



Rethinking the causes of maternal mortality in Tolon district: Analyses of socio-cultural believes and practices as barriers to achieving MDG 5

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Abstract: Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration of the pregnancy, from any cause aggravated by the pregnancy or its management, but not from accidental or incidental causes. In Ghana, the estimated maternal mortality ratio (MMR) is 350, while the number of maternal deaths stands at 2700. MMR for the Sub-Saharan countries is 500 with maternal deaths of 162,000. The estimates for global MMR are 210, with 28700 as the number of deaths. Though the Tamale Teaching Hospital recorded a 74% reduction of maternal mortality in 2011, it is argued that this institutional figure represents an insignificant number of women who deliver at the hospital and that the majority of births in the region occurs at home are not captured. The contribution of socio-cultural beliefs and practices to maternal mortality is incalculable. It prevents pregnant women from attending hospitals for ANC and delivery and even from taken certain food that can help improve pregnant women's health. This paper elaborates on the question of maternal mortality, it interrogates the overemphasis on medical explanation to the maternal mortality and how that alone is not helping the situation. It delves into the issue of socio-cultural beliefs and practices as contributing factors to maternal mortality in Tolon district and the need to address these cultural beliefs and practices to pave the way for achieving the MDG 5 and safe maternal delivery. The paper contributes to the ongoing debate on achieving the MDGs as the benchmark of 2014 is just around the corner. It also sensitizes the policy makers, the Ministry of Health and the public on the need to recast their efforts and focus on socio-cultural beliefs and practices to reduce maternal mortality in Ghana.

Key words: Maternal mortality, socio-cultural beliefs, health, pregnancy, child birth

Introduction

With barely a year to 2015 which was sets as the endline to achieve the eight Millennium Development Goals (MDGs), Ghana has made a lot of tremendous strides towards achieving these MDGs except MGD 5: Improve maternal health. The two targets for assessing MDG 5 are reducing the

maternal mortality ratio (MMR) by three quarters between 1990 and 2015, and achieving universal access to reproductive health by 2015. A Study conducted by WHO, UNICEF, UNFPA and the World Bank in 2012 to estimate the trends of maternal mortality globally, acknowledged that the MDG 5 has made slow progress [1]. Despite the

heavy investments into achieving the MDG 5, in Ghana, much emphasis is placed on medical and clinical solutions to the causes of maternal mortality to the neglect of socio-cultural beliefs and practices which contribute significantly to maternal mortality. Maternal mortality is defined by the World Health Organization as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration of the pregnancy, from any cause aggravated by the pregnancy or its management, but not from accidental or incidental causes” [1].

This definition only categorizes causes of maternal deaths into either direct or indirect causes. Direct maternal deaths are those resulting from obstetric complications of the pregnant state (pregnancy, delivery and postpartum), interventions, omissions, incorrect treatment, or a chain of events resulting from any of the above. Deaths due to conditions such as obstetric haemorrhage or hypertensive disorders in pregnancy, or those due to complications of anaesthesia or caesarean section are classified as direct maternal deaths [2]. While indirect maternal deaths are those resulting from previously existing diseases, or from diseases that developed during pregnancy but aggravated by physiological effects of pregnancy [1].

The MDG 5 sets out to reduce maternal mortality by 75% by 2015 and barely one year to 2015, maternal mortality in Ghana is still high [2]. Globally, there were an estimated 287 000 maternal deaths in 2010, yielding a maternal mortality ratio (MMR) of 210 maternal deaths per 100 000 live births among the 180 countries that were covered by WHO, UNICEF, UNFPA and the World Bank. They estimated the trends of maternal mortality from 1990 to 2010 [1]. The study further estimates that global MMR plausibly ranges from 170 to 300 maternal deaths per 100 000 live births. Developing countries according to the study account for 99% (284 000) of the global maternal deaths, the majority of which are in sub-Saharan Africa (162 000) and Southern Asia (83 000). These two regions accounted for 85% of global burden, with sub-Saharan Africa alone accounting for 56%. The MMR in developing regions (240) was 15 times higher than in developed regions [1].

