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

Bougangue Bassoumah ^α & Mpawenimana Abdallah Saidi ^σ

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

Keywords: awareness, maternity, signs, intra-household, decision-making, clinic attendance, needs assessment.

1. BACKGROUND

Studies on maternity have shown that intra-household decision-making is an essential component of maternal healthcare service utilisation (Tsikata, 2007; Babalola & Fatusi, 2009;

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Hagman, 2013; Ghana Statistical Service [GSS], 2008, 2009, 2015; International Centre for Research on Women [ICRW], 2008, 2010; Bougangue, 2017). Informed decision is a necessary requirement to ensure appropriate timing and choice of source of healthcare. However, reaching an informed decision depends on the couple or the care-giver's awareness of signs of obstetric complications as well as their health implications (GSS, 2008; ICRW, 2010). This is because awareness of signs and complications arising from pregnancy and childbirth facilitates early recognition of danger signs/symptoms associated with maternity, which forms the basis of care-seeking decision-making (Waiswa et al., 2010; Comb Thorsen et al., 2012). This requires active involvement of women, for appropriate clinical diagnosis is largely dependent on the information that is given to professionals by the women or their care-givers (WHO, 2002, 2003).

Research has established that, apart from bleeding, most obstetric conditions cannot easily be recognised by non-professionals until the situation aggravates, whilst some other complications occur suddenly at the onset and quickly progress to become life-threatening (WHO, 2003; GSS, 2015). Based on this, the WHO enjoins all member countries to educate women on maternity issues with the view to increasing their knowledge and understanding of pregnancy and childbirth as a pre-condition for adequate preparation and sound decision-making towards pre-natal, intra-partum and post-partum care (WHO, 2002; 2013). Some couples may be aware of key danger signs of obstetric conditions but lack of knowledge and understanding of the implications of these signs for pregnancy outcomes could influence their care-seeking decisions. Sometimes, early signs and symptoms may be ignored by the pregnant woman or her spouse because the signs may be considered as 'normal' (WHO, 2001; Senah, 2003; Okolocha et al., 1998 in WHO, 2003 pg.45).

Female autonomy and joint decision-making are recommended for couples to ensure informed decisions for positive maternal and child health outcomes (ICRW, 2008, 2010; UNFPA/ICRW, 2014). However, this usually



becomes impossible, particularly in patriarchal societies where decision-making is considered as a men's space (Nwokocha, 2007; Bougangue, 2017). This act of gender discrimination, which creates inequality in decision-making is more entrenched in rural communities and amongst people who are not well informed about maternity and its associated complications (Bougangue & Ling, 2017). It is women who carry pregnancy and experience the symptoms of its complications, and, therefore, they, in particular, can best determine the severity of the conditions and the need for healthcare. However, most women are marginalised at the household level in decision-making towards maternity care-seeking (Hagman, 2013; Bougangue, 2017). In some patriarchal communities in Ghana, decision-making is regarded as an act of protection for women, with spirituality attached as a restriction to the females (Bougangue, 2017). This situation compromises quality decision and positive maternal healthcare behaviour towards care-seeking, with an implication for health outcome.

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

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

II. METHODOLOGY

a) Study setting

The Awutu-Senya West and the Chereponi Districts are newly created districts in the Central and Northern Regions of Ghana, with Awutu-Beraku and Chereponi as the administrative capitals respectively. The Yendi Municipality is located in the Northern Region, with Yendi, the paramountcy of Dagban Traditional Area as the capital town. Both the Yendi Municipality and the Chereponi District are Muslim-dominated settings, whilst the Awutu-Senya West District is dominated by Christians. The Dagombas, from the Mole-Dagbani ethnic group, form the largest proportion in the Yendi Municipality whilst the Awutus and the Chokosis, from the Guan and Akan ethnic groups, are the main ethnic groups in the Awutu-Senya and Chereponi districts respectively (Awutu-Senya West District Assembly, 2015; Yendi Municipal Assembly, 2015; Chereponi District Assembly, 2015). Most of the households in Yendi Municipality and the Chereponi District are headed by men. The compound house system forms the predominant housing system in these areas, where couples live together with members of the extended family, usually relatives of the husbands (Chereponi District Assembly, 2015; Yendi Municipal Assembly, 2015).

