UNIVERSITY OF CAPE COAST

ASSESSING THE SOCIOCULTURAL BARRIERS TO HEALTHCARE UTILISATION AMONG PREGNANT WOMEN IN SELECTED COMMUNITIES OF SUHUM MUNICIPALITY

BY

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DECLARATION

Candidate's Declaration

I sincerely affirm with certainty this thesis is the outcome of my own unique research and that no part of it has been presented for another degree in this university or elsewhere with the exception of where proper sources or citations are provided.

Candidate's Signature: ..... Date: .....

Name: Belinda Mensah

Supervisor's Declaration

We hereby affirm that the conduct and presentation of this thesis were supervised in harmony with the guidelines on the supervision of the thesis outlined by the University of Cape Coast.

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ABSTRACT

Healthcare matters are paramount to mankind to ensure their survival. The utilization of maternal health care services in developing countries is largely predisposed by socio-cultural factors. There is a need for an increase in studies peculiar to women's health as this can help developing nations address problems and make policies with their subsequent implementations to improve health and wellbeing of women since it is positively correlated with a socioeconomic productive life. The study focuses on two main communities under Nankese, a sub district under the Suhum Municipality where attendance for healthcare utilization has been very low although a lot of measures have been put in place. In total, fourty (40) respondents were selected and 14 informants from the hospitals and the community were also considered in this category. The researcher used purposive sampling technique in selecting respondents and used a structured interview to collect data from the participants. Respondent's questions provided reasons why they attended or stayed away from hospitals for healthcare treatment. Majority of them indicated they preferred the Traditional Birth Attendant (TBA) over hospital treatment for numerous reasons. The findings shows majority of respondents were working but they relied on their husbands or family decisions on visiting or attending hospitals for treatment. Some do not go to hospitals because their husbands deny or disallow them and for others their families will not allow them to go to hospitals. Some recommendations include continuous education on the effects of some traditional practices that may harm the mother and the baby should be hammered on in Dawa and Asore-ase.

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I am indebted to my parents Mr. & Mrs. Owusu Fordjour for their support and advice throughout my journey, I love you so much. And to my entire family, I acknowledge your immense support.

DEDICATION

To my lovely son, Cyril Akyede Sarpong.

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LIST OF ABBREVIATIONS

GHS	Ghana Health Service
GSS	Ghana Statistical Service
HBM	Health Belief Model
ICF	International Classification of Functioning, Disability and Health
IRB	Institutional Review Board
MDGs	Millennium Development Goals
MHA	Mental Health Association
MMR	Maternal Mortality Ratio
NHIS	National Health Insurance Scheme
PRMR	Pregnancy- Related Mortality Ratio
SDG	Sustainable Development Goals
SMHD	Self-reported Mental Health Diagnoses
TBA	Traditional Birth Attendants
TPB	Theory of Planned Behavior
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization
WIFA	Women In Fertility Age

CHAPTER ONE

INTRODUCTION

Everyone's health care matters but women have unique health care needs and access to that care is paramount. Women, due to their role as primary caregivers to children, parents, spouses, and siblings, sacrifice their health care to put that of others ahead of themselves (Stewart-Cousins, 2009). World Health Organization (1948) explains health as the state of complete social, physical, and mental well-being capacity and not merely the absence of disease. Similarly, Marriam-Webster dictionary (2016) defines health simply as "the condition of being well or free from disease".

As stated by Feidiib (2017 and Madadi and Curtis (2003) reported that women's health-seeking behaviour is a complex behavioural phenomenon. Many studies have associated the link between sociocultural features and health-related manners of females, especially in the villages or rural areas who seek healthcare is related to accessibility, the superiority of healthcare service, and financial requirements of health services including the social facilities in place, well-being opinions, and individual features of the women seeking the healthcare.

Different factors are related to the application of healthcare facilities and services in the community. These related factors can be classified under socio-economic and demographic factors such as; health-seekers educational background, the age of the person, the work or occupation of the health seeker, knowledge of health risks, marital status and level of independence, procreation

order, the religious status of the health seeker, the type of person in charge of the house, financial level of household, number of people in the given house, husbands' knowledge of healthcare, and other factors that may hinder the access to proper healthcare. For example, a mother's knowledge of danger signs and autonomy are reported as significant determinations of care utilization of health services by women (Abebe, Berhane, & Girma, 2012). Good health status among women improves not only their well-being but affects them and other members of the family (McKeehan, 2010).

Background to the Study

The rate of healthcare utilisation among women in rural areas is largely influenced by socio-cultural factors which include ethnicity, religious beliefs practices, and culture. For example, in more rural areas, most babies get delivered in homes by TBAs or traditional healers of which most of them are not qualified (Feleke, Mirkuzie, & Fikru, 2013). Leininger (1995) indicates that culture is received, learned, communicated, and transferred ethics, principles, standards, and ways of life of a given group of people to provide guidance and direction for their way of life. Similarly, it determines people's definition of mental, and physical health, and their interpretations determine how they deal with the illness (Gardener, Komans & Mutter 1998).

Socio-cultural factors can be described in general terms as sets of characteristics that people portray as part of a given group or society (Prinz, 2011). These factors have double roles thus they both facilitate and constrain human

action. Firstly, these factors help people to interact with others and appear as creating more choices for the community or society (Savalainen, 2016).

Abubakari and Yahaya (2014) indicated that health-seeking behaviours among women include specific baby gender preference, asking for permission from the husband or family members before visiting the health facilities or seeking medical services, and many others. Lu, Samuels, Kletke, and Whitler (2010) also acknowledged inaccessible clinics or hospitals, long or far away from health facilities, poor transport systems, insufficient healthcare providers, and high cost of healthcare services restrain rural people from getting health services.

Arhin (2001) indicates that most Ghanaian communities are expected to follow or observe certain cultural norms to ensure safe delivery during childbirth. Several health problems related to reproductive health have just been recently discovered (Sen, George, & Ostlin, 2002). Unable to achieve its health Millennium Development Goals (MDGs 4, 5, and 6) target, the goals were upgraded with the SDG (3, 5) for the next fifteen years (2015-2030) for the various countries under the UN Assembly to transform the world. Ghana's current maternal mortality rate of 350 deaths per 100,000 live births is considered a far cry from the SDG 3 target of fewer than 70 deaths per 100,000 live births.

Similarly, its infant mortality rate of 12 deaths per 1,000 live births and under-five mortality rate of 25 deaths per 1,000 live births were also distant of their MDG 4 targets of 26 deaths per 1,000 live births and 39.9 deaths per 1,000 live births respectively (GSS, GHS, and ICF. 2018). Among factors mentioned for the nation's inability to achieve stated health MDGs targets are poor road and

communication networks, lack of transport and health infrastructure; inaccessible health facilities, cultural beliefs, and practices, weak referral system between health facilities, lack of blood products, inadequate number of midwives and other health professionals, weak implementation of health interventions and inadequate funding for the health sector to mention just a few (Alliance for Reproductive Health, 2016).

The WHO and UHC wish that all people can use the promotion, preventive, curative, rehabilitative and palliative health services they need and of sufficient quality to be effective, while ensuring that the use of these services do not expose the user to financial hardship.

There are many differences in several ethnic groups that may also affect the behaviour of individual health seekers in these groups. However, it depends on individuals to personally decide whether to seek professional healthcare. These decisions may be dependent on their social and economic culture (Dawes, 2006). Women spend most of their time taking care of their families and those in the rural areas also engage in other activities such as clearing of farmlands, growing food and trading them at the expense of their health (WHO, 2010).

When it comes to maternal deaths Abor, Abeka-Nkrumah, Sakyi, & Adjasi, (2011) established that maternal mortality is the largest cause of female deaths and it accounts for 14% of all deaths. Feidiib (2017) also indicated that certain measures have been put in place like the construction of maternal hospitals or clinics to ensure and promote free maternal healthcare and delivery under the National Health Insurance Scheme and developing safe motherhood protocol at the various levels of health delivery in order to reduce maternal mortality and

make utilization of health services attractive and easy for women, these issues continue to exist.

According to the Ghana Maternal Health Survey for (2017), there are 310 deaths per 100,000 births in Ghana. In the quest to perform a supportive role both economically and domestically women might tend to use other alternatives to make them fit for every day.

Statement of the Problem

The Constitution of Ghana has indicated that women are treated with equal rights as men, yet there is still the disparity in terms of education, employment, and health for a woman which remains a prevalent (Mahama & Nkegbe, 2017). It is also known that women have much less access to resources than men in Ghana do (Awumbia, 2006). Ending Preventable Maternal Mortality (EPMM) is very paramount under "Goal 3: Ensure healthy lives and promote well-being for all at all ages" from the Sustainable Development Goals (SDGs) plan from 2015 to 2030.

These strategies outlined some important targets to help reduce if not totally eliminate maternal mortality around the globe. The group consulted stakeholders and planned to implement human rights approach to maternal and new-born health services with the aim of reducing inequalities that affect quality healthcare delivery to mothers and children (Mhtforg, 2017). In recent years, there has been an increase in feminist organizations and women's rights groups as well as donor agencies and Foundations that channel their attention towards the healthcare of women (Amoakohene, 2014; Lawrence, 2010; GHS Annual Report, 2016).

There is a need for an increase in studies peculiar to the health of females as this may aid developing countries to make policy with its subsequent implementations to enhance and ensure access to proper healthcare since wellbeing are significantly associated with a socio-economic productive life. Most research done in this area focuses on socioeconomic issues on pregnancy, delivery, antenatal and post-natal services (Abor, *et al*., 2011; Abubakari, & Yahaya, 2014; Magadi & Curtis, 2003; Senah, 2003;). Although groups exist to help women, most reports still have women on top of mortality and morbidity. CHPs facilities have been built in these communities to cater for the health-related issues that will arise in these communities.

Nurses have been adequately stationed in these facilities yet reports from the District Health Management Team (DHMT) from 2017- 2019 indicated low patronage of the health facility by these communities. Targets rolled out for the years were not attainable because of the non-utilisation for both preventive and curative health streams especially Antenatal Care (ANC). Therefore, this research tries to find out the sociocultural factors that influence the non-utilization of healthcare services among pregnant women for their general wellbeing in some selected communities in the Suhum Municipal Assembly.

Purpose of the Study

The purpose of this study was to identify the sociocultural factors that influence non-utilization of healthcare services among pregnant women of selected communities in the Suhum Municipal Assembly.

Research Questions

The research questions addressed in this study are as follows:

1. What is the level of healthcare utilisation among pregnant women in the Suhum Municipal Assembly?
1. What sociocultural barriers are more peculiar to pregnant women in the Suhum Municipal Assembly?
2. What are some of the perceived effects of these socio-cultural factors on the health of pregnant women in the Suhum Municipal Assembly?

Significance of the Study

The results of this study would be used in the creation of solutions to socio-cultural challenges and their effects on the health care of pregnant women. Governmental and Non-Governmental Organizations (NGOs) may use the recommendations of this study to make changes to how healthcare is delivered in the rural areas and all parts of the country, this will help achieve the rolled out Sustainable Development Goal 3 which seeks to ensure healthy lives and promote well-being for all at all ages. The study will draw the attention of stakeholders to the fact that some people in some parts of the country still lack access to basic amenities and rights. This study can also provide a priceless guide to health professionals in the district to properly channel healthcare services to women in the community and other deprived areas.

Delimitations

The research was delimited to provide sociocultural circumstances that affect the health-seeking behaviours of pregnant women in the Suhum Municipality

irrespective of their religion and other social background. The research was delimited in scope to only effects of socio-cultural factors on the health of pregnant women in the Suhum Municipality of the Eastern Region of Ghana.

Limitations

The researcher used participants from selected communities in the Suhum Municipality for that matter, results of this study cannot be generalised to populations outside the municipality and the country as a whole. Notwithstanding that populations found outside the municipality and the country at large may have similar characteristics. The researcher used the pregnant women with ages between eighteen (18) and thirty-five (35) years for these reason results of this study cannot specifically be generalized to pregnant women who are below eighteen (18) years old and also those who are more than thirty-five (35) years.

