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SOCIO-CULTURAL DRIVERS OF ANTE NATAL CARE ATTENDANCE IN THE SAVANNAH REGION OF GHANA

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Abstract
One of the major concerns of governments in low-income economies is the reduction of maternal morbidity and mortality. Antenatal care attendance is seen as an avenue where pregnant women are provided with pregnancy information, treat existing social and medical conditions and screen for risk factors associated with pregnancy. The objective of this study was to assess the socio-cultural drivers of antenatal care attendance and the associated low skilled delivery. The study employed a cross-sectional design using a mixed method approach. A multistage sampling technique was used to select five communities. In all, 85 respondents were selected from these communities for the study. Majority of the respondents were more than 31 years. More than half of them were married, and all the respondents had attended antenatal clinics within the period they were pregnant. Two important factors were identified as drivers of antenatal care; the good attitude of healthcare providers and foodstuff given to pregnant women at the antenatal clinics. The study showed that husbands had a major say in antenatal attendance. Drivers of the place of delivery were the availability and proximity of Traditional Birth Attendants in the communities, even though the decision to deliver at home was claimed to be the decision of women. A significant relationship was established between age and antennal attendance. The finding reveals the role of socio-cultural factors in antenatal attendance and skilled delivery. More sensitization is therefore needed if Ghana is to attain the Sustainable Development Goal 3.

Keywords: **Socio-Cultural Factors, Antenatal Care, Pregnancy**

Introduction

The provision of adequate antenatal care (ANC) and skilled obstetric assistance during delivery constitutes important strategies that significantly reduce maternal morbidity and mortality (World Health Organization [WHO], 2012). In this regard, ANC serves as avenues that provide pregnant women with information and screen for risk factors associated with pregnancy (Rosliza & Muhamad, 2011; Abor, Abekah-Nkrumah, Sakyi, Adjasi, & Abor, 2011). Antenatal care visits represent an important opportunity for women in resource-poor settings who utilize it to help them prepare for birth and pregnancy-related complications (Apraku, 2016). Research, however, shows that women in rural Ghana still prefer the services of Traditional Birth Attendance (TBA) (Ziblim, Yidana, & Abdul-Rashid 2018; WHO, 2012). One of the most important factors to consider in the prevention of maternal mortality and stillbirths is skilled delivery (Ren, 2011; Openshaw, Hlwelekazi, & Pretlove, 2011; Ndidi & Oseremen, 2010). In most low resource communities, the desire to seek care is often influenced by factors such as cultural beliefs, accessibility and affordability (Neupane & Doku, 2012; Onasoga, Afolayan, & Oladimeij, 2012). As has been alluded to by Shimazaki, Honda, Dulnuan, Chunanon, & Matsuyama, (2013); Ngomane & Mulaudzi, (2010),