b) Research design

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

c) Sampling and data collection

The data were solely collected by the lead author who was the principal researcher in this study. Women who were receiving maternity care between August 2015 to December 2015 and their spouses were purposively selected for the study and reached through quota sampling and snowballing. Based on thematic data saturation, twelve FGDs and twenty-four IDIs were

conducted in the three settings. The districts were put into urban and rural zones. Two FGDs and four IDIs involving *knowledgeable* and *less knowledgeable* couples were conducted in each zone in each district. The use of the IDI was to validate the FGD data by providing privacy to participants to some extent for them to express themselves freely and candidly (Milena et al., 2008). This allowed the research to delve deep into very subtle issues that could not have been possible with the FGD. In each setting and zone, the knowledgeable were separated from *less knowledgeable* for the FGDs.

d) *Ethical consideration*

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

e) *Data analysis*

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

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

III. RESULTS

a) *Awareness of Signs/Symptoms of Obstetric Complications*

i. *The Knowledgeable*

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

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

The husband had this to say about critical period in IDI:

"To me, I will say the first 3 months is normally a month women and their spouses need to be very careful. They say the baby is very delicate at this stage. So, any small thing can terminate the pregnancy or affect the baby in the womb. I also realised that women who normally die from pregnancy and childbirth experience this misfortune either at delivery point or immediately after delivery. So, all these periods are very critical for the woman and the foetus' survival." (34 years, diploma)

These participants explained that the first trimester is critical since the foetus is very delicate, as it undergoes formation within the womb and can be aborted or malformed if not properly taken care of. They mentioned that miscarriages normally occur within this period or within few days after this period. This statement made by a man in IDI was common in the IDIs and FGDs involving the knowledgeable couples:

"Normally, before miscarriage some blood will come out of the woman's vagina. In the early part of pregnancy or before 4 months in pregnancy the baby is like blood. So, if something happens, it will come out like blood. Therefore, if the woman doesn't go to see doctor she may lose her unborn baby. She needs to go and check the pregnancy so that they give her treatment. They say until the baby is fully grown any blood from vagina can lead to termination"

of pregnancy. So, they told us to go to see doctor when we feel strong abdominal pains or we see blood." (Husband, 42 years, JSS).

On signs of labour, below were responses from a husband and a wife in separate interviews:

"When I am getting ready for delivery, I see that water comes from my vagina. I can see that some dirty thing like blood also comes from the vagina. I feel like going to urinate or going to toilet. I get back pains in pregnant but when it is getting to time to born the back pain is seriously." (Wife, 40 years, JSS graduate).

"From my experience in my wife's previous pregnancies, normally some water comes out of her organ. Sometimes too she becomes restless with frequent urination or visiting toilet. When I see that then I know she is about to deliver. Another thing is that there is this dirty fluid from the sex organ thicker than water but not clean." (Husband 46 years, SSS graduate).

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

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

They were also well-informed about postpartum haemorrhage and infections associated with delivery, and they also had adequate knowledge about the need for clinic attendance to stop bleeding or screen both the mother and baby early after birth for infections. For instance, in IDI one woman noted:

"Bleeding after childbirth has killed many women. It is not about the birth cert or for weighing alone that we should attend PNC early as some of the women think. You or your baby may be infected but you or the people around you may not detect except clinical test. I was told by the midwife that after delivery it is important to be screened for and treated

of any infections that might affect the mother or baby." (25 years, social worker, diploma).