Since 1990, government of Ghana has put several measures in place to contain maternal mortality. Some of these measures include free maternal health care, expansion of primary health care, the CHPS compound concept, the National Health Insurance Scheme, increasing access to

skilled delivery and Emergency Obstetrics and Neonatal Care (EmONC) including safe blood, etc towards achieving MDG5 [3]. These measures yielded tremendous results. Various health survey results indicate a fall from a high of 740 per 100,000 live births in 1990 to 451 per 100,000 live births in 2008. Institutional maternal mortality ratio also indicates a decline from 216 per 100,000 live births in 1990 to 164 per 100,000 live births in 2010 [3]. A five year study on maternal mortality at the Tamale Teaching Hospital, the biggest and the only referral hospital in the three northern regions, show that maternal mortality ratio had reduced by 74% from 1870 per 100 000 live births for year 2006 to 493 per 100 000 live births for year 2010 [2]. This shows a significant reduction in the cases of maternal deaths. However, these institutional figures are seriously challenged and are considered to represent only an insignificant number of only women who reported at the health facilities. A large chunk of women do not deliver at the hospitals.

In Ghana and many other Sub-Saharan countries, governments' efforts are often geared towards addressing only the clinical and medical causes of maternal mortality to the neglect of socio-cultural causes. The medical causes of maternal mortality are often attributed to unsafe abortion and complications, obstructed labour, sepsis, amniotic fluid embolism, anemia, haemorrhage, HIV, malaria, pneumonia, pre – eclampsia, pulmonary embolism, septicaemia, sickle cell disease, delays in reporting, etc [4].

However, all these medical conditions and delays in reporting, etc are in turn caused by certain underlying socio-cultural beliefs and practices that consequently lead to maternal mortality. Culture comprises the learned behaviour, beliefs, and attitudes that are characteristic of an individual, a group of people or society as a whole. It is transmitted from one generation to another in both written and spoken form and encompasses people's creations, such as art, music, literature, architecture, etc. It shapes and reflects a society's behaviour, understanding of the world, and attitudes and values [5].

Cultural values, beliefs and practices act as social current that influences human behavior to conform to the societal expectation. Cultural beliefs and practices, such as son preference, pregnancy and childbirth taboos, traditional contraceptives and abortion methods, can affect women's health, especially their reproductive health [6].

In traditional societies such as the Dagomba in Northern Ghana, socio-cultural beliefs and practices exert a kind of social current that controls and determines the behavior of individuals, particularly women, even in their health seeking matters. The Dagombas have a unique culture that distinguishes them from non-Dagombas and which they protect jealously.

In the light of the aforementioned, this paper examines certain socio-cultural beliefs and practices of the Dagombas in Tolon District of Northern Ghana that contribute to the maternal mortality in the district. The paper argues that, Ghana's efforts to achieving the MDG 5 that seeks to reduce the maternal deaths by 75% by the year 2015, will only be a mirage if steps are not taken to address and demystify the socio-cultural beliefs and practices that promotes maternal mortality in Ghana.

The cultural theory

Over three decades ago, Douglas and Wildavsky [7] examined the impact of values and cultural settings on the perception of risks and argued that risk perception and concern about environmental or social issues are socially and culturally framed. In other words, values and worldviews of certain social or cultural contexts shape the individual's perception and evaluation of risks. Douglas and Wildavsky [7] argued that individuals are embedded in a social structure and that the social context of individuals shapes their values, attitudes, and worldviews. In this way, socio-cultural beliefs and practices influence the behavior of a group of people including their health seeking behavior [8,9].

This perspective, premises on the fact that the most important indicators of what people fear or do not fear are not individual cognitive processes such as the perception of threats to health or feelings of uncontrollability, but most importantly, their socially shared worldviews – so-called cultural biases that determine the individual's perceptions [10].

The cultural theory further postulates that, individuals choose what they fear in relation to their way of life-that is, in relation to the 'culture' they belong to [11].

The study area and state of health

Study Area

The Tolon District is one of the twenty-six administrative districts in the Northern Region of Ghana. Tolon district forms about 3.9% of the total landmark of the Northern Region and lies on

Latitude 920°CN and Longitude 10033°W. The district was known as Tolon-Kumbungu District until the Kumbungu district was covered out from Tolon in 2012. The two districts¹ combined have a total population of 112, 331, out of which male population was 56,046 compare with 56,285 female [12]. The population of the two districts constitutes about 4.5% of the total population of the entire Northern Region which stood at 2,479,461.

