University of Alberta

Childbearing Women in a Rural Ghanaian Community –
A Focused Ethnography

by

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ABSTRACT

Maternal mortality is a highly preventable cause of death but continues to be the health indicator that shows the greatest disparity between high and low income countries. Rural Ghana has estimated maternal mortality rates as high as 1077/100,000 whereas the global estimate is 402/100,000. Much research has been carried out to understand what influences maternal health and the causes of maternal morbidity and mortality in low-income countries. This focused ethnography, conducted in a rural Ghanaian town between April and June of 2008, adds to the literature by exploring the community members' perspectives of maternal health. The researcher gained insights into the knowledge, attitudes and beliefs that influence the type and amount of support received by childbearing women in a selected community and offers insights into the cultural practices and beliefs that support or inhibit maternal health.

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Introduction

In 1987, the World Health Organization (WHO), World Bank and United Nations Population Fund (UNFPA) launched the Safe Motherhood Initiatives (SMI) to address the high global maternal morbidity and mortality ratios in low and middle income countries (AbouZahr, 2003). Much research has been carried out to address the global disparity in rates of maternal morbidity and mortality, yet after 20 years no notable reduction in the maternal mortality rate (MMR) is apparent in low and very-low income countries, particularly those in sub Saharan Africa. Maternal mortality is a highly preventable cause of death but continues to be the health indicator that shows the greatest disparity between high and low income countries (Hill et al, 2007). A renewed focus on maternal health is inherent in the Millennium Development Goals (MDG), however the MDGs, like the SMIs, will likely not be met by the target year of 2015 (Campbell & Graham, 2006; WHO, UNICEF & UNFPA, 2007; World Health Organization, 2005).

1.1 *Background: Safe Motherhood Initiatives and MDG -5*

The Safe Motherhood Initiatives (SMIs) were developed in 1987 following recommendations from the Safe Motherhood Conference in Nairobi, Kenya. The conference, co-sponsored by the World Bank, WHO and UNFPA, had as its objective to increase awareness of the gross global disparity in maternal mortality rates between low and high income countries and to mobilize an immediate response to put an end to this tragedy. The SMIs were deemed a "Call to Action" and included recommendations and strategies for decreasing maternal morbidity and mortality such as to strengthen community-based maternal health

care, educate traditional birth attendants (TBAs), provide adequate emergency obstetric care, improve the status of women, educate communities, expand family planning programs, and generate political commitment to maternal health. The overall goal of the SMI was to reduce MMR 50% by the year 2000 (A. Starrs, 1987; A. M. Starrs, 2006). This goal was not achieved.

On September 8, 2000 the *United Nations General Assembly* adopted the *Millennium Declaration* which affirmed that every nation is responsible for upholding the human rights of people globally, particularly for the most vulnerable populations, without discrimination because of race, religion or gender (United Nations General Assembly, 2000). This declaration evolved into the eight MDGs where the aim was to improve the wellbeing of people in low income countries by the year 2015. Goal V of the MDGs is to improve maternal health. More specifically, the aim of MDG-5 is to decrease the MMR in low income countries by 75% by 2015 (United Nations, 2007). What is troubling to note is that of all MDGs, the least progress so far has been seen in Goal V. This goal will not be met by the target year unless serious political and financial commitments are made (Gill, Pande, & Malhotra, 2007). There is no single intervention that can substantially decrease MMRs but rather a commitment to value the lives of childbearing women.

1.2 *Maternal morbidity and mortality: a significant global issue.*

Maternal death is appallingly common in low income countries and has a devastating impact. Not only is the inherent value of the woman herself lost all too soon but her family and community are weakened by her death (Reed et al.,

2006). It is estimated that 536,000 women die each year, one woman every minute, because of complications of pregnancy or childbirth (Simwaka, Theobald, Amekudzi, & Tolhurst, 2005; Thompson, 2005). Ninety-nine percent of maternal deaths will occur in low-income countries, half of these in Sub-Saharan Africa. The measure used to describe the risk of death for pregnant women is the *Maternal Mortality Ratio (MMR)*; the number of maternal deaths per 100,000 live births represents this measure (Hill et al., 2007). According to Hill and associates (2007), the global rate of maternal mortality is 402/100,000. High and low-income regions have an overall MMR of 9/100,000 (high) and 450/100,000 (low) respectively which reflects an appalling disparity based on culture and economics. Sub-Saharan Africa's estimated MMR is 905/100,000. To put the crisis of maternal mortality into perspective, Ireland had the lowest estimated MMR in 2005 at 1:100,000, while Canada in 2003 had an estimated MMR of 7:100,000. Of the low income countries, Sierra Leone has the highest estimated MMR for all countries at 2100/100,000 while Afghanistan and Niger have estimated MMR's of 1800/100,000 (Hill et al., 2007; WHO, UNICEF & UNFPA, 2007). These estimates provide evidence that maternal mortality continues to be the health indicator where the disparity between low and high income countries is greatest (Gill et al., 2007; WHO, UNICEF & UNFPA, 2007).

The most common causes of maternal death in Sub-Saharan Africa are attributed to complications of abortion, pregnancy, and childbirth and include hemorrhage; pregnancy induced hypertension, sepsis, and obstructed labor. All of these causes of maternal death are preventable when women have timely access to

skilled obstetrical care (Callister, 2005; Ghosh, 2001; Hofmeyr, 2004; Thonneau et al., 2004; Vork, Kyanamina, & Van Roosmalen, 1997).

"For every woman who dies because of obstetric complications, 30 to 50 women suffer morbidity and disability" (Simwaka et al., 2005, p.708). The most common and devastating obstetrical morbidity that women face in low income counties is obstetric fistula. When labor is prolonged, and the fetal head is positioned in the vaginal tract for extensive lengths of time, soft tissue is compressed against the bones of the maternal pelvis resulting in tissue necrosis. Following birth, a fistula may develop between the vagina and bladder and/or rectum, causing urine and/or feces to drain continuously. Women with an obstetric fistula face stigmatization because of the resulting odor, and are often shunned by their families and communities. The WHO estimates that 200 million women and girls suffer from untreated obstetric fistulas (Miller, Lester, Webster, & Cowan, 2005; Mukhopadhyay & Arulkumaran, 2002). It ought to be noted however, that women often cannot afford the costs associated with corrective surgery; therefore the incidence is likely under reported (Donnay & Ramsey, 2006; Miller et al., 2005).

Another factor to be considered in maternal health is female genital mutilation (FGM) or circumcision. According to a WHO systematic review of obstetrical outcomes following female circumcision, these women are at increased risk of postpartum hemorrhage and experiencing either a stillbirth or perinatal death (WHO, 2006). The practice of FGM is increasingly scrutinized and is regarded as a human rights and gender equality issue. The practice occurs more

frequently in patriarchal societies where both the status and education of women are low, and in rural areas of countries where cultural traditions, religions, and superstitions that affect access to health care are more prevalent. FGM is most often encouraged and performed by women where it is thought that this practice makes a girl more eligible for marriage (Odoi, Brody, & Elkins, 1997; Oduro et al., 2006). Although men may often prefer to marry women who have undergone FGM, they are rarely involved in the decision making or surgical process (Sakeah, Beke, Doctor, & Hodgson, 2006).

Most of the causes of maternal mortality are preventable, providing there is access to appropriate antenatal and obstetrical care including emergency services. This was recognized when the WHO identified initiatives that were believed to promote Safe Motherhood. However, 20 years of promoting, researching and implementing Safe Motherhood Initiatives have not reduced MMRs in most low income countries. With only eight years until the MDG-5 deadline of reducing MMRs by 75%, in 2015 this lack of progress needs to be explored in the countries and communities where rates are highest. To reduce MMRs it is critical that maternal health be a priority in low-income countries. Okiwelu et al. (2007) studied Ghana's safe motherhood programs and noted that Ghana has one of the best health systems in Africa, but that it remains troubled by poor maternal health indicators and inappropriate use of scarce resources. In their study, the authors note that although maternal health is on the Ghanaian government's priority list, it is at risk of "getting lost in the milieu of other interests" (p. 366).

The perspectives of the women themselves and the providers who attend them may enhance our understanding of the value of childbearing women from the community perspective. This increased understanding is especially important in rural areas of sub Saharan Africa where maternal mortality and morbidity is highest (Geelhoed, Visser, Asare, Schagen Nan Leeuwen, Jules H., & Van Roosmalen, 2003). This research aims to provide insights into how childbearing women and other community members' value and perceive maternal health. The goal is to contribute to an understanding of the multifaceted influences on maternal health in a rural Ghanaian community.

Chapter 2

Literature Review

Evidence with respect to maternal health, maternal mortality, and influences on the health of childbearing women, particularly those in low income countries, was reviewed. The search strategy included searching the following databases; CINAHL, Medline, Global Health, PubMed, SocIndex, Academic Search Premiere, AnthroSource, Humanities, and Google Scholar. The key words were maternal, maternal health, maternal death, maternal mortality, maternal morbidity, birth, Safe Motherhood Initiative, World Health Organization, Millennium Development Goals, Africa, Ghana, low income country, developing country, community, anthropology and ethnography. These words were searched individually and in various combinations. There is a plethora of research available that describes maternal health in low income countries and the various influences on maternal health, including those that are socio-cultural, economic, religious, and geographical. No study that examines maternal health from the perspective of her community was found.

2.0.1 ***Culture, community and maternal health.*** The health of women globally is affected by their culture, status, education, reproduction, environment, and access to health care (Gill, Pande & Malhotra, 2007). In countries where patriarchal societies and cultures prevail, the view of women as inferior to men perpetuates the low status of women and their subsequent health status. The low priority of girls' and women's wellbeing may well contribute to a lack of education, nutrition, and control over health and reproduction. In many

communities around the world a woman's decision-making power over her own health is limited. The societal views of women most often stem from deeply rooted cultural norms where women are not perceived as integral to community functioning or as autonomous persons with rights. (Camacho, Castro, & Kaufman, 2006; Jansen, 2006; Thompson, 2005).

There is evidence that community and family members influence women's decisions about antenatal and obstetrical care (Adeleye & Chiwuzie, 2007; Sibley, Sipe & Koblinsky, 2004). Where women have no power to make decisions concerning their own health, other family and community members make, or at least greatly influence, these decisions. Even where obstetrical services are available, women continue to die of complications due to a religious or cultural distrust of modern obstetrics and the belief that to deliver in a hospital is a sign of female weakness (Lawoyin, Lawoyin, & Adewole, 2007). In an ethnographic Ghanaian study it was found that women only gain respect if they can fulfill their reproductive duty, the more difficult a birth the more respect they gain (Jansen, 2007). As well, women in some Ghanaian communities are expected to follow the advice of their older female relatives, and to say *no* is to show great disrespect (Jansen, 2006). In a needs assessment performed by the *Prevention of Maternal Mortality Network* in the Ejisu-Juaben District in Ghana it was found that cultural factors, including beliefs that hemorrhage was a punishment for infidelity, are prevalent and may influence use of medical services (Opoku et al., 1997).

According to Addai (2000) the cultural perceptions of illness and beliefs of what constitutes a threat to health influences the decision of whether or not to

seek out modern medical services. Some cultures and religions have fatalistic views of health and believe that if the woman is to die of pregnancy or birth, there is a spiritual reason and that it becomes part of her destiny. In a qualitative Ugandan study it was found that birth is viewed as a family affair; "the community except for their husbands and close relatives paid little attention to pregnant women when they developed problems" (Matua, 2004, p. 35). As well, Donnay and Ramsay (2006) note that women were denied transport for medical services when requested because their husbands or mothers-in-law refused to pay. In a Tanzanian study using mixed methods for program evaluation, maternal health was found to not be a priority for communities and obtaining transport for obstetrical emergencies was solely a family responsibility (Ahluwalia, Schmid, Kouletio, & Kanenda, 2003).

In a qualitative study conducted in Nigeria it was reported that the use of reproductive health services was influenced by male attitudes to safe motherhood (Adeleye & Chiwuzie, 2007). The women who participated in focus group discussions in this study recalled instances where men refused to heed medical advice for their wives and their refusal resulted in maternal death. It was revealed that hospital staff members attempted to mobilize community members to participate in fundraising to equip the hospital for maternal child health (MCH) services but that they believed that general public apathy and poverty were reasons for the lack of success (Adeleye & Chiwuzie, 2007).

In a quantitative study using data from the *Ghana Demographic and Health Survey (GDHS)* of 1993, factors that determine the use of maternal-child

health (MCH) services in rural Ghana were examined (Addai, 2000). The most important determinant for using MCH services was the level of maternal education. Traditional religions had a negative affect on the use of these services. It was hypothesized that the magical explanation of diseases caused followers to use traditional rather than modern MCH services (Addai, 2000).

