3 months, then afterwards wear bright coloured dress'. Moreover, soap bars are needed as hygienic measures are not often in place in clinics and gifts for midwives are required.

Health workers recognised that, despite health services were offering essential equipment during delivery, the free access to such items was somehow ambiguous. Abigail (30-year-old), the community health nurse observed:

> Most of the time, we supply some of the delivery materials so that the less privilege that come can get assistance from us, example delivery mats, sanitary pads. We have them so when the person comes and they don't have them and they don't even have the money to buy them, we will use those items to help them. This goes a long way to encourage other pregnant women to attend ANC.

Common beliefs also play a role in the use of home-based remedies. However, there were divergent opinions on the efficacy of these home-remedies. Adwoa (40-year-old), a birth attendant explained that:

> sometimes they use the turkey berries [agbitsa swe swe] in cooking and that is in the case of anaemia and sometimes the midwifes advice to use them as well and it corrects the anaemia and it didn't bring any complication.

Many people confirmed that different types of plants such as 'agbitsa swe swe' are used to replace medications for anaemia in case woman cannot afford to buy them. It was pointed out that the use of the this local 'agbitsa swe swe' can be beneficial to keep the Haemoglobin level within a normal range. However, opinions regarding the efficacy of these homemade treatments were discrepant, and sometimes explicitly negative. Walter (50-year-old) declared: 'Yes, some do (use home-remedies), because they don't have money to go to the hospital. There are some home-remedies that are not a benefit and it ended in complications like death'.

The role of male partners during pregnancy

What men do

Another explored theme was male involvement during pregnancy. Specifically, what are the roles of male partners. Men are not usually involved in domestic tasks; however, things seem to change during pregnancy, Women explained that in certain instances, their male partners helped them to cook when they were pregnant. Most women explained that their partners helped them with the 'house chores' while they were pregnant. Moreover, some participants stated that their partners supported them not only by contributing to the domestic tasks but also economically.

What men do not do

However, in some instances, women felt they were not adequately supported, especially from a financial point of view. Jessica (23-year-old) said: 'My partner helps me in the washing, but he doesn't give me money when I ask for it, when I become adamant, he doesn't respond'. Furthermore, some women highlighted that their partners did not accept any responsibility of the pregnancy and therefore did not provide any kind of support.

When key informants were asked whether males attend ANC with women, considering that the presence of partners at ANC makes attendance faster and easier, they explained that they have never seen them going with women to the ANC.

Although women explained that men were supporting them in the house chores and in some cases also economically, no one mentioned that partners helped them to seek care or to deliver at the hospital. During KIIs, when it was asked why pregnant women, although the services are in place, continue to deliver at home, male responsibility sometimes emerged as a strong theme. Bernard (45-year-old): 'this is due to the irresponsibility of the husbands or partners, the proper arrangements are not made to get the woman to the clinic on time', Abigail (30-year-old) 'some men do not take responsibility for the pregnancy'. Moreover, it was pointed out that men could

also play a role in preventing women from delivering at the hospital. Indeed, Bediako (63-year-old) stated:

> some men don't have money, they encourage their wife to deliver at home and some out of ignorance might advise to, like my great grandmother at the time there was no hospital and at that time they delivered at home so some still do the same thing.

Suggestions to increase access to maternal care

Increase women's empowerment

In the final part of the interviews, participants were asked about suggestions on how to increase access to maternal care. The first suggestion from several participants was the promotion of women's empowerment. In particular, in order to empower women, the role of education from early childhood was acknowledged: 'Educating the girl child is paramount in her life. Let's arm the girl child with knowledge and skills to become productive women in the future' Mary (55-year-old). Moreover, it was further explained that it is essential for girls to remain in school.

Increase male involvement

The second suggestion to improve access to maternal care, the need for increased involvement of men during partners' pregnancy was widely recognised, mainly by women and only partially by some of the men. Bernard (45-year-old) stated:

> It is very good to encourage male involvement because normally when they go for the ANC, they educate them on the diet you should take to protect the child and the woman herself, knowing the estimated time of delivery, so they can come in time during the labour in order that things go accordingly to avoid maternal death.

Furthermore, on this topic, the Abigail (30-year-old) stated:

> We are encouraging them to bring partners, for instance when we are giving the medications to the pregnant women, they are already tired and the forget but because the partners are there, they also hear what you say and when they go home they remind them that this was what they were told to do and not to do.

Improve coverage and effectiveness of health education

Finally, the vital importance of health education in order to encourage women to attend ANC and delivery at the hospital was emphasised by many participants. There was consensus that health education is key in increasing access to maternal healthcare services.