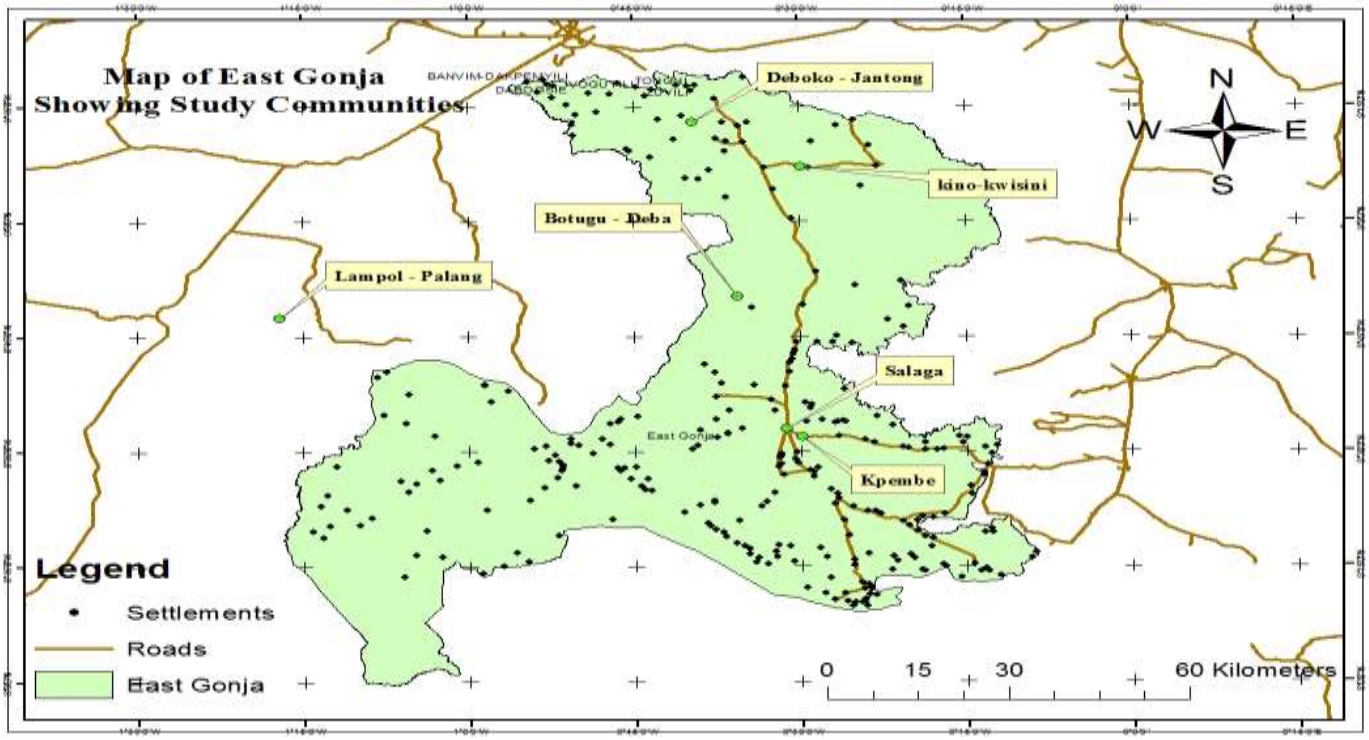
these intervening factors are embedded in the structure of societies, including the diverse norms which shape the way people interact and the choices women make regarding places of birth. Regrettably, some of the obstetric complications occur around the time of delivery, complications many TBAs can hardly predict or manage (Ndidi & Oseremen, 2010; Abebe, Berhane, & Girma, 2012).

According to the Ghana Statistical Service [GSS] (2012), about 75% of maternal deaths occur during birth and the immediate postpartum period. Even though statistics on ANC indicate high attendance; skilled delivery does not reflect the attendance as health professionals may want (Apraku, 2016). Estimates from the World Health Organization suggest that 585,000 maternal deaths occur each year with at least one woman dying every minute from pregnancy-related complications (WHO, 2012). The information further suggests that 99% of the global deaths occurred in low-income economies, with 66% occurring in sub-Saharan Africa (Ziblim, Yidana & Abdul-Rashid, 2018). According to GHS, the maternal mortality rate in Ghana stood at, 230 per 100,000 live birth. It is assumed that women with better knowledge about the danger signs of pregnancy and delivery are more likely to use skilled delivery than their counterparts with lower knowledge (Abera, Gebre, & Belachew, 2011). The national antenatal care coverage in Ghana in 2011 was 91.3%, implying that women are aware of the importance of ANC attendance, though few deliveries took place in the health facilities (GHS, 2011). In the Northern Region of Ghana, skilled delivery for 2011, 2012, and 2013 stood at 39.4%, 47.3%, and 51.2%, respectively (GHS, 2013). In the years 2015, 2016, and 2017, ANC was 786, 968, and 946 respectively with corresponding supervised deliveries as 298, 432, and 412 in the East Gonja Municipality (EGMHD, 2018). Those who delivered with TBAs were 502, 536, and 539 respectively. The poor attitude toward skilled delivery affects maternal health outcomes in this area. It is against this background that this study sought to assess the socio-cultural factors and other predictors that account for high ANC attendance and low skilled delivery within the municipality.