The Tolon district is surrounded by 5 districts; Tamale Metropolis and Sagnarigu to the east, Central Gonja to the south, North Gonja to the west and Kumbungu district to the North. The three major settlements of the District are Tolon, Nyanpkala, and Kasuliyili together constitute nearly 20% of the population. Though Tolon is the district capital, it has tremendous rural characteristics. Nyanpkala is the second important settlement in the district. It is at Nankpala that the University for Development (UDS) has one of its largest campuses. Nankpala also houses the Savanna Agricultural Research Institute (SARI)². Though UDS and SARI are located at Nankpala, the town is still regarded as a rural settlement because about 86% of the workers and students of UDS stay in Tamale, the Regional capital and commute daily. Thus, because of its proximity to Tamale; about 15KMs, most of the social and business activities are transacted in Tamale. Consequently, Nankpala is described as the commercial and educational hub of the district, it is also regarded as a 'ghost' town, especially when the university is on break. Tolon district is thus predominantly rural with about 87% of the inhabitants living in the rural areas.

The Dagombas are the indigenes and the largest ethnic group in the district. They are mainly subsistence farmers who cultivate maize, millet, rice, yam, beans and vegetables for a livelihood and sell excess produce on the local market. They also keep various types of livestock, especially poultry, small stock and cattle for economic, social and religious purposes.

Katin, near Tolon has one of the biggest markets in Northern region. The market day falls

¹ As at the time of doing this study, there were no separation official population figures for Tolon and Kumbungu districts.

² The Savanna Agricultural Research Institute (SARI) is one of the 13 Research Institutes under the Council for Scientific and Industrial Research (CSIR)

weekly and attracts large numbers of business people from Tamale, Savelugu, Kumbungu, Daboya in the North Gonja district, etc. Because of its rural nature, the common commodities in the market are food stuff, animals and poultry. Industrial goods such as textile, sandals, motor bikes, mobile phones, cooking utensils are traded by business people from Tamale. Though Katin market is the most import market in the district, it has no modern facilities. It is a traditional market, made of mainly huts, wooden and thatched structures and mud buildings.

Social and economic infrastructure in the district is poor by all standards. Generally, poverty³ is widespread in the district but more pronounced in the rural areas than in urban settlements. Apart from the UDS campus at Nankpala, educational facilities in the district are in a very poor state. The district has only two Senior Secondary Schools; one is private located at Nyankpla and other is government school located at Tolon, the district capital. Housing, sanitation and water facilities are equally poor. More than 80% of the homes are built of mud or sand-crete with thatched roofs. It is only in Tolon and Nankpala that have sizeable number of houses roofed with aluminium zinc. Portable water (pipe-borne and boreholes) is limited to only Tolon the district capital and Nyankpala. Thus, over 80% of the population in the district relies on dam, streams, hand-dug wells, ponds, river and dugouts for water.

Structure of the Health Care System and State of Health in Tolon district

The Ghana Health Service (GHS) was established in 1997 and charged with the responsibility of managing health service delivery. As part of the decentralization efforts, the Ministry of Health (MOH) has the primary responsibility to make policy and determine priorities for the health sector, while the GHS is responsible for developing implementation guidelines for all the 10 regions and all districts in Ghana. Thus, the Regional Health Directorates are responsible for providing coordination and assistance to the districts as they develop and carry out district implementation plans. At the district level, the District Health Management Teams (DHMTs) have been created to plan and

implement health care service delivery. To make health service delivery effective, the strategic policy of the Ghana Health Service provides for a three tier level of service provision within a district – the District (Hospital) level, the Sub-District (Health Centre) level and Community-based level. All Sub-districts are to be divided into zones with a catchment population of 3000 to 4500 where primary health care services will be provided to the population by a resident Community Health Officer assisted by the Community structures and volunteer systems [13].

State of Health in Tolon district

As at March, 2014, the Tolon district has ten (10) health facilities: three (3) health centres and seven (7) CHPS compounds. These are located at Tolon, Zatani, Gbrumani, Kasuliyili, Yogu, Nyankpala and Gbulahagu. The health sector in the district is seriously challenged by inadequate facilities, drugs, and constant absenteeism of health workers, as well as inadequate doctors and qualified nurses. Record keeping is very rudimentary, and records on health cases such as HIV/AIDS in the district are almost nonexistent. This is partly due to the fact that the District had no testing facility and thus has no data on HIV/AIDS infections.

The Public health and Family Planning

The district records one of the highest population growth rates of 3%, higher than the national rate of 2.6%. This is partly due to the low family planning practices. As at 2013, it was found that less than 9% of the population used contraceptives, such as condoms and other family planning methods [14]. The lack of family planning practices is often attributed to cultural and religious reasons. Other public health problems according to Tolon District Health Directorate [14] are high Maternal Mortality rate, unmet contraceptives needs, poor maternal and child health, high rate of delivery at home, malaria, and delay medical attention.