Definition of Terms

Health as is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". (World Health Organization (WHO), 1948).

Culture: is socially accepted behaviour, value systems, beliefs and practical knowledge. This includes traditions, local practices, taboos, religious affiliations, gender roles, marriage and kinship patterns.

Socio-cultural barriers*:* they are man-made constructs originating from social norms and cultural values. They have mainly an adverse impact on information seeking by restricting access to information sources and giving rise to negative emotions.

Utilisation is the process of seeking professional care and submitting oneself to the application of regular services, with the purpose to prevent or treat health problems.

Healthcare services: they are the various services provided by a healthcare professional at a designated and known open space.

Organization of the Study

This research would be organized into five main chapters with each chapter having various sub-sections and headings. Chapter one is the introduction which includes the background of the study, statement of the problem, research questions, significance, scope, and limitation of the study. Chapter two reviews literature related to the topic under study, the literature on the theoretical framework, empirical evidence of related work and gives an overview of the study. Chapter three gives an account of the methodology and how the study would be conducted. Chapter four elaborates on the presentation and analysis of the data collected. Chapter five would provide a summary of findings, conclusions, and given recommendations.

CHAPTER TWO

LITERATURE REVIEW

The purpose of this study was to identify the sociocultural factors that influence non-utilisation of healthcare services among pregnant women of selected communities in the Suhum Municipal Assembly.

The following are sub-headings comprehensively discussed under this chapter;

1. The theoretical framework of the study
2. Conceptual base of the study
3. Health-seeking behaviours
4. Socio-cultural factors and health care
5. Empirical evidence of the relationship between health-seeking behaviours and socio-cultural factors
6. Programs or policies to mitigate socio-cultural barriers against pregnant women.

Theoretical Framework of the Study

Health Belief Model will be adopted for this study. The model was originally introduced by a group of psychologists in the 1950s. The model was introduced to explain and predict health behaviour of people in a given area with focus on the behaviour, practice, and use of health services to help explain why people would or would not use available preventive health care services. The Health Belief Model (HBM) is a theoretical outline used to comprehend people and their reasons for ignoring or choosing not to adopt or follow healthcare recommendations (Stretcher & Rosenstock, 1997). The HBM concept was originally coined from the

fact that health behaviour is widely due to personal beliefs and perception of a given disease (Hochbaum, 1958). This model has four components, explained below:

(i) **Perceived Susceptibility:** Perceived susceptibility refers to the belief an individual holds about the possibility of developing or contracting a disease or a condition. According to the HBM, in any instance where an individual perceives that he/she is prone to developing or contracting an illness, they engage in behaviours that mitigate their risk of developing or contracting that illness (Rosenstock, 1974). For instance, a woman who perceives that she could develop breast cancer, considering that some members of her family have developed the conditi0on in times past will be interested in obtaining a mammogram or regularly screening her breast for possible lumps. On the other hand, individuals who perceive the low risk of developing or contracting an illness are more likely to engage in activities that might be deemed unhealthy or risky.

(ii). **Perceived Seriousness**: Perceived seriousness deals with an individual's assessment of how severe an illness will be as well as subsequent consequences that comes with contracting or developing the illness (Glanz, Rimer, & Viswanath, 2008). The HBM suggests that an individual who perceives an illness as being serious or with consequences will engage in behaviours that reduce his or her risk of developing or contracting the illness. Perception about the gravity of contracting or developing a disease or illness and leaving it untreated encapsulates evaluation of both medical and clinical consequences including death, disability, and pain as well as likely social repercussions such as poor reflection or performance at work, burden on the immediate family for support or care (Glanz *et*

al., 2008). A case scenario can be that a woman might not take general yeast infections medically seriously but upon the thought of the discomfort, ensuing financial drainage and its impact on general lifestyle will prompt her to consider the condition serious.

(iii). **Perceived Benefits:** HBM discusses a person's valuation of the worth or efficacy of adopting health promoting actions to reduce risk or health-related challenges (Janz & Marshall, 1984). Regardless of an individual's perceived susceptibility or seriousness, behavioural change is influenced by the belief that there exist some benefits attached to the various actions meant to reduce the risk of contracting or developing an illness.

For instance, rural women who burn charcoal will cover their noses if they know that doing so will protect them from respiratory diseases. This is because, they are aware of the benefit of good health perceived to be derived from such an action. Furthermore, there are other perceived non-health related benefits, such as pleasing a relative as a result of an action taken to prevent contracting or developing an illness or the financial savings derived from keeping healthy may also influence behavioural decisions in seeking health care. Hence in a nutshell, individuals are not expected to accept any health actions, even if they perceive susceptibility and seriousness (health threat), unless they perceive the action in reducing the threat is beneficial.

(iv). **Perceived Barriers**: This entails the potentially negative obstacles an individual is likely to face from undertaking a recommended health-seeking behaviour. Each time an individual contemplates on undertaking a health-seeking

behaviour, he/she conducts some form of unconscious cost-benefit analysis, where he/she weighs the behaviours expected benefit with perceived barriers. Thus, before any action or behaviour is considered, the perceived benefits should outweigh the perceived barriers. Perceived barriers could take the form of perceived inconveniences, expenses, pain and side effects among others that are faced when undertaking an action.

For instance, the perception that undergoing family planning comes with certain unpleasant effects such as weight gain, irregular menstrual cycles and the inability to conceive when one decides to opt out can serve as a barrier against women opting to undergo family planning. It is noteworthy that "the combined levels of susceptibility and seriousness provide the energy or force to act and the perception of benefit, minus barriers, provide a preferred path of action" (Rosenstok, 1990).

The model helps to provide a reliable framework to investigate health-seeking behaviours. The components of the model are shown as independent predictors of health behaviour (Armitage & Conner, 2007). People adopt health models only when they realize that diseases are serious threats, free or easy access to healthcare, etc. (Becker & Maiman, 1975).

According to (Bandura, 1975), this might not always be the case since perceived severity or threat that the disease pose might have a weak correlation with health action and people might still choose to avoid taking protective health actions. Therefore, the apparent severity of diseases may not be as significant as alleged susceptibility. Correspondingly, in a review by (Harrisson, Mullen, &

Green, 1992) susceptibility and other barriers to healthcare were the strongest predictors of health-seeking behaviour.

However, it is important for people to take action for the desired effect on health-seeking behaviour to occur. The HBM varies widely from other health models such as the Theory of Planned Behaviour (TPB) which indicates there are no strict guidelines on how the different variables combine to predict behaviours. Instead, the HBM suggests and recommends that the individual independent variables are likely to contribute to the prediction of health behaviours (Sheeran & Abraham, 1996). As a fact-finding project, this created and enabled the flexibility that is required to gather proper and accurate data relevant to the achievement of the objectives set out. It also helps in revealing other information that will arise as a result of the interviews.

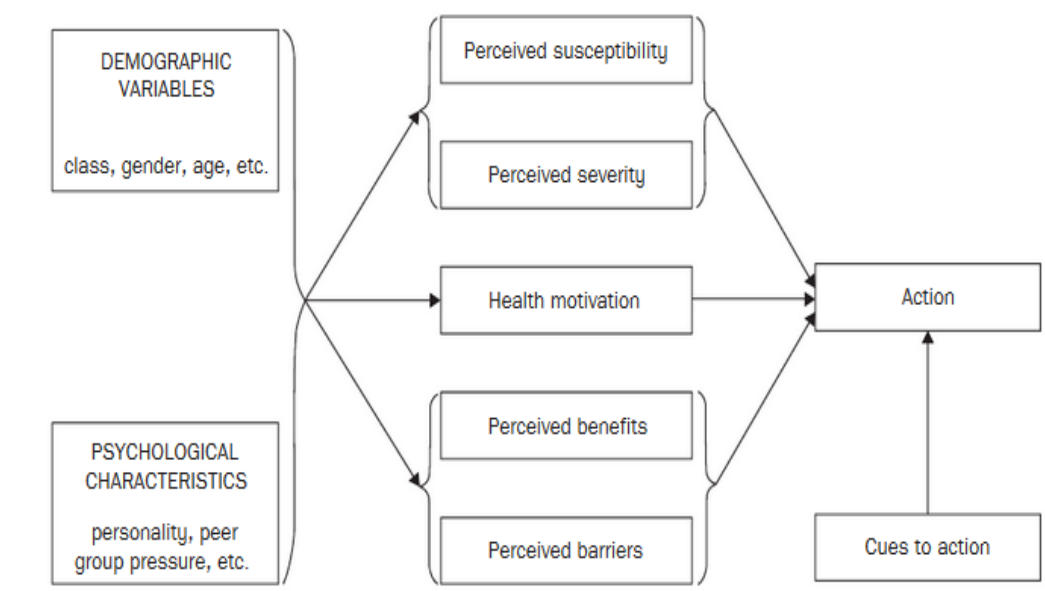


Figure 1: The Health Belief Model (HBM)

Source: (Stretcher & Rosenstock, 1997)

The PEN-3 Cultural Model

The PEN-3 model is a health advancement and illness inhibition conceptual model which was designed in African countries and later adopted for implementation among African Americans in the United States of America (Airhihenbuwa, 1992). It comprises of 3 interconnected and co-dependent dimensions of health belief and behaviours. These include Cultural Appropriateness of Health Behaviour, Health Education, and Educational Diagnosis of Health Behaviour.

It can be observed that, each dimension has three components that form the PEN acronym. The Health Education dimension aids in defining the target audience by looking at their families and neighbourhood.

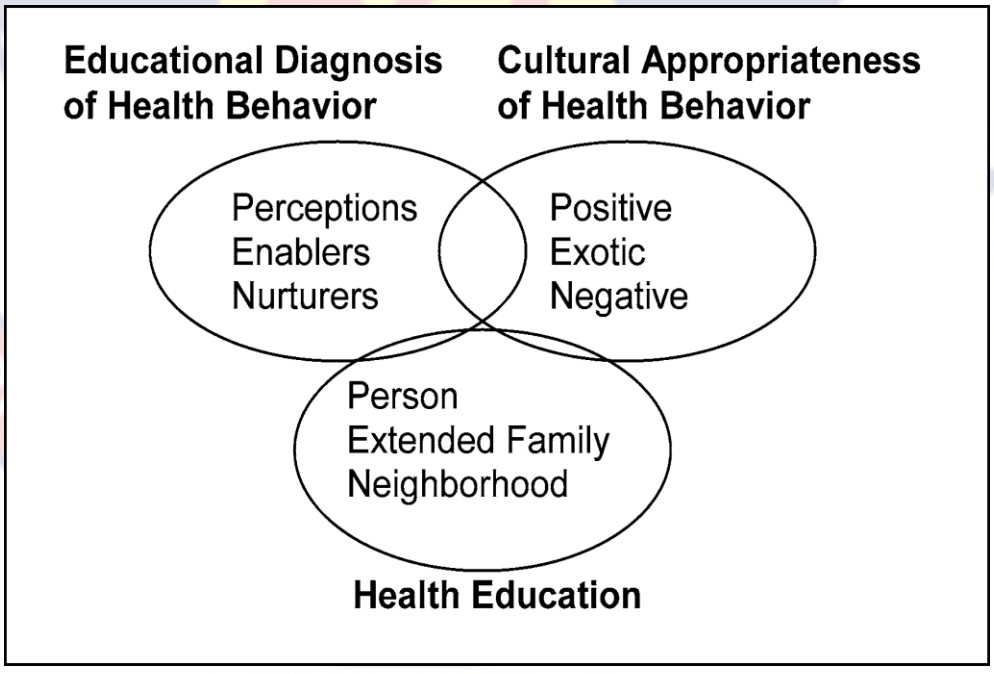


Figure 2: The PEN-3 Model

Source: (Garces, Scarinci, & Harrison, 2006)

The second dimension, Educational Diagnosis of Health Behaviour concentrates on factors such as perceptions, enablers and nurtures that influence the actions of the target audience through interviews, focus groups or surveys. Perception in this context comprise an individual's knowledge, attitude and beliefs that may contribute or serve as an obstacle to the individual engaging in a specific health behaviour. Enablers on the other hand are the structural factors including accessibility, financial strength and type of services available at the disposal of the individual. Nurture is referred to as the motivations received by target audiences from their social networks.