The importance of improving the coverage and effectiveness of health education was also emphasised. Health education has the potential to promote important behavioural changes which could result in increased access to maternal healthcare. Moreover, Elikem (28-year-old) advanced an important suggestion concerning a way health education could be delivered effectively:

> get model women (women who have adhered to the ANC schedule and had skilled delivery) to organize focus groups discussions to enable the pregnant women to understand the dire need to attend ANC and continue to have a skilled delivery.

It was also added that: 'some men and women have been selected to identify non-attendance of ANC in the communities to the health professionals who then pick them up to go the hospital'.

Furthermore, within the domain of health education, the dimension of family planning also emerged as a relevant theme. Overall, only 24.1% of the women reported that they planned their pregnancies, while the remaining 75.9% did not. Other key themes included emotional preparation to birth, and education about the practice of caesarean section. Concerning the latter aspect, Isaac (67-year-old) said 'They are scared, and they have in their mind that they might die during the C-Section, it can be an obstacle for them not to deliver at the hospital'.

Discussion

There is extensive literature regarding the different factors and variables that influence maternal health-seeking behaviour especially in the context of LMICs. However, our research found that even though there are some similarities in these factors and variables across different countries, there are also extensive differences (Stephenson et al., 2006). For this reason, it is important to grasp the contextual issues in order to address properly the barriers that persist in accessing maternal health (Say & Raine, 2007). Moreover, there are not only differences between countries but also within countries. This is the first study reporting the views on pregnancy and consequently, the perceived barriers in seeking maternal care, among communities in the rural villages of the Volta Region, in Ghana. In this region, the rates of ANC coverage and institutional deliveries are particularly low compared to the average of the country. This study adds to the previous existing knowledge an insight on the perception of the population of the Volta Region on why pregnant women may not attend ANC and may not deliver at the hospital. Most importantly, it provides suggestions 'from inside' about possible improvements to access maternal care services.

Overall, the study argues that members of the community of the rural villages acknowledge the benefits of ANC and skilled delivery, and the potential risk related to home-delivery. However, pregnant women in the Volta Region still encounter different kinds of obstacles that prevent them from seeking maternal healthcare. These obstacles are driven by social and economic constraints, and by the fact that women may still lack voice in the decision-making process, and by low males' participation (Ganle et al., 2015; Ganle & Dery, 2015). These findings are in line with what has been already published in the context of Ghana regarding socio-cultural obstacles (Adu et al., 2018; Cofie et al., 2018; Mills et al., 2008). However, it outlines an additional important issue related to traditional practices and common believes such as the list of items that women need to bring along when delivering in a facility like the white dress that is extremely important, but less obvious and not cited in previous studies.

Previous literature found that the distance between villages and health facilities and high costs of transportation represent an impediment when it comes to access to a health centre to give birth (Adu et al., 2018; Apanga & Awoonor-Williams, 2018). Distance from the nearest health facility and the unavailability of transports are negatively associated with delivery at the hospital (Adu et al., 2018; Mills et al., 2008). Similarly, the role of socio-economic factors has been observed in other studies (Akowuah et al., 2018; Bazzano et al., 2008; Cofie et al., 2018; Mills et al., 2008). Although these factors are entwined, it might be argued that economic factors seem more important. Notably, accessing care implied several costs. Beside cost of transportations, which is a first well-documented barrier to seek care (Adu et al., 2018; Bazzano et al., 2008; Cofie et al., 2018; Mills et al., 2008), this study suggested other categories of costs that might occur while seeking maternal healthcare, such as the cost of so-called required items to deliver at the hospital, or gifts to midwifes whose costs amount to approximately ghcedis 100, equivalent to $US19. This issue, not mentioned in the previous literature, must be added to other well-known costs, such as one of treatments not covered by the national health insurance (Cofie et al., 2018; Dalinjong et al., 2018), and the cost of equipment unavailable at the facility level. All these aspects may actually be major determinants in preventing access to care and they clearly demonstrate that free access to health care is not the only economic issue at stake. New research should, as such, address the way to overcome the above-mentioned barriers.