Lack of community support for pregnant women in crisis and fatalistic and superstitious beliefs about maternal health, disability and death diminish efforts to reduce maternal morbidity and mortality at the community and family levels in some countries (Addai, 2000; Gyimah, Takyi, & Addai, 2006; Lawoyin, Lawoyin, & Adewole, 2007; Matua, 2004; Roth & Mbizvo, 2001; Rööst, Johnsdotter, Liljestrand, & Essén, 2004). Community leaders and household heads are influential people and can be supportive participants in maternal health education and awareness programs at the community level. Incorporating their views and opinions can lead to greater acceptance by the community of health programs offered by government or non-governmental organizations (Arulogun, Adewole, Olayinka-Alli, & Adesina, 2007).

Gatekeepers can help or hinder HIV program development (Arulogun, Adewole, Olayinka-Alli & Adesina, 2007). The purpose of a qualitative study that included interviews with community members (n=20) from an urban area of Nigeria was to determine the gatekeepers' awareness and perception of mother-to-child transmission of HIV and the services available. The gatekeepers who included religious leaders, community group leaders, and household heads were lacking knowledge about selected topics. It was reported that without educating

all community members and especially community leaders, false information may continue to be passed to those seeking assistance. It is noted that in order to achieve community participation in health promotion programs, it must be determined if the gatekeepers and community members view a targeted health problem as an actual threat that can be reduced through action (Arulogun et al., 2007).

In summary, maternal health, including attendance at antenatal clinics, and access to and use of emergency obstetrics services, is influenced by culture and the knowledge, beliefs and attitudes of community members. Culture is a powerful construct that influences the way people understand their world, how one lives, and the choices and actions taken in regards to behavior, beliefs, and moral-ethical decisions (Leininger & McFarland, 2002). Culture is a broad term that that requires further exploration at this stage. Fetterman (1998) describes two perspectives for defining the term culture; materialist and ideational. Materialist interpretations of culture focus on behaviour patterns, customs and ways of life. Ideational definitions of culture, specifically cognitive approaches, describe culture as the ideas, beliefs, and knowledge inherent to a group of people. Apparent in her theory of transcultural nursing, Leininger combines these two perspectives and defines culture as "the learned and shared beliefs, values, and lifeways of a designated or particular group that are generally transmitted intergenerationally and influence one's thinking and action modes" (Leininger & McFarland, 2002, p. 9). For the purposes of this thesis, Leininger's framework of culture will be used. The cultures studied in this research are that of the culture of

a rural Ghanaian settlement and the culture of pregnancy and birth within the settlement.

2.1 *Study Aims and Research Question*

The culture of pregnancy and birth in a rural Ghanaian village was examined to further understand influences that support or inhibit maternal health. More specifically, maternal health from the perspectives of community members was explored as well as how community members perceive their role in supporting pregnant and childbearing women. To develop a deeper understanding the knowledge, attitudes and beliefs of community members with regard to maternal health was explored. The findings of the study have been examined to gain a better understanding of the multifaceted influences on maternal health within the chosen community. These findings may subsequently contribute to the development of more effective Safe Motherhood Initiatives and improve maternal health status in Ghana through community education. The following research question was explored:

- What knowledge, attitudes, and beliefs of community members influence the type and amount of support received by pregnant and childbearing women?

Chapter 3

Methodology

The research method that was most appropriate to answer the proposed research question is focused ethnography, which provided an understanding of the culture of pregnancy and birth in the selected rural Ghanaian community. The author will first define ethnography in general and then focused-ethnography in particular. How this methodology was apposite for the proposed research will be defended.

3.1 *Design*

Ethnography is a unique research approach that focuses on culture and is appropriate for nursing research because of the holistic perspective (Fetterman, 1998) that mirrors the nursing process (Roper & Shapira, 2000). The term ethnography means to 'write people' (Holloway & Todres, 2006) and the method is rooted in the social sciences, particularly anthropology (Hammersley & Atkinson, 1995). Ethnography may be one of the oldest research methods in that for centuries explorers have documented and described cultures with which they were unfamiliar in an effort to understand their *emic*, or insider, perspective (Streubert-Speziale & Rinaldi-Carpenter, 2003). The fundamental characteristic of ethnography is a focus on culture that is described through fieldwork and cultural immersion. The researcher becomes the instrument through which data are collected, analyzed and reflected upon in a cyclic way (Streubert-Speziale & Rinaldi-Carpenter, 2003). Ethnography is an inductive process that is guided by general questions on a topic of interest. The ideal in ethnography is to have

minimal preconceived notions about the outcomes of the research and to be aware that the research questions generated before the study begins are subject to change once fieldwork commences (Roper & Shapira, 2000).

The task of ethnographers is to collect information from the *emic* perspective and then generate a description or interpretation of a culture, community, or social group from the *etic*, or outsider, perspective (Fetterman, 1998). The overall goal of ethnography is to gain an *etic* insight; understanding why people behave or believe in they ways they do (Roper & Shapira, 2000). This is done through fieldwork; the hallmark of ethnography, which is immersion in the community and the daily lives of the people, includes observing the environment, behavior, language and interactions, and learning through informal discussion and formal interviews about what the people think and feel (Creswell, 1998; Fetterman, 1998; Hammersley & Atkinson, 1995; Roper & Shapira, 2000; Streubert-Speziale & Rinaldi-Carpenter, 2003). Pellatt (2003) also notes that the aim of ethnographic research is not to create an analyzed theory but rather to give participants the opportunity to share their stories.

3.1.1 ***Focused ethnography.*** Because the research focused on a distinct subject (maternal health) within a specific context (rural Ghanaian community) and among a small group of people (pregnant women and community members), a focused ethnography was apposite to address the research questions. The focused ethnography includes the fundamental characteristics of ethnography however, more specific questions are asked and a shorter time frame to complete

the study is required (Roper & Shapira, 2000; Streubert-Speziale & Rinaldi-Carpenter, 2003).

3.2 *Setting*

The research question was aimed at low and very low-income countries where MMR is high. Ghana was chosen for the study because it is a low income country with a high MMR and because it was most accessible to the researcher. The Universities of Alberta and Ghana have a reputable academic relationship including student exchange programs and research related affiliations. The Faculties of Nursing at both universities have recently concluded a partnership in which a graduate program in nursing at the University of Ghana was initiated with the assistance of faculty from the University of Alberta (Ogilvie, Allen, Laryea, & Opare, 2003). Many faculty members within the University of Alberta, Faculty of Nursing continue to maintain contact with former Ghanaian colleagues and graduate students. As well, the graduate nursing students at the University of Ghana have a 6 week academic experience at the University of Alberta as part of their program. One former student of the graduate nursing program at the University of Ghana, Veronica Dzomeku, served as a mentor to me while I collected data for the study.

Ghana, a West African country bordered by Cotê D'Ivoire, Togo and Burkina Faso, has a population of over 22 million people and is considered a low income country (World Health Organization, 2006). In 2007 Ghana celebrated 50 years of independence from colonial rule and was the first country in sub-Saharan Africa to gain independence in 1957. The capital of Ghana is Accra, which is

situated on the Atlantic coast and is home to the University of Ghana (Briggs, 1998). The peaceful country of Ghana has a stable democratic political system and is divided into ten administrative regions (Ghana Ministry of Information and National Orientation, 2008); including the Ashanti region, the area selected for the study (See Appendix A). The region has been chosen because the researcher's mentor, Veronica Dzomeku, lives in the city of Kumasi, the capital of the Ashanti Region, and is most familiar with this area of Ghana. It is also an area with significant maternal morbidity and mortality.

> A range of barriers limit women's access to maternal and child healthcare in Ghana, including distribution of health services and facilities, informal and formal fees at service sites, lack of client awareness about danger signs in maternal and neonatal health, presence of cultural beliefs and traditional practices in communities, aspects of midwifery practice, and a diminishing and aging workforce (Prosser, Sonneveldt, Hamilton, Menotti, & Davis, 2006)

According to Hill et al. (2007), Ghana's estimated MMR for 2005 was 560/100,000. Two studies on maternal mortality conducted in different regions of Ghana found MMR's ranging from 699/100,000 in Greater Accra (Zakariah, Alexander, Van Roosmalen, & Kwawukume, 2006) to 1077/100,000 in rural Ghana (Geelhoed, Visser, Asare, Schagen Nan Leeuwen, Jules H., & Van Roosmalen, 2003). The Ghanaian Ministry of Health reports a MMR of 214/100,000 for 2001(Ministry of Health, 2004). The process of registering maternal deaths in Accra is incomplete despite having a recognized system in place, causing the reported rates of maternal mortality to be underestimated (Zakariah et al., 2006). There is no international standard for collecting maternal mortality data, each country in high and low income countries has their own set of

guidelines. The WHO adjusts maternal mortality rates in all countries because definitions of maternal mortality and methods of data collection vary. Acceptable methods include; civil registration systems, the direct sisterhood method and surveys (Hill et al., 2007).

In two Ghanaian studies, the most common causes of intrapartum maternal death were hemorrhage, sepsis, and obstructed labor. Studies have reported that obstructed labor alone was the cause of death in 8.7% of cases, while sepsis caused 8.8% to 14.8% of deaths, and postpartum hemorrhage in 20.9% (Zakariah et al., 2006; Geelhoed et al., 2003). Uterine rupture is a specific consequence of obstructed labor and in Ghana caused 8.1% of all maternal deaths (Geelhoed et al., 2003). These results are similar to those of other studies and reports where causes of maternal mortality in low income countries were reported (Callister, 2005; Ghosh, 2001; Hofmeyr, 2004; Thonneau et al., 2004; Vork et al., 1997).

In a retrospective chart review conducted in Kumasi, it was found that the rate of reported and treated fistula in 2006 was 1 per 1000 births and that 73.8% of all fistulas were caused by prolonged labor (Bangser, 2006). FGM is a cause of maternal morbidity in Ghana and could be a predictor of intrapartum mortality due to the association between FGM and hemorrhage. The government in Ghana enacted laws in 1994 criminalizing FGM with penalties that include jail time as a possible deterrent for those performing the surgery. According to a study in northern rural Ghana, the incidence of FGM in that district has decreased from 35.2% in 1996 to 21.1% in 2003. This is possibly associated with criminalization

of the practice, community education, interventions and campaigns to end FGM (Oduro et al., 2006).

Since 2006 antenatal care (ANC) in Ghana has been provided free of charge and is fairly well attended. Of all pregnant women in the Ashanti region 74% attended ANC clinics at least once during pregnancy in 2006. However, the cost of care during labor and birth is not free and only 40% of women in the Ashanti region sought skilled birthing care in 2006 (Ghana Ministry of Health, 2008). The Government of Ghana has recently instituted a National Health Insurance Scheme (NHIS) in which clients pay approximately 20 Ghana Cedis (or 20 dollars Canadian) annually for an insurance card that will cover up to 4 children as well. When clients use the NHIS card, their medical care at the hospital is then covered and no upfront money is required at the time of care. It is apparent that Ghanaian women are interested in receiving appropriate care for their pregnancies; however when faced with fees, geographical constraints, lack of transportation and lack of community support, rural women are not accessing care at the most critical time i.e, during labor and birth (Prosser et al., 2006).

The research was conducted in a small town in the Ejisu-Juaben district in the Ashanti region. The town was chosen by my mentor, Mrs. Dzomeku as she lived nearby, had a close relationship with a midwife in the town and felt comfortable that I would be safe and receive the assistance I needed to conduct the research. The town has a population of over 16, 000 people and one of two hospitals within the region is located there. Permission to access the community was obtained from the hospital administrator and medical officer who both

reviewed the research proposal and ethical approval letters. This access strategy was guided by my mentor and permission was obtained prior to data collection. Ethics approval was obtained from the University of Alberta and the Kwame Nkrumah University of Science and Technology (KNUST) ethical review board in Kumasi. English is the official national language of Ghana (Briggs, 1998), but many people still communicate in Twi, a traditional Ashanti language and therefore translation was required. The hospital administrator and medical officer designated the midwife whom Mrs. Dzomeku first contacted, to be my guide and translator as, at the time, she was not working due to injuries sustained in a motor vehicle accident. A confidentiality agreement was signed.

The population of the Ejisu-Juaben district was 120,869 in 2005 with a higher ratio of females (63,456) to males (57,413) (Ghana Ministry of Local Goverments & Maks Publication & Media Services, 2008). There are four urban centers in this district, sixteen towns, and 74 rural settlements (population less than 5000) that make up 69% of the population; indicating that the district is largely rural (Ejisu-Juaben District Assembly, 2007). Agriculture and forestry are the main economic activities in this district (Ghana Ministry of Local Goverments & Maks Publication & Media Services, 2008; Opoku et al., 1997). The main sources of income for people in the chosen town were noted to be farming and petty trading.

