



**Faculty of Social Sciences**

**Socio-Cultural Dimensions of Maternal Healthcare in Ghana**

**Bassoumah Bougangué**

**Doctor of Philosophy  
2017**

**DECLARATION**

I Bassoumah Bougangue, 14010096, Faculty of Social Sciences hereby declare that the work entitled Socio-Cultural Dimensions of Maternal Healthcare in Ghana is my original work. I have not copied from any other students' work or from any other sources except where due reference or acknowledgment is made explicitly in the text, nor has any part been written for me by another person. The thesis has not been accepted for any degree and is not concurrently submitted in candidature of any other degree.

Signature .....

Name .....

Date .....

## ACKNOWLEDGEMENTS

The success of this study was facilitated by the commitments and contributions of some individuals and organisations. For their patience, guidance, encouragements, duty-consciousness, insightful queries and valuable contributions, Associate Professor Dr. Ling How Kee (main supervisor) and Dr. Kamsiah Binti Ali (co-supervisor), both of the Faculty of Social Sciences, UNIMAS, deserve special appreciation and thanks. The encouragements and psychological support given me by my dear parents, Chief Musah Jadam Bougangué and Mrs. Salamatu Tartey Musah need to be mentioned.

Sincerely, I am indebted to Mrs. Sheila A. Bassoumah of the Criminal Investigation Department of Ghana Police Service for bearing the cost of this study. Again, I extend my appreciation to Mr. Joshua Ohene Sachi of Kasoa for financing the data collection aspect of this research. Equally, the Malaysian Government and the Zamalah Scholarship Committee of UNIMAS Graduate School are acknowledged for providing financial relief for this research programme. It is ungrateful to neglect the assistance offered by Mr K. A. Magewaba of Chereponi SHS who took care of the cost of accommodation for the research.

My heartfelt gratitude also goes to the staffs of Ghana Health Service and the Planning Offices of Yendi Municipal and Chereponi District Assemblies for providing relevant data for the research. Many thanks to Mr Fusheini Fatawu of Yendi through whose cooperation and hard work the research accessed the dedicated participants. Again, the chiefs, assembly members and elders of the study communities deserve special thanks for their cooperation and assistance in making this research a success. The contributions of all other people who facilitated this research directly or indirectly are appreciated and acknowledged.

## ABSTRACT

About 99% of the 830 women who die every day from maternal causes worldwide are from developing countries. Regardless of the 45% improvement in maternal deaths in 2013, the WHO recorded an increase in indirect causes of maternal deaths from 9.1% in 1990 to 10.2% in 2013. Africa contributes only 14% of global population but accounts for more than half of global maternal deaths. The WHO/World Bank current estimate of Ghana's maternal mortality ratio at 320/100,000 live births is unacceptably high in the face of interventions such as National Health Insurance Scheme, safe motherhood protocol and national ambulance system amongst others. Between 2011 and 2012 the Northern Region of Ghana recorded the highest maternal deaths of 302 with 72.8% home deliveries, out of which about 36% were assisted by untrained traditional birth attendants. This qualitative study uses culturally appropriate methods to explore the experiences of women in childbirth and decision-making towards utilisation of maternal healthcare services. In 30 individual and 15 focus group interviews, the study purposively sampled key actors in maternal healthcare such as women aged 15-49 years ever-pregnant or given birth within two years preceding data collection, their spouses, traditional practitioners and health professionals in the Yendi Municipality and Chereponi District of the Northern Region. Guided by the structure-agency theory and the delays model, this study thematically analysed utilisation of maternal healthcare services in the three inter-connected stages of maternity. Amongst other things, the study discovered systemic-structural delays in care-seeking within households inherent in gender norms and religious beliefs such as dietary taboos and behavioural codes that governed women's care-seeking behaviour. The socio-cultural system within households were structured hierarchically and characterised by oppression and marginalisation of women, especially in decision-making towards care-seeking. This male supremacy and gender discriminatory practices facilitated male-dominance in decision-making for care seeking, which denied women timely clinical intervention. Dualism of care characterised by the use of traditional

and pharmaceutical medicines was observed amongst participants as an outcome of dual-faithism. Moreover, attention on maternal healthcare was focused more on delivery, neglecting the inter-connectedness of antenatal, delivery and postnatal care. Facility-based challenges were inadequacy of facilities, equipment and health professionals, lack of professionalism and collection of illegal fees amongst others. In the light of these findings, the thesis has developed a model for viewing maternal healthcare services utilisation. There is the need to adopt gender responsive and mainstreaming policies and programmes as well as a culturally competent and structurally transformative agency strategy to empower women at the household and community levels in all spheres of life through active engagement of men.

