

1 Awareness of Signs of Obstetric Complications amongst Married
2 Couples: Implications for Decision-Making towards Care-Seeking.
3 A Qualitative Study of Selected Districts in Ghana

4 Bougangue Bassoumah¹ and Mpawenimana Abdallah Saidi²

5 ¹ Universiti Malaysia Sarawak, Malaysia

6 *Received: 11 December 2016 Accepted: 3 January 2017 Published: 15 January 2017*

7

8 **Abstract**

9 This paper examined how couples' awareness of obstetric signs and complications inform
10 intra-household decision-making towards care-seeking. The data were generated from twelve
11 focus groups and twenty-four individual interviews involving women who were receiving
12 maternity care and their husbands in the Yendi Municipality, Awutu-Senya West and
13 Chereponi Districts in Ghana. Quota sampling and snowballing were used to reach the
14 participants. The study classified couples as knowledgeable or less knowledgeable based on
15 their level of awareness of key signs of obstetric signs and complications. Most knowledgeable
16 couples took joint decisions devoid of cultural and gender influences. Their decisions were
17 reached based on their knowledge about obstetric signs/symptoms or complications and their
18 implications for maternal and neonatal health. There were some level of gender equality and
19 female autonomy amongst the knowledgeable in decision-making. However, decisions made by
20 less knowledgeable couples were male-dominated, culture and gender-driven embedded in
21 health beliefs and traditional gender norms. The decision-making by the less knowledgeable
22 was associated with delays due to socio-cultural structures within the household and
23 community. Though decisions by knowledgeable couples showed positive attitudes towards
24 care-seeking as compared with the less knowledgeable, the data indicate that awareness of
25 maternity conditions does not necessarily translate into positive clinic attendance because it
26 may be influenced by cultural beliefs and gender roles to determine the need for clinical care
27 as well as the type of care-seeking decision taken by couples. Healthcare practitioners should
28 consider carrying out needs assessment for maternal counselling messaging for couples.
29 Education on pregnancy and related complications as well as their implications for maternal
30 and neonatal health is essential to facilitate informed decisions and prompt maternal clinic
31 attendance. For positive

32

33 **Index terms**— awareness, maternity, signs, intra-household, decision-making, clinic attendance, needs
34 assessment.
35 Informed decision is a necessary requirement to ensure appropriate timing and choice of source of healthcare.
36 However, reaching an informed decision depends on the couple or the care-giver's awareness of signs of obstetric
37 complications as well as their health implications ??GSS, 2008; ??CRW, 2010). This is because awareness of signs
38 and complications arising from pregnancy and childbirth facilitates early recognition of danger signs/symptoms
39 associated with maternity, which forms the basis of care-seeking decision-making (Waiswa et al., 2010; ??omb
40 Thorsen et al., 2012). This requires active involvement of women, for appropriate clinical diagnosis is largely

1 II. METHODOLOGY A) STUDY SETTING

41 dependent on the information that is given to professionals by the women or their care-givers ??WHO, 2002
42 ??WHO, , 2003)).

43 Research has established that, apart from bleeding, most obstetric conditions cannot easily be recognised by
44 non-professionals until the situation aggravates, whilst some other complications occur suddenly at the onset
45 and quickly progress to become life-threatening ??WHO, 2003;GSS, 2015). Based on this, the WHO enjoins
46 all member countries to educate women on maternity issues with the view to increasing their knowledge and
47 understanding of pregnancy and childbirth as a pre-condition for adequate preparation and sound decision-
48 making towards pre-natal, intrapartum and post-partum care ??WHO, 2002;. Some couples may be aware of
49 key danger signs of obstetric conditions but lack of knowledge and understanding of the implications of these
50 signs for pregnancy outcomes could influence their care-seeking decisions. Sometimes, early signs and symptoms
51 may be ignored by the pregnant woman or her spouse because the signs may be considered as 'normal' ??WHO,
52 2001;Senah, 2003; ??kolocha et al., 1998 ??n WHO, 2003 pg.45).

53 Female autonomy and joint decision-making are recommended for couples to ensure informed decisions for
54 positive maternal and child health outcomes ??ICRW, 2008 ??ICRW, , 2010; UNFPA/ICRW, 2014). However,
55 this usually S Abstract-This paper examined how couples' awareness of signs of obstetric complications inform
56 intra-household decision-making towards care-seeking. The data were generated from twelve focus groups and
57 twenty-four individual interviews involving women who were receiving maternity care and their husbands in the
58 Yendi Municipality, Awutu-Senya West and Chereponi Districts in Ghana. Quota sampling and snowballing were
59 used to reach the participants. The study classified couples as knowledgeable or less knowledgeable based on their
60 level of awareness of key signs of obstetric complications. Most knowledgeable couples took joint decisions devoid
61 of cultural and gender influences. Their decisions were reached based on their knowledge about signs/symptoms
62 of obstetric complications and their implications for maternal and neonatal health. There were some level
63 of gender equality and female autonomy amongst the knowledgeable in decision-making. However, decisions
64 made by less knowledgeable couples were male-dominated, culture-and gender-driven embedded in health beliefs
65 and traditional gender norms. Decision-making by the less knowledgeable was associated with delays due to
66 sociocultural structures within the household and community. Though decisions by knowledgeable couples
67 showed positive attitudes towards care-seeking as compared with the less knowledgeable, the data indicated
68 that awareness of maternity conditions did not necessarily translate into positive clinic attendance because it
69 may be influenced by cultural beliefs and gender roles to determine the need for clinical care as well as the type
70 of care-seeking decision taken by couples. Healthcare practitioners should consider carrying out needassessment
71 for maternal counselling messaging for couples. Education on pregnancy and related complications as well as
72 their implications for maternal and neonatal health is essential to facilitate informed decisions and prompt
73 maternal clinic attendance for positive health outcomes. becomes impossible, particularly in patriarchal societies
74 where decision-making is considered as a men's space (Nwokocha, 2007;Bougangue, 2017). This act of gender
75 discrimination, which creates inequality in decision-making is more entrenched in rural communities and amongst
76 people who are not well informed about maternity and its associated complications ??Bougangue & Ling, 2017).
77 It is women who carry pregnancy and experience the symptoms of its complications, and, therefore, they, in
78 particular, can best determine the severity of the conditions and the need for healthcare. However, most
79 women are marginalised at the household level in decision-making towards maternity care-seeking (Hagman,
80 2013;Bougangue, 2017). In some patriarchal communities in Ghana, decision-making is regarded as an act
81 of protection for women, with spirituality attached as a restriction to the females (Bougangue, 2017). This
82 situation compromises quality decision and positive maternal healthcare behaviour towards care-seeking, with an
83 implication for health outcome.