Components of the third dimension are essential in developing customarily delicate intrusions and instruments used in accessing the health behaviour of people in the community. Components under this dimension can be categorized as; "positive", "exotic" or "Negative". Positive components are the insights, enablers and nurturers that influences target groups to get involved in adopting health behaviours. The exotic component comprises practices that do not in any way have harmful health consequences. These practices are not to be altered but rather fused in any intended intervention. Finally, the negative component are the perceptions, enablers and nurturers that influence target audience not to engage in beneficial health behaviours or to engage in harmful behaviours which is not encourage.

Conceptual Base of the Study

This study will be primarily directed by the Health Belief Model (HBM). This model was chosen because it provided a base to understand the failure of people to consider illness prevention strategies or behaviours that will aid in the

early detection and treatment of illnesses. Furthermore, the HBM provides an outlook on patient's response to symptoms and their compliance with medical treatments. These two catapult the researcher into understanding the health-seeking behaviour of women in Suhum Municipality. According to the HBM, personal beliefs in the risk of a disease with the perception of the effectiveness of recommended health behaviour will predict the likelihood of that individual adopting the behaviour.

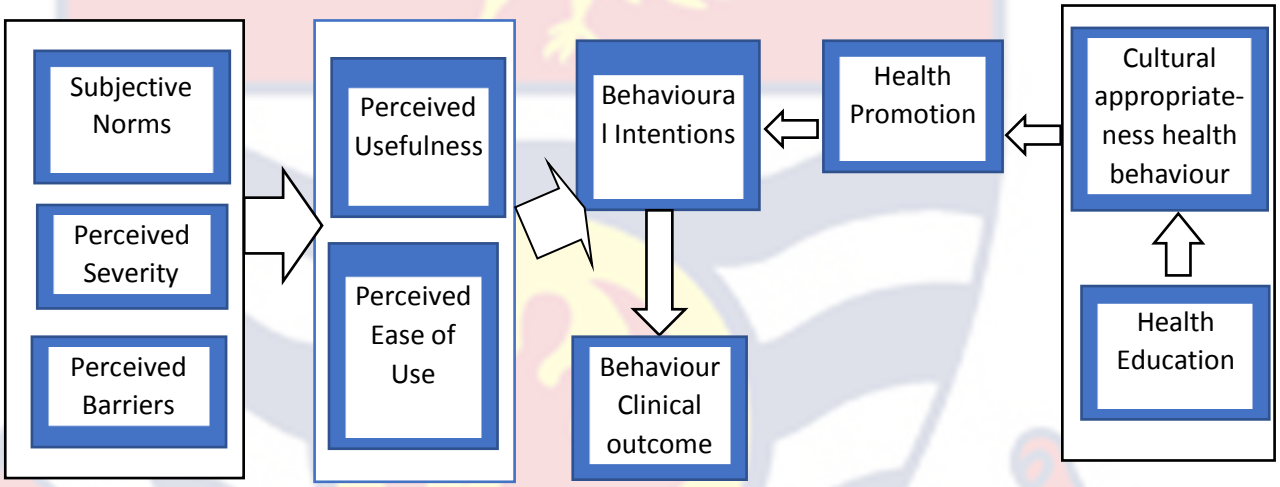


Fig. 3: Conceptual base of the study

Source: (Researcher, 2019)

In addition, the adoption of the PEN-3 model provided an insight into the inter-relatedness and inter-dependence of health beliefs and behaviours. In other words, understanding the socio-cultural values of a society will provide an insight into their beliefs which in turn could be used to understand their health-seeking behaviour. Fig. 2.3 outlines the model on which this study is based.

Health-seeking Behaviours

The health care systems in most developing countries are bedevilled with a myriad of challenges including high maternal mortality rate and increasing

mortality rate among children though substantial progress have been made in militating the adverse effects of poor health care systems vis-à-vis poor infrastructure, shortage of beds and equipment among others. Also, government with the help of Non-Governmental Organisations and civil society groups has made efforts to resolve these challenges.

Thus, it is prudent that health care professionals and major stakeholders in the health sector understand the attributes of health-seeking behaviour which will guide policy formulations, theory development, practice and research (Cornally & McCarthy, 2011).

Health-seeking behaviour can be described as an activity adopted by people who believe to have a health problem or to be sick to find a suitable remedy. In most instances, a precondition of most health-seeking behaviour is the recognition of the symptoms of an illness, that is, the way an individual and those around him or her interprets the meaning of symptoms observed, the attribution of cause, and the belief they hold about suitable and effective treatments. Good health, is no doubt, a basic human right in all facets. However, there exist huge barriers, mostly in developing countries, that impede access to good health including; cultural norm, long distances to health facilities, poor road networks among others.

Furthermore, financial challenges and poor healthcare systems have been found by researchers to be a contributory factor to lower acceptance of optimal treatment patterns observed in developing countries (Dillip, Alba, Mshana, Hetzel, & Lengeler, 2012). Earlier studies have also established features such as the low status of women and social opinions (Mwangome, Prentice, Plugge, & Nweneka,

2010). Research outcomes have linked inappropriate health-seeking behaviours to worse health outcomes, increased mortality and morbidity and poor health statistics (Mwase, 2015).

However, the effects of inappropriate health-seeking behaviours are skewed among different members of a population. For instance, (Rehman, Shaikh, & Romis, 2014) found that households with lower incomes seek less formal medical care for their ailments as compared to those whose income was above the minimum wage. A study in Nigeria showed that as much as 71% of rural residents have reported inappropriate health-seeking behaviours during their last bout of illness while only 53% of urban residents reported inappropriate health-seeking behaviours during their last illness (Onwujekwe, Oneka, Uzochukwu, & Hanson, 2011).

Similarly, a study found that Nigeria women dwelling in high health seeking locations (exceeding 9000:1) were less likely to have an expert birth attendant present during childbirth than lower health-seeking zones (less than 6000:1) (Ononokpono & Odimegwu, 2014). The findings of the two studies point to an underlining disparity and show how skewed the health-seeking behaviours among classes of society are. The poor in society are more probable to adopt inappropriate health-seeking behaviours as likened to the part of the populations that fall in the middle class or wealthy.

Oberoi, Neha, Siriesha and Singh (2016) further found in their study that the educational orientation (literate or illiterate) also influences the health-seeking behaviour of families. (Thompson, Anisimowicz, Miedema, Hogg, Wodchis, &

Aubrey-Bassier, 2016) found in their study that there exist gender differences in health-seeking behaviours, with women reporting they have visited their primary care provider to a greater extent men did for both physical and mental health concerns.

In most developing countries, women are the marginalized in society hence they are prejudiced by cultural and social factors (Ahmadi, Farzadi, & Alimohammadian, 2012). The social gender structure controls the views, attitudes, behaviour and roles defined for both men and women. Consequently, the role women play in the family setting cannot be over-emphasized, often called 'home-keepers'. The pivotal roles they play in raising children imply their health-seeking behaviour are vital in keeping the family healthy and safe. Oberoi et al. (2016) asserts that the female is matriculating and better placed than an illiterate husband, especially in decision making. It is noteworthy that health care decision is often based on their perception and belief in a particular health system (Sarfo, Acquaye, & Sarfo, 2016). Thus, a woman's healthcare-seeking behaviour primarily lies on her; what she perceives and believes is best for herself and her family.

Socio-Cultural Factors and Health Care

Every individual finds him or herself living in a society and is largely influenced by the cultures of that society. People tend to give in to the norms and beliefs in their society and have their lives shaped by these. Thus, social and cultural values play important roles in influencing the lifestyle of individuals including the decisions they make. Socio-cultural influences affect thoughts, feelings and

behaviors. Some of these factors include attitudes, discrimination, ethnic values, religious beliefs and practices, rituals, reputation and taboos.

To be able to comprehensively understand health care utilization patterns in a society, one has to understand the 'culture', a structured way of life that has special meaning to the individuals in the society. (Apsolone & Sumilo, 2012) adopts the definition of culture as "the collective programming of the mind, distinguishing of one group or category of people from the other".

Understanding the culture of people provides a projection as to whether the individuals in the society will utilize or avoid available health care services. For instance, in societies where there is a perception that illnesses are a form of punishment from the gods, inhabitants are less likely to seek biomedical care since they perceive most diseases are unrelated to biomedical causes Dillip et al. (2012). The way and manner people co-habitat largely depend on the culture in the world around them which is transmitted from generation to generation through socialization.

This points the vital role socio-cultural factors play in determining health-seeking behaviors. (Lowe, Chen, & Huang, 2016) found that women residing in rural Gambia never enjoyed any privileges during pregnancy. Rather, they were subjected to the same work routines they endured outside pregnancy including carrying heavy loads with limited opportunities for sick leave and almost non-existent resources to access prenatal care. Any attempt to deviate from this norm will depict truancy or weakness. (Ogundairo & Jegede, 2016), asserted that women in rural areas are known for high pain tolerance.

In the end, the ultimate decision to seek medical attention concerning any member of the family lies with the father (Abubakar, Van Baar, Fischer, Bomu, Gona, & Newton, 2013). In their study, (Azuh, Fayomi, & Ajayi, 2015) of sociocultural factors on gender role in women health care utilization in Nigeria buttresses that the husband's perception of pregnancy complication, age at marriage and family type is the mechanism towards the use of maternal health services.

It implies that men had the mandate to dictate the health-seeking behaviors of their spouses based on their subjective judgment or understanding of the situation at hand. Even the dynamics of the relationship that exist between couples, women have less control in the family and ultimately, relationship (Namasivayam, Osuorah, Syed, & Antai, 2012). Relative to this, it has been found that women with high degree of autonomy were more likely to seek maternal health care services than their counterparts who lacked such level of autonomy (Afful-Mansah, Amponsah, & Boakye-Yiadom, 2014). Lowe, Chen, & Huang (2016) identified some reasons that have necessitated women continuously working till the day of delivery.

According to the authors, it is a common practice that is accepted by both men and women without question. Secondly, women generally do not have cash incomes hence need to work daily. Thirdly, they point to the absence of a mechanism of work sharing within the household, either between husbands and wives or among co-wives in polygamous homes. Most women depend financially on their husbands. Women in rural areas take up the responsibility of paying for their health care.

Empirical evidence of the relationship between Socio-cultural Factors and Health-seeking Behaviors

Researchers over the years have explored avenues to expand access and utilization of health care systems in all parts of the world. Among the main barriers to achieving universal access and utilization of health care systems are socio-cultural barriers. Research works have emphasized on the patronage of health services considering socio-cultural factors in developing countries (Mrisho, et al., 2009). People's perception and belief in a particular health care system greatly influence their patronage of that particular health care system Sarfo et al. (2016). They found that both the modern hospitals and the services of the TBAs are very important predictors of health seeking behaviours.

People tend to trust a system they have developed trust in and can point to evidence of its efficacy. In rural areas, socio-cultural beliefs have allowed inhabitants to self-diagnose illnesses base on observable symptoms and thus recommend suitable avenues to seek treatment. Diagnoses made could lead patients to consult traditional health practitioners or spiritualist regardless of the appropriateness of the treatment method.

The World Health Organization (WHO) estimates that 60% to 80% of the population in developing countries relies on traditional health care for their basic health care needs, either on its own or in combination with orthodox medications (WHO, 2019). Seeking traditional health care forms a core part of the culture of rural dwellers and is in fact their first point of call when they perceive illness. They mostly opt for orthodox treatment when their illnesses are advanced. Though

medical products produced by traditional medical practitioners may contain several different plants and potentially hundreds of chemical constituents, some may come in very low or high concentrations which may be harmful to consumers (Chen, Tsai, & Lee, 2009). Furthermore, concerns have been on the dosage of many traditional products. This notwithstanding, Sarfo, Acquaye and Sarfo (2016) revealed that the efficacy of traditional health system treatments was a significant predictor of health-seeking behaviours. They thus recommend the provision of a more balanced and "culturally congruent" health service that tend to serve the needs of patients.