Material and Methods

Study Area

The East Gonja municipality lies in the Tropical Continental climatic zone. It is located in the south-eastern section of the Savannah region of Ghana. It shares a boundary with the Mion district and the Tamale metropolitan assembly to the north, central Gonja district to the west, Nanumba-North, Nanumba-south and Kpandai districts to the east and the Brong-Ahafo regions to the south. The population of Gonja according to the 2010 population and housing census is 135,450 (Figure 1).



The study was carried out between March – September 2019 and data was collected using focus group discussions, key informants' interviews, and surveys. Five Focus Group Discussions were organized, one in each of the selected communities. The respondents were made up of only persons within the same cohort to avoid few respondents dominating the discussions. The survey data were analyzed using the Statistical Package for Social Sciences (SPSS) version 25 while the qualitative data was analyzed using content analyses. Statistical tests to establish the relationship between variables such as P-values was also done.

Ethical consideration

Permission to conduct the study was obtained from participants. Verbal consent was obtained from each participant. The researcher offered adequate information about the study purpose and its significance to the study participants. Participants were assured of confidentiality and anonimity.

Results

Demographic Characteristics of Respondents

The socio-demographic characteristics of the respondents revealed that of the 110 respondents, 57% were aged above 31 years, 68% were married with 57% having more than two children. Again, 67% did not have any formal education. It further revealed that 65% professed Islam as a religion. The Gonjas as an ethnic group constitutes 43% (Table 1).

Table 1: Socio-Demographic Characteristics of Respondents

Variable	Frequency	Percent
Age		
18-25	17	15.0
26-30	31	28.0
31+	62	57.0
Total	110	100
Marital status		
Never married	26	24.0
Married	75	68. 0
Divorced	9	8.0
Total	110	100
Parity status		
1-2	47	43.0
2+	63	57.0
Total	110	100
Level of education		
No formal education	74	67.0
Middle/JHS	10	9.0
Tertiary	26	24.0
Total	110	100
Religious status		
Christianity	39	35.0
Islam	71	65.0
Total	110	100
Ethnicity		
Gonja	47	43.0
Dagomba	28	25.0
Others	35	32.0
Total	110	100

Source: *Field data 2019*

Factors Influencing ANC Attendants

From the study, almost all the respondents attended ANC at the time of pregnancy. Reasons assigned to the high attendance were the positive attitude of the healthcare staff and the support the World Food Program (WFP) provides to women who attend ANC. Out of the number of ANC attendees, 80% averred that they attended because of the food and and other supplies health workers give them at the health centres. Again, 46% of the respondents attended ANC weekly whilst 8% of the respondents attended when they had pregnancy complications (Table 2). Different reasons were advanced to explain ANC attendance by some of the respondents.

> *I attend ANC because of the food supplement and the supplies given to me by the health workers. I know if I spend 3 Ghana Cedis (GH₵3.00) to transport myself to the health centre for ANC visit I will get food that will be more expensive than the amount I spend on transportation (A focus Group Discussant 1).*

Table 2: Reasons and Frequency of ANC Attendance

Variable	Frequency	Percent
ANC attendance		
Yes	85	100.0
No	00	00
Reasons for ANC attendance		
Health professionals are good	17	20.0
Food and supplies health workers give us	68	80.0
Frequency of ANC attendance		
Once every month	29	34.0
Weekly	39	46.0
Every two month	10	12.0
When pregnancy complications set in	7	8.0

Source: *Field data (2019) (This represents only those who attended ANC)*

Initiating Antenatal Care Visits

From the study, it was revealed that the decision to initiate ANC rests with husbands, who decides whether a pregnant woman should initiate ANC or not. From the survey, 67% of the ANC attendees averred that their husbands decided ANC attendance.