The predominant ethnic group in this district is the Akans, or Ashanti, who constitute about 86% of the population. Other ethnic groups like the Ewes or Gas are 3% and 1% respectively. Christianity is the dominant religion constituting

about 87% of the total population while Muslims and Traditionalists constitute 9.7% and 1.7% of the total population respectively (www.ghanadistricts.com).

There are seven erratically situated health centers that provide normal labor and birth services and three family planning centers. Emergency services are always available in Kumasi and in the selected town. However, if the doctor has travelled out of town, services such as emergency caesarean section and treatment of severe hypertension cannot be managed by the midwife alone. Under these circumstances, the midwife is obliged to call the ambulance from the neighbouring city; approximately 20 minutes drive away, to transfer the patient to a hospital in Kumasi. The ambulance services, when available, are provided free of charge. There are also two other sites within the district that provide care for women who have hemorrhaged and three that offer care for women with cervical lacerations (Ejisu-Juaben District Assembly, 2007; Prosser et al., 2006). In 2004, the physician and nurse ratios per 1000 people were 0.15 and 0.92 respectively (World Health Organization, 2006). According to a report for the U.S. Agency for International Development, there were 23 midwives working in the Ejisu-Juaben district in 2005 (Prosser et al., 2006). In the selected town, there were 6 midwives on staff, one was off work due to the vehicular accident, and another would be taking a maternity leave soon.

3.3 *Sample*

When beginning an ethnographic study, the researcher must first gain entry to the community of interest and "an introduction by a member is the enthnographer's best ticket into the community" (Fetterman, 1998, p.33).

Fetterman warns that walking into a community as a stranger may alone cause community members to be reluctant to participate. Establishing rapport with community 'gatekeepers' by retaining a key informant is the best way gain access to the community (Creswell, 1998). My mentor was the ideal person to initiate this process. Mrs. Veronica Dzomeku is a nurse-midwife who is familiar with the town and was able to introduce me to community gatekeepers including a local midwife who became my key informant, guide and translator. Mrs. Dzomeku also supported me in learning behaviors and ways of interacting that reflected sensitivity toward the values of the community. With her assistance, I was able to easily gain entrance and earn the trust of the community members.

The focus of qualitative research methods is the depth and quality of the data obtained and the interactive process. Thus, the number of participants interviewed or observed cannot be determined *a priori*. The key to qualitative and in particular, ethnographic research is to collect data until saturation occurs or until no new concepts or themes emerge from the data (Creswell, 1998; Fetterman, 1998; Roper & Shapira, 2000). I anticipated that I would formally interview approximately 10 community members including 3 to 5 childbearing women nearing the end of their pregnancy, as well as traditional birth attendants, midwives, community leaders, expectant fathers and other key informants. Many insights emerged with respect to pregnancy and childbearing within the selected community. During my initial visits to the town, I was able to establish a good rapport with the midwife, my key informant, who assisted me with identifying those who are community leaders, most knowledgeable of the culture and who

might be willing to participate in interviews. A key informant is the term used to describe a person who is willing to spend time with the researcher to explain customs and beliefs and is able to view the subject from a variety of perspectives (Fetterman, 1998; Roper & Shapira, 2000). My key informant was able to identify people who she thought would be interested in being interviewed or was able to find someone who I was interested in interviewing. For example, I was interested in interviewing an elderly woman, and through her contacts, she was able to identify an appropriate interviewee. This method was culturally appropriate and avoided coercion by the researcher.

The initial method of sampling that I used for observation was the "big-net approach" (Fetterman, 1998) which involved mingling with as many people as possible and narrowing those I observe as the study progresses. The methods of recruitment for interviewing were purposive. Purposive sampling is useful in qualitative research as it allows the researcher to choose the participants believed to be the most knowledgeable about the cultural group and who will provide information necessary to gain insights into the area of study (Creswell, 1998; Roper & Shapira, 2000). To avoid coercion, I did not approach potential interview participants myself. I had my key informant briefly explain the research to the selected person and provide my contact information as well as the information letter to them. They could then choose to contact me for further information and/or to arrange a time to meet for an interview. In reality, a less formal process was adopted as was most culturally appropriate in that area. In most cases, the person agreed at that time, was read the information letter, signed

the consent form, and the interview was carried out on the spot. To recruit pregnant women, my key informant thought that it would be most appropriate to make an announcement at the antenatal clinics. The midwife gave a brief explanation, in Twi, of the research and asked that if any woman was interested in participating, to inform the midwives at the clinic, or at any time following. I was told that nearly every woman at the clinic was interested, however only women from the town of study could be included. In all, five women signed consents after being read the information letter. Two of these women gave birth before any observations or interviews could be done. One of these women invited the researcher to visit her in her home, and I visited her on three occasions and the observational data gained will therefore be included in the study. The remaining three pregnant women who could be interviewed and observed prior to birthing were included in the study. Posters advertising the research were deemed unnecessary by the key informant and were therefore not utilized.

3.4 *Data Collection*

Three data collection strategies are germane to ethnography; participant observation, formal and informal interviews and examination of relevant documents. The ethnographer as the research instrument is required to keep an open mind, write detailed field notes and generate pertinent interview questions, all the while analyzing the data collected to be able to adapt observations and interviews accordingly (Roper & Shapira, 2000). Ethnography usually begins with participant observation, which is the central strategy for data collection.

3.4.1 ***Participant observation.*** "Participant observation is immersion in a culture" (Fetterman, 1998) and ideally the ethnographer should be in the community for at least six months. A focused ethnography requires a shorter timeframe, which made the proposed study feasible in that the researcher was able to be in the selected community for eight weeks. After gaining access to the community, the initial step was to engage in observation of the community and conduct a general observational survey. This was the exploratory phase of the study where descriptive observations were made of situations and people in their natural setting. Field notes were collected in this phase and included observations of the community members; the settings where people live, work, and socialize; location of important structures such as health clinics, schools and transportation (Roper & Shapira, 2000). Those observed were not identified by name or described in any way that could breach confidentiality or privacy.

Roper & Shapira (2000) describe four levels of participant observation from observer only, observer-as-participant, participant-as-observer, to participant only. On one end of the spectrum is participant only in which the researcher is intimately involved with the community. This method is typically used in covert observation. On the other hand, the observer only role requires no participation with the community, which has advantages in maintaining objectivity and is appropriate in the beginning of the study or during the general survey. Because I had never been to Ghana and was unfamiliar to the community, I anticipated that I would begin the study in the "observer-only" role and hoped to progress to the "observer-as-participant" role (formal contact, some participation). Although it is

ideal that the researcher attain a "participant-as-observer" role (extended contact with the community, insider perspective), this was not possible in this focused ethnography with a short timeframe. By spending as much time in the community as possible, I hoped to achieve the "participant-as-observer" role on some level, realizing that this would not be sustainable throughout the research time. This approach of changing from outsider to an insider role is common in ethnographic research (Creswell, 1998) and gives the ethnographer the best opportunity to understand events and their meanings. Using these roles allows the researcher to "step back from the situation, interpret their observations, and analyze the event" (Roper & Shapira, 2000, p.19).

During the research time, I travelled to the town on Tuesday mornings and returned to the city of Kumasi on Friday afternoons. I was given a room in the student's hostel behind the hospital for the 3 nights per week that I stayed in the town. My mentors agreed that this would be appropriate and safe and would allow enough time to be spent in the community to conduct the research. The Canadian High Commission was aware of my whereabouts, as was the colleague with whom I travelled to Ghana. I initially observed the community as a whole, and later I focused my observations more specifically. To be able to observe the interactions of pregnant women within the community, I recruited three pregnant women to observe and interview. I had planned to participate in their daily activities and observe them in their natural setting. This was deemed to be unnecessary by my mentors as pregnant women in Ghana do not do much work when they are heavily pregnant. Therefore, I observed the women during the

weekly visits and observed pregnant women in the community in general. This type of selective observation allows the ethnographer to focus on the specific area of interest (Roper & Shapira, 2000), which in this case included the pregnant woman's formal and informal relationships and sources of support within her community. I was also invited to attend one of the women's births at the hospital, which provided the researcher with invaluable information with respect to how birthing women are supported, and how community members interpret their role in the process. Roper (2000) notes that a key element in ethnography is to observe significant events as they happen and to note how people react, what they talk about and with whom they interact.

Field notes are written documentation of the observed events and were collected using the 'who, what, when, where, why, and how' strategy as described by Agar in Roper & Shapira (2000). I wrote observations in a small pocketbook as they happened, or as soon as possible after the observed event. I kept the descriptive, concrete notes separate from reflective notes by drawing a line down the center of the page, writing observations and conversations on the left side and my interpretations or reflections on the right (Creswell, 1998). At the end of each week I transcribed these shorthand observations using a word processor and the same headings and expanded upon descriptions and interpretations at that time. I also kept a personal diary of events to reflect upon my experience, reactions and emotions in order to maintain balance and to determine if interpretations of events had been influenced by my mood at the time (Hammersley & Atkinson, 1995; Roper & Shapira, 2000). I also debriefed as needed with my mentor and

communicated with my supervisor through the use of email. This awareness of self is termed *reflexivity* and allows ethnographers to identify their personal biases and recognize how this influences the data collected and how they interpret the data (Roper & Shapira, 2000).

To document conversations, Roper and Shapira (2000) suggest using Strauss & Corbin's (1990) method. To do this, I used quotations when I had an exact recall of what was said, apostrophes when paraphrasing, and no marks when I had a fair recollection of the conversation. Each entry included the date, time and location of the observation or conversation. No names appeared within the field notes and no descriptions were used that could ultimately identify sources of information. Field notes were kept confidential and in a secure location, either in my locked backpack or the locked cabinet in my room (Hammersley & Atkinson, 1995).

The goal of participant observation is to gain an understanding of the day to day lives of a cultural group within their natural setting. The presence of the researcher in the community can have an affect upon how the community members act and interact. It is suggested that ethnographers make every attempt to "blend in" and although copying the dress and demeanor of the people they are researching is not necessary, it can be helpful. It was important for me to have an awareness of how I present myself to others by minding my dress and speech to minimize the impact that I had upon the community and to make positive impressions upon the community members (Hammersley & Atkinson, 1995). As well, I hoped that after the first month in the community the members would

"forget their 'company' behavior and fall back into familiar patterns of behavior" (Fetterman, 1998, p. 36).

3.4.2. *Interviews.* The most important data gathering technique of ethnography is interviewing (Fetterman, 1998). Two types of interviews, formal and informal, are commonly used within the ethnography. Formal interviews are similar to questionnaires. There is an explicit research goal, and questions may be open or close-ended (Fetterman, 1998; Roper & Shapira, 2000). Fetterman (1998) suggests using this type of interview near the end of the study when the questions may be generated from the *emic* perspective. Informal interviews are more common to ethnographic research and can be difficult to conduct. Unlike formal interviews, the research agenda is implicit rather than explicit. Fetterman states, "informal interviews are useful throughout an ethnographic study in discovering what people think and how one person's perceptions compare with another's" (p.38). During observations is it common to ask specific questions about what has been observed to gather the *emic* perspective. The researcher may have a list of questions to ask but the informal interview is often spontaneous and the questions may arise serendipitously from the conversation (Fetterman, 1998; Roper & Shapira, 2000). If it was suspected that a conversation may be lengthy and the researcher would benefit from audio recording, the purpose of the recording and confidentiality were explained.

Interviews included the following; 7 formal interviews, 1 informal interview and one focus group interview. In total 12 people participated in the interviews. I used a standard form to collect important demographic information

such as age, gender, parity, number of children, occupation, education and religion, (See Appendix B). Interviews were conducted with the childbearing women, whom I observed, both prior to and following the birth. I also interviewed a farmer, traditional birth attendant, a taxi driver, a nurse, a midwife, an elderly woman, a petty trader and a researcher. To discover as many perspectives as possible, I chose people with varying demographic characteristics. As planned, a focus group interview as a form of *member checking* was conducted and participants were four market women (Creswell, 1998). The interview guides are included and it is important to note that as insights were gained and narrowing of the focus occurred, these preliminary questions were altered (See Appendix B).

English is the official national language of Ghana, but many people prefer to speak one of the traditional languages. Roper & Shapira (2000) state that interviews should be conducted in the participants' native language and thus an interpreter was required. My mentor, Mrs. Dzomeku was able to arrange for a local midwife to be my key informant. This midwife also acted as my translator. The hospital administrator and physician appointed her to this role as she was not working at the time due to a motor vehicle accident. I was initially wary of having a midwife as the translator because she might have been seen by participants as a person with power, who they might have to impress. My concern was that they might respond in ways that they believed she would approve. However, as I became acquainted with her it was obvious that she had good rapport with community members and was someone who seemed to be respected. She often engaged in friendly conversation with the market women, crafts persons

and childbearing women in the antenatal clinics and in the delivery ward. When the research began, she diligently interviewed the participants with the questions I had prepared. As time passed and we became more comfortable with each other, I was able to ask for her insights into how I could frame the questions more appropriately to get the information I needed. Her professionalism and knowledge of maternal health proved invaluable as she was able to suggest further questioning during some interviews and on one occasion recognized a need for further questioning of a certain topic before I had even thought of it. As well, because she was raised in a different region of Ghana and was a member of another cultural group, she was not familiar with all of the cultural practices and beliefs of the people in this community. Although her presence may have affected some of the information received, I believe the positive impact she had on the research far outweighed the negative.