**Keywords:** gender, male-dominance, decision-making, utilisation, maternal healthcare, oppressive, marginalisation, dualism, transformative.

## ***Dimensi Sosial-Budaya di dalam Penjagaan Kesihatan Ibu di Ghana***

### **ABSTRAK**

*Kira-kira 99% daripada 830 orang wanita yang meninggal dunia semasa kelahiran bayi setiap hari di seluruh dunia berasal daripada Negara membangun. Walaupun pada tahun 2013 sebanyak 45% pengurangan kematian ibu telah dicapai, WHO telah melaporkan peningkatan sebab-sebab tidak langsung kematian semasa kelahiran iaitu daripada 9.1% pada tahun 1990 kepada 10.2% pada tahun 2013. Afrika menyumbang hanya sebanyak 14% jumlah penduduk dunia tetapi menyumbang lebih daripada separuh kematian ibu semasa kelahiran. Anggaran semasa WHO/Bank Dunia bagi kadar nisbah kematian para ibu di Ghana ialah pada kadar 320/100,000 kelahiran adalah terlampau tinggi mengambilkira adanya intervensi melalui Skim Insuran Kesihatan Kebangsaan, Protokol Keselamatan Ibu dan Sistem Ambulan Kebangsaan. Antara tahun 2011 dan 2012, Wilayah Utara Ghana telah merekodkan kematian semasa kelahiran yang tertinggi iaitu seramai 302 (72.8%) orang ibu yang memilih untuk melahirkan anak secara tradisional di rumah dan 36% kelahiran anak tersebut dibantu oleh bidan tradisi tidak terlatih. Kajian kualitatif ini menggunakan metodologi yang sesuai dengan budaya untuk meneroka pengalaman wanita semasa melahirkan anak dan pembuatan-keputusan dalam penggunaan perkhidmatan penjagaan kesihatan ibu. Temubual bersama 30 individu dan 15 kumpulan sasar merupakan sampel bertujuan yang terdiri daripada mereka yang terlibat secara langsung dalam penjagaan kesihatan ibu seperti wanita berumur antara 15-49 tahun yang pernah mengandung dan melahirkan anak dalam tempoh dua tahun pengumpulan data berjalan; pasangan kepada ibu-ibu tersebut, pengamal tradisional dan perubatan moden di Yendi Municipality dan Dearah Chereponidi dalam Wilayah Utara. Didukungi oleh teori struktur-agensi dan model delay, kajian ini secara tematik menganalisis penggunaan perkhidmatan penjagaan kesihatan ibu dalam tiga fasa yang saling berkaitan. Kajian mendapati kelewatan yang bersifat systemic-structural untuk mendapatkan penjagaan dalam kalangan*

*isirumah disebabkan oleh norma gender dan kepercayaan agama seperti pantang larang pemakanan atau resam tingkahlaku. Sistem sosio-budaya dalam kalangan isirumah berdasarkan hieraki yang bercirikan penindasan dan peminggiran wanita terutama dalam pembuatan-keputusan untuk mendapatkan penjagaan. Sistem diskriminasi gender memudahkan dominasi lelaki dalam proses pembuatan keputusan untuk mendapatkan penjagaan yang mana menafikan intervensi klinikal tepat pada waktunya. Dualisme penjagaan dicirikan oleh penggunaan perubatan tradisional dan farmaseutikal diperhatikan dalam kalangan peserta sebagai hasil daripada dwi-pengamalan. Di samping itu, perhatian kepada penjagaan kesihatan ibu lebih menumpukan kepada aspek kelahiran sehingga mengabaikan kesaling-keterikatan antinatal, kelahiran dan penjagaan selepas bersalin. Kesulitan ini ditambah pula dengan kekurangan kemudahan, peralatan dan pakar kesihatan, kekurangan kepakaran dan wujudnya pengutipan yuran haram. Dengan mengambilkira dapatan kajian, tesis ini telah membina satu model untuk menilai penggunaan servis penjagaan kesihatan ibu. Terdapat keperluan untuk mengarus perdana gender melalui dasar dan program serta strategi transformatif yang mengambilkira budaya di dalam memperkasakan wanita di peringkat isi rumah dan komuniti dalam semua bidang kehidupan melalui penglibatan golongan lelaki secara aktif.*