In their study, Darko-Gyeke, Aikins, Ayeetey, McCough, & Adongo, 2013 assessed the influence of socio-cultural interpretations of pregnancy threats on health-seeking behaviours among pregnant women in urban Accra, Accra. The study employed a focus group qualitative study comprising mothers who had delivered within the past 12 month of the study, pregnant women, religious and community leaders, community members as well as orthodox and non-orthodox health care providers. Results from the study showed evidence of apparent health risks, which often was given socio-cultural interpretations, and amplified anxieties which drove women to find more health treatments. The healthcare-seeking behaviour of pregnant women indicated a simultaneous use of hospitals or clinics and other forms of care such as herbalist, traditional birth attendants and spiritual care. This attitude the study found interrupted the continuous use of skilled care.

There was evidence from the study that health seeking behaviour of pregnant women was largely intermediated by the socio-cultural influence that shape individual perceptions of threat to pregnancy. Threats felt during pregnancies

emanated from socio-cultural beliefs about disclosure, sorcery and witchcraft. Findings from the study points to the disruptive role socio-cultural practices had on pregnant women seeking health care. Findings of Islary, 2014 who assessed the health and health-seeking behaviour among tribal communities in India, corroborated those of Darko Gyekye et al. (2013)

The study found that the health-seeking behaviours among tribal communities in India were influenced by socio-cultural factors where they live. The study also found inhabitants shifting between health care systems or utilizing more than one health care system at the same time. The study notes that though tribal communities seem to be taking a turn towards modern systems of medicine, they still had trust in their traditional medicinal systems. Their health-seeking behaviours was closely related to their conceptualization of diseases and health.

Warren, 2010 in her study, care-seeking for maternal health: challenges remain for poor women, found that pregnant women were influenced by their attendants and only seek appropriate health care services for complications if local or herbal remedies and prayer failed. However, the recognition of the cause and severity of the complications influenced subsequent health-seeking behaviours. The study highlights the religious foundation of all the communities considered under the study where all religious sects, Christians and Muslims inclusive, attribute complications and its consequences to the will of God. From the study, it can be deduced that pregnant women were well aware of the risk involved in seeking heath care outside health facilities and recognized that health providers

were experienced and qualified with the ability to handle complications should it occur.

They, however, pointed to factors such as the unavailability of money to pay for proper health care, which is mainly the responsibility of their husbands, and convenience as the reasons for their preference of non-conventional health care. If complications do not occur, they see no reason to consult a trained health practitioner. Even the decision to seek proper medical care in the instance of a complication lie on the husband whose decision making, the study found, was influenced by the identity, knowledge, educational level and financial resources of the man.

Ojua, Ishor and Ndom (2013) strongly linked health-seeking behaviours and socio-cultural implications by outlining various conditions that influence how women in the rural areas seek healthcare. The authors found that religious beliefs provided at avenue for rural dwellers to provide an underpinning explanation for any serious illness as the anger of ancestral spirit. Ancestors are a core part of African Traditional belief and it is believed that provoking them attracts calamity of which illnesses and natural disaster are consequences. Thus, appeasing the ancestors was a sure way to treat perceived illnesses. To the African traditionalist, there is a perfect harmony between a man and his environment where health exists (Abia, 2012). Thus, the perception is that people do not fall ill just by chance, with the primary cause of serious illnesses attributed to spiritual causes. Viral, bacterial, fungal or parasitic causing illnesses are considered secondary causes.

Furthermore, traditional African medications have been with inhabitants for generations and are easily accessible and relatively cheap as compared to orthodox medicines. Hence, for most rural dwellers, traditional medicines are their first-choice medication and it is only when they do not provide relieve that they turn to orthodox medicines. Ojua *et al*. (2013) stated that herbalists' treatment includes divination, confessions, portions and other medicines in African traditional medicine practice for treatment. In as much as considerable positive results have been attained from these practices, there are also issues of complications, standardization and efficacy. Consistently, traditional medicines are portrayed as having the efficacy to treat multiple illnesses and since almost every illness is interpreted as spiritual that need traditional healing, patronage of traditional medicine is high among rural dwellers.

Many rural dwellers do not believe orthodox medicine is effective for the treatment of chronic illnesses such as diabetes, asthma, hypertension and epilepsy among others (Obot, 2010). Thus, when they envision that treatment at a health facility will not bring the desired results, they opt to go home for traditional treatment (Omotosho, 2010). There is clear evidence from the literature reviewed that the socio-cultural practices of a community influence their health-seeking behaviour of inhabitants of the community.

Programs or Policies to Mitigate Sociocultural Barriers against Women

The acceptance of reproductive, maternal and neonatal health service in rural areas is particularly poor mainly due to socio-cultural barriers. These practices have a tendency of creating complications during pregnancy and delivery which

may result in death. The Ghana 2017 Maternal Health Survey conducted by the Ghana Health Service in conjunction with the Ghana Statistical Service reveal that the Maternal Mortality Ratio (MMR) for Ghana is 310 deaths per 100,000 live births for the seven-year period before the survey.

The Pregnancy- Related Mortality Ratio (PRMR) also stood at 343 deaths per 100,000 live births for the seven-year period before the study. The survey found that two-thirds of maternal deaths were direct maternal deaths. Direct maternal deaths are deaths resulting from obstetric complications during pregnancy, labour or 42 days after delivery or end of pregnancy. The survey further showed that the lowest health facility deliveries of 59% was recorded in the northern region of Ghana with highest of 92% recorded in the Greater Accra Region.

Though 79% of live births or stillbirths were reported to be delivered in health facilities and a decline of home deliveries from 40% in 2007 to 20%, more needs to be done especially in rural areas to improve health-seeking behaviours of women. (Wester, *et al*. 2018) outlined a number of best practices that addresses socio-cultural barriers against women including; strengthening the traditional governance structure, the formation of volunteer groups and committee to monitor cases of complications and educate women on best practices, create constructive engagements with Traditional Birth Attendants (TBA), promoting male involvement in reproductive, maternal and neonatal health, engaging leaders and influential figures in improving health-seeking behaviours among women, promoting family planning and deploying mobile health teams and clinics.

CHAPTER THREE

RESEARCH METHODS

The purpose of this study was to identify the sociocultural factors that influence non-utilisation of healthcare services among pregnant women of selected communities in the Suhum Municipal Assembly.

This chapter is made-up of

1. Research design
2. Study area
3. Study population
4. Sample size
5. Sampling procedure
6. Data collection instrument
7. Data Processing and analysis

Research Design

Research design is a general strategy of the procedures used to collect and analyse data during a given study. Hair, Black, Babin, Anderson and Thatham (2008) indicates it has been presented and proves very essential for researchers and scholars to structure their designs based on the objectives of the research or the research questions. This study will be steered qualitatively. The research problem was formulated from existing theories as well as the practice-based problem to explore the sociocultural factors that influence non-utilization of healthcare services among women in the Suhum municipality.

A phenomenological design was adopted in this study as an approach to qualitative research that focuses on the commonality of a lived experience or practices within a particular group of people. The fundamental goal was to arrive at a description of the nature of the phenomenon involved (Creswell, 2013). The focus was on answering 'what is it' rather than how much frequency because this study aimed to identify the sociocultural barriers that influences non-utilisation of healthcare (Polkinghorne, 1989). Its main aim was to seek reality from individuals' narratives of their experiences and feelings, and to produce in-depth descriptions of the experience and therefore be used to unearth the fundamental sociocultural variables that influence non-utilization of healthcare services among pregnant women in the Suhum municipality, Ghana.

This design can be difficult to analyse sometimes and very time consuming but on the other hand, it helps to appreciate people's meanings and also help to fine-tune to new ideas and issues as they arise, it also helps to contribute to the development of some new theories, data gathered using this method is seen as natural rather than artificial Easterby-Smith, Thorpe, & Jackson, 2008).

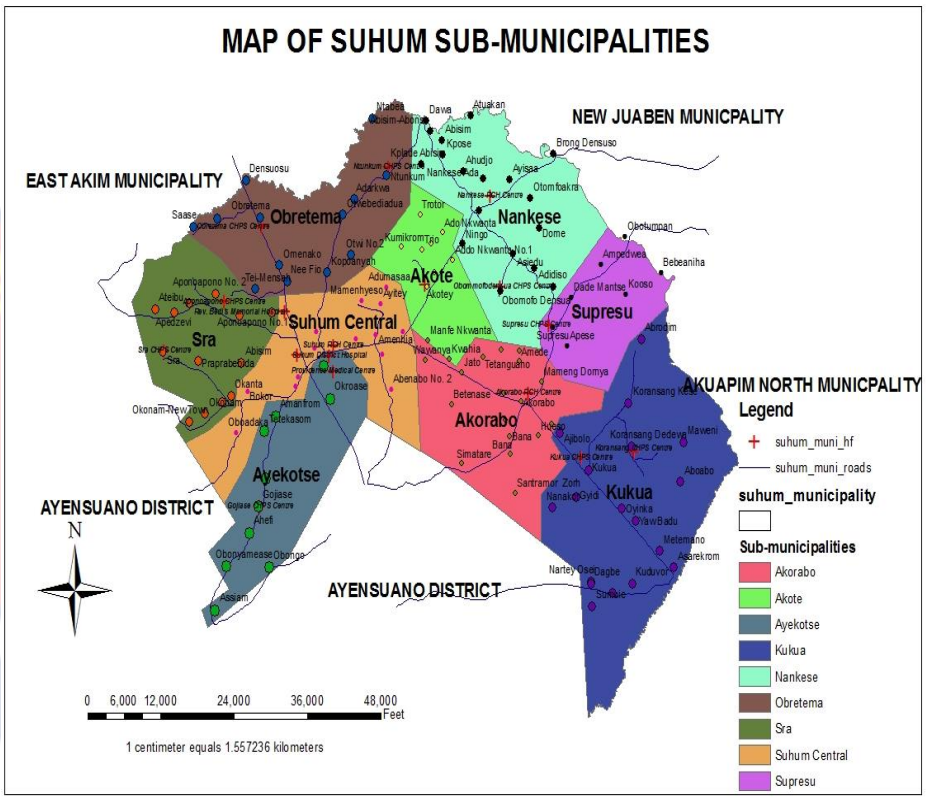
Study Area

The study focused on two main communities under Nankese. Nankese is a sub municipal under the Suhum Municipality where attendance for healthcare utilization has been very low although a lot of measures have been put in place. These two communities are Dawa and Asore-ase. Dawa is a farming community and estimate for Women in Fertility Age (WIFA) is 841 and it also has expected pregnancies to be 140 (SMHD, Population Distribution budget, 2019).

Out of the expected pregnancies less than 50% attendance was recorded for the community (MHA Annual Report 2019). The second community that will be considered in this study is Asore-ase. As the name depicts this is a community where a prayer camp has been established and hence turns into a small community for people to be closer to their object of worship. Estimate for WIFA is 75 and has expected pregnancies to be 22 (SMHD, Population Distribution budget, 2019). The main occupation of the inhabitants in these communities are farming and trading. The study respondents will therefore be drawn from the study area.

The Municipality shares boundaries with East Akim to the North, Ayensuano to west and south, Akwapim North municipality to the East and New Juaben Municipality to the North East. Its capital, Suhum Town, is only sixty (60) kilometres northwest of Accra on the busy Accra-Kumasi-Tamale-Ouagadougou Highway. It has 9 sub municipal's which are all highlighted in the map below.

Health care in the Municipality is provided by both the public and private sectors. Although there are thirty-three (33) facilities (public and private), the distribution of the facilities is skewed geographically (MHA Annual Report 2019)



Population

According to the programme-based budget estimates for 2019, the municipality has a population of 113,080 made up of 55,070 males and 58,010 females. The locational distribution into rural and urban classification shows that, 57.2% (51,610) of the municipality's population reside in rural areas or villages with the remainder (42.8%) residing in the urban areas or towns of the municipality.