Nutrition

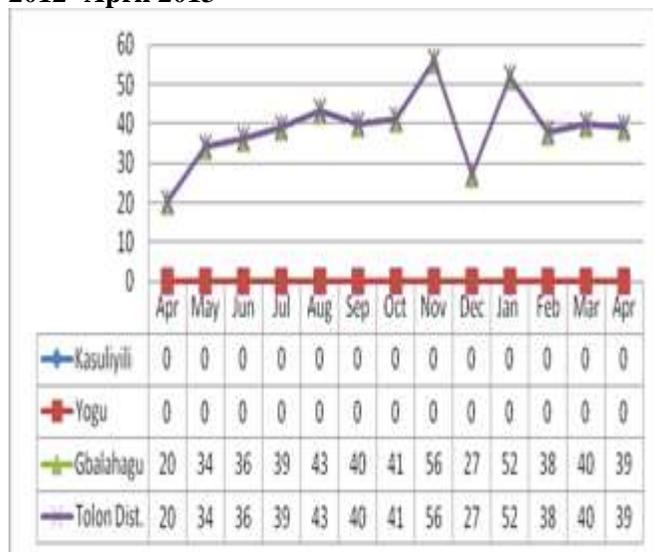
Available data from the health centres and the Community-based Health Planning and Services (CHPS) compounds revealed that the use of iodated salt is on the increase, while the number of designated baby friendly health facilities and Vitamin A coverage for children between 6 and 59 months are on the increase. Vitamin A coverage for women within 8 weeks of post-partum is also on the increase along side with reduction in the number of

³ Poverty is defined in terms of the physical assets owned by the individual or household, the size of the livestock herd, access to land for farming and the type of housing used. Other criteria used were access to income and food

children with stunted growth, wasted and underweight. This significant reduction in cases of malnutrition is partly attributed to a number of interventions of World Food Programme and UNICEF, which distribute supplementary feeding and plumpy nuts to malnourished children. Thus, cases of malnutrition at Tolon Health Centre continue to decrease from 8 cases in January 2014, to 6 cases and 2 cases in February, and March 2014 respectively [14].

Despite this impressive reduction in malnutrition cases, available records at three health facilities; Kasuliyil, Yogu and Gbalahagu CHPS compounds revealed poor OPD and ANC attendance. Gbalahagu and Yogu for instance consistently recorded less than 250 OPD cases per month between April 2012 and April 2013. Monthly ANC attendance at the three health facilities are shown in the Figure below 1.

Figure 1: ANC Attendance in Tolon from April 2012 -April 2013



Source: Field data, 2014

Disease control

Malaria remains the number one disease for OPD cases. Tolon Health Centre alone recorded 257 malaria cases in January 2014, two hundred and twenty-two (222) cases in February, 173 in March and 207 in April 2014. Some of the actions being pursued are the supply of treated mosquito nets especially to pregnant women and women mothers with children under five years. From 2003-2005, about 40,035 bed nets were received from organizations such as UNICEF and WHO and distributed. In addition to treated bed-nets for the

prevention of malaria in pregnancy, amodiaquine and fansidar are now provided to pregnant women. There is also an on-going study on the efficacy of spraying of insecticide as a malaria control strategy in 16 communities in the district. Cases of diarrhea and typhoid fever are very minimal, while hypertension is never recorded beyond 80 cases per month [14]. Over the years, combined efforts of WHO, Ghana Health Service, Medicine San Frontiers, UNICEF, etc have resulted in almost eradication of diseases such as Guinea worm, Cholera, Measles, Meningitis and polio in the district.

Research Methods

This study involved the collection of primary data from the field and secondary data from relevant institutions in Tolon district and in Tamale Regional health Directorate. The secondary data involved a review of existing literature on health in Ghana, Northern region and Tolon District in particular. A considerable volume of information was obtained from the internet, libraries, the Ministry of Health Education and Ghana Health Service. Records from the Tolon Health Centre, Tolon District Health Directorate, and the CHPS Compounds at Kasuliyili, Yogu and Gbalahagu were systematically reviewed. Fieldwork was carried out in April-May 2013 and between January and March 2014 in Tolon, Nyankpala, Gbalahagu, Yogu and Kasuliyili all in the Tolon District. Data was also collected in Tamale. Unstructured interviews and data were collected from key informants in Tolon, Tamale and Nyankpala where several interviews were held with District Health Directorate (involving the District Health Management Team Leader, the Disease Control Officer, the Public Health Officer, the District Nutrition Officer, etc.), Doctors and nurses at Tolon Health Centre, nurses and midwives at the CHPS Compounds at Kasuliyi, Gbalahagu and Yogu. These were complemented with observations, focus group discussions and informal interviews in five selected communities in the district and Tamale. In all these communities, in-depth interviews were held with key informants, pregnant women, traditional and religious leaders and some elderly men and women who are well versed in the tradition and culture of the Dagombas.