***Kata kunci:*** *gender, dominasi lelaki, pembuatan-keputusan, penggunaan, penjagaan kesihatan ibu, penindasan, peminggiran, dualisme, transformatif.*

## TABLE OF CONTENTS

	<b>Page</b>
<b>DECLARATION</b> .....	i
<b>ACKNOWLEDGEMENTS</b> .....	ii
<b>ABSTRACT</b> .....	iii
<b>ABSTRAK</b> .....	v
<b>TABLE OF CONTENTS</b> .....	vii
<b>LIST OF TABLES</b> .....	xv
<b>LISTS OF FIGURES</b> .....	xvi
<b>LIST OF ABBREVIATIONS</b> .....	xvii
<b>CHAPTER 1: INTRODUCTION</b> .....	1
1.1 Background.....	1
1.2 Ghanaian Women's Status and Maternal Health.....	8
1.3 The Study Setting.....	10
1.4 Gaps in Existing Studies.....	11
1.5 Statement of the Problem.....	13
1.6 Research Questions.....	15
1.7 Objectives of the Study.....	16
1.8 Significance of the Study.....	16
1.9 Scope of the Study.....	18
1.10 Research Methods.....	19
1.11 Organisation of the Thesis Chapters.....	19

<b>CHAPTER 2: BACKGROUND OF GHANA AND MATERNAL HEALTHCARE.....</b>	<b>21</b>
2.1 Introduction.....	21
2.2 Profile of Ghana.....	21
2.3 Safe Motherhood Interventions in Ghana.....	26
2.3.1 Challenges to Implementation of the Safe Motherhood Policies.....	30
2.4 Rationale for the Choice of Study Site.....	31
2.5 Conclusions.....	33
<b>CHAPTER 3: LITERATURE REVIEW.....</b>	<b>35</b>
3.1 Introduction.....	35
3.2 Previous Studies.....	35
3.2.1 Gender and Maternal Healthcare.....	36
3.2.2 Culture and Indigenous Birthing Practices .....	37
3.2.3 Social, Economic and Demographic Determinants .....	41
3.2.4 Organisational and Institutional Conditions.....	44
3.2.5 Critical Summary .....	46
3.3 Theories and Models of Healthcare Services Utilisation.....	48
3.3.1 Andersen's Model.....	49
3.3.2 The Structure and Agency Theory.....	50
3.3.2.1 Structuration and Health Inequalities.....	52
3.3.3 Gender Empowerment Framework.....	56
3.3.4 The Three Delays Model.....	58
3.3.5 Critical Review of the Theories and Models.....	60
3.4 Conceptual Framework.....	64

3.5 Conclusions.....	67
<b>CHAPTER 4: METHODOLOGY.....</b>	<b>69</b>
4.1 Introduction.....	69
4.2. Qualitative Research Method.....	69
4.2.1 Justification of Qualitative Design for the Study.....	70
4.2.2 Culturally Appropriate Approach.....	73
4.3 Research Participants and Sampling Procedures.....	76
4.3.1 Research Participants.....	76
4.3.2 Sampling Procedures.....	77
4.3.3 Socio-Demographic Data.....	79
4.3.3.1 Age Distribution of Participants.....	79
4.3.3.2 Distribution of Participants by Educational Level.....	80
4.3.3.3 Distribution of Participants by Occupation.....	80
4.4 Sample Size.....	81
4.5 Research Instruments and Rationale.....	84
4.6 Pilot Study .....	88
4.7 Training of a Rapporteur .....	91
4.8 Pre-field Activities.....	91
4.9 Ethical and Political Considerations.....	91
4.10 Trustworthiness and Dependability.....	94
4.10.1 Ensuring Trustworthiness and Dependability.....	95
4.11 Fieldwork.....	98
4.12 Field Challenges and How they were Overcome.....	98
4.13 Data Management and Analysis.....	100