The largest settlements in the Municipality are as follows: Suhum, Nankese, Akorabo, Okorase, Brong Densuso, Obretema, Omenako, Adarkwa, Okanta, Abenabo No 2, Kofigya, Ayisaa, Akote, Aponoapono, Amanhia, Supresu, Otwebediadua and Densuso. According to the Population Distribution Budget for 2019, Dawa has a population of 3348 and Asore-ase has a population of 280 in the

community. The main occupation of the inhabitants in these communities are farming and trading. The study respondents will therefore be drawn from this total population at the time of study. WIFA will be used due to their characteristics during this age brackets. (SMHD, Population Distribution budget, 2019).

Sample size

In total, fourty (40) respondents were selected from the communities together with 14 informants from the hospitals and key members in the community were also considered in this category. The study took the form of an individual interview for both women and key informants. The Key Informant Interviews in each community comprised of nurses or healthcare providers in the communities, traditional birth attendant, herbal practitioners and the queen mothers of the community. In total, 14 informants were used in this category. The study therefore had a total of 54 respondents in all.

Sampling Procedure

The study used a purposive and accidental sampling to select all respondents in each community. Hair *et al.* (2008) defines Accidental sampling as a form of non-probability sampling that includes selecting a population sample that is close at hand, rather than vigilantly firm and obtained whereas purposive sampling is used for the identification and selection of information-rich cases for the most effective use of limited resources (Patton, 2002). This sampling was used to select the respondents on the basis of their availability and willingness to take part in the study.

The respondents were both women who use healthcare facilities and those who do not use the healthcare facilities. Accidental sampling was used because it expedites data collection and also cost effective. Since most convenience sampling is collected with the population at hand, the data is readily available for the researcher to collect it is just simply pulling from whatever environment that is nearby. It, therefore, helps in meeting timelines quickly (Wright & Sim, 2002). It can be biased but the researcher tried to eliminate that to make the research data reflect the information given by the community by selecting participants strictly per the research goals. This is a judgmental selection of respondents founded on the evaluation of the relevance of their roles, or knowledge on the research topic (Wright *et al*. 2002).

The importance of qualitative research is not always on generalization hence randomization might not be a necessary prerequisite. However, accidental sampling was used because the researcher wanted to assure fairness by using a fair and transparent sampling procedure, which ensured that every pregnant woman in the study communities had a fair chance of taking part in the research. Indeed, the idea of chance, which is embedded in the sampling procedure helps to eradicate questions about why one woman is included and another excluded from the study. In total, forty (40) respondents were selected in this category.

Any woman met in the community and falls within the WIFA bracket and pregnant was selected and invited to participate in the study. Where any of the selected women was not available or declined to participate in the study on the agreed date, repetition of the selection process was done to get a replacement. The

study took the form of an individual interview for both women and key informants. The study therefore has a total of 54 respondents in all.

Data Collection Instruments

In this current study, primary data are collected. The study however, employs an interview guide to obtain primary data. Creating the interview guide helps interview research in some ways. An interview guide is simply a list of the high-level topics that you plan on covering in the interview with the high-level questions that you want to answer under each topic (Bird, 2016).

Concerning the interview guide, the researcher used a semi-structured type of interview guide. Semi-structured interviews are the most commonly used data-collection technique in phenomenological studies. The interview guide was structured into four (4) main parts with each section labelled as: Demographics of respondents, sociocultural barriers peculiar to women in the Suhum municipality, sociocultural barriers that influence healthcare utilisation of women in the Suhum municipality and lastly, the effect of these factors on the health of women in the Suhum municipality.

The interview guide for Key Informants was also structured into three (3) main parts with each section labelled as: Demographics of respondents, sociocultural barriers peculiar to women in the Suhum municipality and lastly, the effect of these factors on the health of women in the Suhum municipality. Unlike the respondents' section, the Key Informants section allowed them to talk more about the experiences they encounter as health professionals and non-health professionals (traditional rulers).

The researcher therefore employed member –checking measures to pursue intent opinion as to how questions could be made easier to understand, avoid bias or leading question and ambiguity. This is more related to the study's overall reliability (Whitehead, 2014). On the other hand, validity is the extent to which a test, scale or instrument measure what is intended to measure or assess (Ofori & Dampson, 2011). The researcher checked for correct spelling and grammatical mistakes, checking for wording to eliminate ambiguities are series of activities done to enhance the validity of the data as well. The answered/filled instrument was further given to the researcher's supervisors for proof reading and helps eliminate blurred wording and errors that might be in it.

Data Collection Procedure

The data collection for the entire study took six weeks. There was a team which comprised of the researcher, an assistant and an interpreter to do the data collection. Approval was sought from the Institutional Review Board (IRB) with reference ID (UCCIRB/CES/2021/74) which was later sent to the Regional Health Directorate and also the Municipal Health Directorate then discussions were done with the stationed health professionals who was to help the research team. Community entry was done to involve the leaders of the community to make the interaction very smooth before participants were informed of the intended study. Selection of respondents was done afterwards and women who agreed to be part of the study were interviewed on the scheduled date. Any possible difficulty or problem will be reported at the end of the collection.

Data Processing and Analysis

To save time and resources, the oral interviews were recorded with the consent of the informants. Transcription was done verbatim to reflect the answers of the participants. Tape recorded interviews were listened for numerous times for transcription and comprehensive description of explanations and notes written out to reflect the interviews. To ensure familiarisation with data, transcripts were read several times and compared with research notes occasionally.

Repetitive words and expressions were distinguished and coded; these codes were grouped into similar categories while bearing in mind the other factors noted in the researchers notes that may have affected the responses. Words and sentences were sorted by similarities and similar coded data grouped into categories that reflect the similarity of information and finally grouped into themes and non-thematic items that were identified.

Analysis of qualitative research involves reviewing, synthesizing and interpreting data in order to describe and explain a phenomenon (Fossey, Harvey, McDermott & Davidson, 2012). Collected data were analysed using the thematic analysis method. The data analysis involved the breakdown of data to allow classifications, creation of concepts and making connections between the concepts and classifications provided the basis for fresh descriptions (Dey, 2005). The main stages of the thematic analysis included reading, re-reading, development of themes/patterns, coding of data, analysis/illustration of themes and relationship and finally summarizing themes (Niel, 2011).

Ethical Considerations

For discretion purposes, sensitive information including names of the respondents, health status of the respondent and other personal information on respondents were kept secret to avoid possible victimisation. The respondents were adequately informed that their involvement in the study comes with no reward or penalty, hence it is just voluntary, and that they could retire at any point if they so desire in the process**.**

Chapter Summary

This research is qualitative research which was conducted on women in the Suhum Municipal Assembly on their low utilisation of health facilities in respect to their cultural systems and settings. The research will comprise health care users, non-health care users, women who make vital decisions in the family and the community for their fellow women and healthcare personnel. Accidental sampling was used for sampling the population. Analyses will be done using the thematic analysis method.

CHAPTER FOUR

RESULTS AND DISCUSSION

The purpose of this study was to identify the sociocultural factors that influence non-utilisation of healthcare services among pregnant women of selected communities in the Suhum Municipal Assembly. It adopts a qualitative approach based on the commonality of a lived experience or practices within the people of Nankese in the Suhum Municipality. Two communities in the municipality were used. A total of 40 pregnant women and 14 key informants comprising health workers, traditional birth attendants, and herbalists were interviewed during the study. The chapter presents the results and discussions of responses received from participants of the study.

Research Question 1: What is the level of Healthcare Utilisation among Women in the Suhum Municipal Assembly?

The question aimed at finding out the level of Healthcare Utilisation among Women of selected communities in the Suhum Municipal Assembly by assessing the frequency of visits by the participants at the hospital. The analysis this research question was done using frequencies and percentages. The intention is to give a clearer and a better understanding of how the level of healthcare utilization is although expressing the answers in 'often', 'not often' and 'never'. The image below provides a summary of data collected from the respondents. The graph below shows the frequency at which the respondents go to the hospital for treatment. 2 respondents representing 5% indicated they have never been to the hospital. The majority representing 80% indicated they do not often go to the hospital for

treatment. 6 respondents representing 15% indicated they often go to the hospital for healthcare services.

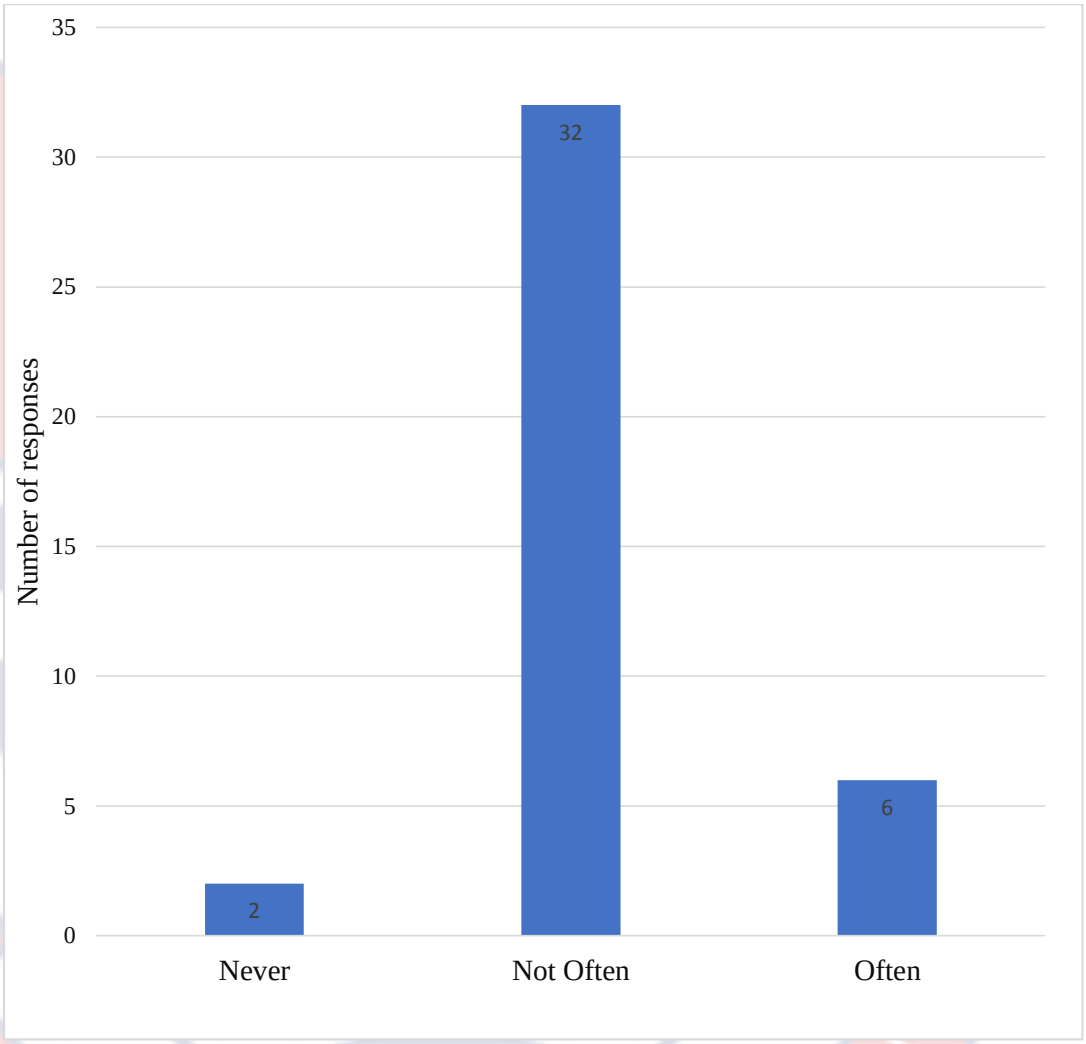


***Figure 4*: Level of healthcare utilisation**

The participants were probed further to know the last time they visited the hospital. The chart below shows the last time a respondent visited the hospital for treatment. The majority of respondents visited the hospital over a year ago for treatment.