Below was the response from her husband in IDI:

"After delivery women have to see the doctor as soon as possible to avoid bleeding because it can kill. It has killed many women in this village. They go for traditional treatment and they die. Doctors say women should go to hospital early after delivery for care to check bleeding and other things." (33 years, farmer, SSS)

ii. The Less Knowledgeable

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

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

This was her husband's reaction in the FGD:

"It is serious. For me to be sure that a woman is pregnant the stomach must be very big. It is women who normally know those things. I think my wife knows better." (47 years, A'Level).

They had limited or no idea about the physiological causes of labour dystocia, prolonged labour and retention of placenta, as well as post-partum haemorrhage (PPH). Below are the response of a 45-year old woman and mother of 3 children and her husband in FGD on obstructed labour and retention of the placenta. These statements were supported by most members of the group.

"Women who suffer before they born may have very big babies or they had sex with different men. Some people too have been cursed by their family gods if they sinned against them. It is the same way for those who experience delays in expulsion of the placenta. If the baby is big what about the placenta? It is because of sin. We have to be faithful in our marriages so that God will have mercy on us." (Wife).

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

Though some of them were informed about early postnatal care for preventing PPH, they were not aware of infections that women and babies contract during and after delivery.

"Yea, when my wife born I take her go to doctor after 2 days so that they can do my baby birth certificate and do weighing for him. Some women in this town die when they give birth some time. They are bleeding and go hospital late and they die." (Husband, 44 years, MSLC)

"Yes, I go for check up when I born. My first born I go after three days and my second born I go after naming ceremony for doctor to do my daughter papers and to do weighing. Oh!! I don't go early because I was not weak and my baby is strong. If you born and you are weak you for go and see doctor so that they give you medicine. If the baby too is weak you take it to the doctor to check and give drugs. Women that are weak after delivery go for doctor early or when the baby is sick when they born. They go for doctor to check the baby. Yes, that is what we do normally." (Wife, 40 years, MSLC).

b) Intra-Household Decision-Making

i. The Knowledgeable

Generally, amongst most knowledgeable couples, decision-making was the responsibility of both spouses. The men did not exercise their traditional gender powers, but rather gave the women some degree of liberty to take autonomous decisions where necessary without seeking approval from husbands. They considered women as the best people in the right position to make decisions towards maternity care since it is women who directly experience the conditions related to pregnancy and childbirth. These couples also mentioned that, even though some men may equally have knowledge about maternity, women usually attend maternal healthcare promotion programmes and are therefore more exposed to issues of pregnancy and childbirth as compared with men. Decisions taken by the knowledgeable were mostly joint decisions or non-tentative individual decisions taken by the women. There were no evidences of delays in decision-making by the knowledgeable. Most of them chose clinical care for treatment of complications and general check-ups during maternity. Below are responses of a couple in separate IDI sessions:

"I don't have the eyes to see what is in the woman's womb. I can only see the seriousness when my wife tells me. I cannot decide for my pregnant wife regarding where and when she should seek care. It is even better for women to decide for themselves." (Husband, 34 years old, SSS graduate).

"Sometimes I decide with my husband but in most cases I decide when, where and the type of care to seek. My husband always say that I should be better

than him in determining the seriousness of what I experience. One thing is that I go to seek care whenever I need care without delays." (Wife, 28 years, SSS graduate).

ii. The less knowledgeable

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

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

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

c) Interplay of Awareness, Culture and Gender

The decisions made by the knowledgeable were devoid of cultural and gender influences. In the light of this, most of the wives had the freedom to make autonomous decisions which resulted in quicker decision-making and positive clinic attendance. Amongst the knowledgeable, joint decision making was to grant women the listening ears and help the couple to make informed decisions. However, the less knowledgeable reached decisions based on the judgments of the men. Their delayed decisions were male-dominated, culturally determined and gender driven. Most of the less knowledgeable supported this statement, which run through various interviews.