4.13.1 Transcription and Translation.....	100
4.13.2 Coding and Analysis.....	100
4.13.3 Worldviews and Health Beliefs around Pregnancy and Childbirth.....	101
4.13.4 Decision-Making for Care Seeking.....	102
4.13.5 The Role of Traditional Birth Attendants in Maternity.....	103
4.14 Conclusions.....	105

## **CHAPTER 5: WORLDVIEWS, HEALTH BELIEFS AND INDIGENOUS**

<b>BIRTHING PRACTICES .....</b>	<b>107</b>
5.1 Introduction.....	107
5.2 Worldviews and Health Beliefs around Maternity.....	108
5.2.1 Dietary Taboos.....	109
5.2.2 Non-Food Taboos.....	113
5.2.2.1 Unacceptable Sexual Relationships.....	113
5.2.2.1.1 Influence of Compound Housing and Extended Family Systems.....	118
5.2.2.2 Restrictions on Movement.....	121
5.2.2.3 Protection of Babies.....	124
5.2.2.4 Burial of Placenta.....	125
5.2.3 Ethical Values and Implications for Clinical Care .....	126
5.2.4 Commentary.....	128
5.3 The Role of Traditional Practitioners in Indigenous Care.....	133
5.3.1 Prenatal Period.....	133
5.3.1.1 The Role of Traditional Birth Attendants in Prenatal Period.....	134
5.3.1.2 The Role of Spiritualists in Prenatal Period.....	137
5.3.2 Intra-Partum Period.....	139

5.3.2.1 The Role of Traditional Birth Attendants in Intra-Partum Period.....	140
5.3.2.2 The Role of Spiritualists in Intra-Partum Period.....	144
5.3.3 Postnatal Period.....	146
5.3.3.1 The Role of Traditional Birth Attendants in Postnatal Period.....	147
5.3.3.2 The Role of Spiritualists in Postnatal Period.....	150
5.3.4 Commentary.....	151
5.4 Conclusions.....	155
<b>CHAPTER 6: DECISION-MAKING AND UTILISATION OF MATERNAL</b>	
<b>HEALTHCARE SERVICES .....</b>	<b>158</b>
6.1 Introduction.....	158
6.2 Gender and Decision-Making Towards Healthcare Seeking.....	158
6.2.1 Masculine and Feminine Roles.....	159
6.2.2 Decision-Making Towards Care Seeking.....	162
6.2.2.1 Women's Involvement in Decision-Making.....	164
6.2.3 Gender, Health Beliefs and Decision-Making.....	166
6.2.4 Husbands' Contribution in Maternal Healthcare.....	175
6.2.5 Commentary.....	181
6.3 Provision and Reception of Maternal Healthcare Services.....	186
6.3.1 Inadequate Staffing.....	187
6.3.2 Financial Constraints.....	188
6.3.3 Inadequacy of Equipment and Facilities.....	191
6.3.4 Lack of Professionalism.....	194
6.3.5 Transportation Means and Network .....	196
6.3.6 Poor Clinical Attendance.....	198

6.3.7 Commentary .....	199
6.4 Conclusions.....	203
<b>CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS.....</b>	<b>207</b>
7.1 Introduction.....	207
7.2 Key Findings.....	208
7.3 Conclusions to the Key Findings.....	212
7.4 Contribution to Knowledge.....	217
7.5 Implications for Healthcare Practices, Education, Policy Development and Recommendations.....	222
7.6 Limitations of the Study.....	227
7.7 Recommendations for Future Research.....	227
7.8 Conclusions.....	228
<b>REFERENCES.....</b>	<b>230</b>
<b>APPENDICES.....</b>	<b>250</b>

## LIST OF TABLES

	<b>Page</b>
Table 3.1 Critical Summary .....	63
Table 4.1 Distribution of Participants by Age.....	79
Table 4.2 Distribution of Participants by level of education.....	80
Table 4.3 Distribution of Participants by Occupation.....	80
Table 4.4 Distribution of Participants by Location.....	82
Table 4.5 Distribution of Participants by Districts.....	84
Table 4.6 Worldviews and Health Beliefs around Pregnancy and Childbirth.....	102
Table 4.7 Decision-Making for Care Seeking.....	103
Table 4.8 The Role of TBAs in Maternity.....	104