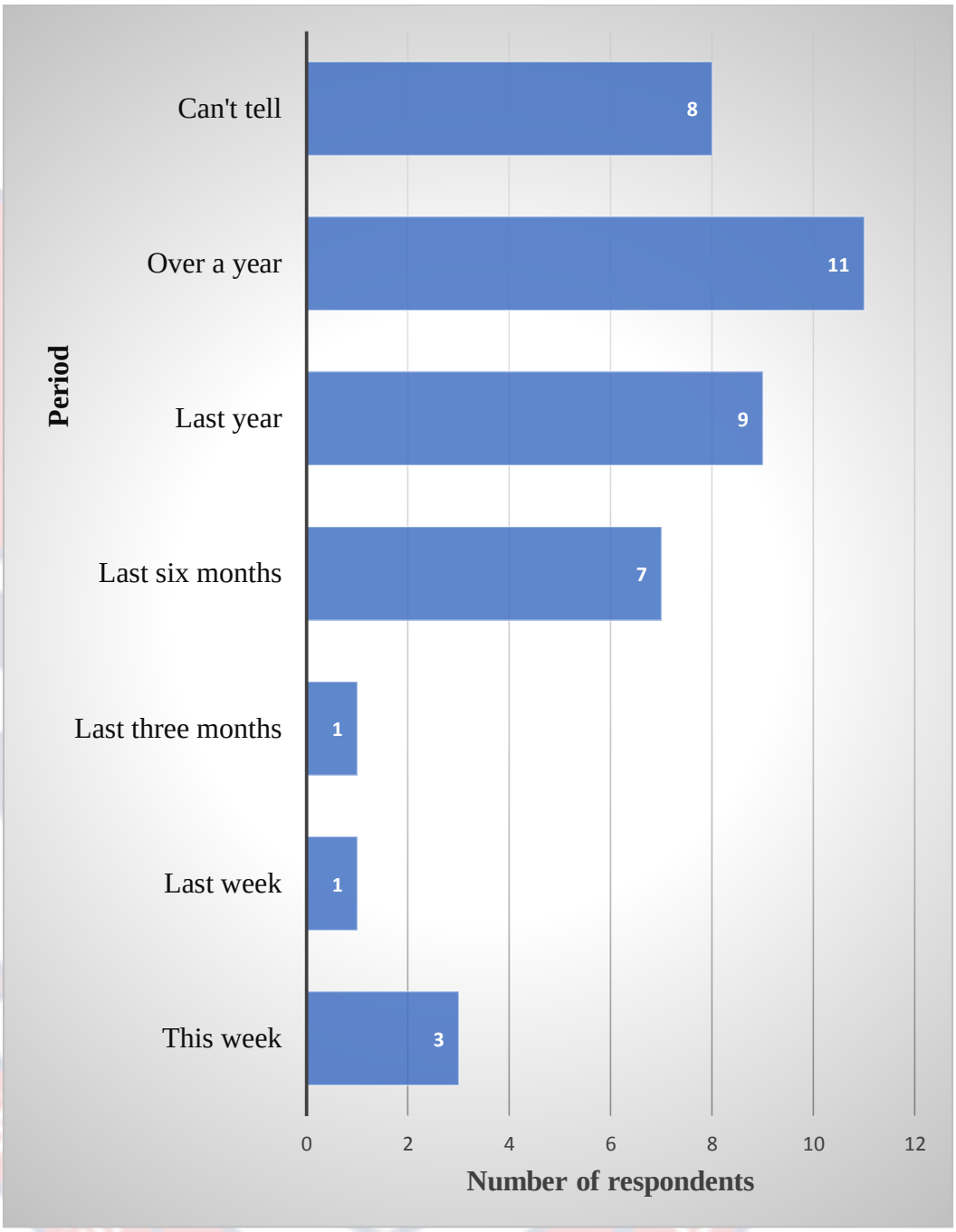


Figure 5: Frequency of hospital attendance

Research Question 2: What sociocultural barriers are more peculiar to pregnant women in the Suhum Municipal Assembly?

This research question sought to find out the reasons why or what prevents pregnant women in the selected communities from accessing health facilities. The questions under this section were therefore grouped into themes. The thematic grouping of the various aspects which formed the responses was then analysed using frequencies and percentages. Most of the pregnant women were able to share their reasons for not visiting the health facility, only a few felt reluctant to share their thought on this subject. During the analysis, five themes came up: "Family denial", "Husband denial", "Lack of money", "Other personal reasons" and "Cultural settings"

Family denial

The majority of respondents (14 out of 40) representing 41% of the total participants did not visit hospitals because of family denials. Some pregnant women were confident that they will not be supported even if they make their minds to visit the health centre because of some norms and beliefs that their families follow. This is evident in their statements and these quotes represent such information.

> *"My family influences everything we do; they will even deny you of the hospital idea"* (R 8)
>
> *"I won't go to the hospital, even if I'm dying. My family will not even take you there so don't worry yourself asking me hospital questions"* (R 9).
>
> *"My family will tell you to go or not go to the hospital."* (R 7)

Husband denial

Another reason why pregnant women could not visit the health centre is that in a typical traditional setting the voice of the man is the final decision taken for the family. With such women, the husband has to be the final say in hospital utilisation, in instances where the husband does not support orthodox medicine or healthcare, the woman can't do otherwise.

This is evident in these quotes from interviewing some pregnant women.

> *"it's my partner who makes that decision and I should respect it"* (R 11)
>
> *"I don't know ooh. my husband has not talked about the hospital before and I am not the one to go and raise that topic. I don't even have a card to go there."* (R 26)
>
> *"The last time I told my husband to let me go to the hospital, he told me if I want to disobey him, I should pack my things and go to my parents' house."* (R 30)

Lack of money or Financial Constraints

Some respondents saw accessing healthcare to be expensive and about access to the National Health Insurance Scheme (NHIS), the ability to buy clinical medicines, and the proximity of the hospital to respondents (cost of transportation). Some of the pregnant women had issues of lack of funds to see them through the modern healthcare system. These are how two pregnant women expressed this barrier.

"I don't have money to go to hospital and I have not done National Health Insurance Scheme (NHIS)." (R 2)

"The money I take from my husband is to cook and help take care of the home so I don't have money to pay for the cost of services that will be given at the hospital." (R 39)

Cultural settings

The form of medicine that was known to Ghanaians before orthodox medicine was herbs. In recent healthcare provisions, herbal drugs and trained professional herbal healthcare givers are infused into our healthcare system to help patients with herbal preferences. This is no different from rural settings, some people have not yet accepted orthodox medicine and will still practice the use of herbs for all health conditions. Pregnant women who find themselves in this setting are no exception and use different herbs prescribed by either herbalists or elderly women in their families. Services of herbal or traditionalists are also sought with every health condition. One participant expressed herself with his quote.

"*In my family, we have a lot of "adunsifuo" (traditional healers) so I can't go outside to seek healthcare somewhere else."* (R 35)

Other personal reasons

Some participants were reluctant to give their reasons for not going to health centres. This is evident in the quotes below

"*I just prefer a home solution for personal reasons*." (R 23)

Others on the other hand had personal experiences that have made them choose the traditional setting over the foreign/modern setting. Below in these quotes are how some pregnant women expressed themselves.

> "*I don't suffer to get home medicine. The herbalist I go brings me the medicine himself, but when you go to the hospital you will go around to go and buy the medicine (laughs at the end).*" (R 3)
>
> "*When you go to the TBA and go to the hospital and see the two, you will never go to the hospital again. TBA's gives more attention and they are experienced.*" (R13)
>
> *"Oh! We came to meet the home delivery and remedy but I have not challenged or asked why because the results are clear*." (R 22).

The way people or respondents think and feel about their health and healthcare problems affect how and from whom they seek medical health care. Also getting information and level of acceptance depends on individual perspectives. The quality of healthcare services provided by the hospitals and TBA affect the degree to which respondents patronize them.

Table 1: Barriers to Healthcare in the Suhum Municipality

Theme	Frequency	%
Family denial	14	41
Husband denial	10	29
Other reasons	7	21
Lack of money	2	6
Cultural settings	1	3
Total	**34**	**100**

Source: Field Survey (2021)

Improving quality and performance in the healthcare environment can help providers with dependable, cost-effective, and continuous healthcare processes and enable them to achieve their goal of improving care delivery and enhancing patient outcomes. In this same community, some women gave positive feedback during the interview. The table below explains with their quotes some women who access healthcare at the health centre.

Table 2: Positive Feedback on Healthcare Utilisation

Theme	Meaning	Respondents	Evidence from data
Knowledge of benefits	Some participants preferred the utilization of modern healthcare because they were educated and had accepted the benefits that come with it	3	"My partner does not side with the idea of using traditional methods besides I have been educated on it and I know the benefits of accessing proper healthcare." (R 1)
Quality Healthcare	Some participants have experienced the services of modern healthcare and appreciated it.	3	"The care the nurses give to the mother and baby is good and nice." (R 4) I go because they will even tell you the date you will deliver." (R 5)
Total		**6**	

Source: Field Survey (2021)

Research Question 3: What are some of the perceived effects of these sociocultural factors on the health of pregnant women in the Suhum Municipal Assembly?

This question also sought to know some of the effects of these sociocultural factors on health of pregnant women of selected communities (in their perspective) in the Suhum Municipal Assembly. This research question was analysed using frequencies. The chart below shows or indicates the responses given by the pregnant women in the municipality.

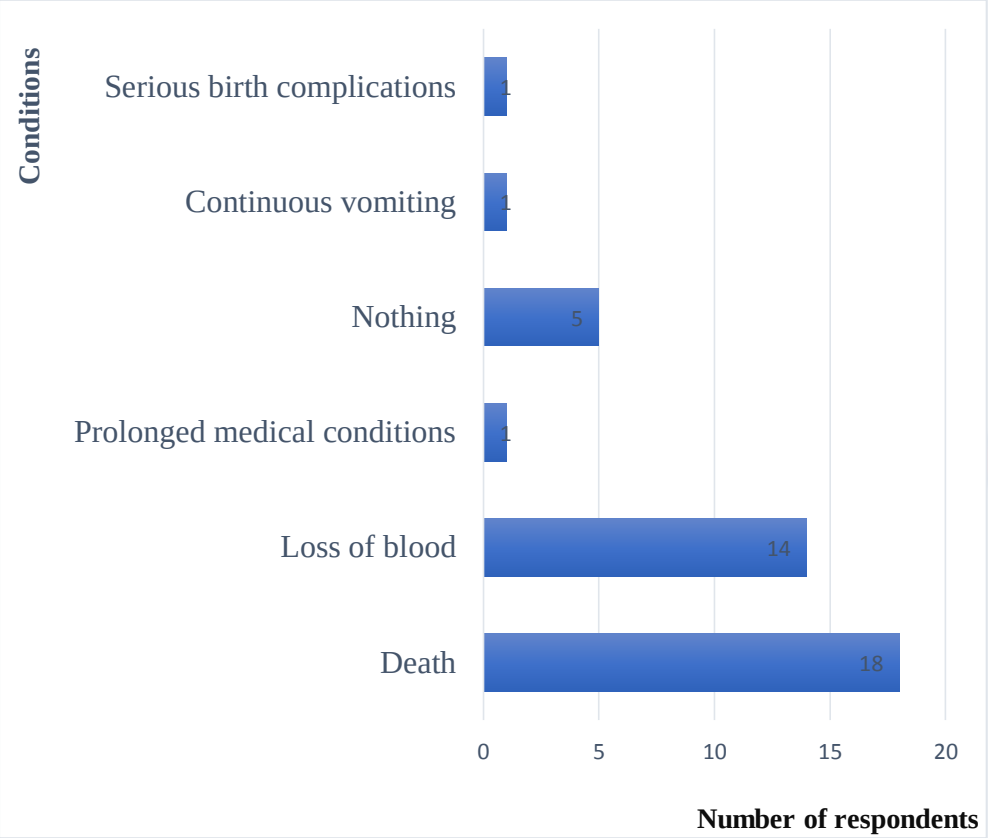


***Figure 6*: Effects of sociocultural factors on healthcare**

Responses from participants were highlighted under 6 thematic areas that were dominant. The themes are 'serious birth complications', 'continuous vomiting', 'prolonged medical conditions', 'loss of blood', 'death' and 'nothing'. Eighteen

(18) respondents representing 45% of the sample size indicated socio-cultural barriers to their healthcare could lead to their death or miscarriage when they do not visit the hospital on time. 14 respondents representing 35% of the total participants indicated socio-cultural barriers to their healthcare could lead to dangerous blood loss. Respondents representing 3% of the participants indicated she could suffer from prolonged medical conditions due to socio-cultural barriers to her healthcare. 5 respondents representing 13% of the sample size of the study indicated they will not suffer any serious condition attributable to socio-cultural barriers to their healthcare. A respondent representing 3% indicated socio-cultural barriers could lead to continuous vomiting and the remaining 3% indicated it could lead to serious childbirth complications.