I spent some time with the midwife before conducting any interviews to explain the purpose of my research and the information I hoped to gain from the interviews. When it was necessary to conduct the interview in Twi, I had the midwife communicate the participant's responses to me during the interview so that I was able to prompt accordingly. The interviews were audiotaped and transcribed by the researcher soon after the interview so that I was able to clarify responses and discuss how the next interview could be improved.

One interview, the focus group, began informally in the market with a group of women. In this case the women did not want to sign a consent form and verbally agreed to the audiotaping after the research was explained to them from

the consent form. My mentors and I feel that this was appropriate because jotting notes during a conversation can be distracting for the participants (Fetterman, 1998; Hammersley & Atkinson, 1995) and the women were given all of the appropriate information and offered a verbal consent.

3.4.3 ***Review of existing documents.*** The third method of data collection that I used in the study was the examination of existing documents. I explored media within the community including posters, pamphlets, television or radio adds that pertained to maternal health to get a sense of how maternal health is perceived within the community (Roper & Shapira, 2000). I was also given information on community population, and birth statistics. No maternal mortality information was available.

3.5 *Data Analysis*

The process of data analysis in ethnography is continual and iterative; from the time data collection begins to when manuscripts for publication are developed, the researcher is continuously analyzing and looking for patterns in the data to assist with narrowing the focus. A great deal of data are collected during the study period from observations, interviews and documents and the goal of analysis is to organize the data, look for patterns and make sense of the experience and the cultural patterns that present themselves. (Creswell, 1998; Fetterman, 1998; Hammersly & Atkinson, 1995; Roper & Shapira, 2000; Speziale & Carpenter, 2003)

There are many analytic strategies for ethnography and the approach used depends upon the purpose of the research (Hammersly & Atkinson, 1995).

Because data analysis is continuous in ethnography, the step-by-step process for this stage of the research is difficult to describe. Techniques described by Roper and Shapira (2000) that included coding field notes, sorting to identify patterns, generating concepts, and memoing reflective remarks were used. A linear process is not suitable for ethnographic research so techniques were used concurrently.

Coding field notes and interview transcripts entails assigning labels to segments of the data to reconstruct the data and condense it to a more manageable size. Roper and Shapira suggest organizing the data under broad headings, such as events, activities, relationships, meanings, repeated phrases, and perspectives. More detailed coding can be done by underlining key words in the data and thus creating more specific, and perhaps fewer, subheadings (Roper & Shapira, 2000).

Patterns of thought and behavior are identified by comparing, contrasting and sorting the data (Fetterman, 1998). Patterns are identified by looking for anything that stands out as surprising, noting any inconsistencies or contradictions in beliefs or attitudes, and by noting how the data relate to what was expected on the basis of previous knowledge (Hammersly & Atkinson, 1995). Roper and Shapira suggest sorting the coded data into an even smaller number of sets based upon the patterns that arise and comparing these patterns to current literature on the subject. When dealing with outliers at this point (events or statements that do not fit with the rest of the data), Roper and Shapira suggest testing these against the rest of the data to strengthen the analysis.

Generating concepts is a significant aim of ethnography (Roper & Shapira, 2000) and may arise from what participants have said or be identified by the

researcher through the earlier analysis (Hammersly & Atkinson, 1995). Concepts that are generated need to be compared with those found in existing literature to determine if what the data are saying is, in fact, related to an existing theory or if a new theory has emerged (Roper & Shapira, 2000).

Throughout the analytic process I recorded reflective insights alongside the coding and conceptualizing processes. These reflections were written in such a way as to ensure they are distinguished from the objective field notes. This is referred to as *memoing* and may take the form of questions or ideas that need further testing (Roper & Shapira, 2000). Memoing is a tool to assist with the analysis as it captures the thought process of the researcher from the beginning of data collection through to the end of analysis.

3.6 *Rigor*

It is important in qualitative research to maintain rigor with openness, thoroughness in data collection and adherence to a philosophical perspective. *Validity* is a measure of rigor in qualitative research and refers to the accuracy of the methods used to collect and analyze data (Burns & Grove, 2007). Credibility is supported in ethnography when the results reflect the reality; the challenge is to capture the reality by eliciting what participants believe to be true (Roper & Shapira, 2000). In ethnographic research, *triangulation* is used to enhance the trustworthiness of the research by improving the accuracy and quality of the data. Using three types of data collection strategies i.e, interviews, observations and reviewing documents, a more complete picture of the studied group is possible (Fetterman, 1998; Hammersly & Atkinson, 1995; Roper & Shapira, 2000).

Triangulation involves testing one source of data against another to generate the best explanation (Creswell, 1998).

Trustworthiness in qualitative research refers to the credibility, transferability, and dependability of the data (Guba & Lincoln, 1989 as cited in Koch, 2006). Guba & Lincoln (1989) claim that a study is credible when it presents authentic descriptions that can be recognized by readers when they are confronted with the same experience. By making detailed field notes, generating accurate interview transcriptions and maintaining the focus of the research question, the researcher should be able recount how each theme was derived from the descriptions by returning to the original text (Koch, 1994). Transferability, or 'fittingness', refers to how well the data can relate to contexts outside of the study. A sign of transferability is when the audience perceives the findings to be meaningful and useful (Koch, 2006). Dependability is reliant upon how easily the findings can be audited and it is recommended that a decision trail be left to show how conclusions were reached and how choices were made during the study. This is best achieved by memoing to indicate research decisions and influences throughout the study (Koch, 2006).

Reflexivity can be defined as continually reflecting upon and discussing the experience of conducting ethnography. Because the researcher is the instrument in ethnography, it is not possible nor is it desirable to separate the researcher from the research to obtain complete objectivity. Reflexivity allows ethnographers to identify biases and preconceived notions, and to recognize influences on the data and on the interpretation (Hammersly & Atkinson, 1995;

Roper & Shapira, 2000; Pellatt, 2003). To increase rigor in ethnographic research the researcher kept a reflective journal and then included a reflexive account. This will allow readers the opportunity to critique the believability of the text and consider its applicability to their particular setting (Pellatt, 2003). My reflective journal was actually started prior to data collection so that reflections of my expectations and preconceived notions were included. These acknowledgements enhanced the rigor.

3.7 *Ethical Issues*

This proposal was approved by the University of Alberta, Health Research Ethics Board, the Kwame Nkrumah University of Science and Technology (KNUST) Ethical Review Board in Kumasi prior to beginning data collection. Because ethnographers often inquire into personal beliefs and stories, she/he must subscribe to a code of ethics that preserves the participants' rights, facilitates communication and allows for future research (Fetterman, 1998).

Informed consent is an important ethical consideration and requires that the researcher explain the purpose of the research along with potential risks and benefits so that potential participants can consider whether or not they choose to participate (Hammersly, 1995). When observing the pregnant women and when conducting interviews, I provided full disclosure of the research purpose and potential known risks and benefits. A formal written information letter was provided to the participant and a formal written consent was signed. The information letter and consent form were written in English and then translated by the midwife that I worked with. The information letter and consent were read to

the participant in their first language by this midwife (See Appendix C). When working in the field, ethnographers may need to revisit previously obtained formal consent from participants if a significant event, such as the birth of a child, should occur (Speziale & Carpenter, 2003). When I was invited to observe a participants' labor and birth experience, I revisited the formal consent with them upon invitation. Formal written consent is not required when observing activities that occur normally within the setting and specific individuals cannot be identified, because sight approval was obtained from community leaders (Roper & Shapira, 2000).

Privacy and confidentiality are of utmost importance in any research. It is important to keep all data in a secure location separate from any identifying information such as signed informed consents. A number and letter combination was assigned to each participant and the lists of participants and their corresponding number was kept secure. I did not reveal to anyone who had, or had not, participated in the study. As aforementioned, I kept documents including consent forms, field notes and interview transcripts in a secure location.

Safety of the researcher was also an ethical concern in this study. I was in an unfamiliar setting where there was a language barrier and isolation. I felt that it was safe to reside in the town because my mentor and key informants agreed that it would be safe for me to do so. I maintained communication with Mrs. Dzomeku and my University of Alberta colleague; as well, the accommodation provided was inhabited by medical students, nursing students and midwives, and therefore I was never alone. I carried a cell phone with me at all times so that

participants could contact me or so that I could call for help if I believed my security was threatened. I never encountered an unsafe or threatening situation in the whole three months that I stayed in Ghana. I was sure to inform my colleagues of my whereabouts at all times and also register my whereabouts and scheduled plans with the Canadian High Commission upon arrival in Ghana.

Role conflict is a consideration for this study. As a Registered Nurse and a researcher there was potential for others to confuse my role within the community (Roper & Shapira, 2000). I ensured that everyone I worked with was aware than I was in the community as a researcher and not as a nurse. I was, however, prepared to attend to a medical emergency or situation in which my experience as a nurse was sought out by the community and no other person at the time could provide the same assistance. Fortunately, no such situation ever occurred.

Chapter 4

Results

The purpose of the research was to describe knowledge, attitudes, and beliefs of community members that influence the type and amount of support received by pregnant and childbearing women. To accomplish this, field notes of observations within the community were collected and available documents or advertisements that pertained to maternal health were reviewed. Seven formal semi-structured interviews were conducted, including interviews with three pregnant women and six other community members. A focus group interview was conducted with a group of four market women. One informal interview was also included. The interviews consisted of open-ended questions designed to incite responses that would reveal the knowledge, attitudes and beliefs that the interviewees held in regards to pregnancy, birth and the support that childbearing women need and/or receive (Appendix A). All of the people that were approached agreed to participate in the study.

The interviews were conducted in Twi by the key informant and translated into English throughout so that I could respond or prompt for further details. The interviews were transcribed in English and analyzed concurrently with ongoing data collection so that new questions could be developed based on the insights gained in the earlier interviews. The first participant was interviewed a second time because new questions emerged after the researcher became more familiar with members of the community. Data were further analyzed upon returning to Canada, and a number of themes emerged that were based on insights gained from

the data collection process. The community is described first; then insights gained about the how childbearing women are supported in this community are described. Finally, emerging themes from these findings are identified and exemplars provided to support their inclusion as themes.

The community is situated in the Ashanti region and has population of over 16, 000 people. It is approximately 30 kilometers from Kumasi, the second largest city in Ghana. The Ashanti culture is prominent in this community as is the traditional Ashanti language, Twi. Although English is the official national language, Twi is most commonly spoken, and in the chosen community, most people understood very little English. This town is located alongside a major, paved highway that is filled with packed trotros as well as taxis and trucks carrying loads of palm nuts to the palm oil mill. The heart of the town is the lorry station and market; both located near the Chief's Palace. In Ashanti culture, each community or village is governed by a Chief and a Queen Mother, both of whom are chosen through matrilineal lines by the Royal clan of their particular town. Their role is to see to the municipal needs of the town, such as ensuring that the government maintains their highways and provides access to health care and education. Child health clinics are held monthly at a building that is actually part of the Chief's palace.

4.0.1 ***Customs.*** Particular customs are very important in Ghanaian culture. Whenever I visited a home with my key informant, we entered the property from the right side, even if we had to go out of our way to do so. When greeting a group of people, I was told to greet the person on the right first and

then move to the person on the left and so on. It is customary to remove ones shoes at the door of the home before entering and guests must always be offered something to drink, traditionally water is offered as "water is life". When we were seated in the home, small talk would ensue between my key informant and participants, and it seemed she would wait for the host or hostess to "ask of our mission" before she would introduce the research or discuss the woman's pregnancy or any other personal detail. When our mission was explained and the host agreed, we would carry on with our conversations. As well, when it was time to leave, the key informant always asked permission from the host for us to depart. We would then be escorted off the property and wished a safe journey home.

4.0.2 ***Income.*** The main sources of income in this town are farming, petty trading, and skilled crafts making. Skilled crafts persons included Kente cloth weavers, shoemakers, tailors and carpenters. Agriculture is the main source of employment for the people in the Ejisu-Juaben District with over half of the total labor force working in agriculture. The chosen town is surrounded by palm nut farms and a large plant that produces palm oil and Shea butter is situated within the community. This plant employs approximately 450 people.