## LIST OF FIGURES

	<b>Page</b>
Figure 1.1 Map of Ghana showing the Ten Administrative Regions.....	10
Figure 2.1 Africa Map showing the Position of Ghana.....	22
Figure 2.2 The Position of Ghana in West Africa.....	22
Figure 2.3 Map of Ghana showing the Ten Administrative Regions.....	24
Figure 2.4 Map of Northern Region of Ghana Showing the Study Districts.....	32
Figure 2.5 Thematic Illustration of Maternal Healthcare Services Utilisation.....	47
Figure 3.1 Empowerment Framework.....	57
Figure 3.2 The Delays Model.....	64
Figure 5.1 Compound House.....	118
Figure 6.1 Major Transport Means in a Village Compound House.....	177
Figure 6.2 Transport network in the study area.....	178
Figure 7.1 Systemic Structural Model for Viewing Maternal Healthcare Services Utilisation.....	219

## LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Management of Third Stage Labour
ANC	Antenatal Care
ATR	African Traditional Religion
AU	African Union
CCT	Controlled Cord Traction
CEDAW	Convention on Elimination of all Forms of Discrimination Against Women
CHO	Community Health Officer
CHPS	Community-based Health Planning and Services
CRS	Catholic Relief Services
EoC	Emergency Obstetric Complication/Care
FAO	Food and Agriculture Organisation
FCUBE	Free Compulsory Universal Basic Education
FGD	Focus Group Discussion
FHI	Family Health International
GBV	Gender-Based Violence
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus,

ICRW	International Centre for Research on Women
IDI	In-Depth Interview
IMMPACT	Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials
IPT	Intermittent Preventive Treatment
JSS	Junior Secondary School
JHS	Junior High School
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MPS	Making Pregnancy Safer
MSLC	Middle School Leaving Certificate
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
PHC	Primary Health Care
PNC	Postnatal Care
RBM	Ghana Roll Back Malaria Programme
SD	Skilled Delivery
SP	Sulphadoxine-Pyrimethamine
SSA	Sub-Saharan Africa
SSS	Senior Secondary School
SSSCE	Senior Secondary School Certificate Examination
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TP	Traditional Practitioner
UN	United Nations
UNDP	United Nations Development Programme

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

# CHAPTER 1

## INTRODUCTION

### 1.1 Background

The need to improve the health of women in maternity has always been a serious global concern since the mid 1980s when researchers drew the attention of the world to the alarming rates at which women were dying from pregnancy and childbirth, especially, in developing countries. This led to the establishment of the safe motherhood initiative in the late 1980s by the World Health Organisation (WHO). In recognition of the importance of women's health, the United Nations (UN) has set up the Commission on Information and Accountability for Women's and Children's Health in support of Global Strategy for Women's and Children's Health. The establishment of this commission is to enable the UN develop a framework for global reporting, oversight and accountability on women's and children's health, especially, in high burden and low income countries (WHO, 2013).

The United Nations Development Programme (UNDP) in 2004 attaches particular importance to the health of women in the quality of life, level of productivity, and life expectancy of the women, their families, and the citizenry at large. A better health for women is a necessary priority and an improvement in maternal mortality and morbidity should be a target of all nations (WHO, 2013), because improved women's health constitutes a critical input into economic growth, poverty reduction and a long term socio-economic development (African Union (AU), 2006; UNDP, 2007).

Almost three decades after the establishment of the safe motherhood initiative by the WHO, deaths related to pregnancy and childbirth, and the associated complications still confront the world, especially the developing countries where access to the inadequate healthcare services are mediated by social and cultural factors (WHO, 2013). The 2000 World Summit came out with the

Millennium Development Goals (MDGs) of which the goal number five was to improve maternal health by reducing maternal mortality by three quarters between 1990 and 2015, and to achieve universal access to reproductive health by 2015. The key target in reducing maternal mortality is to record 100% of deliveries assisted by skilled health personnel. There have been some improvement in many countries especially regarding increase in antenatal care coverage. However, assistance by skilled personnel remains a challenge especially in South East Asia and Africa Regions (WHO, 2011, 2012, 2013, 2015).