In all, data was collected from 6 communities and involved 5 health facilities: 3 CHPS Compounds were randomly selected out of 7 in the district – Kasuliyili, Yogu and Gbalahagu, while the 2 health centres: Tolon and Nyankpala

were purposely selected because they were the only health centres in the district.

An overview of Barriers to accessing health services

Although there is no universally accepted definition for access to health services as acknowledged by Oliver and Mossialos [15], however, the definition by Peters et al [16] which implies ‘the timely use of service according to need’ is often used. Utilization of health care is used as an operational proxy for access to health care. However, access to health care has four dimensions: availability, geographic accessibility, affordability and acceptability [17].

Barriers to accessing health services can stem from the demand side and/or the supply side. Demand-side determinants are factors influencing the ability to use health services at individual, household or community level, while supply-side determinants are aspects inherent in the health system that hinder service uptake by individuals, households or the community. The need to differentiate demand-side from supply-side barriers is related to the formulation of appropriate interventions. O’Donnell [17] notes that both sides have to be addressed concurrently to ensure real access to health care.

This view was reinforced by Bart Jacobs, Por Ir, Maryam Bigdeli, Peter Leslie Annear and Wim Van Damme [18], who argued that access barriers may not always be mutually exclusive and may interact and influence each other. Bart et al [18] provide a framework for assessing barriers along the four dimensions of access (each of them having supply-side and demand-side aspects) while Ensor and Cooper [19] present a framework of supply-side and/or demand-side barriers.

Drawing from the two approaches, quality of care is an integral component of each of the four dimensions, while service location and household location are considered separate barriers by Peters D.H, Mirchandani G, and Hansen P. M [16] and by Ensor and Cooper [19]. However, they are also regarded as constituting barrier, related to distance from the household to the place of service delivery. Waiting time and direct payment for services are considered mixed supply-side factors.

Maternal Mortality: Medical and Clinical perspectives

Gumanga et al, [2], relying on only reported cases at the Tamale Teaching Hospital, identified the five top direct causes of maternal mortality as, in order of importance; Sepsis, which accounted for 19.4% of the cases, followed by hypertensive

disorders, 18.6%, haemorrhage, 15.8%, unsafe abortion and complications, 11.5% and obstructed labour accounted for 5.7%. Altogether, these direct causes were responsible for 71.2% causes of maternal mortality. They identified other causes to be indirect to include, anaemia, sickle cell disease, malaria, HIV, viral hepatitis and its complications, etc.

Most prevalent direct medical causes of maternal mortality are thought to be severe bleeding, hypertensive diseases, and infections. However, indirect causes of maternal mortality must also be addressed. The “Three Delays Model” Thaddeus and Maine [22] identifies delays in seeking, reaching, and receiving care as the key factors contributing to maternal death. The delay in seeking care is related to having the knowledge to recognize a life-threatening problem and making the decision to go for care.

The delay in reaching care results from inaccessibility of health services due to distance, poor infrastructure, lack of money, or other barriers to access. The delay in receiving care refers to problems in content and quality of maternal health care services. Most maternal deaths occur during labor, delivery, or the first 24 hours after delivery, and most complications cannot be prevented or predicted [21]. Skilled care during pregnancy, childbirth, and the immediate postpartum period, by health care professionals with appropriate skills has been recognized as the key intervention to reduce maternal mortality [23]. Family planning and safe abortion services also play key roles in reducing maternal deaths [22]. Family planning can prevent pregnancies that contribute to a disproportionate amount of mortality, specifically, high parity births, births to very young or older women, and unwanted pregnancies. Prevention of unwanted pregnancies can reduce the risk of dying posed by unsafe abortion. The exact contribution of abortion to maternal mortality is unclear. The World Health Organization (WHO) estimates that in western Africa unsafe abortion could contribute to as many as 90 deaths per 100,000 live births.