4.0.3 ***The market.*** Market day is held on Tuesdays; this is when farmers from near and far bring their produce to be sold in the streets. A small portion of the main road from the lorry station to the hospital is closed down during market day as vendors set out their blankets and tarps to sell their wares. The rest of the market is set up along a one-kilometer stretch of road behind the lorry station.

This market area provided a great location to observe community members interacting with each other. I would walk through the market most Tuesdays and I rarely saw a heavily pregnant woman, buying or selling. If I did, she would have a person with her to help carry her purchases. I learned that it is customary for women to stop doing strenuous work when they get to a certain time in their pregnancy, usually around 36 weeks gestation, or when they become more tired or when their back is aching from the weight of the baby. When observing in the community, and also throughout areas travelled in Ghana, it was uncommon to see a heavily pregnant woman participating in strenuous labor such as carrying heavy things in the market, fetching water or firewood, or even travelling. I asked about this in one interview and I was told that indeed, heavily pregnant women do come to the markets alone. One participant explained how sometimes a pregnant woman will bring her goods to market and unless she is with a family member, she is not likely to be assisted by anyone;

> "In the market place itself, it's a place where everybody has come to do something, so some, they won't mind [pay attention to] you. But if maybe it's your family, they'll mind you. But maybe (I'm) tired, and you too you've carried your thing and you're coming to sell, so (I) won't leave (mine) to come and help you. So nobody will mind you."

4.0.4 ***Pregnant women and travelling.*** On one occasion when travelling in a different region of the country, I boarded an overloaded bus where people had to stand in the aisles because every seat was full. On this bus was a very heavily pregnant woman travelling with three small children. She was forced to stand on this bus, over the bumpy dirt roads, because no person offered their seat to her. On one other occasion a woman boarded a trotro in the town heading to Kumasi.

She had a baby on her back, approximately three months old, as well as young boy about two years old. As she struggled to board the trotro, someone eventually assisted her by holding the baby for her until she took her seat. However, she was seated on the edge of the row, which was most inconvenient for her because she had to get off and on the trotro on two more occasions to allow the passengers beside and behind her to get off.

4.0.5 ***Education.*** The town has many schools from pre-kindergarten to secondary, including public schools and religiously affiliated private schools. I was told that it is free for children to attend the public schools in Ghana. The family must still pay for the child's uniform and extras like pencils and notebooks, but school fees are waived. While trekking through town on a weekly basis, it seemed that most children in the town attended school. On school days the streets were very quiet, and when the children had days off, the sounds of children playing filled the air. I often passed by a soccer field that would be full of children playing with a make-shift ball during the evenings and afternoons when there was no school. Occasionally I would see children not in school during school hours. When I asked about this on one occasion, I was told that this group of children was following their mother to their farm to work.

4.0.6 ***Healthcare.*** The hospital is located on the outskirts of the town about one kilometer from the main highway. The hospital has two general units for medical and surgical patients as well as an operating theatre and the maternity unit. Adults and children as well as the postpartum mothers are treated on the general wards. The hospital also has a lab, an ultrasound and a public health

office. Posters are placed on walls near the public health office and antenatal clinic promoting breastfeeding, immunizations for mothers and babies, prenatal vitamins and malaria prevention. There was also a large billboard outside of the hospital promoting breastfeeding that read; "Breastfeeding is Best".

A new wing was added to the hospital which was just nearing completion at the end of my study. This new wing is the new maternity unit and it is well equipped with its own operating theatre, space for the antenatal clinics, a larger, private area for postpartum women and new equipment for the delivery room, including a new bed. There is a separate staff lounge equipped with a table and chairs, beds for the staff to utilize when working nights, a private shower and toilets for the staff. When touring the new maternity unit I noticed that this unit had three toilets stalls for the postpartum and laboring patients. In the old unit, the women would use a small pot to urinate or stool in when in labor. This pot would need to be emptied by a family member at a certain place behind the hospital. When I commented to the midwife that it was good to see the women having access to actual toilets, I was told that the patients would still use the pots because there would not be enough toilets for everyone to use. The obstetrical unit seemed to have six patients maximum at any given time and three toilets would be sufficient for them to have access whenever they needed it.

When observing postpartum and laboring women in the hospital, I noticed that the women most often had at least one female family member in the room with them while in labor. During the delivery, the patient had the midwives only for support because the room was too small to allow any visitors. The midwives

seemed to be kind to the patients, speaking to them calmly and encouraging them on occasion. For example, I visited with a midwife in the unit for approximately one hour. There was a woman in the adjoining labor room, behind the closed door to the delivery room where we sat, who was having her first baby and she was in the active phase of labor at six centimeters dilatation. She squatted, silently, on a stool beside her bed, her mother sat in the only chair in the tiny room. When I was leaving the unit, the midwife walked me out. As we passed this laboring woman, the midwife asked how she was fairing and the patient responded that she was "fine" but that the pains were "coming stronger now". The midwife reassured her in a soft voice and told her that all would be fine, God willing, and left the room.

4.0.7 ***Antenatal clinic.*** When observing antenatal clinics at the hospital, I learned that multiparous women (those who have one or more children) were assigned to attend the clinic on Wednesdays and nulliparous women (those who have no children) to attend on Thursdays. I was told that this was to facilitate their learning needs in that multiparous women would not need as much information as the nulliparous women. The clinics began at approximately 8:00 a.m. and continued until the last woman was assessed, usually before noon. The women were seated together on benches, clad in their nicest dresses and one woman was asked to pray for the group. They then all sang a song in Twi, followed by a brief informational lecture provided by a nurse-midwife. The women were then systematically assessed. The assessment included blood pressure, abdominal palpation for fetal lie, measurement of fundal height,

auscultation of the fetal heart rate, conjunctiva, and a urinalysis for protein, ketones and glucose. I noticed that the women often paid the nurse-midwives 1 Ghanaian Cedis ($1) (a significant cost for market women or traders) for a container for their urine specimen, which was actually a used, empty vial from the oxytocin used in the delivery room. The women's antenatal record book was examined, assessments recorded and ultrasounds reviewed. The pregnant women rarely spoke unless when responding to the nurse-midwife. When their assessments were complete and they required no further intervention such as an ultrasound or malaria testing, they were free to leave. Women were usually seen leaving with their family members who waited outside of the hospital for them.

4.0.8 ***Lights, water and homes.*** The hospital is situated across the road from the oil mill which generates power as a byproduct. Power is provided to the hospital free of charge. For the rest of the community, power availability was unpredictable and I would often spend evenings with a flashlight as the only source of energy, especially during the rainstorms that became a nightly occurrence near the end of my time in Ghana. The hospital and nurses residences also had flowing tap water, but at times this would also shut off for unknown reasons and water would be hauled from a well for cooking and bathing. For the rest of the community, water was hauled from open or pump-handled wells by the women and children. I passed by many wells in my travels through town, and thus it seemed that people would not have to travel too far to have access to water, although I could not determine how clean this water was.

A typical Ghanaian family dwelling in this community is made of concrete that has four or more separate rooms that are entered from the outside. These buildings are often L-shaped or square with a central courtyard. The main room is used for the parents and children to sleep in and is usually equipped with a small couch or some stools for visitors to sit on. I learned that one particular family used to have a television but that the children were not finishing their homework because they spent too much time watching, and therefore their father sold it. The homes I visited all had a radio that would often be blaring "highlife", a popular style of music in Ghana, or a Christian program. One room in a typical home is intended to be a kitchen, which is only used if the family has a stove. Generally, the cooking takes place outdoors, sometimes under a shanty made of sticks and mud with a traditional Ghanaian "stove" made of clay. Firewood is either collected from the bush or the farm or purchased from the market. Some families have a propane tank with a gas range attached that can be used outdoors. I also saw a family using charcoal in a small barbeque to cook their food. Water is most often collected from nearby wells by the women and children. This water is often kept in a large cistern for bathing, cooking and cleaning.

4.0.9 ***Women's work.*** Women are responsible for the majority of upkeep in the family home, including laundry, hauling water, cooking, cleaning and walking to the farm to collect produce as well as firewood. I learned that, when women are pregnant and feeling unwell, either due to morning sickness or when they near the end of their pregnancy their family and neighbors will help

them with these chores. All of the participants agreed that pregnant women in this community had all of the support they needed, from one source or another.

4.0.10 ***Marriage.*** Marriage is very important in Ghanaian culture. Unlike in "western" culture, common-law relationships are rare, if not non-existent in this community. Marriages are generally based upon love between a man and woman and they will seek approval of their parents when they decide to be married. Because of the importance of the matriarchy in Ashanti culture the bride's uncle (her mother's brother) is consulted prior to the wedding. He is often deemed the guardian of the marriage and, should the couple need counseling during their marriage, he is the one they will talk to. However, when women marry, they typically join the husband's family, and most often the family lives together in a larger dwelling. This helps the pregnant women to be supported as they are not frequently left alone to tend to the chores themselves. One participant stated;

> If you are pregnant and you don't have any problem, then you do everything on your own. But in case you are sick, your husband's sisters will help you. If you are staying with your mother and father-in-law, the immediate siblings there will help you. If you don't have any of them, your friend, any friend that you have – that is why you have to get friends who you can be free with – so that when you are sick or you want to do something and you can't do it and there is nobody around, they will come and help you.

4.0.11 ***Bringing forth.*** When a woman is married, the couple is expected to bring forth a new baby when they are ready to do so. Participants told me that childbearing is very important in Ghanaian culture; that all women must bring

forth. Participants described different reasons for having children. For example, one participant stated;

> The belief is that you have to bring forth. So that when you grow old, your child will come and look after you. But if you don't deliver, who will look after you? We are not like maybe, those places when it happens; they will just...when you're 70 push you to some place. In Ghana it's not like that, so if you don't have anybody, then you will starve to death.

Another participant described the importance of one's legacy by saying,

> ...if you are young...you have to deliver so that your children, even when you grow old and you die, your children will come and replace you. And then the children too will be in the house and they will not let your name go away. Because if you don't deliver and you die, nobody remembers you. But because of your children, they will remember you.

Many participants talked about the importance of having children in the community as an issue of status; one participant in particular stated;

> In this community here, if you don't bring forth, when the family is gathering, at times they don't regard you....So if you don't deliver you're not very important.

Another participant expressed the importance of childbearing as becoming a member of the community; she stated,

> If you don't bring forth, we have a saying here, they call you names, that you are unable to bear fruit. So you must bear fruit, and when you bear fruit, then when they are counting, they count you too among them. So it is good that you become pregnant and then deliver.

Earning respect from your community and gaining a deeper respect for your elders was also described;

> Pregnancy and delivery is good...every woman must go through. If you don't go through and you don't bear the pains, how childbearing pain is, you'll not know how it is. So the children that don't respect, when it reaches that time and you feel the pains, you know that you have to respect your elders. So it is painful...so that those who don't respect can respect.

Clearly, childbearing is an important aspect of community life in this Ghanaian community. I was told many times that if you do not have children, nobody will remember you after you die and that the only people that can carry on your name are your children. Just by spending time within the community and travelling through it with my key informant, I got the sense that marriage and children are very important in this culture. I was frequently asked if I was married and/or had children. Since I am neither married nor a mother, the following question was always "when will you marry?"

4.0.12 ***Support for childbearing women.*** The participants all agreed that childbearing women in this community get as much support as they need, in many different ways. For the first week after the birth, the women typically stay indoors with the baby to breastfeed, rest and recover from the birthing process. On the eighth day, the birth will be celebrated in a ceremony call the "outdooring". Traditionally, both families would travel to the new baby's home to welcome the baby into their midst. Some prayers would be said and libations poured. Nowadays, most Ghanaians are Christian and so the outdooring is celebrated only as the day that the baby's name will be announced. Baby names are chosen by their fathers, and most often the baby is named after a special person. The person whose name is being given to the baby must come to see the baby, hold it and agree to share his or her name with the child. In my experience, the baby would not be officially named until long after the eighth day because the person whose name is being used must travel to see the baby. As well, modern Ghanaian families may wait to celebrate an outdooring so that all of the family

living in other communities can travel to celebrate with them. On one occasion, the outdooring was taking place when the baby was four months old.

The mother is also celebrated when she gives birth to a healthy baby. One participant explained;

> In the culture here, the celebration of the birth of a child is that, on the eighth day, the man will bring the name he wants. If it's a baby girl or baby boy, the man who is the head of the house will bring the name. So when he bring the name and maybe because she has carried his pregnancy throughout the nine months and delivered the baby for him, if he has a present to give you, then on the eighth day, he will gather those things and then he will come and give you.

Another woman stated,

> Because (our) husbands are not interested in what (we) like, and so the man, maybe when you are pregnant he will give you money. Then you have to go and buy the things you need for the baby and yourself.