As already highlighted by previous studies, it is important to address the issue of male involvement (Craymah et al., 2017; Ditekemena et al., 2012; Ganle & Dery, 2015). The need for an increased male involvement during pregnancy resulted to be an emergent theme in this study as well. Women that took part in FDGs highlighted what are the roles covered by men during the pregnancy, never pointing out the importance of their participation in attending ANC. Indeed, KIIs suggested that to improve women's access to maternal healthcare services, it is pivotal to increase

male involvement. Other studies showed that male involvement during pregnancy is increasingly advocated even among patriarchal societies such as the Ghanaian one (Aborigo et al., 2018; Atuahene et al., 2017; Craymah et al., 2017; Ganle et al., 2016). In particular, in countries where the rate of teenage pregnancy is high, as in the case of Ghana (14%) (Ghana, n.d.), partners should be encouraged to provide support to women, especially during a delicate period such as pregnancy is. The promotion of male involvement may even be considered a form of gender equity. In this perspective, it can be seen as an encouragement to more equitable gender roles and a tool for joint decision-making among couples (Ganle et al., 2016). Active male participation in supporting and accompanying the female partners to maternal health services is definitively associated with better women's and children's health (Aborigo et al., 2018; Ampt et al., 2015; Bougangue & Ling, 2017).

Since cultural beliefs can vary, more studies are needed to explore whether other rural communities in the Volta Region or in other regions of Ghana have similar traditions. More open discussions are needed between the communities and the health workers, who play a pivotal role in promoting health education, this will allow women a greater and better consciousness of their health, their bodies and their entire lives.

We acknowledge the limits of this study. In particular, recruitment methods may have implied a selection bias. Additionally, due to practical reasons (distance from hospital) the sample of participants from Fievie was very small compared to the other two villages. However, the study has the strength of being the first evaluation of this type in the Volta Region. In designing the study, we recognised the importance of including in the sample male participants, although for cultural reasons their number was limited. Most importantly, the study provided the opportunity for an open and transparent discussion among members of different communities, on themes relevant to them. The level of active participation and the spontaneous request of some of the participants to join the study somehow mirrored the relevance of the topic for the local communities. More studies may be conducted to confirm the findings of this study.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from KCL ethical approval board (MR/16/17-1091). The participants were told about the study objectives and that their participation was voluntary and they could withdraw at any time, without giving any reason. They were aware that although the conversation was audio-recorded, their identity would not be revealed. Verbal consent at the beginning of the FGDs and KIIs was obtained.

Consent for publication

Consent was obtained from participants to use anonymous quotes to be published in peer reviewed journal publications.

Availability of data and material

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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Appendices

Appendix 1

Key informants' questionnaire

(1) In your opinion, which are the obstacles women face in seeking care during pregnancy?
(2) Which are the most common health problems pregnant women present in your community? What are the causes and how can them be eradicated?
(3) Did some women that attended ANC used home-remedies during the pregnancy? If yes, which ones? Did these remedies result in benefits or complications?
(4) Are husbands/partners involved? Do they come with women to the ANC?
(5) In your opinion, would it be better to encourage male involvement during pregnancy or not? Why?
(6) Have you met women that attended ANC but then delivered at home? If yes, why was that the case?
(7) In your opinion, what is the major reason why pregnant women opt to deliver at home?
(8) Which category of people fall in line of not attending ANC and delivering at home?
(9) Are women scared of C-sections? How do perceive it? Is it an obstacle to come to deliver at the hospital in your opinion?
(10) Who is the one in charge of assisting women when they deliver at home? How is this procedure compared to deliver at the hospital?
(11) Has there ever been any complication after home delivery? How was that solved?

(12) In your opinion which measures can be adopted to encourage women to come to the ANC and deliver at the hospital?

Appendix 2

FGD questionnaire

(1) How old are you?
(2) Are you married? At what age did you get married?
(3) How many children do you have?
(4) At what age did you have your first child?
(5) Did you and do you still have preferences about the child sex?
(6) Did you attend school? If yes, for how many years?
(7) Did you plan to have children or did it just happen?
(8) How do you perceive the act of pregnancy? Do you see as something natural?
(9) Does female circumcision in your opinion play a role in the context of maternal health care? If yes, why and in which ways?
(10) Did you use some homemade remedies during the pregnancy? If yes, of what kind?
(11) What are the obstacles pregnant women in your community face in seeking and receiving care?
(12) What are your activities during the day?
(13) What are the ones of your husband?
(14) Did things change while you were pregnant?
(15) Was your husband involved during the pregnancy? If yes, in which ways?
(16) Did you attend the antenatal care visits during the pregnancy? If yes, were the visits a burden to your family or yourself?
(17) Did you make the decision to seek care or someone else? If it was someone else, why was this person very important in your decision to seek care?
(18) In the case, they attended antenatal care visits
(19) Could you describe your experience at the hospital?
(20) How were you treated by the staff of the hospital?
(21) Do you think it is important to seek care during pregnancy?
(22) Where did you deliver? If at the hospital, how was the experience?
(23) Do you think it is better to deliver at the hospital or at home?