84 Though some men may engage their spouses in intra-household decision-making, the final decision on care-
85 seeking is usually reached based on the man's own assessment of the severity of the woman's condition and the need
86 for care (Ampim, 2013;Bougangue, 2017). Meanwhile, studies show that some men are not aware of maternity
87 signs and complications, which suggests that men may lack the knowledge to make informed decisions for their
88 spouses. This presupposes that male-dominated decisions are most likely to have far-reaching implications for
89 maternal and neonatal healthcare. Thus, active involvement of women in intra-household decision-making is a
90 crucial strategy for positive maternal outcomes ??ICRW, 2008 ??ICRW, , 2010)). Moreover, female autonomy
91 at the household level facilitates quicker decision-making and promotes positive behaviour towards maternity
92 care-seeking, which is a necessary pre-condition for improved maternal and neonatal health (Babalola & Fatusi,
93 2009;Hagman, 2013).

94 This paper assessed how couples' awareness of maternity signs and complications influences female spousal
95 involvement in intra-household decision-making towards maternity care-seeking vis-a-vis clinic attendance. The
96 paper provides insight into how healthcare decision-making affects women's health during the pregnancy-
97 postpartum period. This study is motivated by the fact that gender inequality and women's low social status
98 and disempowerment, relative to men, significantly impact women's healthcare decisions, their health and the
99 demand for maternal healthcare services (African Union, 2006; Nwokocha, 2007; Bougangue & Ling, 2017).

100 1 II. Methodology a) Study setting

101 The Awutu-Senya West and the Chereponi Districts are newly created districts in the Central and Northern
102 Regions of Ghana, with Awutu-Beraku and Chereponi as the administrative capitals respectively. The Yendi

103 Municipality is located in the Northern Region, with Yendi, the paramouncty of Dagban Traditional Area as the
104 capital town. Both the Yendi Municipality and the Chereponi District are Muslim-dominated settings, whilst the
105 Awutu-Senya West District is dominated by Christians. The Dagombas, from the Mole-Dagbani ethnic group,
106 form the largest proportion in the Yendi Municipality whilst the Awutus and the Chokosis, from the Guan and
107 Akan ethnic groups, are the main ethnic groups in the Awutu-Senya and Chereponi districts respectively (Awutu-
108 Senya West District Assembly, 2015; Yendi Municipal Assembly, 2015; Chereponi District Assembly, 2015). Most
109 of the households in Yendi Municipality and the Chereponi District are headed by men. The compound house
110 system forms the predominant housing system in these areas, where couples live together with members of the
111 extended family, usually relatives of the husbands (Chereponi District Assembly, 2015; Yendi Municipal Assembly,
112 2015).

113 **2 b) Research design**

114 The study adopted a qualitative design, using culturally appropriate methods in the data collection and analysis.
115 This design was adopted to provide space for married couples to share their experiences/knowledge about signs
116 of pregnancy/labour-related complications through focus group and individual interviews. The questions used in
117 this study to assess the awareness of couples of the complications related to pregnancy and childbirth were adapted
118 from the 2008 Ghana Demographic and Health Survey and the 2007 Ghana Maternal Health Survey. Spouses were
119 made to identify pregnancy-related signs/symptoms, complications and their implications individually. Couples
120 who exhibited high level of awareness were categorised as knowledgeable whilst those with low level of awareness
121 were classified as less knowledgeable. The research organised separate focus group interviews for the two categories
122 of couples. Also, some of the spouses from both the knowledgeable and less knowledgeable categories of couples
123 were individually interviewed.

124 **3 c) Sampling and data collection**

125 The data were solely collected by the lead author who was the principal researcher in this study. Women who
126 were receiving maternity care between August 2015 to December 2015 and their spouses were purposively selected
127 for the study and reached through quota sampling and snowballing. Based on thematic data saturation, twelve
128 FGDs and twenty-four IDIs were conducted in the three settings. The districts were put into urban and rural
129 zones. Two FGDs and four IDIs involving knowledgeable and less knowledgeable couples were conducted in each
130 zone in each district. The use of the IDI was to validate the FGD data by providing privacy to participants to
131 some extent for them to express themselves freely and candidly (Milena et al., 2008). This allowed the research
132 to delve deep into very subtle issues that could not have been possible with the FGD. In each setting and zone,
133 the knowledgeable were separated from less knowledgeable for the FGDs.

134 **4 d) Ethical consideration**

135 Following the Ghanaian custom and research ethics, permission was sought from the chiefs and assembly members
136 of the sampled communities, family heads, as well as the participants before data collection. The purpose and
137 importance of the research outcome were explained to both the community leaders and participants. In addition,
138 each participant was given consent form to sign or thumb-print, and was assured of anonymity and confidentiality
139 before the interview sessions. The participants' consent was also sought for publication of the outcome of the
140 study in both electronic and print format.

141 **5 e) Data analysis**

142 For analysis, expansion of field notes and transcription of recorded data were done within 24 hours. This
143 guided subsequent data collection where the initial analysis suggested change of questioning, and the participants
144 were easily contacted for clarity in cases where important information was missing. To ensure trustworthiness
145 and dependability, the research employed strategies such as combining FGD with IDI, reflexivity during the
146 preparation of the research design and questions, the data collection process and in the various stages of analysis.
147 Also, iterative questioning was employed to ensure that deliberate lies were uncovered during the interactions.

148 Inductive thematic analysis was the major framework for analysing the data. The data were recorded with
149 a tape recorder during the FGDs and IDIs sessions. Inter-coder analysis was employed, using the results of
150 NVIVO software application and manual coding system. Final coding was done by judging the outcomes of the
151 two techniques. Similar thoughts experienced across the participants were identified, coded and grouped. Out of
152 each group of similar thoughts, a unifying concept or underlying theme was derived. Key points, phrases, and
153 illustrations were also identified to back up the findings, whilst similar emerging themes were grouped together
154 to form major themes.

155 6 III. Results

156 7 a) Awareness of Signs/Symptoms of Obstetric Complications
157 i. The Knowledgeable

158 Couples who were aware of maternity and its related complications were able to identify critical periods in
159 pregnancy and complications, such as bleeding, severe waist pain/abdominal pain, persistent severe vomiting
160 (hyperemesis gravidarum) leading to weight loss and dehydration, severe morning sickness and general body
161 weakness, with a few of them mentioning symptoms of pre-eclampsia such as blur vision, frequent headaches and
162 fatigue. In a response to a question on signs of pregnancy, a 28-year old SHS graduate pregnant woman in her
163 first pregnancy in an urban community explained this in IDI:

164 "I think nausea, enlargement of breast and the tommy, vomiting and feeling sleeping always are all signs but
165 the seriousness of a particular sign depends on the individual. Mine started with sleeping and I did not realise
166 until I missed my menses before I went to hospital and they told me I was pregnant. I don't vomit and I eat
167 any food without problem but I know some women find it difficult to eat especially, in their first three months
168 in pregnancy." The husband had this to say about critical period in IDI:

169 "To me, I will say the first 3 months is normally a month women and their spouses need to be very careful.
170 They say the baby is very delicate at this stage. So, any small thing can terminate the pregnancy or affect
171 the baby in the womb. I also realised that women who normally die from pregnancy and childbirth experience
172 this misfortune either at delivery point or immediately after delivery. So, all these periods are very critical for
173 the woman and the foetus' survival." (34 years, diploma) These participants explained that the first trimester
174 is critical since the foetus is very delicate, as it undergoes formation within the womb and can be aborted or
175 malformed if not properly taken care of. They mentioned that miscarriages normally occur within this period
176 or within few days after this period. This statement made by a man in IDI was common in the IDIs and FGDs
177 involving the knowledgeable couples:

178 "Normally, before miscarriage some blood will come out of the woman's vagina. The conditions associated
179 with labour, such as labour dystocia, prolonged labour and retention of the placenta were also mentioned by
180 these participants. However, the causes of these conditions were received with mixed ideas inclined to women's
181 physiology and spiritualism. They were also well-informed about postpartum haemorrhage, as well as puerperal
182 and neonatal infections. Others who knew about the physiological causes also added that there is a spiritual
183 aspect to retention of baby/placenta during delivery. Whilst agreeing with their colleagues, some participants
184 also held these views expressed by their colleague in FGD:

185 "I agree with Agi but sometimes it is not a doctor's issue because some bad spirits can attack the women and
186 make them suffer. They may even die. Even the spirits can hold the placenta so that the woman or the baby
187 will die. Some are as a result of curses from fathers, mothers or ancestors of either of the spouses which requires
188 rituals for solution." (36 years, 2 children, primary school, urban community).

189 They were also well-informed about postpartum haemorrhage and infections associated with delivery, and they
190 also had adequate knowledge about the need for clinic attendance to stop bleeding or screen both the mother
191 and baby early after birth for infections. For instance, in IDI one woman noted: "Bleeding after childbirth has
192 killed many women. It is not about the birth cert or for weighing alone that we should attend PNC early as
193 some of the women think. You or your baby may be infected but you or the people around you may not detect
194 except clinical test. I was told by the midwife that after delivery it is important to be screened for and treated of
195 any infections that might affect the mother or baby." (25 years, social worker, diploma). Below was the response
196 from her husband in IDI:

197 " b) Intra-Household Decision-Making i. The Knowledgeable Generally, amongst most knowledgeable couples,
198 decision-making was the responsibility of both spouses. The men did not exercise their traditional gender powers,
199 but rather gave the women some degree of liberty to take autonomous decisions where necessary without seeking
200 approval from husbands. They considered women as the best people in the right position to make decisions
201 towards maternity care since it is women who directly experience the conditions related to pregnancy and
202 childbirth. These couples also mentioned that, even though some men may equally have knowledge about
203 maternity, women usually attend maternal healthcare promotion programmes and are therefore more exposed to
204 issues of pregnancy and childbirth as compared with men. Decisions taken by the knowledgeable were mostly
205 joint decisions or nontentative individual decisions taken by the women. There were no evidences of delays in
206 decision-making by the knowledgeable. ??ost

207 8 ii. The less knowledgeable

208 The case of the less knowledgeable was almost a direct opposite of the knowledgeable. Though there were
209 few traces of joint decision-making between spouses, the husbands were the final decision-makers. Unlike the
210 knowledgeable, most husbands amongst these couples were conservative in exercising traditional gender powers.
211 Women did not have the liberty to make autonomous decisions towards care-seeking. Whatever they decided
212 were tentative and subject to approval by husbands. The statements below were made by a couple in FGD
213 session, supported by the discussants and repeated in other FGD and IDI sessions.

214 9 "You see, certain things are done by men and some by women.
215 Would you allow your son or daughter to decide for you?
216 We are supposed to act as fathers to our wives and we must
217 be accountable to any decision or action taken about their
218 welfare including health issues. Decision-making is a sole
219 responsibility of the family head. Yes, I listen to my wife but I
220 make my decisions and implement them with her." (Husband,
221 42 years old, A' Level Graduate).

222 10 "As wives, we normally look up to our husbands to tell us
223 what to do. We can't do anything without their approval.
224 They are mandated to play the role of fathers so we are
225 supposed to wait for them or listen to them. I always tell my
226 husband what I experience then he decides whether I should
227 go to hospital or for alternative care from the traditional
228 practitioners." (Wife, 38 years, JSS graduate). c) Interplay
229 of Awareness, Culture and Gender

230 The decisions made by the knowledgeable were devoid of cultural and gender influences. In the light of this,
231 most of the wives had the freedom to make autonomous decisions which resulted in quicker decision-making
232 and positive clinic attendance. Amongst the knowledgeable, joint decision making was to grant women the
233 listening ears and help the couple to make informed decisions. However, the less knowledgeable reached decisions
234 based on the judgments of the men. Their delayed decisions were male-dominated, culturally determined and
235 gender driven. Most of the less knowledgeable supported this statement, which run through various interviews.
236 "E supposed to make spiritual consultations and therefore, cannot be part of decision-making that is based on
237 spiritual consultation outcomes." (Husband, 39 years old).

238 11 "It is difficult to allow women to make decisions especially in
239 pregnancy because some conditions will provoke the woman
240 to move to the health facility where she would end her life.
241 Certain pregnancy related conditions can best be treated
242 with spiritual eyes or with herbs. Traditionally, women are
243 not

244 12 d) Background of Couples and Intra-Household Decision-
245 Making

246 Apart from level of education and media exposure, which were the major sources of knowledge to the couples, other
247 factors, such as religion, location of participants, age, occupation and experiences of maternity were important
248 in determining the involvement of wives in decision-making towards care-seeking. Most Muslim husbands were
249 more conservative and did not involve their spouses in decision-making, although some of them had adequate
250 knowledge and much experience of maternity from their wives. Most Muslim couples supported this statement
251 which was common across the datasets of IDIs and FGDs:

252 "I am the man and head of the family. I have to take family decisions. Women only decide on what to cook for
253 the family. ... She only told me she felt like giving birth. So, I took it upon myself to make a good decision about
254 where to go and the time she should seek care." (52 years old, Muslim, A'level) Members of traditional religion
255 were also conservative, delayed decision-making, and denied their wives access to modern maternity care in some
256 cases, as the primary choice of care amongst them was traditional practitioners. However, they were more liberal
257 as compared with the Muslims because a few of them involved their wives in decision-making. Most Christians
258 were more liberal and granted their wives autonomy in making and implementing decisions as compared with
259 the members of traditional religion and Muslims. Irrespective of the level of awareness, urban couples were more
260 liberal and the women were more autonomous. Generally, couples who worked together made joint and quicker

261 decisions as compared with those who worked in different environments or workplaces. Although most of them
262 worked together, farmers were more conservative and their decisionmaking process and outcome were influenced
263 by gender norms and cultural factors.

264 Husbands whose wives had several pregnancy experiences were more liberal and their wives had opportunities
265 in making decisions about care-seeking as compared with their counterparts without experiences. The men noted
266 that they were comfortable with such women because they had both knowledge and experience to make informed
267 decisions. Also, husbands with much experience of pregnancy were more democratic, as they sought and used the
268 views of their wives in intra-household decision-making as compared with their colleagues with less experience.
269 Joint decision making was more common amongst the younger couples as compared with older ones. Couples
270 with younger wives and older husbands exhibited a different tendency. The older husbands treated their wives
271 like children by marginalising them in decision-making.

272 13 e) Patriarchy, Matriarchy and Intra-Household Decision 273 Making

274 The study observed that patriarchal and matriarchal communities exhibited differences in decision-making
275 regarding the involvement of women and the type of decisions taken by the couples. Generally, couples from
276 patriarchal society were less gender responsive, less democratic and more conservative, which resulted in male-
277 dominated and culture-driven decisions. Data from the Muslim dominated Yendi Municipality and the Chereponi
278 District of the patriarchal Northern Region of Ghana showed that women had limited opportunities to make
279 autonomous decisions as compared with the women from matriarchal Awutu community. Men from Awutu
280 communities gave women more power and autonomy in taking decisions. The women had the chances of finalising
281 decisions which were not likely to be contested by husbands.

282 14 f) Implication for Maternal and Neonatal Healthcare

283 The knowledgeable took prompt and informed decisions for care-seeking, which resulted in early antenatal care
284 attendance, mostly in the first month of the first trimester; timely attendance for institutionsupervised delivery
285 and postnatal care within the critical period as well as increased number of ANC and PNC visits. The data
286 indicates that most of the women met the recommended ANC attendance of four visits with at least one visit in
287 each trimester for women without serious risk factors. Most of them made about six visits before delivery. In an
288 FGD a couple noted:

289 "My wife made several ANC visits. The visits were timely as well including PNC visits. Because she knew I
290 would not worry her she was able to go to the clinic as early as possible when she felt like giving birth in my
291 absence. I only received a phone call from the clinic and joined her there till she delivered." (Husband, 48 years,
292 No formal education).

293 15 My husband does not interfere in decisions. He allows me 294 to do what I think is good for me and my unborn baby. I 295 don't need to seek permission before

296 going to the hospital for treatment." (Wife, 42 years, JSS graduate) However, apart from delayed decision-making,
297 the less knowledgeable couples took uniformed decisions, which had implications for the health of women and
298 their babies. The poor decisions translated into poor clinic attendance in the form of low ANC visits, late ANC,
299 delivery care and PNC. In separate IDIs, a couple shared their experiences: "... from the herbalist then we
300 decided to carry her to the clinic but when we got there the midwife said it E was too late so we lost the baby
301 and my wife sustained some injuries. Later, they had to clean her womb." (Husband, 45 years old, MSLC).

302 "When I felt like going to toilet several times, I told my husband to take me to the clinic but he went out
303 and when he returned he gave me some herbs. After some time he took me an herbalist but the baby delayed in
304 coming out. Later, they carried me to the clinic but my baby died in the womb and I sustained injuries." (Wife,
305 39 years, JSS graduate).

306 16 IV. Discussion

307 The observation of this study concurs with the observations of previous studies that pregnancy is usually
308 associated with complications that require proper care from the onset to the post-partum period (Graham,
309 1998; Stevens, 2000; GSS, 2015). To a large extent, appropriate care-seeking depends on individuals' awareness
310 of signs of obstetric complications for making informed decisions (Pembe et al., 2009; Kabakyenga, Östergren,
311 Turyakira & Pettersson, 2011). This study discovered that awareness of pregnancy and its related complications
312 forms an essential component of intra-household decisionmaking. Couples' awareness of maternity was
313 instrumental in spousal decision-making towards careseeking, as the well-informed couples were able to make
314 quicker and informed decisions. The couples' awareness did not only enable the husbands to actively involve
315 their spouses in decision-making with equal opportunity, but also granted women the autonomy to make and
316 implement decisions about their own health. This resulted in timely and regular clinic attendance amongst

317 the knowledgeable which is essential for positive maternal and neonatal health outcomes (Ministry of Health,
318 Uganda cited in ??abakyenga et al. The findings also confirm previous studies that awareness of danger signs
319 of obstetric complications enables women or the care-givers to take timely and appropriate actions towards
320 healthcare (Pembe et al., 2009;Kabakyenga et al., 2011). The timely and regular clinic visits noticed amongst the
321 knowledgeable positioned them for better chances of maternal screening and early treatment of complications.
322 Most knowledgeable couples were able to stand dominant against gender norms and cultural beliefs to make
323 informed decisions which is a pre-condition for better maternal outcome. The argument that awareness
324 of pregnancy and its related complications translates into informed decisions and positive attitudes towards
325 careseeking is maintained in this study ??ICRW, 2008 ??ICRW, , 2010 ??ICRW, , 2014)). As shown in earlier
326 studies, the awareness empowered the couples and guided them to take appropriate decisions during the maternity
327 period (Bhutta, Darmstadt, Hasan & Haws, 2005;Hagman, 2013;Winta, 2013; UNDP/ICRW, 2014). However,
328 women from the less knowledgeable families had higher risks of developing maternal complications or aggravating
329 existing conditions because most of them missed early screening and identification of risks factors for timely
330 intervention due to wrong decisions that led to late clinic attendance ??WHO, 2013; ??SS, 2008 ??SS, , 2009GSS,
331 , 2015)).

332 The observed entrenched gender norms and cultural adherence amongst the less knowledgeable and some of the
333 knowledgeable had a serious repercussion on decision type as well as maternal clinic attendance. This observation
334 supports the findings in previous studies that have shown evidences of gender inequalities in decision-making
335 towards maternal healthcare (Tsikata, 2007; ??CRW, 2008 ??CRW, , 2010 ??CRW, , 2014)). The views of
336 women about their own health were central in determining the timing and choice of care type, which guarantees
337 the need for gender equality and women's empowerment in healthcare decision-making at the household level. The
338 marginalisation of women in decision-making and the normalisation of cultural and traditional gender norms as
339 observed in this study had a serious implication for maternal health, particularly amongst the less knowledgeable
340 who entrusted the decision-making power to the sole hands of men. Some husbands did not count women's
341 experience of pregnancy-related symptoms as important for decisionmaking, and this resulted in some women
342 developing serious complications and injuries during delivery with others losing their lives in the process of giving
343 life.

344 Self-medication and the use of herbs during pregnancy as this study observed, are associated with health risks
345 in the form of pregnancy termination such as premature birth, spontaneous abortion and stillbirth (Cnattingius
346 et al., 2000; Kirsten, Ulrik, Bodil, Morten, & Tine, 2003; Abasiubong et al., 2012;Liao et al., 2015). The herbs
347 may contain substances such as caffeine, which has adverse effects on the growth and development of the foetus
348 (Bakker et al., 2010;Creanga et al., 2012). There was no guarantee of purity and safety of the herbs used by
349 the women, because they were not subjected to laboratory investigations to ascertain the efficacy, composition,
350 expiry dates as well as the side effects (Lapi et al., 2010). Besides, traditional practitioners lack the skills and
351 equipment to save women's lives in the event of obstructed labour or delay in placenta expulsion, which were
352 evident amongst the less knowledgeable. This exposes the women and their unborn babies to risks of further
353 complications which may result in injuries, lifetime disabilities and deaths Year 2017 As highlighted in the
354 findings, some of the maternal complications, injuries and deaths observed in this study were mainly due to
355 uninformed decision-making that led the women to nonprofessionals who could not give the needed treatment.

356 Another finding of this study is that the women's decision-making power about reproduction and sexuality was
357 extremely limited, particularly amongst the less knowledgeable couples. The exclusion of women from decision-
358 making concerning their own health is a violation of women's reproductive rights (Republic of Ghana, 1992;
359 African Union, 2006). Women are the direct objects of complications arising from pregnancy and childbirth, and,
360 therefore, must be given the autonomy to take non-tentative care-seeking decisions. The fundamental human
361 rights guarantee women the right to make decisions and to access healthcare services of their choice (Republic
362 of Ghana, 1992). Studies show that if women are given the power, they make meaningful decisions that can
363 positively affect their lives (Babalola & Fatusi, 2009;Hagman, 2013). However, differences in status between
364 women and men lead to differences in opportunities to claim, benefit from, and enjoy human rights, including
365 the right to decision-making and health ??WHO, 2013 ??WHO, , 2014)).

366 The interplay of couples' awareness of signs and complications of maternity with gender norms and cultural
367 beliefs influenced the involvement of female spouses in intra-household decisions and the type of decisions they
368 took. Whilst the educational level of couples remains important and necessary for informed decision-making,
369 the study also noticed that couples' exposure to the media as well as their inclination to cultural and gender
370 norms impacted their decisions. Irrespective of awareness, some couples considered decision-making as a sole
371 responsibility of men, and the women relied fully on the decisions made by their spouses for care-seeking. However,
372 despite the cultural, religious and gender influences, the study observed a seeming changing pattern of men's
373 behaviour in intrahousehold decision-making, with a gradual shift from the hitherto male-centred decision-making
374 to joint and female autonomous decision-making even amongst some illiterate couples. This behavioural pattern
375 was evident, particularly amongst the Christian husbands and the believers of traditional religion. Whilst this
376 is positive and essential for improvement of maternal healthcare (ICRW, 2010, 2014), the norms and principles
377 governing marriage amongst the Muslims, particularly regarding gender ideologies, were observed to be very
378 strong and resilient.

379 Media exposure had a far-reaching impact, particularly on the illiterates and rural couples. Some of the

17 V. CONCLUSIONS

380 knowledgeable gained awareness from local radio programmes which were accessible to them even in their
381 farms. The illiterate couples in the urban communities had more knowledge than their rural counterparts due to
382 exposure to multiple sources of the media and information (different TV and Radio stations/programmes) and
383 the opportunity to interact with literates and experienced people from whom they tapped knowledge.

384 Spousal age difference emerged as a crucial factor in intra-household decision-making. Men who were married
385 to very young women as compared to their ages considered their wives as incapable of taking appropriate decision.
386 Most of the participants aged between 25 and 35 years who had at least secondary education were in support
387 of joint decision-making and female autonomous decisions. However, regardless of age and experience, female
388 educational attainment was central to women's involvement in decision-making. Female spouses who had at least
389 secondary education were more involved in decision-making as compared with their illiterate counterparts, as
390 well as those who had basic education. This observation maintains the importance of formal education, which
391 is often used as a proxy for knowledge, informed decisions and empowerment, as well as positive behaviour
392 towards care-seeking though there were evidences of exceptional cases (Preston, 1989 The less knowledgeable
393 women, particularly those from rural areas with much experience of pregnancy and antenatal counselling, were
394 not wellinformed about maternity complications, and their implications were observed to be attributable to
395 poor messaging during ANC counselling. This maintains previous discoveries that poor messaging during ANC
396 counselling contributes to low knowledge about pregnancy and childbirth -a recipe for poor maternal health
397 (Perumal et al., 2013). This reinforces the view that dialectical differences and poor communication create
398 barriers to women during antenatal counselling, and these deny women the desired knowledge, thereby leading
399 to lack of perceived need for clinic attendance (Andersen & Newman, 2005; Bougangue & Kumi-Kyereme, 2015).

400 Most of the couples in the Muslim-dominated patriarchal societies of the Northern Region entrusted decision-
401 making to the hands of men. They were more influenced by gender and cultural norms as compared with
402 their counterparts from the matriarchal Awutu community in the south most of whom gave autonomy to female
403 spouses to take and implement decisions towards care-seeking. In effect, the Awutu female spouses put up better
404 attitudes towards care-seeking as compared with their northern counterparts. This caused late clinic attendance
405 and denial of professional care in some instances, which partly explains the persistent high maternal and child
406 morbidities and mortalities ??GSS, 2008 ??GSS, , 2009(GSS, , 2015)).

407 17 V. Conclusions

408 The study observed that awareness of signs of obstetric complications as well as their implications is an essential
409 ingredient in reaching well-informed decisions towards care-seeking. However, cultural, religious and gender
410 norms may collide with couples' awareness to adversely influence the involvement of female spouses in decision-
411 making, which has far-reaching implications for health outcome. Adherence to cultural and gender norms, and
412 the associated male-dominant decisionmaking were acts of disempowerment and marginalisation of women with
413 the tendency of making uninformed decisions and the resultant negative health outcomes.

414 Healthcare promotion programmes should be directed towards the dangers cultural, religious and gender norms
415 care and the to empower women make decisions about their own health and that of their babies. Also, there
416 should be public education on pregnancy and childbirth and the associated benefits and dangers to equip couples,
417 especially men, to recognise pregnancy-related complications for informed decision-making.

418 This study established that couples' awareness of signs of obstetric complications is essential for female spousal
419 involvement in decision-making as well as reaching well-informed decisions for positive maternal outcome. ^{1 2}

420 Figure 1:

¹© 2017 Global Journals Inc. (US)

²© 2017 Global Journals Inc. (US)Year 2017

³ Awareness of Signs of Obstetric Complications amongst Married Couples: Implications for Decision-Making
towards Care-Seeking. A Qualitative Study of Selected Districts in Ghana © 2017 Global Journals Inc. (US)

⁴ Awareness of Signs of Obstetric Complications amongst Married Couples: Implications for Decision-Making
towards Care-Seeking. A Qualitative Study of Selected Districts in Ghana

They go for traditional treatment and they die. Doctors say women should go to hospital early after delivery for care to check bleeding and other things." (33 years, farmer, SSS)

ii. The Less Knowledgeable

Most of the less knowledgeable were aware of common signs such as nausea/vomiting, cessation of menses and weight gain. The statement below made by a woman in FGD was supported by her colleagues, and similar statements were repeated in other FGDs and IDIs involving the same category of participants.

"To me I only realise that I am pregnant when I see my breast enlarging and my stomach becoming bigger and bigger. I don't agree that stoppage of menses is a sign of pregnancy because sometimes the menses can delay and if you eat food that does not contain enough pepper and ginger you can vomit and that does not mean you are pregnant. I have been vomiting and even my husband vomits as well." (40 years, mother of 4 children, SHS graduate). This was her husband's reaction in the FGD: "It is serious. For me to be sure that a woman is

pregnant the stomach must be very big. It is women who normally know those things. I think my wife

Volume
XVII
Is-
sue
II
Ver-
sion
I
(
D
D
D
D
D
D
)

Medical
Re-
search

Global
Jour-
nal
of

knows better." (47 years, A'Level). They had limited or no idea about the physiological causes of labour dystocia, prolonged labour and retention of placenta, as well as post-partum haemorrhage (PPH). Below are the response of a 45-year old woman and mother of 3 children and her husband in FGD on obstructed labour and retention of

the placenta. These statements were supported by most members of the group. "Women who suffer before they born may have very big babies or they had sex with different men. Some people too have been cursed by their family gods if they sinned against them. It is the same way for those who experience delays in expulsion of the

placenta. If the baby is big what about the placenta?

It is because of sin. We have to be faithful in our marriages so that God will have mercy on us." (Wife).

[Note: "I know many slim women who delivered very big babies but they did not suffer in giving birth. They didn't also struggle before the placenta came out. I think most women who suffer prolonged labour and delay of placenta expulsion only suffer the consequences of their sins and nothing else." (Husband, 47 years).E]

Figure 2:

Figure 3:

Figure 4:

421 [Solar O, Irwin A. ()] 'A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy & Practice)'. *World Health Organisation Commission on Social Determinants of Health* Solar O, Irwin A. (ed.) 2010. WHO.

422

423

424 [Bridging the gap The 5th International Conference on Women's Issues in Transportation ()] 'Bridging the gap'. *The 5th International Conference on Women's Issues in Transportation*, (Paris) 2014.

425

426 [Cnattingius et al. ()] 'Caffeine intake and the risk of first-trimester spontaneous abortion'. S Cnattingius , L B Signorello , G Anneren , B Claesson , A Ekbom , E Ljunger . *N Engl J Med* 2000. 343 (25) p. .

427

428 [Closing the gap in a generation: Health equity through action on the social determinants of health. The Final Report of the WHO Commission on Social Determinants of Health]. *World Health Organisation Commission on Social Determinants of Health* 2008. 28 August, 2008. WHO.

429

430

431

432 [Bhutta et al. ()] 'Community-based interventions for improving perinatal and neonatal health outcomes in developing countries: a review of the evidence'. Z A Bhutta , G L Darmstadt , B S Hasan , R A Haws . *Pediatrics* 2005. 115 (2) p. . (Suppl)

433

434

435 [Babalola and Fatusi ()] 'Determinants of use of maternal health services in Nigeria Looking beyond individual and household factor'. S Babalola , A Fatusi . *Pregnancy and Childbirth* 2009. 15 (9) p. 43.

436

437 [Assembly (ed.) ()] *District profile*, Awutu-Senya West District Assembly (ed.) (Awutu-Breku, CR, Ghana) 2015.

438 [District profile, District Planning Office, Chereponi Chereponi District Assembly ()] 'District profile, District Planning Office, Chereponi'. *Chereponi District Assembly*, (Northern Region, Ghana) 2015.

439

440 [Graham ()] 'Every pregnancy faces risks'. W Graham . *Plan Parent Chall* 1998. 1998 (1) p. .

441 [Mcalister and Baskett ()] 'Female education and maternal Mortality: A worldwide survey'. C Mcalister , F T Baskett . *Department of Obstetrics and Gynaecology* 2006. Dalhousie University

442

443 [Ghana demographic and health survey Ghana Health Service ICF Macro ()] 'Ghana demographic and health survey'. Ghana Health Service & ICF Macro 2009. 2008. Ghana Statistical Service. Ghana Statistical Service

444

445 [Gss ()] 'Ghana demographic and health survey'. Ghs Gss . *Ghana Health Service & ICF International* 2015. 2014. Ghana Statistical Service

446

447 [Ghana maternal health survey Ghana Health Service Macro International Inc ()] 'Ghana maternal health survey'. *Ghana Health Service & Macro International Inc* 2008. 2007. Macro International Inc. Ghana Statistical Service

448

449

450 [Perumal et al. ()] 'Health and nutrition knowledge, attitudes and practices of pregnant women attending and not-attending ANC clinics in Western Kenya: a cross-sectional analysis'. N Perumal , D C Cole , H Z Ouédraogo , K Sindi , C Loechl , J Low , C Levin , C Kiria , Kurji , M Oyunga . 10.1186/1471-2393-13-146. *BMC Pregnancy and Childbirth* 2013. 2013. 13 p. 146.

451

452

453

454 [Winta ()] *Knowledge and Practice of Reproductive Health Among Mothers and Their Impact on Fetal Birth Outcomes: A Case of Eritrea* A PhD dissertation, N Winta . 2013. USA. College of Nursing, University of South Florida

455

456

457 [Kabakyenga et al. ()] 'Knowledge of obstetric danger signs and birth preparedness practices among women in rural Uganda'. J K Kabakyenga , P O Östergren , Turyakira , K Pettersson . 10.1186/1742-4755-8-33. *Journal of Reproductive Health* 2011.

458

459

460 [Elizabeth I. Ransom Nancy V. Yinger ()] 'Making motherhood safer: Overcoming obstacles on the pathway to care'. *World Health Organisation* Elizabeth I. Ransom & Nancy V. Yinger (ed.) 2001. World Health Organisation. (United Nations Children's Fund & World Bank)

461

462

463 [Bakker et al. ()] 'Maternal caffeine intake from coffee and tea, fetal growth, and the risk of adverse birth outcomes: the generation R study'. R Bakker , E A Steegers , A Obradov , H Raat , Hofman , V W Jaddoe . *Am J Clin Nutr* 2010. 91 (6) p. .

464

465

466 [Kirsten et al. ()] 'Maternal consumption of coffee during pregnancy and still birth and infant death in first year of life: prospective study'. W Kirsten , K Ulrik , H B Bodil , Morten , B Tine . *BMJ* 2003. 326 p. .

467

468 [Nwokocha ()] 'Maternal crises and the role of African men. The case of a Nigerian community'. E E Nwokocha . *African Population Studies* 2007. 22 (1) p. .

469

470 [Creanga et al. ()] 'Maternal drug use and its effect on neonates: a population-based study in Washington State'. A A Creanga , J C Sabel , J Y Ko , C R Wasserman , C K Shapiro-Mendoza , P Taylor . *Obstet Gynecol* 2012. 119 (5) p. .

471

472

473 [Bougangue and Kumi-Kyereme ()] 'Maternal health clinic attendance in Awutu-Senya District'. B Bougangue , A Kumi-Kyereme . *Ghana. International Journal of Economics & Social Science* 2015. 2015. 5.

474

475 [Senah ()] 'Maternal mortality in Ghana: The other side. Research review. Socio-cultural Dimensions of Reproductive Health and Human Development. Institute of African Studies'. K Senah . *New Series* 2003. 19 (1) p. . University of Ghana

476

477

478 [Hagman ()] 'Maternal mortality: Gender and access to health services. The case of Ghana.' M Hagman . *Journal*
479 *of Politics and International Studies* 2047-7651. 2013. 9.

480 [Ampim ()] 'Men's Involvement in Maternal Healthcare in Accra, Ghana. From Household to Delivery Room'. A
481 Ampim . *Gender and Development: Universitas Bergensis; 2013. Google Scholar*, 2013. (M. Phil Thesis)

482 [Neilson et al. ()] 'Obstructed labour: Reducing maternal death and disability during pregnancy'. J P Neilson ,
483 T Lavender , Quenby , S Wray . *British Medical Bulletin* 2003. 67 p. .

484 [Combs Thorsen et al. ()] 'Piecing together the maternal death puzzle through narratives: The three delays
485 model revisited'. V Combs Thorsen , J Sundby , L Malata . 1371/journal-pone.00520 90. *PLOS ONE* 2012.
486 7 (12) p. e52090.

487 [Promoting Effective Perinatal Care; Essential Antenatal, Perinatal and Postpartum Care Training modules World Health Organiza
488 'Promoting Effective Perinatal Care; Essential Antenatal, Perinatal and Postpartum Care Training modules'.
489 *World Health Organisation* 2002. WHO Regional Office for Europe

490 [Milena et al. ()] 'Qualitative research methods: a comparison between focus group and in-depth interview'. Z R
491 Milena , G Dainora , S Alin . *Annals of Faculty of Economics* 2008. 4 (1) p. . University of Oradea

492 [Preston ()] 'Resources, knowledge and child mortality: Selected readings in the cultural and behavioural
493 determinants of health. A comparison of the US in the late nineteenth century and developing countries
494 today'. S H Preston . *The constitution. Abridged* Caldwell, J. C. & Santow, W. G. (ed.) 1989. 1992. NCD.
495 (Canberra: Health Transition Centre. 31. Republic of Ghana)

496 [Pembe et al. ()] 'Rural Tanzanian women's awareness of danger signs of obstetric complications'. A B Pembe ,
497 D P Urassa , A Carlstedt , G Lindmark , L Nyström , E Darj . 12-10.1186/1471-2393-9-12. *BMC Pregnancy*
498 *Childbirth* 2009. 9.

499 [Stevens ()] *Safe motherhood: an insight into maternal mortality in the developing world. Health Millions*, R
500 Stevens . 2000. 2000. 26 p. . (PubMedGoogle Scholar)

501 [Abasiubong et al. ()] 'Self-Medication: potential risks and hazards among pregnant women in Uyo'. F Abasi-
502 ubong , E A Bassey , J A Udobang , O S Akinbami , S Udoh , A B & Idung . *Nigeria. The Pan African*
503 *Medical Journal* 2012. 13 p. 15.

504 [L de Bernis, D. R Sherratt, C. AbouZahr W.V. Lerberghen ()] 'Skilled attendants for pregnancy, childbirth
505 and postnatal care'. *World Health Organisation* L de Bernis, D. R Sherratt, C. AbouZahr & W.V. Lerberghen
506 (ed.) 2003. 2003. 67 p. . (World Health Organisation)

507 [Andersen and Newman ()] 'Societal and individual determinants of medical care utilization in the united states'.
508 R Andersen , J F Newman . *The Milbank Quarterly* 2005. 83 (4) p. .

509 [Bougangue ()] *Socio-cultural dimensions of maternal healthcare in Ghana*, B Bougangue . 2017. Faculty of Social
510 Sciences, Universiti Malaysia Sarawak (PhD Thesis)

511 [Liao et al. ()] 'Substance use and self-medication during pregnancy and associations with sociodemographic
512 data: A cross-sectional survey'. S Liao , B Luo , X Feng , Y Yin , Y & Yang , W Jing . *International Journal*
513 *of Nursing Sciences* 2015. 2 (1) p. .

514 [The state of African population report, population dynamics: implications for achieving the MDGs ()] *The*
515 *state of African population report, population dynamics: implications for achieving the MDGs*, 2006. African
516 Union Commission.

517 [Lapi et al. ()] 'Use, Attitudes and Knowledge of Complementary and Alternative Drugs (CADs) among
518 Pregnant Women: a Preliminary Survey in Tuscany'. F Lapi , A Vannacci , M Moschini , F Cipollini ,
519 M Morsuillo , E Gallo . *PubMed, eCAM* 2010. 7 (4) p. 477.

520 [Waiswa et al. ()] 'Using the three delays model to understand why newborn babies die in eastern
521 Uganda.Tropical Medicine and International Health'. P Waiswa , K Kallander , S Peterson , G Tomson ,
522 G Pariyo . *Karolinska Institutet* 2010. Department of Public Health Sciences. 15 (8) . (pp 964-972. Division
523 of Global Health)

524 [Tsikata ()] *Women in Ghana at 50 still struggling to achieve full citizenship? Ghana Studies*, D Tsikata . 2007.
525 10 p. .