It is customary as well that women rest in their homes for 40 days, until both "the mother and the baby become fat". After 40 days, the baby is big enough to be placed on the mother's back, and the mother is healthy and strong enough to begin her work again. During this time, community members that know her will bring her food, firewood, water, or do chores such as cleaning and laundry for her. One participant noted that those who can not afford to give food or firewood will fetch water and put it on the fire for her to bathe. When observing the pregnant and postpartum women who participated in the study, I found that what I was told in the interviews was congruent with what I observed. Whenever I arrived to visit the women, at various times of the day, they were most often indoors and stated they had been resting while the other family members were outdoors cooking, washing clothes or cleaning.

When observing postpartum women in the hospital, they were often surrounded by family. I often saw women outside of the hospital washing clothes for their relative who had just had a baby. Sometimes I saw women who had just given birth doing their own washing. I also noticed that the family members brought food for the new mother, since the hospital does not routinely offer this service to patients. Participants explained that the community members support the mother because they are happy for her and because they are pleased that she has brought a healthy baby into their community.

> They will support you because they are...wishing you well because you are able to pass through the childbearing age and you've brought the baby out. Everybody is happy with the baby because the baby will grow and become part of the community; it has increased the population, so that is why everybody will help.

It was noted by the participants however, that family members are the most responsible for caring for the women. A woman most often lives with her husband's family and they are most responsible for ensuring her health and safety during pregnancy. They are responsible for helping her with heavy work, ensuring she has healthy food to eat and guaranteeing there is enough money for her to go to hospital if she needs to. One participant explained;

> If the girl grows up and she reaches adult age and then she gets married, it is the traditional way that if you have a husband, the husband is responsible for everything. So the husband has come to marry you and you are part of the husband, you are staying with the husband and so now you are part of that family, so they will help you.

4.0.13 ***Respect and support.*** Through the interviews and observations I learned that respect is an extremely important value in Ghanaian culture. All of the participants noted this in their interviews, that in order to receive assistance

from your community, you had to be friendly, respectful and helpful to others.

One participant stated;

> It will be from you, the pregnant woman, the way you behave, the way you interact with the people in the community. If you insult everybody in the community, nobody will mind you. If you don't respect, nobody will mind you. But if you are somebody you respects, somebody who helps and is good in the community, other people will show the same to you.

Another participant explained;

> When you live in a community, the way you relate with the people in the community, that is what carries the most. Because somebody will come to this community, say she doesn't come from here, but she relates nicely with everybody in the community so when she delivers or she is sick and there is no family, others bring her firewood, somebody brings water, somebody even devotes herself to bath the baby for her for the first few days that she cannot do anything. Everything they will do for her. But some when they don't relate nicely to people, they don't talk to people, they don't greet, and maybe always locking heads with people. That one, you will suffer. They wouldn't mind you. But if you are nice to people, and you are good, then they will also show kindness to you.

During my time in the community, an impoverished pregnant woman came to the hospital from a neighboring village with hypertension and anemia. She was in labor and was very ill. The midwife was working alone on the unit and the doctor was out of town and so the midwife felt that the woman needed to be transferred to a tertiary hospital in Kumasi. The ambulance is free in Ghana but the ambulance driver did not answer the phone when called. The woman had no money for transport and so the midwife asked the other patients and nurses in the hospital to donate any change they could spare to send this woman to the city by trotro. They raised enough money to send her, however the woman did not get far from the hospital when the woman demanded the taxi driver pull over because she was going to deliver. She exited the taxi and managed to deliver her baby

outside on the street. I was told that many people came running to her aid and called the TBA who lived nearby to come and assist her. The mother fainted and began to hemorrhage. The TBA cut the cord, delivered the placenta and sent the mother, her husband and baby back to the hospital by taxi. The woman's life was saved; she received a blood transfusion, IV fluids and drugs to stop the bleeding. The midwife stated that she had to beg the blood bank to give the patient one unit of blood without payment. In Ghana, blood must be paid for before it is provided.

In the days to follow, the woman received gifts of dresses for herself and her baby because she did not have anything. Her husband is an alcoholic and does not work; the woman herself works as a porter for people going to the farm or to market. They were unable to pay the hospital bill, however a woman from the United States who was there visiting her mother paid the $150 hospital bill for her. I was told that if the American woman had not paid the bill, the hospital would have had to try to fundraise within the community to at least pay for the blood. The rest of the bill would be paid for by the government because they can not imprison women at the hospital for payment when the woman just does not have the money. I was told that, if this incident had transpired in her own village, because they are people who do not contribute much to the community, that they would not have received as much assistance and she most likely would have died. But because nobody in this town knew her, they helped her.

Most of the participants emphasized that the community is very supportive of childbearing women and would do anything they could to help a woman in an emergency. I was told that if a woman was experiencing complications and had

no money to get to the hospital, the community members would often lend money to the family to help her get there. One participant explained;

> Those who have money a little they are able to help those who don't have. It also depends on you, the one who they are helping. Some people they are respectful so when something happens they say 'oh this person, let's go and help that person'.... Family members, the woman's family, the man's family and then the immediate environment that woman is in, will help the one laboring whom the TBA has pronounced that 'now I cannot do anything unless hospital'. You see them, people will come out from everyplace and then give something and then send them to the hospital...when the bill comes then the man can go and then borrow money from anywhere.

4.0.14 ***Elders and traditional birth attendants.*** Elders are highly respected in Ghanaian culture and the elder women play an important role in the health of pregnant women. Participants explained that the elders give the pregnant women advice about what herbs to eat to make them healthy, teach them about pregnancy and what to expect, support them when they are in labor and help them to decide when to go to the hospital when they are in labor. Elder women will often help to deliver babies that arrive too quickly to send the mothers to the hospital or when the family does not have enough money to go to the hospital or to a trained TBA.

There are four traditional birth attendants in the community that provide delivery services for women who cannot afford insurance or to go to the hospital. Traditional birth attendants are women in the community who have learned how to deliver babies from other TBAs through apprenticeship. Some TBAs have been trained by the government and apprentice with midwives to learn when to refer women to the hospital and how to correctly suture vaginal tears, among other important skills. I spent some time with one TBA and she explained her

role in the health of pregnant women as an advisor, a counselor and guardian for safe birth. The TBAs teach women about nutrition, hygiene and warning signs in pregnancy. They help them to deliver their babies, and are trained to refer the women who are experiencing complications. I learned that some TBAs practice more safely than others and that some declined participating in the training sessions and either did not transfer seriously ill women to the hospital, or transferred them late.

4.0.15 ***Births.*** Births are registered at the baby's first visit to the child health clinic, usually when baby is past 40 days old because they believe that then the child has "come to stay". This was a statement that I heard often when speaking with the new mothers and other family members. Ghana, like other low income countries, has high neonatal and under-five mortality rates. It was explained to me by one participant that childhood death is common and that children do not have funerals. The explanation that I received for this was the same explanation that I received for why women who died from complications in pregnancy or birth did not have funerals. It is to prevent the same thing from occurring in the community again. The "Handbook on Asante Culture" that I purchased at a museum in Kumasi explains that children were not given funerals because they were meant to live and bury their parents. If they died, then something must be wrong "and that was not to be tolerated" (Kwadwo, 2002, p. 64). The book explains that although there is no funeral ceremony, traditionally parents would practice rituals such as eating certain foods that would help to prevent the deaths of their other or future children. I was also told that women are

not allowed to grieve the loss of their first child, because it is only the first one to have died and she can have more children. If she should lose two or more children, then it is acceptable for her to grieve.

Immunizations are done at the child health clinics and infants are weighed at this time as well. I learned that most mothers take their babies and children to the community health clinic because it is seen as a social event. "All the mothers dress up or else maybe their dress will be made fun of". Some women do not go because they do not have a nice dress to wear. However, there is community support or pressure to attend these clinics. If someone does not take their child the other mothers will scold them because if their child has something, all the other children will get it too. Even some old women will say "the other women have taken their children today, why are you not there too".

4.0.16 ***Funerals.*** Funerals are an important function in Ghana. In Ashanti culture, it is the mother's eldest brother who is the head of the family and he organizes the funerals. Every weekend in any given community one can see the red plastic funeral chairs, embossed with the Adinkra symbol of Gye Nyame, set up under a tent for shade often blocking off a street. On any day I would see men and women in the red and black traditional funeral garb travelling in the trotros I used to commute from Kumasi to the town. The funerals are large parties with hundreds of guests dancing and celebrating the life of the person who has passed on. These celebrations often last from Friday to Sunday, if not longer, and the guests bring gifts to the bereaved family. The closer the relation, the more expensive your gift ought to be. Funerals are very expensive for the bereaved

family and for the guests that must travel and bring gifts; I learned that some funerals can cost a family upward of one thousand Ghana cedis (one thousand Canadian dollars). Funerals are a show of wealth and love for the deceased. I discovered that women who die during pregnancy, childbirth or in the postpartum time do not have funerals. They are quickly buried in their town as it is believed that this kind of death is not a good death and to prevent it from happening to someone else in the community, her life is not celebrated. I was also informed that people who die from HIV, motor vehicle accidents or strange occurrences such as a lightning strike, will not have funerals because of the superstition that it may happen again.

4.0.17 ***Maternal mortality.*** When I arrived to visit the community one Tuesday, I was told by my key informant that a young girl had died two days prior, on Sunday night. It was explained to me that the unmarried teenage girl had come to the hospital on the Friday from her village because she felt she was in labor. She was examined by the midwife and found to be in very early labor. The girl was also anemic so the midwife encouraged her to come back to the hospital when the contractions were more painful, and reminded the girl's mother to make sure she delivered in the hospital because of her anemia. The family explained to my key informant that, on Sunday the girl went into labor but that her mother refused to bring her to the hospital again. The mother had delivered all of her own babies at home and thought that her daughter should do the same. The girl gave birth to a healthy newborn, and then began to hemorrhage. The mother called for help and the girl was brought to the hospital by taxi, but by then

it was too late. The young girl was pronounced dead in the taxi. The girl was taken back to her village where she would have been immediately buried. It was unclear as to whether or not there would be any record of her death or any investigation into her death.

Another participant described a maternal death that occurred in the community during my time in Ghana;

> (The woman) started complaining, she had some boil in the throat and so she was vomiting, and when they brought her to the hospital she was treated and discharged. Then later on, still it was severe and when she was brought, they referred her to (a tertiary hospital). Then when they took her to the theatre, they couldn't even operate to remove the baby before she died. They have some beliefs that when you die like this, they don't bury you at where they bury other people. They say you've died a bloody death, so they do everything before they put you in the coffin then bring you straight to the burial and they have a special place where they bury them….they just took her through the edges of town, they wouldn't even pass her through the town. They believe that it will happen again, so they will pass you by the edge of the town and then go and bury you.

The public health nurse in the hospital is responsible for keeping records of the births. The midwives record all deliveries in a book and monthly sends the numbers to the public health nurse. The information that is recorded by the midwives includes the number of vaginal births, caesarean sections, vacuum assisted deliveries, episiotomies, and stillbirths, as well as the number of twins and triplets that are born. The delivery record does not include a section for maternal death and I was told that no records were kept in the hospital on maternal mortality since it is a very rare occurrence. Often, women who are deemed at risk are sent to a larger hospital in a larger city. Records of maternal mortality within the hospital may not include information about where a woman

resides. For this reason, her death may only be recorded as occurring at a particular hospital.

When asked about maternal mortality, the general consensus from the participants was that it is not common. An elder explained that when she was of childbearing age, maternal death was rampant, but that now it is not common, "only one maybe in one hundred". Another participant stated that it is not common, but it does happen and even one maternal death is too much. Another participant said that he has seen a lot of maternal death in his time, but that now that there is a hospital with maternity services in the community, it is happening less and less.

4.0.18 ***Superstitions and traditional beliefs.*** Superstitions and traditional beliefs play a major role in the Ashanti culture. My key informant and I visited the pregnant participants weekly, and when we would arrive at their homes my key informant would say "ah, I see she has delivered already" as we entered the compound. When I asked her how she new that the woman had already given birth before we even spoke to someone in the family, she told me that she new because the small white baby dresses had been washed and hung out on the line to dry. She said that it is bad luck to have these things washed and ready before the baby is born and so it is done after. And so, if you see the baby dresses on the line for the first time, you know they now have the baby. I also learned that many women come for antenatal care only once, sometimes very late in pregnancy, but others will come for regular visits. However, superstitions often prevent women from seeking care in early pregnancy because they fear that someone will put a

hex on their baby. As well, I learned that pregnant women are advised to not eat outdoors, in places such as the market or from food vendors. Once participant explained;

> They have some belief that there are some people that are bad. They have some juju so that when they see you eating outside; when you deliver the child becomes a sickler or becomes very tiny.