Maternal mortality continues to be an indicator that shows the largest disparity between the developed and developing regions. Many women in developing countries, most often in rural Africa, register high antenatal care attendance but very low attendance for institutional deliveries and postnatal care (WHO, 2013). According to WHO, only 48% of deliveries in Africa is assisted by skilled health professionals compared with 98% in Europe. Again, postnatal care during the critical period registered very poor attendance of only 37% of the deliveries in the year under review. The postnatal period is the critical phase in the lives of mothers and newborn babies and most of maternal and infants deaths occur during this time (WHO, 2013; Ghana Statistical Service (GSS), 2015), yet this is the most neglected period for the provision of quality care (WHO, 2013). Postnatal care is very important for medical professionals to screen for signs of infections and haemorrhage (bleeding), which currently accounts for 20% of maternal deaths in Ghana and the leading cause of maternal mortality in the world (GSS, 2009).

Even though maternal mortality has dropped globally by 45% from 1990 to 2013 (WHO, 2013; World Bank, 2014), only 50% of the women in developing regions receive the recommended healthcare during pregnancy, and only 51% of women in low income countries access skilled care during childbirth (WHO, 2015). About 830 women die everyday due to complications during pregnancy and childbirth, and 99% of these deaths occur in developing countries (WHO et al., 2015). Maternal mortality is five times higher in developing regions as

compared to those of developed regions, with an increase in indirect causes from 9.1% in 1990 to 10.2% in 2013 (World Bank, 2014).

One out of 40 women in Africa has a lifetime risk of dying from pregnancy related complications as compared to one in 3,300 women in Europe. The majority of these maternal deaths occur in sub-Saharan Africa (SSA), which accounts for 56% of global maternal deaths (WHO, 2013). In Africa, most of the maternal deaths and complications are from indirect causes which have direct link with the cultural and traditional beliefs and practices (AU, 2006). Africa accounts for about 20% of births in the world, but contributes to 40% of maternal deaths with many more suffering injuries and lifetime disabilities, estimated to be about 15 million women a year (AU, 2006).

Human reproduction is a biological event, but strongly determined by cultural factors (Dubois, 1985). Thus, pregnancy and childbirth in Africa are prone to crises due to socio-cultural factors (Nwokocha, 2007). Cultural beliefs and traditional practices together with poor medical system hinder women's access to and use of hospital facilities, especially during emergencies (Nwokocha, 2007; Bawah, 2008; Nyanzi, 2008).

About 60% of African population is rural based, and as a result, cultural norms and practices still exert strong influence on reproductive healthcare (Nyanzi, 2008). This makes traditional healthcare system the first option for healthcare in most instances (Addai, 2000; Nyanzi, 2008). The role of traditional birth attendants (TBAs) often reflects the culture and social organisation of the community in which they operate. As a result of the strong attachment to socio-cultural factors, high quality maternity is often unavailable and home delivery remains a strong preference for many women (Mainbolwa, Yamba, Diwan & Ransjo-Arvidson, 2003; Nyanzi, 2008).

The complex interaction between biology and socio-cultural environment means that even when skilled care is available, women may not seek or receive it (WHO, 1999; Senah, 2003). This is because the attitudes of women towards maternal healthcare services, their perceptions

about health facilities, and the utilisation of such facilities are strongly influenced by their socio-cultural environment (Andersen, 1995; Andersen & Newman 2005; Furuta & Salway, 2006; Cannavan, 2008; Ononokpono & Odimegwu, 2014). Meanwhile, delivery in health facility is associated with lower maternal and newborn deaths and morbidity rates compared with home delivery (GSS, 2008, 2009; WHO, 2011, 2013; Ononokpono & Odimegwu, 2014).

According to AU (2006), an important factor in the utilisation of maternity care services is the cultural background of the woman. In most African rural communities, maternal health services co-exist with indigenous healthcare services; therefore, women have to choose between these options, and the culture of the women usually determines the choice (Addai, 2000). Factors that influence maternal healthcare services utilisation operate at various levels - the individual, household, community and state levels (Babalola & Fatusi, 2009; International Centre for Research on Women (ICRW), 2010; Abel & Frohlich, 2012). Thus, the cultural and social organisation of the individual's family, community and state at large defines the option to make in terms of choice of healthcare services.