Discussion of Results

Level of Healthcare Utilisation among Women in the Suhum Municipal Assembly

The results received from participants of the study were clear from the analysis that a huge majority of respondents representing 85% of the sample size did not like to attend the hospitals or clinics for treatments due to various reasons. This evaluation is in line with the findings of Omotosho (2010), which stipulates people in rural areas prefer to seek the services of local, traditional, or native herbalists for treatment when they believe and trust their results and are sure of desired outcomes. Almost all the respondents were exposed to the services of the TBA or herbalist since birth so they do not even want to give the clinics or hospitals

a chance. Many respondents trust the TBAs are doing a far better job in healthcare than the clinics.

The finding from the analysis is in line with Warren (2010), which indicated that many people in rural areas only go to hospitals or clinics for the appropriate treatments when herbal or local treatments and prayers fail them. Healthcare utilization is very important in enabling proper and improved healthcare in mankind. In the local or traditional setup or community, women are the principal care providers in the family. Their roles include ensuring sanitation, a proper home environment, and taking care of almost all the needs of the spouse, children, siblings, and parents, etc. To succeed at the above task, women put the need of their family first before their personal needs. This behavior contributes to low healthcare utilization in most women.

Many people in the rural areas are more used to the services of the TBA or herbalists for healthcare. They believe that there are numerous diseases that can only be treated by traditional medicines. With this idea in mind, rural dwellers prefer to stay home or visit a traditional healer for treatment. Even if they are taken to hospitals, they choose to go home to seek the services of the traditional healers. Dillip *et al.* (2012) indicated that the lack of monetary resources in the hospitals and clinics is a contributing factor in deterring women from seeking medical or healthcare services in rural areas.

The study by Ononokpono & Odimegwu (2014) showed that people in rural areas or low-income families are likely to adopt certain health-seeking characteristics that are different from those in the upper or middle-income class.

Thompson *et al.*, (2016) established in their study that there are gender differences in health-seeking behaviours.

In the traditional household, women rely on their male counterparts for direction and advice on healthcare. When the man of the house does not approve of the woman seeking treatment at the hospitals, it becomes difficult for women to disobey them. The decision of family members or spouses also affects the rate at which women utilize healthcare services in rural areas.

The level of knowledge women has, has greatly affected their utilization. Some women don't even know the services being rendered at the health facilities; they only refer to hear say. This means that pregnant women (connoting, together with their spouses and family) will not access healthcare because they don't even have an idea as to which stage, they should start seeking proper healthcare. This implies that attention will be sought only when conditions become critical which is wrong because women are to report exactly the time, they suspect being pregnant. This can cause serious birth complications like loss of pregnancy, death of baby or mother, and even fistula.

Socio-cultural barriers that are more peculiar to pregnant women in the Municipality

Hochbaum, (1995) concluded in his study that the health behaviour of people is determined by personal beliefs and strategies to minimize its occurrence while relying on trusted means of treatment. The results are also in line with the conclusion from Dilip *et al.* (2012) considers under-resource or financial constraints as a contributory factor to optimal treatment patterns in people in the

rural areas. Mwangome *et al*. (2010) further established the status of women (whether dependent and independent on family or spouse for resources or assistance) and their cultural beliefs affect the choice of health decisions.

Oberoi *et al*. (2016) argued that academic qualification or orientation (literacy level) also influences the health-seeking behavior of people in the community. Their study mentioned several factors interrelate to form health-seeking behaviors of people in a geographic setup. They indicated some of these factors include the perception of caretaking , demographic, economic, and social factors among others. Ahmadi, Farzadi and Alimohammadian (2012) indicated in their research that women in rural areas are disregarded when it comes to health matters in the society. The study further added that most of the reasons why the health concerns of women are not prioritized are mainly social and cultural factors.

Lowe *et al.* (2016) indicated in their research that women in rural areas do not enjoy any benefits or special privileges during pregnancy. They are subjected to the regular if not harder tasks and activities endured outside their pregnancies. These activities include carrying heavy loads without any sick leaves or days off work, and limited financial resources to seek proper antenatal care. Afful-Mansah *et al*. (2014) stipulated women with an advanced degree of independence are likely to seek healthcare services than women who depend on their spouse or family for financial and other forms of assistance.

Most pregnant women in rural areas rely on their spouse or family for financial or manual support. Because of this, pregnant women in rural areas are limited and controlled when it comes to making important health decisions. Many

women believe being admitted to the hospitals or clinics for treatment would increase the workload on spouses or family members. This is because, on admission, the family or spouse would be responsible for purchasing drugs for the patients, buying food, washing their clothes, paying their large hospital bills, and on top of all of that, the hospitals deny the family the right of visitation at their suitable time because there is "visiting hours".

These and many other reasons discourage women from going to hospitals for treatment. The majority of respondents depended on assistance from their husbands or family for survival and are therefore unable to make their own decisions on important health matters without first consulting their guardians or custodians. Abubakar, *et al*. (2013) confirmed this by concluding the final decision of whether or not to attend the hospital for treatment lies with the father (head of the family). Their study further confirmed that husbands or heads of the family or guardians had the mandate to dictate health-seeking behaviors for their spouse, Azuh *et al*. (2015).

Other socio-cultural barriers to healthcare in rural areas are people's perceptions or beliefs and cultural reasons about healthcare Sarfo *et al*. (2016). They concluded in their study that traditional and conventional health systems were great predictors of health-seeking behaviors among people in a geographic location. Many people in rural areas trust the traditional healers more than the treatments by the hospitals and modern medicines. The WHO, 2019 confirms the assessment above by estimating that majority of the people in developing countries rely on traditional health care singularly or in combination with orthodox medications.

Relying on traditional healthcare forms the culture of rural dwellers and it is their first point-of-call of any sickness or disease.

Several factors hinder the utilization of health care services for women in the Suhum Municipality. The utilization of maternal health care services in developing countries is largely predisposed by socio-cultural factors which include ethnicity, religious beliefs practices, and culture. There is a need for an increase in studies peculiar to women's health as this can help developing nations address problems and make policies with its subsequent implementations to improve the health and wellbeing of women since it is positively correlated with a socio-economic productive life.

The findings show the majority of respondents representing 60% were working but they relied on their husbands or family's decisions on visiting or attending hospitals for treatment. 25% indicated they do not go to hospitals because their husbands deny or disallow them and 35% indicated their families will not allow them to go to hospitals. Understanding the culture of people provides a projection as to whether the individuals in the society will utilize or avoid available health care services. For instance, in societies where there is a perception that illnesses are a form of punishment from the gods, inhabitants are less likely to seek biomedical care since they perceive most diseases are unrelated to biomedical causes Dillip *et al.* (2012). The way and manner people co-habitat are systems of shared beliefs, values, customs, and behaviours that members of the society use to deal with one another and with the world around them which is transmitted from generation to generation through socialisation.

Quality of services offered by health-service providers also influences the health decisions of people seeking healthcare. People in the rural areas are more used to the traditional healers or herbalists almost all their lives. During health complications, the traditional healers provide accessible services to patients by going to their various houses to treat them. The healers perform other roles such as preparing medicines, giving proper treatment before asking for rewards or financial paybacks, etc. Many people in the rural areas believe and trust in the competency of the TBA or the traditional healers more than the hospitals or clinics.

Other barriers to healthcare utilisation include the cost involved, proximity, the number of health providers, etc. The cost of healthcare in the traditional setup is readily available and very cheap. As explained above, the traditional healers charge next to nothing for their services provided but the cost of modern medicines is very high with several side effects.

There are many healers in the rural areas and the herbs they require for portions are known by many of the rural dwellers. There are only a few clinics or hospitals in rural areas. People seeking these services end up walking long distances or spending a lot of money on transport fare to get to the hospitals or health centres. The study showed all women in the municipality had access to healthcare. Majority of them preferred the traditional healers to the hospitals or clinics due to the reasons explained above.

If the woman tends to be disobedient to the decisions of the family, it will create enmity between the woman and the man or the woman and her in-laws which can even lead to divorce in the long run. In cases where divorce is an extreme

punishment, the woman may be asked to stay in the matrimonial home but she will be asked to fend for herself or take responsibility for her upkeep. This decision may make the woman unhappy and will be burdened since most rural dwellers (women in particular) are unemployed and solely depend on the man for every provision in the home.

Women who frequent hospitals are seen to be weak and timid, drugs (orthodox) given to these women sometimes need to be bought from the big town nearby. This is an extra cost (in terms of transportation) whereas herbs are available in the backyards of houses. Availability makes them reluctant to go for proper healthcare services. Seeing someone as weak instils fear and embarrassment and will deter women from visiting the hospitals, this is a small community where everyone sees each other and are concerned about each other's day-to-day activities. This implies that women who have this notion will continually run away from proper healthcare services as a result of this serious complication during pregnancy, labour, and prenatal disorders can occur

Perceived effects of these sociocultural factors on the health of women in the Municipality

With traditional healers being the preferred choice of treatment for most women in the urban areas they mostly opt for orthodox treatment when their illnesses are advanced. Though medical products produced by traditional medical practitioners may contain several different plants and possibly hundreds of chemical constituents, some may be in very low or high concentrations which may be harmful to consumers (Chen et al., 2009). Furthermore, concerns have been

about the dosage of many traditional products. This notwithstanding Sarfo *et al*., (2016) revealed that the efficacy of traditional health system treatments was a significant predictor of health-seeking behaviours. Thus, they recommend the provision of a more balanced and "culturally corresponding" health service that tends to serve the needs of patients.

The results are in line with the conclusion of Ogundairo *et al.* (2016) who argued that women from the rural communities are known for their high ability to suppress and ignore the pain and other diseases until it becomes serious and unbearable. This reason also contributes to low hospital attendance in women in rural areas. Darko-Gyeke *et al.* (2013) stipulated that perceived threats and increased anxieties often drive women in rural areas to seek multiple sources of health care including both traditional and spiritual means.

Many rural dwellers take their diseases to the hospitals when their conditions are severe or when the illness becomes life-threatening. In many cases, pregnant women in rural areas face high ordeals when they are transported from their locations to hospitals. There are many challenges since the availability of vehicles, the poor state of roads, etc. may even delay the treatment of the women. This aspect implies that this may increase bleeding and blood loss in pregnant women, severe cases of vomiting (some as a result of vehicular movement), miscarriage or loss of life (either the mother or baby), other serious health complications, etc.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

The study was conducted to identify the sociocultural factors that influence non-utilisation of healthcare services among pregnant women of selected communities in the Suhum Municipal Assembly.

The study focused on the following

1. Assessing the level of healthcare utilisation among pregnant women in Suhum Municipality.
2. Finding the sociocultural barriers more peculiar to pregnant women in Suhum.
3. Examining the perceived effects of sociocultural factors on the health of pregnant women in the Suhum Municipality.

This section summarizes the results of the study with a focus on the research objectives and questions while making conclusions and recommendations based on the key findings of the study. The chapter will also present the implications of the study for future research.