Another participant described some traditional beliefs that may still affect how women eat today;

> Some say when I am pregnant I shouldn't eat snails because then the baby will be drooling. Some say that when you are pregnant you shouldn't eat eggs or else your child will steal. Because eggs are sweet. And mango too, they say the nerves in the waist will be too loose and so maybe you can abort or anything.

These superstitions could negatively affect the health of pregnant women. Protein is an important nutrient and is often deficient in impoverished families. Snails are easy to find along the river banks and are inexpensive in the markets, as are eggs, and if a woman will not eat them based on superstition her protein intake may be insufficient to nourish a fetus.

Another belief that I learned about, that some people in the community may still believe in, is that edema in the legs indicates the woman is having twins or a boy. This belief could be harmful to a woman's health because edema in the legs could actually indicate hypertension in pregnancy, one of the most common causes of maternal mortality. Another traditional practice that was referred to a lot was enemas in pregnancy. Many women talked about using enemas to ensure a healthy pregnancy. They explained that herbs are mixed with water and either a vaginal or rectal enema is performed to clean any toxins out of the body so that the baby will be born healthy and to make the labor faster and less painful. Some

enemas were used as a kind of induction; they believed that the enemas would help to start the labor if the woman felt she was overdue.

I learned a lot about the beliefs concerning certain foods in this community. Many participants spoke about the importance of eating healthy food in pregnancy, but also about the certain herbs that contribute to a pregnant woman's wellbeing. Kontomire, or cocoyam leaves, are like spinach and are rich in iron. Abedru is a small green nut or fruit that when added to palm nut soup is believed to help the mother's breastmilk supply increase. The elders and herbalists, or traditional doctors, are the ones that pass along these recipes to pregnant women. One participant discussed the importance of consulting an herbalist when pregnant;

> They have some herbs that they use to prepare soup, so it is very strong, so if the pregnancy is early and you have the soup it can let you abort. So some are not good. But maybe if the person does not know and they eat and they abort, they will not know it was that drug...now we are telling them they should exercise patience until after delivery. When the baby is out and the mother is well, the baby is well, they can go for that now, and it helps with the breastmilk to come. Because they use it with palm nut soup, so when you eat it the breastmilk comes plenty.

Most of the participants discussed the importance of prenatal care in the health of pregnant women, but they noted that conventional medicine was not the only way to receive prenatal care. The community members discussed the importance of choosing one or the other, or both, and sticking to their advice.

> If you do not do the herbal medicine and you'll not go to the hospital, then you want to die. So you want your own death, since now the hospital is there you have to go, and then if you don't go to the hospital you do the herbal one. So, some do both, some choose one, if you don't choose any, then you want to die.

When asked how women learn about when to seek prenatal care, I was told that it is mostly through word of mouth. The elders or their parents or friends will tell the pregnant woman where and when she should attend the prenatal clinics or the traditional doctor so that she will have a healthy pregnancy.

4.0.20 ***Summary of results.*** There seems to be a tacit understanding that, in one way or another, the community will ensure that the basic needs of the childbearing woman are met so as to ensure continuance of the community. Whether through educating each other about nutrition in pregnancy, encouraging each other to seek out some form of prenatal care, assisting the pregnant woman with daily chores or bringing her gifts to show their adoration, the community members believe that the childbearing women in their community will be supported. There is a sense of community responsibility for ensuring that women have healthy pregnancies and give birth to healthy babies to ensure a healthy population. But it seems that this sense of community responsibility ends with the healthy mother and baby since it was often described by participants that if they baby is not well or if the mother experiences complications, the mother may be to blame for not adhering to advice provided by her elders or health professionals.

Chapter 5

Discussion

Throughout the data collection process and analysis of findings, several themes emerged that reflect the knowledge, attitudes and beliefs that influence the health of, and support received by, childbearing bearing women in this rural Ghanaian community. In this community, pregnancy is highly valued. Many of the participants stated that pregnancy is good, it is not a sickness and that it is something that every woman must experience in her life or "nobody will mind you". They further described the importance of bearing children as adding to the population, thus contributing to society and assuring the continuation of both community and family. Women are pressured to have children as part of their social responsibility to the community.

The individual importance of having children was that the mother would have someone to care for her in her old age. This is congruent with other research conducted in Ghana. Jansen (2006) found that a woman who did not have children was not considered a "woman" and would be a burden on her family in her old age because she would not have her own children to look after her. Further, women who were unable to conceive were thought to be 'bewitched'. Senah (2003) explains that the Asante (Ashanti) consider pregnancy to be the goal of most marriages because of their strong belief in kinship. Ghanaian women who experience infertility may be scorned as a witch, or pitied as a victim of demons. In the selected town, the ideal number of children for one woman seemed variable. Some women say that they will have as many children as God

grants them, whereas others believe that two children would be sufficient. Senah (2003) further states that "the high cultural value placed on conception and multiparity often leads several women to their graves" (p. 50).

Participants spoke of the importance of respecting others in the community as a determinant of the amount and type of support a childbearing woman would receive. They explained that those women who were thoughtful, helpful and friendly to others are more likely to receive help when they need it, compared to women who are unkind and noncontributory to others in the community. The staunch community value of respect for others aids community cohesion and supports a peaceful society. This belief has the potential to powerfully modify the behaviour of young women. It seems that reputation or status of the woman's family is also a part of this theme. If the woman herself or her family is not respected by the community, they may receive little or no support from their community. In Jansen's (2006) focused ethnography in the Kwame Danso Region of Ghana, the concept of respect had a vast impact on social structure in that region. Childbearing women were subject to the advice of their older female relatives because to say 'no' to them is disrespectful. In order to be accepted within a community and earn respect, one must show respect to older females as they are in the most powerful position in the community. Ghanaian women who have children gain respect of their elders, especially if they birthed at home (Jansen, 2003). The importance of including older female community members in educational interventions to improve maternal health is

emphasized because they are in a position to change and transform old beliefs and practices.

Cultural perceptions of health and the impact of these perceptions on childbearing women is a theme that emerged early on. When asked about maternal death and its incidence in this community, the participants considered it to be an uncommon event. Participants felt that as long as women followed the advice of the practitioner they attended; childbearing women in this community were healthy and would have a healthy birth. I was told that there were no maternal deaths at the hospital in over six years and that maternal death occurred "only maybe one in one hundred" births. Perceptions of maternal health in this community may immensely affect how and when women seek medical care during pregnancy, birth and the puerperium. These findings support the work of Alhuwhalia (2003) who reported that in their Tanzanian community, reducing maternal mortality was not a priority health issue for them. If community members in this town perceive maternal death to be uncommon and that pregnant women in their community are generally healthy, improving their health and decreasing the MMR will not be a priority health issue for this community either.

Superstitions are prevalent in this community and have a strong affect on attitudes toward, and the health of, childbearing women. Women who die due to complications of pregnancy or childbirth do not receive the honor of a traditional funeral; community awareness and perpetuation of this attitude affect how maternal death is reported and perceived. Senah (2003) explains; "maternal death is honhon fi (Akan: uncleanliness)" (p. 47) which provokes a pregnant woman

from Osu (a section of Accra) whose friend has died in pregnancy or birth to have a ritual bath in the sea. In other regions of Ghana, the women are quickly buried. In this community, maternal deaths that occur outside of the hospital are not reported or recorded. I was told that the women are quickly buried and that no funeral is held. Nyinah (1997) explains that women who die in pregnancy or in the forty days after birth are given;

> ...a quiet and low-profile burial because her death is considered a bad omen. Destiny or fate may often be perceived as the reason why women die from childbirth. Adultery and rebellion against traditional norms are considered to be other causes. (p. 3)

Possibly because maternal deaths are not reported, recorded, or publicly mourned; the community's perception is that it is not a common occurrence. Some participants stated that they rarely heard of women who died in pregnancy or during birth and had not known anyone personally who had died. Conversely, some participants described witnessing and hearing about many maternal deaths in nearby villages, but that in the town itself, with its hospital equipped to handle any emergency, maternal death was not common.

Other superstitions and cultural beliefs in this community affect many aspects of childbearing. Women concealed their pregnancy as long as possible to prevent being hexed. This is consistent with previous studies where women were considered to be boastful if they revealed that they were pregnant prior to it being obvious or visible (Arhin 2001 as sited in Senah 2003; Bazanno et al, 2008). This particular belief affects the timing of a pregnant woman's first prenatal visit, which in Ghana is typically near the end of the second trimester. By this time, a woman who may have been anemic at the onset of her pregnancy could well be

experiencing a more protracted condition that affects the healthy growth of her baby and leaves her vulnerable to severe post partum hemorrhage. Further, if a woman is HIV positive, she may not be receiving the proper antiretroviral medication to prevent maternal-fetal transmission, or she may develop pregnancy induced hypertension that would go untreated and lead to her death. Some superstitions unsupported by evidence may also adversely affect maternal/newborn well being. For example, dietary restrictions due to cultural beliefs, such as exclusion of eggs or snails, can negatively affect maternal health and maternal newborn outcomes. Senah (2003) describes similar beliefs from other areas of Ghana. Such beliefs may be rooted in history, for example, restricting nutrition in pregnancy may ensure an easier birth because the baby would be smaller. In malnourished women, the pelvis tends to be small and therefore having a smaller baby could prevent obstructed labor.

Personal responsibility for her pregnancy is a duty. Women are expected to seek support during their pregnancy from either conventional health providers or traditional healers and to obediently follow any advice they are given. Emphasis is placed upon the woman's choice to seek this care, and her family is responsible to support her choice and encourage her adherence to the regimes advised by whichever practitioner she attends. Those women who do not adhere to the advice "choose to die". As well, if the baby is born underweight or malnourished, the mother may be blamed to have not been attentive to her own nutrition in pregnancy. A pregnant woman's responsibility in the Kintampo District did not end at pursuing prenatal care and taking the recommended

vitamins or herbs (Bazzano et al, 2008). Rather, the pregnant women in that community felt responsible for laboring alone and possibly even delivering their own babies. Women who delivered in secrecy in their own homes with minimal assistance from others earned an enhanced status from their community and peers (Bazzano et al, 2008). While a woman is responsible for ensuring a healthy baby, her husband's responsibility was mainly monetary. Jansen (2006) found that husbands are expected to pay for the prenatal and delivery care, as well as for the education and healthcare for their children; to ensure that the children have a better life. However, f the husband can not afford to pay these expenses, the woman must pay herself.

There was a strong belief among community members, including the pregnant women themselves, that childbearing women have all of the support that they need to have a healthy pregnancy, birth and recovery. Participants described how community members help pregnant women by assisting them with household chores and other work when the woman is too tired or feeling unwell. They described how near the end of pregnancy, the community members help the pregnant women with their work because they fear too much manual labor might cause them to lose the pregnancy or have a stillbirth. The pregnant women I observed did not do much work after approximately 36 weeks gestation. They stated that they mostly rested and tended to light work around the home, such as cooking and cleaning. What I am able to conclude with confidence is that as long as pregnant women have good relationships with their friends and neighbors; if they are deemed to be respectful and are respected, they will receive the support

they need, such as assistance in hauling water and firewood. They may also receive financial aid in emergency situations.

What I cannot say for sure is how particular cultural practices or beliefs truly affect childbearing women in this community. I assume that an absence of funerals for victims of maternal mortality influence the perception of these women and of maternal mortality itself, however further research is needed to delve into this topic more completely. It is not clear, for example, that nutritional inadequacies due to superstitions are a detriment for pregnant women because certainly a large fetus will be less likely to pass through the small pelvis of a woman who has been malnourished since childhood. All cultural beliefs and practices have a rationale and this rationale must be explored. The questions remain; are these practices harmful, beneficial, or neither, and are they negotiable?

According to the Ghana Demographic and Health Survey (2003) the lower a woman's social, economic and educational status, the less likely it is that she will access antenatal or delivery care at the hospitals or health centers. This survey did not include questions about maternal death as only women who had a live birth were interviewed, however, it can be concluded that disadvantaged women who have a lower socioeconomic status and less access to health care are more likely to die due to complications of pregnancy and birth. The disparity between MMRs in high and low income countries is staggering; however the inequality is also evident between the rural and urban MMRs in Ghana. The role that cultural practices in rural areas play in these rates is unclear. Msengi (2001)

found that in the Cape Coast area of Ghana, women are shaken after the baby is born to hasten the delivery of the placenta, which would be ineffective. If this resulted in a retained placenta, the woman would likely hemorrhage. Nyimah (1997) and Kwadwo (2002) explain that Ghanaian women suffering from prolonged or difficult labor are believed to have committed adultery, and unless they confess to their sins, they will not deliver. Should the woman die during or after the birth process, it is believed that she concealed her infidelities. These beliefs were not mentioned by participants in this study; however, if they exist they would most certainly affect maternal mortality and how it is perceived by community members.