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

supposed to make spiritual consultations and therefore, cannot be part of decision-making that is based on spiritual consultation outcomes." (Husband, 39 years old).

d) *Background of Couples and Intra-Household Decision-Making*

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

"I am the man and head of the family. I have to take family decisions. Women only decide on what to cook for the family. ... She only told me she felt like giving birth. So, I took it upon myself to make a good decision about where to go and the time she should seek care." (52 years old, Muslim, A'level)

Members of traditional religion were also conservative, delayed decision-making, and denied their wives access to modern maternity care in some cases, as the primary choice of care amongst them was traditional practitioners. However, they were more liberal as compared with the Muslims because a few of them involved their wives in decision-making. Most Christians were more liberal and granted their wives autonomy in making and implementing decisions as compared with the members of traditional religion and Muslims. Irrespective of the level of awareness, urban couples were more liberal and the women were more autonomous. Generally, couples who worked together made joint and quicker decisions as compared with those who worked in different environments or workplaces. Although most of them worked together, farmers were more conservative and their decision-making process and outcome were influenced by gender norms and cultural factors.

Husbands whose wives had several pregnancy experiences were more liberal and their wives had opportunities in making decisions about care-seeking as compared with their counterparts without experiences. The men noted that they were comfortable with such women because they had both knowledge and experience to make informed decisions. Also, husbands with much experience of pregnancy were more democratic, as they sought and used the views of their wives in intra-household decision-making as compared with their colleagues with less experience. Joint decision making was more common amongst the younger couples as compared with older ones. Couples with

younger wives and older husbands exhibited a different tendency. The older husbands treated their wives like children by marginalising them in decision-making.

e) *Patriarchy, Matriarchy and Intra-Household Decision Making*

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

f) *Implication for Maternal and Neonatal Healthcare*

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

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

My husband does not interfere in decisions. He allows me to do what I think is good for me and my unborn baby. I don't need to seek permission before going to the hospital for treatment." (Wife, 42 years, JSS graduate)

However, apart from delayed decision-making, the less knowledgeable couples took uniformed decisions, which had implications for the health of women and their babies. The poor decisions translated into poor clinic attendance in the form of low ANC visits, late ANC, delivery care and PNC. In separate IDIs, a couple shared their experiences:

"... from the herbalist then we decided to carry her to the clinic but when we got there the midwife said it

was too late so we lost the baby and my wife sustained some injuries. Later, they had to clean her womb." (Husband, 45 years old, MSLC).

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

IV. DISCUSSION

The observation of this study concurs with the observations of previous studies that pregnancy is usually associated with complications that require proper care from the onset to the post-partum period (Graham, 1998; Stevens, 2000; GSS, 2015). To a large extent, appropriate care-seeking depends on individuals' awareness of signs of obstetric complications for making informed decisions (Pembe et al., 2009; Kabakyenga, Östergren, Turyakira & Pettersson, 2011). This study discovered that awareness of pregnancy and its related complications forms an essential component of intra-household decision-making. Couples' awareness of maternity was instrumental in spousal decision-making towards care-seeking, as the well-informed couples were able to make quicker and informed decisions. The couples' awareness did not only enable the husbands to actively involve their spouses in decision-making with equal opportunity, but also granted women the autonomy to make and implement decisions about their own health. This resulted in timely and regular clinic attendance amongst the knowledgeable which is essential for positive maternal and neonatal health outcomes (Ministry of Health, Uganda cited in Kabakyenga et al., 2011, pg.2; Comb Thorsen et al., 2012; Waiswa et al., 2010). The findings sustain the observation that gender role affects women's autonomy to make decisions about healthcare at the household level which, in turn, play out at the agency level (ICRW, 2008, 2010; WHO Commission on Social Determinants Health, 2008, 2010; Bougangue, 2017).