Several health indicators in Ghana help us better understand the factors contributing to high rates of maternal mortality. Data from the 2003 Ghana Demographic and Health Survey (GDHS) show that the contraceptive prevalence rate is low; only one-quarter of currently married women are using a method of contraception [24]. As a result, 34 percent of currently married women have unmet need for family planning, and 40 percent of all

pregnancies are unwanted or mistimed. The 2003 GDHS also shows that 47 percent of births are attended by a health care professional. The Ghana Health Service 2007 Annual Report states that the proportion of deliveries attended by a health care professional was 35 percent in 2007, which it notes is a substantial decrease from 45 percent in 2006. In 2006, the institutional MMR was 244/100,000 live births, which represents an increase over 2005 when the MMR was 197/100,000 [3].

Socio-Cultural beliefs and Practices that cause maternal mortality in Tolon District

This section presents some of the socio-cultural beliefs and practices in Tolon District that contribute to the increasing number of maternal mortality in Ghana.

About 80% of the population in the district professed to be Muslims while the rest are Christian and traditional African believers. The people have strong passion and love for their culture and tradition. The majority of the married men are polygamous. Marriage and child bearing are extremely important for both men and women. Child birth is seen not only as means of perpetuating one's species, but also as a source of happiness, protection and security, prestige, wealth and power. Dagombas often tease men and women who are not married or have no children as worthless people. Such people are often not respected in society and regarded as 'children' no matter how old they may be. An unmarried man cannot hold traditional leadership positions and is not qualified to become ancestors when he dies.

Sanctity of the child birth

Most Dagombas strongly believe in the sanctity of child birth and the private part of a woman is the preserve of only the husband. For them a child without a father has no place in the family and Dagomba society abhors that. Most importantly, Dagombas are proud of their biological children, who they believe can take after them, inherit them and have emotional attachment to their families. For them, a child can only take after these qualities if it is the biological child of their father. Since it will be difficult for them to be 100% sure that a child is a biological father of a particular person, it often beholds on the woman to avoid all doubtful behaviour that will tarnish her image with regards to her relationship with other men, and about her pregnancy. For Dagombas, it is sacrilegious for a woman to sleep with men other than her husband. It

is also expected that all pregnant women must deliver at her husband's house. To the extent that, when a woman stays somewhere during her pregnancy, she is expected by tradition to return to the husband's house to deliver. Failure to do this will mean she was not faithful to her husband and therefore, the child that she will deliver will be tagged as a non-biological child of the family. The general belief is that a woman who is unfaithful to her husband will find it extremely difficult to deliver. By Dagomba culture, such a woman is expected on the day of delivery, to mention the names of all other men that she slept with before she can safely deliver. Because women are expected to deliver at their husband's home, women who go to hospital to deliver are prime suspects of those who might have slept with other men, and therefore were not faithful to their husbands. To avoid this suspicion, women refrain from going to hospital to deliver, even if the labour is life threatening.

All our respondents mentioned that, Dagombas abhor women who are said to be unfaithful to their husbands and the only way a woman can exonerate herself and prove to the society that she is faithful to her husband is to deliver at home. This act is even more crucial and extremely necessary in a polygamous family, where failure to deliver at home will, as one of our female respondents put "you will be providing ammunition to your rivals when you fail to deliver at home".

Over 90% of our respondents believe that a woman's failure to deliver at her husband home will be interpreted to mean she was not faithful to her husband and infidelity of a woman has several negative ramifications for the family, the woman and the child in particular, especially, if the child is a boy. The family will lose its respect in the community, especially the husband. Respondents frequently argued that, people may interpret it to mean several things; either the man is weak sexually or impotent, poor or irresponsible and cannot provide for the needs of the woman, or has lost control over his family. Any of these connotations has damning consequences on the man. Similarly, the woman will be tagged as prostitute, disrespectful to the husband, greedy and dangerous. In polygamous homes, the woman may not have her peace among her rivals. This tag will remain as an albatross on her neck and may be extended to her all her children, particularly the one who deliver outside the matrimonial home. Any child delivered outside the matrimonial home, will have to battle with the stigma of not being the biological child of the man. Participants during the

FGDs indicated that some men neglect such children on suspicion that they are not their biological children.

Closely linked to the above is the belief by most Dagomba women that only their husbands have the right to see or access their private parts. For them attending ANC or going to hospital to deliver may expose them to male doctors, nurses and midwives to examine their private parts.

To play it safe to avoid stigmatization, name calling, backbiting and all the negative connotations associated with childbirth outside the matrimonial home, women in Tolon district try as much as possible to delivery at home. Furthermore, the sanctity of the woman's private part is highly valued and can be guaranteed when deliver at home.