> *Women in this traditional set up have little say when it comes to decision making. It is our husbands who decide for us. Their decision is final. When I was pregnant, my husband told me not to visit the health facility until they perform some rituals. It took me four months before I was able to attend ANC for examination. (A Focus Group Discussant 2)*

Associated Benefits of Antenatal Care Attendance

About 70.6% received newborn care education at ANC, 89.4% saw ANC attendance as a way to prevent pregnancy complications. Again, 65.9% felt ANC enhances their knowledge of pregnancy, with 74.1% indicating that they get accurate nutritional information during ANC visits (Table 3)

Table 3: Benefits Associated with ANC Attendance

Statement	Yes	No	Do not know
Newborn care education is provided at ANC	60 (70.6%)	20 (23.5%)	5 (5.9%)
ANC attendance can prevent pregnancy complication	76 (89.4%)	0 (0.0%)	9 (10.6%)
ANC enhances women knowledge on pregnancy	56 (65.9%)	11 (12.9%)	18 (21.2%)
At ANC you get accurate nutritional information	63 (74.1%)	3 (3.5%)	19 (22.4%)
ANC keep track of your baby's development	79 (92.9%)	4 (4.7%)	2 (2.4%)
ANC attendance schedule you for appropriate testing	67 (78.8%)	6 (7.1%)	12 (14.1%)

Source: *Field data 2019*

Relationship between Socio-Demographic Background and ANC Attendance

The study revealed a statistically significant relationship between women's age and frequency of ANC attendance (χ^2=13.88). Women in the age category above 25 years were more likely to attend ANC frequently as compared to their counterparts in the age category less than 25. There was no statistical relationship between women's marital status and frequency of ANC attendance (χ^2=23.10) (Table 4).

Table 4: Relationship between Socio-Demographics and ANC Attendance

Frequency of ANC attendance						
Variable	Weekly	Monthly	2 months	Complication	χ^2	Cramer's V
Age (≤ 25; 25<)	8.8.0%	12.5%	3.8%	0.9%	13.88	0.652
Marital status Single: Married	14.4%	8.7%	5.1%	3.1%	23.10	0.336
Educational Not: educated	22.8%	12.8%	3.1%	4.0%	13.12	0.232

Source: *Field data 2019*

Stakeholders who assist Women to attend ANC

From the study, it was observed that, as the age increases by a unit from 25 years, there was no assistance or support to attend ANC (p=0.012). The results suggest that as the age of the mothers increases the probability of getting support to attend ANC decreases. Again, the marital status of women was highly associated with some form of assistance to travel to a health facility (p = 0.003). This could be due to the reason that in view of the fact that two heads are better than one, married women were more likely than never-married women to get support from their partners (Table 5).

Table 5: Comparative Analysis of Parties who assist women to attend ANC

Independent Variables	Coefficients Myself	Husband	T	P-value
Age (≤ 25; 25<)	40%	4%	-5.290	0.012
Marital status	20%	3%	3.221	0.003

Single: Married				
Educational	10	2%	-2.942	0.12
Not educated: educated				
Parity	20%	1%	1.231	0.001
≤ 1: 1<				

Source: *Field data 2019*

Socio-cultural and economic factors that influence home delivery

From the study, 58% reported having delivered their last babies at home. Again, 57% of respondents who delivered at home were assisted by the TBAs. Again, the study further showed that those who delivered at health facilities were those who reside not far from the facility.