The findings also confirm previous studies that awareness of danger signs of obstetric complications enables women or the care-givers to take timely and appropriate actions towards healthcare (Pembe et al., 2009; Kabakyenga et al., 2011). The timely and regular clinic visits noticed amongst the knowledgeable positioned them for better chances of maternal screening and early treatment of complications. Most knowledgeable couples were able to stand dominant against gender norms and cultural beliefs to make informed decisions which is a pre-condition for better maternal outcome. The argument that awareness of pregnancy and its related complications translates into

informed decisions and positive attitudes towards care-seeking is maintained in this study (ICRW, 2008, 2010, 2014). As shown in earlier studies, the awareness empowered the couples and guided them to take appropriate decisions during the maternity period (Bhutta, Darmstadt, Hasan & Haws, 2005; Hagman, 2013; Winta, 2013; UNDP/ICRW, 2014). However, women from the less knowledgeable families had higher risks of developing maternal complications or aggravating existing conditions because most of them missed early screening and identification of risks factors for timely intervention due to wrong decisions that led to late clinic attendance (WHO, 2013; GSS, 2008, 2009, 2015).

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

Self-medication and the use of herbs during pregnancy as this study observed, are associated with health risks in the form of pregnancy termination such as premature birth, spontaneous abortion and stillbirth (Cnatingius et al., 2000; Kirsten, Ulrik, Bodil, Morten, & Tine, 2003; Abasiubong et al., 2012; Liao et al., 2015). The herbs may contain substances such as caffeine, which has adverse effects on the growth and development of the foetus (Bakker et al., 2010; Creanga et al., 2012). There was no guarantee of purity and safety of the herbs used by the women, because they were not subjected to laboratory investigations to ascertain the efficacy, composition, expiry dates as well as the side effects (Lapi et al., 2010). Besides, traditional practitioners lack the skills and equipment to save women's lives in the event of obstructed labour or delay in placenta expulsion, which were evident amongst the less knowledgeable. This exposes the women and their unborn babies to risks of further complications which may result in injuries, lifetime disabilities and deaths



(WHO, 2001, 2013; GSS, 2008; Neilson, Lavender, Quenby & Wray, 2003). As highlighted in the findings, some of the maternal complications, injuries and deaths observed in this study were mainly due to uninformed decision-making that led the women to non-professionals who could not give the needed treatment.

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

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

Media exposure had a far-reaching impact, particularly on the illiterates and rural couples. Some of the knowledgeable gained awareness from local radio programmes which were accessible to them even in their farms. The illiterate couples in the urban

communities had more knowledge than their rural counterparts due to exposure to multiple sources of the media and information (different TV and Radio stations/programmes) and the opportunity to interact with literates and experienced people from whom they tapped knowledge.

Spousal age difference emerged as a crucial factor in intra-household decision-making. Men who were married to very young women as compared to their ages considered their wives as incapable of taking appropriate decision. Most of the participants aged between 25 and 35 years who had at least secondary education were in support of joint decision-making and female autonomous decisions. However, regardless of age and experience, female educational attainment was central to women's involvement in decision-making. Female spouses who had at least secondary education were more involved in decision-making as compared with their illiterate counterparts, as well as those who had basic education. This observation maintains the importance of formal education, which is often used as a proxy for knowledge, informed decisions and empowerment, as well as positive behaviour towards care-seeking though there were evidences of exceptional cases (Preston, 1989; McAlister & Baskett, 2006; GSS, 2008, 2009, 2015; Hagman, 2013; Perumal et al., 2013; UNFPA/ICRW, 2013, 2014; Bougangue, 2017; Bougangue & Ling, 2017).

The less knowledgeable women, particularly those from rural areas with much experience of pregnancy and antenatal counselling, were not well-informed about maternity complications, and their implications were observed to be attributable to poor messaging during ANC counselling. This maintains previous discoveries that poor messaging during ANC counselling contributes to low knowledge about pregnancy and childbirth - a recipe for poor maternal health (Perumal et al., 2013). This reinforces the view that dialectical differences and poor communication create barriers to women during antenatal counselling, and these deny women the desired knowledge, thereby leading to lack of perceived need for clinic attendance (Andersen & Newman, 2005; Bougangue & Kumi-Kyereme, 2015).

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

observed in the Northern Region (GSS, 2008, 2009, 2015).

V. CONCLUSIONS

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

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

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

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