Summary

The study aims to assess the socio-cultural barriers to healthcare utilisation in pregnant women. A homogeneous purposive sampling technique was used to sample women for the study. The researcher employed a semi-structured interview guide. Ethical clearance was granted by the UCC and subsequent approval at the study area as well as participants' informed consent was obtained. Data were analysed using MS Excel and thematic content analysis.

The researcher interviewed 40 women in Suhum Municipality of which 30% were less than 25years old and 50% were between the ages of 26-35. The remaining 20% were above 35 years. Further analysis showed that 38% of respondents had no form of formal education (uneducated) and 30% had primary level education. 20% of respondents had education up to the junior high school level and the remaining 13% had education beyond senior high level. 38% of the respondents were single or co-habituating and 48% were married. 13% of respondents were separated and the remaining 3% were divorced. The occupational analysis showed that 18% of the women were farmers and 39% were unemployed. 18% of them were self-employed and the remaining 35% were traders.

Out of the 40 respondents for the study, 6 respondents representing 15% indicated they go to the hospital for treatment and the remaining 85% indicated they did not go to the hospital for treatment. The respondents that go to the hospitals for the treatment indicated they visit the hospitals because of proper healthcare and personal reasons. The findings were grouped under thematic areas namely: husband denial, family denial, cultural reasons, financial reasons and other personal reasons.

The remaining women who preferred the TBA indicated their family and husbands denied them from going to the hospitals for treatment. Some indicated they do not go to hospitals because of financial reasons and the remaining indicated they do not go to hospitals because of personal or cultural reasons.

Concerning the frequency of respondents' hospital attendance, 2 respondents indicated they have never been to the hospital and 6 respondents indicated they sometimes go to the hospitals for treatment. The majority indicated

they do not go to the hospital for treatment. The frequency of respondents' hospital attendance confirms and matches their choice of treatments since 32 indicated they prefer the TBA treatment to hospitals. 3 of the respondents indicated they suffered serious birth complications and continuous vomiting because they refused clinical or hospital attendance.17 of them indicated they suffered prolonged medical conditions and blood loss and 18 indicated their refusal to attend hospitals could have led to the death of their babies or their demise.

Conclusions

These conclusions were made from the findings. Financial constraints, inability to make sensitive decisions that pertains to one's own health (women in the community), dependency and the traditional settings we find ourselves in this part of the world does not always permit women to stand up for themselves and make decisions and take responsibilities for themselves. This concludes that pregnant women in these communities do not have the right to own their decisions and or healthcare choices. The study showed a lot of these women (about 85%) do not visit the hospital and are high chasers of traditional methods.

Sociocultural barriers to healthcare in the municipality are husband denial, family denial, financial and cultural reasons. The respondents interviewed provided reasons why they attended or stayed away from hospitals for healthcare treatment. The majority of them indicated they preferred the TBA over hospital treatment because women who go to hospitals during labour are seen as weak and fragile, some also believe giving birth with the traditional processes increases one's chance of having a male born. Others also believe traditional method is their family's

business and they can't leave to practice orthodox services, these are some of the reasons they had low hospital attendance.

The women who utilize the health facility are also women who have either been educated on the reason why it is beneficial to visit health facilities especially during conception, women who have experienced orthodox services either willingly or at the verge of complications during pregnancy or labour. Some of the participants also have a bit of formal education which influences their decision to accept modern health care services. Some common effects of these sociocultural barriers to the health of the respondents include death, blood loss, prolonged medical conditions, continuous vomiting, and serious birth complications. The results of the study made it clear that the people in the community are exposed to and are more familiar with the services of the TBA than the clinics and hospitals.

Recommendations

Given the findings of this study, the following are some recommendations for the study:

1. Pregnant women in Dawa and Asore-ase need to be educated by health professionals and the women leadership in their communities to visit the health centre as soon as they find out they are pregnant.
2. Husbands, In-laws and mothers of pregnant women in Dawa and Asore-ase should be the target on education by health professionals to prioritize orthodox healthcare over traditional methods when it comes to making decisions about pregnant women in these communities. Family system can

also be educated to empower pregnant women to have a say in choosing which method of service they want to access when they become pregnant.

3. Continuous education on the effects of some traditional practices that may harm the mother and the baby should be hammered on by health professionals and women leadership in Dawa and Asore-ase.

Suggestions for Further Study

Further studies could use

1. Quantitative-based approach to examine the degree of healthcare utilisation in Dawa and Asore-ase
2. Qualitative study should be stretched to encompass nurses, doctors, and hospital administrators regarding their views on support services received by mothers at the various hospitals and how it can increase utilization in Dawa and Asore-ase.

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APPENDICES

APPENDIX A

INTERVIEW GUIDE FOR RESPONDENTS

(Pregnant Women)

Assessing The Sociocultural Barriers to Healthcare Utilization Among Pregnant Women in The Suhum Municipality

This interview guide is part of a study being steered by a student of University of Cape Coast. You are therefore, humbly required to read this instruction and co-operate by providing the answers. You are assured that your responses will be treated as strictly confidential as possible.

SECTION A

Respondent's Background Information

Please Tick the Appropriate:

1. Gender: Male [] Female []
2. Age: < 25 [] 26-35 [] Above 36 []
3. Marital Status: Single [] Married [] Divorce [] Separated [] Widow [] Co-habituating [ ]
4. Employment Category: Government Worker [] Self-Employed [] Unemployed [] Trader [] Farmer []
5. Qualification: HND [] 1st Degree [] Masters [] Doctorate [] No Formal Education [ ]

SECTION B

The Sociocultural Barriers Peculiar to Pregnant Women in The Suhum

6. How often do you visit the hospital/health centre?

   Very Often [] Often [] Don't know [] Not Often [ ] Long time

   WHY……

   ……...

7. When was the last time you visited the hospital/health centre?

   This week [] Last week [] Last three months [] last six months [] Last Year [ ]

   More than a year [ ] Can't really tell [ ]

   Any other comment……...

   ……

   ……

   ……

   ……

SECTION C

Sociocultural Barriers That Influence Healthcare Utilisation of Pregnant Women in The Suhum Municipality

8. What is your number one or foremost ***reason to which you do or do not visit the health facilities? As cited in Qns. 9***

   (Sociocultural barriers- language, period of occurrence, family influence, husband support/denial, cultural/ traditional settings)

   ……

   ……

SECTION D

The Effect of These Factors on The Health of Pregnant Women in The Suhum Municipality

9. What do you think will happen to you if you do not visit the health centre when you have a health problem?

   (e.g., Disability, other infections, prolong medical condition, severe pains intermittently, death)

   ……

   ……

   ……

   Any other comment?

   ……

   ……

   ……

   ……

Thank you!

APPENDIX B

INTERVIEW QUIDE FOR RESPONDENTS
(Key Informants)

Assessing The Sociocultural Barriers to Healthcare Utilization Among Pregnant Women in The Suhum Municipality

This interview guide is part of a study being steered by a student of University of Cape Coast. You are therefore, humbly required to read this instruction and co-operate by providing the answers. You are assured that your responses will be treated as strictly confidentiality as possible.

SECTION A

Respondent's Background Information

Please tick (/)

1. Gender: Male [] Female []
2. Age: < 25 [] 26-35 [ ] Above 36 [ ]
3. Qualification: No formal education [] HND [ ] 1st Degree [ ] Masters [ ] Doctorate [ ] Other [ ] Specify other……
4. Years Working: Below 5 yrs. [] 5-10 yrs. [] Above 10 years [ ]
5. Position/Department (Hospital Staff only):

   Board Member [] Management [] Internal Audit Unit [] Pharmacy Directorate [ ]

   Finance Directorate [ ] Medical Directorate [ ] Nursing Directorate [ ]

SECTION B

The Sociocultural Barriers Peculiar to Pregnant Women in The Suhum

6. Mention as many as you know the ***reasons for not reporting to health facilities*** among women in the Suhum Municipality? (Hospital Staff and Queen mother's only)

……

……

……

……

7. Do women in the Municipality report their health conditions to you? (TBA's and Herbal Practitioners)

Yes [] No []

8. What do you think is the reason why pregnant women report their conditions to you rather than going to the hospital? (TBA's, Herbal Practitioner's)

……

……

……

SECTION C

(Hospital Staff only)

The Effect of Sociocultural Barriers on The Health of Pregnant Women in The Suhum Municipality

9. What are the effects of sociocultural barriers on the health of pregnant women in the Suhum municipality?

……

……

……

……

SECTION C

(Herbal Practitioner's and TBA's)

The Effect of Sociocultural Factors on The Health of Pregnant Women in The Suhum Municipality

10. What are some of the signs you see in women after attending to them (to see if they are cured or not)?

……

……

……

11. What are some of the recurrent conditions that persist among women in the municipality?

……

……

……

……

Any other comment?

……

……

……

Thank you!

APPENDIX C

INTRODUCTORY LETTER

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF SCIENCE AND TECHNOLOGY EDUCATION
DEPARTMENT OF HEALTH, PHYSICAL EDUCATION & RECREATION
TELEPHONE: +233 - (0)206610931 / (0)543021384/ EMAIL: hper@ucc.edu.gh

(0)268392819

TELEX: 2552, UCC, GH. Cables & Telegrams:

UNIVERSITY, CAPE COAST

our Ref: ET/MHE/18/0011/5

23rd February, 2021.

The Chairman
Institutional Review Board
University of Cape Coast Cape Coast

INTRODUCTORY LETTER: BELINDA MENSAH (ET/MHE/18/0011)

The bearer of this letter, Belinda Mensah, is an MPhil student of the above-named department. I support her application for ethical clearance from your outfit. She is conducting research on the topic "Sociocultural Barriers to Health Care Utilisation Among Pregnant Woman in the Suhum Municipality." As part of the requirements for obtaining a Master of Philosophy degree in Health Education at the University of Cape Coast.

I am the Principal Supervisor of her work and she has satisfied the conditions for data collection. I shall be grateful if she is given the necessary assistance.

Counting on your usual co-operation.

Thank you.

Dr. Mrs. Salome Amissah-EsseI
PRINCIPAL SUPERVISOR
salome.amissah-essel@ucc.edu.gh

APPENDIX D

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

FACULTY OF SCIENCE AND TECHNOLOGY EDUCATION
DEPARTMENT OF HEALTH, PHYSICAL EDUCA TION & RECREATION

TELEPHONE: +233 - (0)206610931 /
(0)543021384/ (0)268392819
TELEX: 2552, UCC, GH.
Cables & Telegrams:
Our Ref: **ET/MHE/18/0011/4**

EMAIL: hper@ucc.edu.gh

UNIVERSITY, CAPE COAST

11th February, 2021.

The Chairman
Institutional Review Board
University of Cape Coast Cape Coast

INTRODUCTORY LETTER: BELINDA MENSAH (ET/MHE/18/0011)

The above-named person is a student of the Department of Health, Physical Education and Recreation of the University of Cape Coast. She is pursuing a Master of Philosophy degree in Health Education. In partial fulfilment of the requirements for the programme, she is conducting research for her thesis titled "**Sociocultural Barriers to Health Care Utilization Among Pregnant Women in the Suhum Municipality."**

She has defended her thesis proposal and has passed. I therefore kindly request that she is granted ethical clearance to enable her conduct the research.

Counting on your usual co-operation.

Thank you.

Dr. Daniel Apaa
HEAD

APPENDIX E

UNIVERSITY OF CAPE COAST
INSTITUTIONAL REVIEW BOARD SECRETARIAT
TEL: 0558093143/0508878309
E-MAIL: irb@ucc.edu.gh
OUR REF: UCC/IRB/A/2016/1083
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

1ST SEPTEMBER 2021

Ms. Belinda Mensah
Department of Health, Physical Education and Recreation
University of Cape Coast
Dear Ms. Mensah,

ETHICAL CLEARANCE - ID (UCCIRB/CES/2021/74)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted Provisional Approval for the implementation of your research titled **Sociocultural Barriers to Healthcare Utilization among Pregnant Women in the Suhum Municipality**. This approval is valid from 1st September 2021 to 31st August 2022. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Cvyysu, PHD
UCCIRB Administrator

INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST