

Motivations for Non-Formal Maternal Health Care in Low-Income Communities in Urban Ghana

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Abstract

Considerable efforts are being made to improve access to maternal health care in order to reduce maternal mortality rate in Ghana. However, the use of non-formal care during pregnancy and childbirth among women still remain high in some communities. In this study, we investigated factors influencing the use of non-formal health care by women during pregnancy and childbirth, when formal health care services are readily available, in a centrally-located low-income neighborhood in Accra, the capital city of Ghana. Twelve (12) focus group discussions and six (6) individual interviews were conducted with ninety (90) women who had at least one child, to examine factors determining the use of non-formal health care during pregnancy and child birthing. Traditional birth attendant and spiritual care were identified as forms of non-formal maternal health care utilized by pregnant women. Cost of seeking formal health care, the belief that traditional birth attendants and spiritual churches could offer spiritual protection during childbirth, fear of cesarean delivery, the belief in the potency of herbal medicine in sustaining pregnancy, lack of antenatal clinic attendance, and influence of parents on site of delivery were reasons for preference for non-formal health care by pregnant women. The findings point to the need to look beyond formal physical access, the need for government absorbing full cost of maternal care for women who cannot pay, to accommodating women's religious beliefs and integrate non-formal health care providers into the formal health care system in low income urban communities in Ghana.

Keywords: Non-formal health care, maternal health, care seeking behavior, low income communities, urban Ghana

1.0 Introduction

High maternal mortality rates continue to be a major public health concern globally. The World Health Organization (WHO) estimates that about 800 women die from pregnancy-related complications each day, and over a quarter a million maternal deaths still occur worldwide, despite the sustained efforts by governments and non-governmental organizations around the world to reduce maternal death (WHO, 2014).

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In developing countries, a woman's lifetime risk of death due to pregnancy-related complications is 1 in 160 as compared to 1 in 3700 in developed countries (WHO, 2014). Current estimates show that 99 percent of approximately 290,000 women around the world who die from pregnancy-related causes are from developing countries (WHO, 2014). Presently, maternal mortality rate in Ghana ranges from 240 to 800 per 100,000 live births, indicating a high maternal mortality rate as in most countries in sub-Saharan Africa (WHO/UNICEF/UNFPA/World Bank, 2012; GSS/GHS/Macro International, 2009).

The most prevalent direct causes of maternal mortality are postpartum hemorrhage, eclampsia, obstructed labor, unsafe abortion, miscarriages, infections, embolism and sepsis (WHO, 2014; GSS/GHS/Macro International, 2009; Asamoah et al., 2011). Indirect causes include factors captured in the Three Delay Model. This model proposes that pregnancy-related deaths are due to delays in 1) recognizing and deciding to seek professional maternal medical care for an obstetric emergency; 2) reaching an appropriate obstetric facility in a timely manner (most commonly not possible because of poor roads and lack of efficient means of transport); and 3) receiving professional and humane care when a woman reaches health facility (Barnes-Josiah et al. 1998; Okafo & Rizzuta, 1994; Thaddeus & Maine, 1994). Despite the critical importance of these factors, there are host of socio-cultural, economic and institutional factors that can contribute to maternal mortality (Gyimah et al., 2006; van den Heuvel et al., 1999).

Ghana aimed to achieve the Millennium Development Goal 5 (MGD5) of reducing maternal mortality in the country by three-quarters by 2015. In light of this goal, the Ghana Ministry of Health (GMH) invested significant financial and human resources in the Safe Motherhood Program, a comprehensive national reproductive health strategy for maternal mortality reduction. One major component of the national strategy seeks to make formal health care geographically more accessible to pregnant women. In addition, there are efforts to improve the quality of obstetric and midwifery services. Moreover, a free delivery health care policy was introduced in 2003, which was designed to cover intrapartum care for all pregnant women who seek care in public, private or religious-associated health facilities (Asamoah et al., 2011; Witter et al., 2009; Ansong-Tornui et al., 2007). The initial funding for the free delivery care policy was provided through the local government common fund and later through the health sector. Subsequent funding was provided through the debt relief fund under the Highly Indebted Countries Initiative in 2006, and then, in 2008, it was replaced by the National Health Insurance Scheme (Witter et al., 2009).

As in most countries, Ghana has most of its formal health care infrastructure located in urban areas (e.g. approximately 68.1 % of their workforce works in urban areas) (GSS, 2011). As a result, one might expect that urban women would utilize the formal health care system more than non-formal health care when they are pregnant. However, reports have shown that women in some urban communities do not fully use formal health care during pregnancy; in fact, a little over 50% of pregnant women who reside in poor urban areas give birth in health centers and hospitals. Thus, they prefer to use non-formal health services, such as traditional birth attendants, who are frequently family or community members, or from spiritual churches operating in their communities (Anafi et al., 2007; GHS, 2007, Kennedy, 1999). Unfortunately, most traditional birth attendants operating in urban areas do not have basic midwifery training due to the assumption that traditional birth attendants do not operate in urban areas (Bergstrom & Goodman, 2001; Jemal et al., 2010).

In April 2005, the government began scaling up its free maternal delivery program to cover pregnant women in Ashiedu-Keteki sub-metropolitan area in Accra in order to reduce maternal and perinatal deaths in the area (Anafi et al., 2007; Dzakpasu et al., 2012). The sub-metropolitan district received support from the Danish Agency for International Development Health Sector Support Office to boost the government's policy of free delivery. These initiatives aimed to reduce the financial barrier to maternal health care. In spite of these efforts, a number of pregnant women in this sub-metropolitan continue to utilize traditional birth attendants (TBAs) during pregnancy and childbirth (Anafi et al., 2007). It was therefore important to understand why urban women use non-formal health services during pregnancy and childbirth.

The goal of this study was to investigate the reasons for use of non-formal health care during pregnancy and delivery by low-income urban women living in this sub-metropolitan area in Accra, Ghana, where physical access to modern health care was not a barrier. In particular, we examined the kinds of non-formal health care and services utilized by the women in the study area during pregnancy and childbirth, and explored the motivations behind the use of these services. Our study was designed to answer the following questions: What kinds of the non-formal health care are used by women in the study area during pregnancy and childbirth? And, why do women in the study area use non-formal health care centers during pregnancy and childbirth.

2. Study Site

The study was conducted in the Ashiedu-Keteke sub-metropolitan district in Accra, in the capital of Ghana. Ashiedu-Keteke has an estimated population of 250,000, and it has the largest slums in the city and, indeed, the nation (Accra Metropolitan Assembly, 2011). The population of Ashiedu-Keteke is mainly made up of the indigenous Ga people, who live in communities along the Guinea coast and other the migrant populations, who have settled a bit further away from the coast. The main occupation of the indigenous Ga people is fishing; the men catch the fish and the women smoke it for the market. The migrant population engages in small-scale commercial activities, mainly trading.

Approximately half of the population (44%) is between ages 0-15 years (Razzau, 2005). Data on education show that only about 25% of school-age children attend school. In terms of maternal health, Ashiedu-Keteke has the poorest maternal health outcomes in Accra (GHS, 2007). Observed incidence of teenage pregnancies is very high. Some teenagers have more than one child before they reach their twenties and there have been reported cases of girls as young as 11 and 12 years being pregnant (Anafi et al., 2007). According to available data, approximately 40% of pregnant women who live in Ashiedu-Keteke did not seek antenatal care until the second and third trimester, a situation quite similar to the national rural trend (GSS, 2011; GSS/GHS/DHS Program/ICF International, 2015).

3. Methodology

3.1 Study Design

This was an exploratory study that targeted residents of above study site. The study was carried out from May to August, 2010. We utilized focus group discussions (FGDs) and individual interviews to collect data on women's perceptions and experiences with non-formal maternal health care and why they use these services during pregnancy and childbirth.

3.2 Participants Selection and Data Collection Procedure

Ninety women in different age cohorts were selected for 12 FGDs and 6 individual interviews in the study area. Purposive sampling strategy was used to select six neighborhoods from which the participants for FGDs and interviews were recruited. A list of the study site was obtained from the Ashiedu-Keteke Health Service Administration and we selected neighborhoods with poor maternal and neonatal health outcomes. This sampling technique also ensured that neighborhoods in which women utilized services of non-formal health care providers were fully represented in the study.

A snowball sampling strategy was used to choose participants for the FGDs. In each of the selected neighborhoods, an initial household that had a woman who had given birth to at least one child was chosen. The woman was then asked to help us recruit women in the neighborhood who also had at least one child. Each woman identified helped to identify other women she knew. The process continued until we got our sample frame for each FGD. We conducted two FGDs in each selected neighborhood. We grouped the women in the FGDs into the following age cohorts — age 17-29; age 30-45 and 46 years and above. Each FGD consisted an average of 7 women of the same age cohort. This effort was made to capture women from different age cohorts to provide a broad picture of maternal health care seeking behavior of the population and to facilitate discussions in the FGDs.

For the individual interviews, we recruited 6 women who had at least one child from the six selected neighborhoods (one woman from each of the 6 selected neighborhoods). We contacted two community informants to assist us to recruit the women.

The FGDs and interview guides were similar and organized around our research objectives. Participants were asked to identify existing forms of non-formal maternal health care that pregnant women in their neighborhood used and why they used these services during pregnancy and childbirth. Both the FGDs and interviews were conducted in Twi and Ga, the two major local languages spoken in the area, with help of two fieldwork assistants. The fieldwork assistants are indigenes and fluent in both languages. The FGDs and interviews were audio recorded with permission from participants.

3.2 Ethical Consideration and Informed Consent

The initial ethical approval to conduct this study was obtained from the Human Subject Review Committee of the School of Public Health and Health Sciences, University of Massachusetts-Amherst. In addition, the Ghana Health Service Institutional Review Board approved the research. Finally, investigators were also given permission from the Asheidu- Keteke sub-metropolitan Health Administration and the local communities to conduct the study. Verbal consent was obtained from all study participants before recruitment. Most participants had low level of formal education and so it would have been quite difficult to obtain written consent. All prospective participants were informed about the purpose of the study, the expected duration of the FGDs and interviews, and we repeatedly emphasized that participation was completely voluntary, and that they had the right to withdraw from the study any time they wanted.

3.4 Data Analysis

Data analysis was done concurrently with the data collection. The FGDs and interviews audio recordings were transcribed verbatim from the local languages into English with the help of our fieldwork assistants; each FGDs and interview was transcribed separately. After transcription, we compared the transcripts from the two assistants to ensure that the responses have transcribed and translated accurately from the local languages into English. We read through the final transcripts to identify words and statements that were relevant to our research objectives. We used thematic content analysis approach to categorize the data into common themes. Relevant concepts and statements were given unique codes as we read through the transcripts. Using the codes, we organized the data into three major themes: "non-formal pregnancy care in urban areas," "non-formal delivery care in urban areas" and "reasons for women's preferences for TBAs and spiritual care in urban area." Finally, we summarized text segments under each major theme with the illustrative quotes.

4. Results

4.1 Participants' Socio Demographics

Forty-two percent (42%) of the participants were between the ages of 17 and 29 while 40% percent were between ages 30 and 45. The remaining 18% were 46 years and above. The age range was 17 and 87 years. The highest educational attainment of the participants was senior high school (3%) while 39% had basic education, 19% had primary education and approximately 37% had no formal education. Over a half of them (55%) reported being married, 14% were single mothers, and 24% were divorced, while 7% were widows. Majority (87%) of them were small traders and fishmongers. The rest were female porters, dressmakers, hair beauticians and unemployed. Their average income per month was GH¢ 80. 00 (i.e. approximately US \$ 40.00 during the time of the study) with the highest monthly income of GH¢ 178.00 (~ US \$ 98.00), and the lowest income was GH¢ 50.00 (~ US \$ 25.00). On ethnicity, 58% reported that they were *Ga* and the remaining 42% were from the other tribes in Ghana (mainly Akans, Gonjas, Dagombas and Ewes). The majority of the participants (83%) were Christians, 9% were Muslims, and 8% identified believers in the traditional African religion.

Several points are worth noting with regard to the socio-demographic composition of the participants. It can be seen from the data that some of the participants were teenage mothers. Also, the monthly average income and educational attainment of most of the participants were low. This suggests that most of the participants have low socio-economic status. In fact, studies have shown that lower maternal age, low education and poor economic status negatively affect women's autonomy in health care decision making and maternal health outcomes (Acharya et al., 2010; Amin et al., 2010; Gabrysch & Campbell, 2009).

4.2 Non-Formal Pregnancy Care in Urban Areas

Data from the study indicated that the main forms of non-formal health care that women in the study area used during pregnancy were spiritual and TBA care. The spiritual care was sought mainly from the divine and faith healing churches (also known as Awoyo or 12 Apostles and Aladura spiritual churches) located in and around communities in the study area. The form of worship in the divine and faith healing churches is a blend of Traditional African Religion practice and Christianity. According to participants, the women who usually attended these churches for spiritual care during pregnancy were young mothers and indigenous women. The following statement by a 26-year-old woman FGD participant confirmed the above report:

“It is the women in Jamestown [a Ga neighborhood] who go to Awoyo, a spiritual church along the beach to seek for care and prayer when they are pregnant. But also some of the teens and young mothers in Abgobloshie area [a different neighborhood] also seek pregnancy care from the Awoyo churches in Jamestown and Bukum areas. They go there to seek care from the women who operate the Awoyo churches there.”

The participants described the care that they received at the spiritual churches as prayer, counseling, anointing oil and holy water, where women could spend the whole day seeking care at the spiritual churches. According to participants, these functions were usually performed by leaders of the spiritual centers, some of whom are female pastors (priestesses) who were also TBAs. A 29-year-old woman FGD participant explained:

“When they go to the Awoyo churches, the women pastors pray for them and anoint the pregnancy; I mean the stomach. They use holy water and anointing oil to massage their stomach to ensure and maintain the baby proper position in the womb.”

This statement was corroborated by interview participants who said that in the spiritual churches, prayers and intercessions were made for pregnant women who sought care there.

In addition to the spiritual churches, participants identified community and family TBAs as individuals who provided pregnancy care to women. This category of care givers provided herbal medicine, and counseling on healthy lifestyle during pregnancy to women who sought their services during pregnancy. A woman aged 31 in an FGD narrated the assistance she got from her TBA as: “My TBA helped me a lot during my second pregnancy. She did not pray for me, but she advised me to eat well, like, not to eat my dinner too late. She also told me not to stress myself, [and] add fruits and vegetable to my meals.”

The following statement, made by a 34-year-old woman FGD participant, supports the above account:

“When I was pregnant with my second child, I went to see the TBA who stays near our house and she made herbs for me. When you go there she would ask you how old is your pregnancy, then she would make some herbs for you—the herbs, you have to drink it every morning.”

The accounts by interview participants also confirmed views of FGDs participants regarding the pregnancy care provided by community and family TBAs.

4.3 Non-Formal Delivery Care in Urban Areas

Similar to the pregnancy care, accounts from FGDs and interviews showed that women in the study area sought delivery care from the TBAs and spiritual churches. Even some women who regularly attended antenatal clinics also sought delivery care with a family or community TBAs or in the divine and faith healing churches. A 65 years old woman FGD participant narrated:

“Oh yes, when it becomes necessary, we deliver our babies with the help of the TBAs here. We call TBAs to assist us.... We call them (TBAs) to help cut the umbilical cord and wash the baby, but later we send the baby to Korle-bu [the local hospital] for medical care.”

Another 46-year-old woman FGD participant who used the services of the spiritual churches remarked:

“That is where we go to deliver our babies. We don't know their names. We only call them church. We call them by names like Auntie Nortey church or Auntie Korkor church. These churches are not like the organized churches that we all know. They are spiritualists who care for pregnant mothers.”

According to participants, some community TBAs have links with the spiritual churches and they go there to assist the mothers during child birth. They explained that, in the spiritual churches, prayers were often offered for pregnant women who sought delivery care. Pregnant women were also offered holy water and their bodies rubbed over with anointing oil while birthing. In cases where labor prolonged, the priests in the churches and TBAs who worked with the churches, could induce delivery through prayers and intercessions. The participants also reported that the family and community TBAs who were not affiliated to the spiritual churches sometimes prayed for women during childbirth.

4.4 Reasons for Women's Preference for TBA and Spiritual Care in Urban Area

4.4.1 *Cost of formal health care:* The one of the main motivations for women's preference for TBAs and spiritual care is cost associated with care at the public health care centers. Responses from the interviews and FGDs indicated that although many women had registered for free maternal health at the public health centers, antenatal care and delivery care were not completely free. Pregnant women who sought antenatal and delivery care at the public health centers were made to pay for some of the services that they received and this was hard for some of them to do since they were poor. A 26-year-old woman interview participant explained:

"Yes, they say it's free and we don't have to pay anything, but when you go to the clinic, they ask you to pay something. When I started antenatal, the nurse told me that, even though they say it is free, we should bring money any time we visit the clinic. So, what do you do if you don't have money...?"

The above comment is supported by a remark by a 25-year-old FGD participant:

"They are lying, it is not free. Here in Accra, it is not free, you have to pay something. You pay for the lab tests, scan (ultrasound scan) and sometimes, talking to the doctor or nurse (consultation). You start paying from the day you begin to seek antenatal care in the clinic till the day you deliver. If you deliver in the village, it is free, but not in Accra or Korle Bu hospital."

The participants explained that pregnant women who did not have money (cash) to pay immediately for care in the public health centers sought care from the TBAs or spiritual churches. An account from a 32-year-old woman FGD participant illustrates the above statement:

"In my case, my husband did not give me money because he has heard that it is free. When I went there (antenatal clinic), they asked me to pay, I came back home because I did not have enough money with me."

A 29-year-old interview participant also mentioned that:

"If you don't have money and your husband or the man who made you pregnant does not give you money, you can't attend clinic to receive care. I have a sister that the man who made her pregnant did not accept responsibility for the pregnancy, she did not attend clinic, because she did not have the money to pay for the cost of care, so she went to the TBA for care."

Also, the TBAs and spiritual churches had flexible payment arrangements for their services. According to the participants, unlike the formal health care system, which would demand immediate payment for service, payment for services provided by the spiritual churches and TBAs can be deferred to a later date or made by installments.

4.1.2 *Belief that TBAs and spiritual churches offer protection:* Another reason why the women preferred to use the spiritual churches and TBAs during pregnancy and delivery is the belief that these sources provided spiritual protection. Some participants indicated that the TBAs and spiritual churches had the ability to neutralize the potency of curses and spells that could prolong labor or cause death during delivery. According to participants, some women, especially the young ones are disrespectful and quarrelsome. They believe that engaging in quarrels could lead to a pregnant woman being bewitched or cursed, and this could prolong labor and lead to the death of the baby or the mother during childbirth. They used the spiritual churches because they believe that modern medical care does not offer this kind of protection. This belief seemed to be widespread in the study area as most of the participants in the FGDs and interviews spoke about it. A 40-year-old woman FGD participant put it this way:

"In this community, people like fighting each other and the female youths are very rude and insulting.....So when they become pregnant, they believe a neighbor or somebody they insulted or fought will curse them and that may affect their pregnancy. When you go there right now, you will see them in the church, the young pregnant women, that is where they go to give birth because they fear that when they go to the clinic or Korle-bu hospital, they will die or their babies will die during childbirth." With this belief, even if there was no cost for formal health care, some pregnant women would still seek care from the spiritual churches and TBAs.

4.1.3 *Use of herbal medicine for pregnancy:* The responses also indicated that some women preferred TBAs because they wanted to use only herbal medicine during their pregnancy. Both the FGDs and interview participants acknowledged the relevance of herbal medicine in sustaining healthy pregnancy. The following account by a 36-year-old woman interview participant elucidates the value of herbal medicine for pregnant women in the community:

“You see...., some of this herbal medicine that I am talking about, I have to drink it first thing in the morning before I eat. You feel the baby is moving in your womb after you drink it. When you have swollen feet and you drink, it disappears. Some women go to the TBAs to drink the herbs, but I make it myself and drink every morning when I am pregnant.”

A 46-year-old woman FGD participant also narrated the importance of herbal medicine for pregnancy as:

“When you take certain herbs, you don’t feel like you are pregnant because it makes the baby in your womb healthy, and you also feel strong. You know, herbs are used to make biomedicine, so both are good. Some people use biomedicine and it does not work for them unless they use herbal medicine, some use herbs and it does not work for them, unless they use biomedicine, so it all depends on what works for the individual.”

4.1.4 Fear of caesarean section: Fear of giving birth by caesarean section was cited as reason for preference for TBAs and spiritual care. It emerged from the FGDs and interviews that some women often delayed at home when labor starts and to avoid the possibility of delivering through caesarean sections, as a result of complications that might be caused by the delay, they resorted to the TBAs and the spiritual churches with the belief that they would have their babies delivered there through normal delivery. The following quote from a woman interview participant illustrate how perception about cesarean section, and delays during labor motivated some women to seek non formal health care during delivery. “Some people say they are afraid to go the Korle-Bu hospital because when they go there, they would operate on them. See, there are some who wait too long at home when labor begins and they fear that when they go to the clinic, they will take them to Korle-Bu (hospital) for operation. That is why they don’t go there and they go the TBAs and the churches.”

4.1.5 Lack of antenatal clinic attendance: Discussions with the FGD and interview participants revealed a relationship between lack of attendance at the antenatal clinics and visits to spiritual churches and TBAs: women who used the spiritual churches and TBAs were likely to be those who did not attend antenatal clinics during their entire pregnancy period. To avoid being reprimanded (or verbally abused) by the midwives and nurses for not attending antenatal clinics during pregnancy, they resorted to the spiritual churches and TBAs. This is how a 28-year-old woman FGD participant said it:

“Like when you are pregnant and you don’t attend antenatal (clinic) and you go there to deliver your baby, the nurses and midwives will insult you... You know some teen pregnant mothers don’t have husbands, and they don’t want to be embarrassed by the nurses, so they don’t attend antenatal. And because they did not attend antenatal (clinic), they don’t go the clinic to give birth because they know the nurses there will insult them. So, that is why some go the TBAs and spiritual churches.”

4.1.6 Influence of parents on site of delivery: Participants related that in some instances, parents made decisions and choices on behalf of their pregnant children during labor. According to some FGDs and interview participants, when young pregnant women are in labor, it was often their mothers who made the decision about where to deliver and so the decision to deliver at the spiritual churches and TBAs was sometimes made by mothers of the women in labor.

5.0 Discussion

This study examined maternal health care seeking behavior of women in Ashiedu-Keteke sub-metropolis in Accra, Ghana. The findings from the study are consistent with a number of other studies on maternal health care seeking behavior of women in Africa. For example, the findings that TBAs and spiritual care were the main non-formal care utilized by pregnant women from the study area is consistent with the health care seeking behavior by pregnant women in some urban communities in Africa. In a qualitative study by Izugbara & Afangideh (2005), it was found that Igbo urban women in Aba City in Nigeria utilized the services of non-formal health care providers who were indigenous healers, TBAs and faith or spiritual healers for conditions such as infertility, abortions, and child birthing.

The findings that the pregnant women preferred the services of TBAs and Spiritual churches even though formal health services are available in the study area was not surprising. In Ghanaian traditional society, there are myths surrounding pregnancy and childbirth, and pregnant women are supposed to perform certain activities to protect the mother and the unborn baby.

The use of herbs and eating special types of foods during pregnancy is common in traditional societies in Ghana. Also, the pregnant woman may fortify herself with mystical medicine against evil spirits and persons. Items used for the protection include talismans, "holy water" or/and "holy oil" (Sarpong, 1974). The spiritual churches and TBAs perform some of these traditional functions, thus making them attractive to the women. In fact, it is common for women, included educated women, to combine formal health care with traditional medicine during pregnancy (Barimah & van Teijlingen, 2008).