It has been established in many studies that background variables such as ethnicity, religion, income level, educational attainment, place of residence, age amongst others also have impact on the use of healthcare facilities by women (Tsikata, 2007; UNDP, 2007; GSS, 2008, 2009, 2015). Again, the means and cost of transportation, the behaviour of health professionals, have influence on the utilisation of maternal healthcare services (Addai, 2000; GSS, 2008, 2009).

The MDG 3 aims to promote gender equality and empowerment of women. Gender equality implies equal rights and opportunities for both sexes. It involves changing how men and women relate to each other and bringing about distribution of power and resources and care-giving responsibilities (UNFPA & ICRW, 2014). Article 12 of the convention on elimination of all forms of discrimination against women (CEDAW) requires states to ensure equality of men and women on basis of access to healthcare services especially, reproductive health and granting free services

where necessary. The Beijing Declaration and the Platform for Action set strategic objectives and actions for advancement of women and the achievement of gender equality in 12 critical areas including women and poverty, education and training of women, women and health, violence against women and human rights of women amongst others. Gender inequality, which is socially created within cultures creates a position for women within households, which in turn determines their utilisation of maternal healthcare services (McAlister & Baskett, 2006; WHO, 2014).

Article 25 of the 1992 Republican Constitution of Ghana recognises and protects gender equality and women's human right to healthcare. Again, the revised version of 1994 Population Policy of Ghana enjoins all institutions to protect the reproductive right of women and promote maternal health at all levels of the public healthcare system. This policy calls for the collaboration between the traditional institutions and the healthcare institutions for the elimination of all social and cultural barriers to healthcare access.

Decision-making at the household level is a very important determinant of the choice of healthcare services by women. When women have the power to decide they can make meaningful decisions that can positively affect their lives (Babalola & Fatusi, 2009; Hagman, 2013). However, differences in the status of women and men lead to differences in opportunities to claim, benefit from, and enjoy human rights including the right to decision-making and health (WHO, 2013, 2014). In many parts of Africa, women's decision-making power is extremely limited, particularly in matters of reproduction and sexuality. In this regard, decision about maternity care are often made by husbands or other family members usually, males (WHO, 2001).

Gender inequality is capable of rendering women vulnerable and affecting their demand for services including healthcare at all socio-economic levels (Nwokocha, 2007), because gender factors affect the individual's autonomy to make decisions like seeking healthcare, engaging in social interaction, moving freely outside the home, controlling vital resources like income and assets (ICRW, 2008). Gender inequality which manifests in the decision-making process within

the household is a critical and neglected factor in the utilisation of maternal healthcare services. Deeply entrenched gender inequalities exist in many low-income countries where maternal deaths are high and health services utilisation is low (Nyanzi, 2008; ICRW, 2008; WHO, 2013; UNFPA & ICRW, 2014). Gender inequality is defined and perpetuated by social norms and culture, and reflects differences in power between men and women both within the household and in the wider society (WHO, 2001; Nukunya, 2003). The effects are relatively high rates of poverty and lower levels of education amongst women than men, women's lack of autonomy and mobility, intimate partner violence and overall, lower social status and disempowerment of women relative to men (UNDP, 2007).

Women's low social status and constraints relative to men significantly impact women's health, the health of mothers and overall demand for maternal healthcare services. In many conservative communities, cultural and social norms restrict women's mobility and prevent them from seeking healthcare (WHO, 2001; Nwokocha, 2007). This is compounded by their limited access to education which deprives them of the knowledge and tools to make informed decisions and choices (McAlister & Baskett, 2006; GSS, 2009; Hagman, 2013; UNFPA & ICRW, 2014).

According to UNDP (2007), gender role in decision-making interacts with age to make young women particularly vulnerable to the ill effects of gender inequitable norms on maternal healthcare access. These norms may dictate early marriage for girls which may in turn lead to early child bearing and its consequential increase in total fertility, both of which are linked to higher risks of maternal morbidity and mortality (GSS, 2008, 2009, 2015).

In recent times, the impact of gender-based violence (GBV) on maternal health is great. The physical, sexual, psychological and economic abuses resulting from women's subordinate status in society and controlling behaviours that restrict women's access to resources impact the utilisation of healthcare services by women (Nwokocha, 2007; ICRW, 2008). Most often, these abuses are perpetuated by intimate partners and may begin or become aggravated by pregnancy