> *I delivered my baby at the health facility because the place is not far from my house. It will be difficult to deliver with the help of a TBA when the health facility is just by my house. Also, my husband will not allow me to deliver at home. (A focus Group Discussant 1)*

Reasons for Delivering at Home

The majority of the respondents representing 82% said women's choice of delivery place influences home delivery whilst 44% cited cultural beliefs as factors that influence their choice of place of delivery. Again, 64% cited items needed for delivery at the health facility as the reason for home delivery, whilst 88% cited bad attitude of health staff as the reason they chose to deliver at home (Table 6). During the focus group discussion, the respondents reported that one of the reasons why they deliver at home:

> *We deliver at home because of the bad nature of our road network. The roads are in a very deplorable state and the cost of transporting a pregnant woman to the nearest health facility is too high and time-wasting (FG Discussant 3).*

Table 6: Reasons for Home Delivery (multiple responses)

Variable	Frequency	Percent (%)
Cultural belief	37	44.0
Hospital payment	54	64.0
Bad attitude of the staff	75	88.0
Successful home deliveries	65	76.0
Availability of TBAS	85	100.0
Grandparents support for home delivery	65	76.0
Sudden onset of labour	45	53.0
The uncaring attitude of health staff	68	80.0
Preferences	70	82.0

Source: *Field data (2019) (The table denotes multiple responses)*

Discussion

Antenatal care is the routine health control of presumed healthy pregnant women without symptoms, to diagnose diseases or complications to provide information about lifestyle and delivery. Almost all the

respondents have had the experience of ANC attendance during their last pregnancy, confirming Ghana Health Service (GHS) reports that ANC coverage in the Northern region of Ghana was high (GHS/RCH, 2007). Food supply to pregnant women was identified as a motivating factor for the high antenatal attendance, which again supports GHS report of pregnant women and nursing mothers in rural health facilities where food supplied has increased health facility attendance (GHS, 2014). Women do not play any key role in decisions concerning ANC attendance in terms of getting their husbands to reason and agree with them regarding their attendance. This revelation reflects Ngomane and Mulaudzi's finding in Nigeria where men took sole responsibility in the decision on the health-seeking behaviours of their wives, especially ANC attendance (Ngomane & Mulaudzi, 2010).

From the study, it emerged that women with formal education delivered with the assistance of professional nurses or midwives within health facilities. This supports Ren as well as Feyissa and Genemo's findings, which suggest that couples with higher education underscored the need for skill delivery and that poverty was a major challenge affecting skill delivery among rural women (Ren, 2011; Feyissa & Genemo, 2014). Distance to a health facility plays a crucial role in health service accessibility. One of the reasons provided for home delivery was socio-cultural factors that resonate well with respondents, to influence the choice of place of birth (Gloria, 2016; Apraku, 2016). The availability of TBAs in the community influences women to deliver at home, confirming Eades et al. claim that TBAs supervise major deliveries in rural communities in Ghana (Eades, Brace, Osei, & Languardia, 1993). Again, 76% of the respondents cited the availability of family support as a factor influencing home delivery, and appear to disagree with Wanjira et al. study where women educational status was associated with home delivery (Wanjira, Mwangi, Mathenge, Mbugua, & Ng'ang'a, 2011). From the study, it was shown that women who were not educated were 5.4 times more likely to deliver at home as compared to those who were educated (OR= 5.4, 95% CI; 6.12-10.83, p=0.002). This corroborates Adamu and Salihu study where the educational status of pregnant women was associated with place of delivery (Adamu & Salihu, 2002). These factors, therefore, enable women to seek for safer childbirth under the supervision of skilled attendants. Generally, the financial status of a woman plays an important role in her ability to access antenatal care in that those with mother finds it easy to mobilize transport to attend as against the poor who may not be able to do so.

Conclusion

The study established that almost all the respondents have had the experience of antenatal care visits. More than half delivered their last babies at home. A statistically significant relationship was established between age and antenatal attendance as well as educational status and antenatal care visits. Again, it was also observed that though beliefs and traditional practices perception played a role in the determination of place of delivery, women had a greater stake in that regard. There was no direct influence of antenatal care attendance in the reduction of home delivery because of the presence of Traditional Birth Attendants. It is therefore imperative for the government of Ghana and stakeholders to step up and sustain the campaign on maternal health if the Sustainable Development Goal 3 is to be achieved.

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