Protection for the pregnant woman and her inborn baby

In Dagomba tradition, a young maiden who has picked seed for the first time has to be protected together with the unborn baby. It is believed that not everybody will be happy about the pregnancy and out of jealous or sheer hatred may spiritually want to harm this young and inexperienced lady and her inborn baby. To protect this lady and her unborn baby, they normally will not want to announce this pregnancy to the public. The woman, the husband and the close relatives will keep this secrete and nobody will dare referrer to her as pregnant woman until certain rituals are performed. These rituals will be performed when the mother-in-law observes that the fetus is now matured and the woman begins to feel certain movements of the baby in her stomach. At this time, the pregnancy is advanced and ready for the rituals. Before these rituals are performed, the lady cannot go to hospital.

The ritual is normally performed on the woman at night by the sister-in-law. It is normally a gift and a talisman given to the woman to fortify the pregnancy. The sister-in-law will give her a knock on the head and say "you were a child but now you are no longer a child". By this, the pregnant woman is admonished that she is now mature and should be cautious and careful about herself. Until these rituals are performed the woman cannot access hospital.

Ante natal Care (ANC) leads to difficulties in delivery

Another belief that prevents most women from attending ANC is that it leads to the unborn child growing big and makes delivery difficult during labour. Over 76% of the women participated in this

study claimed that, those who attend ANC are often told by the nurses to take eggs, fish, meat, etc. They claimed that when a pregnant woman eats these, she turns to experience difficulties during labour because the unborn child grows bigger.

Additionally, women who eat eggs and fish are regarded as bad women by Dagomba culture. 'Such women cannot be good housewives who can take care of the family' as remarked by one of our respondents. It is believed that women who are used to eating eggs and fish can use the meager family money meant for cooking to buy and eat eggs at the expense of the whole family. It is also believed that women who are used to eating eggs can steal eggs from the hencoop when the men are away on their farms. This can deplete the family wealth. For these reasons, women are discouraged from eating eggs. To avoid being asked by the doctors to eat eggs, some pregnant women will not attend ANC.

Closely related to this is the belief that, pregnant women are not supposed to take eggs, sweets and delicious things. It is believed that whatever the mother takes affects the inborn baby. Consequently, over indulgence in taking these will let the child born out of this pregnancy, grow up to be a thief.

Allergies

The study further found that most women claimed they are allergic to certain medicines and therefore refrain from going to hospital. The women also claimed they are used to their fresh rural environment and rather find the hospital environment nauseating because of the smell of drugs.

Closely linked to this is the claimed that most rural women fear the hospital environment because it gives them bad memories. Customarily, dead people are shrouded with white calico for burial. In the hospital, white bed sheets are used to ensure hygiene and cleanliness. Most women are dreaded at the white sheets at the hospitals because it reminds them of dead people who are shrouded in white materials for burial.

Fears

Traditionally, herbalist and traditional healers are revered by people because they are considered to possess some juju magical powers that enable them perform their duties. Some rural women are dreaded at the doctors and nurses because they think they also possess certain powers that enable them treat the sick.

Most traditional women/people do not know the chemical composition or the herbs that are used to make drugs that are given to them at the hospital. They are used to herbs and leaves that are found in their traditional areas which are used by traditional healers. As a result of this lack of knowledge some women do not feel comfortable taking the drugs.

The hospital environment is strange to some rural women. The bureaucracy and the officialdom associated with accessing health care make some rural women shy away from hospitals. The illiterates often find it difficult to find their way in the hospitals without assistants.

Postmortem in some cases to establish the cause of certain disease appears to be very strange to most people and not known to the people who are used to divination and soothsaying to establish the cause of diseases and death. Most women believe that they will undergo caesarian if labour is difficult. Consequently, they are dreaded at going to hospital to deliver.

Secondly, they believe that the hospitals/doctors when they carry out operation cut some parts of their bodies or steal these body parts for some purposes. This is contrary to their belief that 'they came full from their maker and must return/dye in full'. The fact that during operation they are unconscious and some pieces of their body will be cut off is something that they cannot withstand.

Cultural explanation to certain diseases

Certain illness and disease are culturally considered to be anti- steel or iron and the patients must not come into contact with iron or steel when they are suffering from them. These diseases include anthrax, snake bites and boils. The people believe that people suffering from these diseases will die when they come into contact with steel. In the hospitals, they use syringes to inject patients and these syringes are made with steel. Most of the hospital bed, cabinets, benches, etc, are made up of iron. To avoid getting into contact with these equipments and complicating their situation or being dead, when they discover that a patient is suffering from any of these diseases, they prevent them from going to the hospitals.