The influence of cost in limiting the use of medical care was still significant irrespective of strong traditional beliefs surrounding pregnancy and childbirth. This is particularly so for poor women such as those in the study area. For women who are poor, the cost of antenatal and delivery care, no matter the magnitude, can be deterrent to the use of formal health care, especially if there are alternatives that are cheaper and "better." The TBAs and spiritual churches charges seemed to be "better" substitutes due to flexible payment methods. It is important to note that until recently, the cost of maternal care was a major financial barrier confronting pregnant women in Ghana because of the fee-for-service policy carried over from the mid-80s that required users of health care to pay for services at the point of use (Asenso-Okyere et al. 1998). This policy compelled many women to turn to socially acceptable and economically affordable alternatives such as TBAs and spiritual churches. Thus, in spite of the "free" maternal care for all pregnant women, full cost of antenatal and delivery care in public clinics is shared by both users and government. It will require some efforts to motivate users of the non-formal care to use formal health care since most of them are poor.

The revelation that women fear to use the public health facilities because of the possibility that they may undergo cesarean delivery is a challenge for the Safe Motherhood program in Ghana. In poor communities such as the Ashiedu-Keteke sub-metropolis, where there may be complications during delivery as a result of inadequate antenatal care and delays during labor, cesarean delivery can save lives. Thus, if women fear to use formal health care for fear of undergoing caesarean section, it will be a major setback to the country's efforts to reduce maternal and neonatal mortalities.

Evidence from the study that mothers sometimes made decisions for their pregnant daughters points to the healthcare decision making process in Ghanaian society in general, and the ability of pregnant women to exercise choice and personal control over their lives. In Ghana, the decision of an individual regarding the type of health care to use during ill-health is not the sole responsibility of the sick person; the whole extended family and even friends, in some cases, are involved in the decision making. This is mostly true when the person needing care depends on her parents or husbands financially (White et al., 2013). Consequently, many young pregnant women who sought care from the TBAs and spiritual churches probably did so because they did not make the decisions themselves.

6.0 Implications

This study uncovered several issues relevant to strengthening maternal and child health policies, programs and practices. The findings suggest that TBAs and spiritual churches are active providers of antenatal and delivery care in the study area despite the common assumption that they operate only in rural communities (Bergstrom & Goodman, 2001; Jemal et al., 2010; Ebuehi & Akintujoye, 2012). However, these care givers have no formal training and links with the health facilities in the area. Therefore, there is the need for training programs for urban TBAs, and protocols to track their activities in urban areas. Furthermore, considerations should be given to programs that would encourage medical practitioners and TBAs to collaborate, so that women can benefit from a wide range of services during pregnancy and childbirth.

The results of this study indicates that cost of pregnancy and delivery care is still a deterrent to many women who utilize antenatal and delivery care in the public health facilities. Therefore, it is important for government to be more explicit about antenatal and delivery care services that qualify for cost exemption under the National Health Insurance Scheme. Ideally, government should absorb the full cost of maternal health care for women who cannot pay to encourage women to use professional midwifery services in order to improve maternal and neonatal health outcomes.

Moreover, the study provides lessons for formal sector midwives and nurses to be more tolerant and friendly to all women who visit their facilities. Health training institutions should emphasize aspects of human relations in the training of midwives and other staff to improve on provider-client interaction, so that they will be more responsive to the needs of their clients.

7.0 Conclusion

This study has demonstrated that TBAs and spiritual churches are still active as maternal health care providers in large urban slums in the capital city of Ghana and many poor women utilize their services during pregnancy and childbirth. Pregnant women use these services for reasons such as their beliefs in the functions performed by TBAs and spiritual churches, cost of formal health care, fear of caesarean delivery and lack of antenatal clinic attendance. Although this study focused on one urban setting, the situation is unlikely to be much different in other urban areas. The findings have implications for maternal health care policies, programs and practices in urban areas in Ghana.

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