Cultural appropriation of women's conduct

A traditional Dagomba woman is expected to give unconditional respect to the husband and his family members. Good housewives are expected to be humble and do not ask excessive questions or

demand for their rights. A woman is supposed to seek permission from her husband before embarking on any action. Women are more or less the property of their husbands and must always seek permission from their husbands before paying a visit to her friends, her family members, going to the market, hospital, etc. It is more difficult when the husband travels out of the community and left the woman behind. A typical Dagomba woman cannot take decision in matters pertaining to their health. Decisions regarding whether or not, a woman should attend ANC, when to attend, how to attend, etc, rest with the husband. The husband or the family equally determines whether the woman should deliver at the hospital or at home. Illiteracy and the economic powerlessness hold women back. Without support from their husbands, most rural women cannot travel to the nearest clinic for ANC.

Demystifying Socio-cultural Beliefs and practices: Towards reducing maternal mortality and achieving the MDG5

There is the need to change the discourse of putting too much emphasis on clinical and medical causes of maternal mortality and tackle the underlying socio-cultural beliefs and practices to pave the way for universal reduction of maternal mortality. The socio-cultural beliefs and practices that are injurious to maternal mortality must be addressed. This is not to say that we should condemn this cultural values and beliefs but deal with it to yield positive results. A number of measures can be taken. First and foremost is education and sensitization. It is important to note and emphasize that culture is dynamic and should always change to suit society. Such education should target and involve custodians of culture in the communities. These people include chiefs, religious leaders, opinion leaders, youth groups and women organizations. Society should be helped to understand that everybody stands to benefit if women are encouraged to deliver at the hospital under the care of competent health workers. Delivering at hospital must not be construed to mean the women seek to cover their infidelity.

Furthermore, many health workers could be deployed to embark on door-to-door campaign and provide ANC health services to pregnant women. These will further reduce the incidence of having to seek permission from their husbands before going to clinic, prevent rural women from going through the bureaucracy and officialdom associated with

seeking health services at the hospital and the general fear that rural women have for hospital environment. As a long term measure, issues on how to amend negative cultural beliefs and practices can be introduced into the school curriculum. In a society where socio-cultural beliefs and practices are so dominant, sensitization and education programmes have a cardinal responsibility to equip those for whom they have responsibility with the knowledge, skills, attitudes and values that will reduce incidence of maternal mortality. This means that education programmes should seek to empower members of the society to be flexible with some of the cultural beliefs and practices that affect the health of women. Ministry of Education can facilitate to incorporate topics into the school curriculum that deals cultural studies and how to identify and modernize aspects of socio-cultural practices and beliefs that are harmful to society.

Conclusion

This paper analyses the socio-cultural beliefs and practices that perpetuate maternal mortality in Tolon district. It has recognized the medical and clinical explanation to the situation, but went further to indicate that these causes are in turn triggered by socio-cultural beliefs and practices. It outlines some of the socio-cultural practices and beliefs that contribute to maternal mortality to include, ensuring the sanctity of the child birth, protection for the pregnant woman and her unborn baby, belief that ANC leads to difficulties in delivery, allergies, fears, cultural explanation to certain diseases and cultural appropriation of women's conduct. In most cases, socio-cultural beliefs and practices influence the behavior and action of women. For fear of going contrary to societal expectation, women in most instances pregnant women delay or altogether prevented from accessing health facilities. This leads to needless complications and deaths, thus adding to the numbers of maternal mortality cases.

Additionally, this calls for a shift from overemphasis on medical and clinical causes of maternal mortality in Ghana to focusing attention also on socio-cultural beliefs and practices. This is a fruitful one. Focusing on dealing with socio-cultural beliefs and practices can relieve most rural women from entertaining negative fears about the hospital environment, their perception about doctors and nurses, drugs, etc and facilitate their frequent and early visitations to the hospitals for ANC and delivery.

Thus, it is of great importance that women are educated to be freed from some negative socio-cultural beliefs and practices so as to facilitate their access to health facilities for safe delivery. This is the surest way to ensure complete reduction in maternal mortality and achieving the MDG 5.

Addressing socio-cultural beliefs and practices is paramount in the realization of the MDGs 5. Socio-cultural beliefs and practices prevent women from attending ANC and delivery at hospitals. The Alma Ata declaration of Primary Health Care stated clearly that participation of the people is important and addressing these socio-cultural barriers will prevent needless maternal mortalities in Ghana.

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