Chapter 6

Summary and Conclusion

In this study, the perceptions of community members in regards to maternal health and mortality were explored, as well as the knowledge, attitudes and beliefs that influence the type and amount of support received by childbearing women. During the 8 weeks of field work at the study site, 12 community members were interviewed and observations were recorded in field notes. The data were analyzed and the findings indicate that community members in the selected community play a significant role in the health of childbearing women. Whether through transmission of information or cultural beliefs, or through providing gifts of food or donating their time to haul water for the childbearing woman, community members contributed positively or negatively in ways that affected maternal health. How community members perceive maternal health is described and the need to raise awareness of the problem of maternal mortality in this area of Ghana is apparent.

6.1 *Strengths of the Study*

The length of time spent in the community for data collection is a strength in this focused ethnography. Although interviews did not occur every day, a great deal of time was spent observing within the community, generating field notes and being present in the community in an attempt to "blend in". Credibility is supported in this study because the results reflect what participants believe to be true and this is strengthened through triangulation of findings; testing one source of data against another to generate the best explanation. By making detailed field

notes, accurate interview transcriptions and maintaining the focus of the research question I am able to support the trustworthiness and credibility of the findings.

Findings will contribute to what is known with respect to maternal health in low-income countries and will fill in some gaps in current knowledge. Firstly, the findings provide insights into how community members perceive the health of pregnant women in general and the occurrence of maternal death. Because community members of the selected town do not feel that maternal death is a common occurrence some may not see it as a priority health issue. The findings can be used to urge health care professionals, governments and researchers increase awareness of the issue through enhanced community education.

Secondly, the findings provide insight into the knowledge, attitudes and beliefs that support or impede maternal health, and also reveal rationale for some of the practices and behaviors surrounding childbirth in the community. These findings may help healthcare providers develop a greater respect and understanding of the culture in the community and could help them to work with community members to develop more effective ways of imparting important information to pregnant women and community members.

6.2 *Limitations of the Study*

This study contributes to knowledge gaps regarding community perceptions of maternal health in a rural Ghana, however some limitations exist. The researcher, not being Ghanaian, was at a disadvantage in an ethnography because "blending in" could not be achieved. While the participants who were visited weekly became more comfortable with my presence, comments made by

some participants indicated that they felt a need to impress the "oboroni" (foreigner) and this may have affected they way they answered questions. Also because I was unable to speak Twi, the language spoken by most of the participants, the data collected may have been affected as translation and/or interpretation are not always accurate. Having a midwife as the translator and key informant may have also limited the research as the participants may have been more likely to speak highly of the hospital services than of traditional practices in pregnancy. As well, participants were generally chosen by the key informant and therefore those who participated may have wanted to please her. However, some interviews, such as the interview with market women, were spontaneous and their answers were consistent with those of the selected participants.

The pregnant participants were recruited from the antenatal clinics and therefore only women who adhered to either conventional medicine or a combination of conventional and traditional practices during pregnancy were interviewed. As well, having a hospital within the community that provides obstetric services may affect the perceptions of community members. It can be argued that the participants in this study have access to more resources and may therefore perceive that the women are healthier because of this. It is possible that perceptions would be different in a smaller, more remote community without immediate access to a health facility and with women who utilize traditional medicine during their pregnancies.

6.3 *Implications for Education, Practice, Research and Policy*

6.3.1 ***Implications for Education.*** The findings of the study indicate that more sensitivity, education and awareness of the issue of maternal mortality is needed among community members and health care professionals in this community. Although specific data on the rates of maternal mortality for this area or district were not available, at least three maternal deaths occurred in the eight weeks the researcher was in the community. One was witnessed by a health care professional and two others were simply spoken about by participants in the study. Maternal mortality rates for rural Ghana have been estimated at 1077/100,000 (Geelhoed, Visser, Asare, Schagen Nan Leeuwen, Jules H., & Van Roosmalen, 2003) but participants perceive that women do not die often in pregnancy, or during or after birth. The secrecy surrounding maternal death and the immediacy with which women are buried may affect this perception.

Theories of community development and mobilization assert that health is influenced by all aspects of a society and healthy individuals contribute to social and economic development of a community. The first step in the process of community mobilization for health is to sensitize community members to their health needs and current development status (WHO, 2003). To effectively sensitize this community to their needs for improved maternal health and a reduction in maternal mortality, education must be carried out to raise awareness of the problem. If community members do not perceive this as a priority health issue, they will not be motivated to address it.

In a country as culturally diverse as Ghana with 5 major ethnic groups (Asante, Ewe, Mole-Dagbane, Guan, and Ga-Adangbe) who have varying traditions, beliefs, practices and languages, education in cultural competence may be needed for healthcare workers and researchers to improve understanding of varying cultural practices and beliefs. Because most healthcare workers do not choose where they work, they are posted by their agency to a certain community, midwives, nurses and doctors are likely to practice in an region they are not familiar with and where practices and beliefs may be different and misunderstood. Explanations of sickness are shaped culturally and influence how health and illness are perceived and experienced. This is true in all societies. Education to increase cultural competence is intended to improve knowledge of, and attitudes towards, certain cultural groups (Seeleman, Suurmond & Stronks, 2009). In this community, cultural competence among health care workers may help improve communication between them and community members and contribute to more effective community education for maternal health.

6.3.2. ***Implications for practice.*** Implications for practice for health care professionals, specifically public health nurses and midwives, include developing enhanced prenatal education for childbearing women and their communities. Currently in the selected town, prenatal classes are held once a week during the antenatal clinics in a large group where a nurse-midwife provides a brief lecture on a selected topic. Because the pregnant women do not seem to be given an opportunity to ask questions, and due to the lack of privacy offered to them during their visits, many women may not have important learning needs met. Bansah,

O'Brien & Oware-Gyekye (2007) found that multigravid women in Ghana who were interviewed believed the prenatal classes offered to them did not meet their learning needs. Participants described the lack of privacy, the non-collaborative approach and the advice they received that conflicted with advice offered by their elders, as barriers to their learning. Bansah recommends that nurse-midwives collaborate with childbearing women and their families to select topics for discussion or at least provide a comfortable, private environment for them to ask sensitive questions as needed.

Findings indicate that certain cultural practices and beliefs, such as exclusion of certain foods in a pregnant woman's diet, may still be practiced in this community. Because elder women and traditional birth attendants play a significant and important role in the antenatal care of pregnant women, including advice giving and guidance during pregnancy, it is important that health care professionals include these women and other community members in prenatal education planning and delivery. During the prenatal classes the nurse midwives often provide lectures on the falsity of the beliefs transmitted to them by their elders and inform the women that they are simply superstition. Some practices however, such as the vaginal, rectal or oral enema, could not be explained by the health care professionals, and therefore it is not clear if they are harmful or helpful. As well, other traditional beliefs such as how communities support childbearing women are beneficial, as are some practices such as using certain herbals to help enhance the woman's supply of breastmilk. Therefore, engaging the elder women in discussions of these traditional practices to understand their

perspectives and rationale for recommending certain practices is warranted to be capable of providing the best prenatal education for pregnant women.

Other potential strategies were discussed with health care professionals during the study period, such as including a midwife on the outreach community health clinics to neighboring villages. At this time, community and public health nurses travel to neighboring villages to provide immunizations to children and families and health assessments as needed. If a midwife accompanied these health professionals, she could provide antenatal care to women who may otherwise not be able to attend at the hospital due to transportation or financial reasons. The midwife could then provide prenatal assessments as well as education for the women and their families, right in their own community.

6.3.3. ***Implications for research.*** Further research is needed to determine if community perceptions of maternal health are similar in other Ghanaian communities, including urban and more remote places. Participatory action research may be the next step to developing community programs of education for childbearing women and their communities to effectively address the cultural beliefs and practices that affect maternal health and awareness of maternal mortality. Munhall (2007) describes participatory action research (PAR) as a method most often used in oppressed societies or segments of societies, such as childbearing women living in poverty for instance, to challenge the customs and assumptions that perpetuate the oppression. The goal is to affect practical changes within a society and also to challenge the fundamental traditions and structures that enable oppression. The process of PAR is collaborative, including

members of the whole society, wherein learning priorities, project planning and execution, and evaluation are all carried out collaboratively. Generation of knowledge/evidence through PAR methods strengthens the community because the actual members are involved in identifying the health issues that are most important to them and in the process of changing the status quo (Munhall, 2007). Because childbearing women in Ghana are often disadvantaged by their circumstances and frequently live in poverty without adequate nutrition or access to healthcare, PAR is an ideal research method to examine and support maternal health. The problem would be defined by them and potential solutions would be advanced. The process of PAR at the study site could increase understanding of cultural beliefs and practices that support or inhibit the health of childbearing women and contribute to the reduction of maternal morbidity and mortality because the women themselves would collaboratively develop a plan of action to address the problem.

Multi-disciplinary research would enhance what is known about cultural practices during pregnancy and childbirth in rural areas of the Ashanti region. Investigators in the social sciences such as anthropology and sociology could strengthen understanding of the practices that affect maternal health and thus improve cultural competence and sensitivity among all community members, including health care providers.

6.3.4. *Implications for policy.* Lastly, there are clear implications for policy. The government of Ghana must assist health care professionals, researchers and educators to work collaboratively with community members to

make maternal health and survival a priority. The government can support awareness campaigns that emphasize the current situation of maternal mortality and morbidity in Ghana to help change community perspectives. If the people do not believe that maternal mortality is an issue, they will not be motivated to effect change.

While residing in Ghana, the government announced that funding aid from Britain will be directed to providing women with free birthing care in the hospitals under the National Health Insurance Scheme (NHIS). Previously, women could benefit from free delivery if they paid an annual 20 Ghana Cedis ($20) fee for the insurance premium, which is a huge sum of money for those who live in an area where a typical home rental may cost $5 per month. With this new funding, women can now register with the NHIS without cost during pregnancy or if they are experiencing complications following a birth, miscarriage or abortion. However, increasing the number of women attending the hospital for antenatal and intrapartum care will significantly increase the workload for midwives and therefore more staff, including physicians, will be needed to be able to provide obstetric care to the women demanding it.

There is evidence that maternal health is on the agenda for the Ministry of Health in Ghana. In November, 2008 the Ghana Health Summit included presentations on reducing maternal mortality and in the report of the summit, the importance of involving communities and pregnant women in the development and management of maternity services was highlighted. The Ministry of Health also claimed responsibility for improving the monitoring and tracking of maternal

mortality (Ghana Ministry of Health, 2008). Careful observation and time will tell if a renewed commitment to maternal health, as emphasized by the government, will result in improved education and services for women and their communities.

6.4 *Conclusion*

The health of women globally is affected by their culture, status, education, environment, and access to health care. In the Ghanaian community where this study took place, childbearing women are supported by their family, friends and neighbors to have healthy pregnancies because this helps ensure the continuation of a healthy community. Cultural beliefs and practices such as providing women a 40 day rest period following birth, made possible by their family and neighbors, promotes a healthy recovery for both mom and baby. Community members advise pregnant women to adhere to the recommendations of either the traditional healers or the midwives to ensure they meet their nutritional requirements and have a safe birth.

Maternal mortality from direct or indirect causes, a highly preventable and premature death, remains far too common in rural Ghana. The perception of community members that maternal death is uncommon is disturbing, yet not surprising. If the people have not been made aware of the issue, they cannot know that in their home, childbearing women are 100 times more likely to die than childbearing women in my home; Canada. In order to effect change, the people of Ghana must address the problem of maternal morbidity and mortality.

Maternal health and survival must be made a priority, not only by governments and health care professionals, but by the community members themselves.

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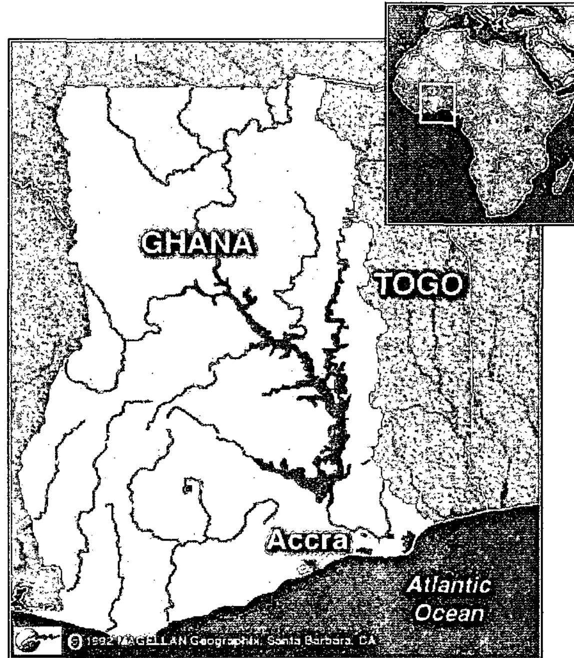
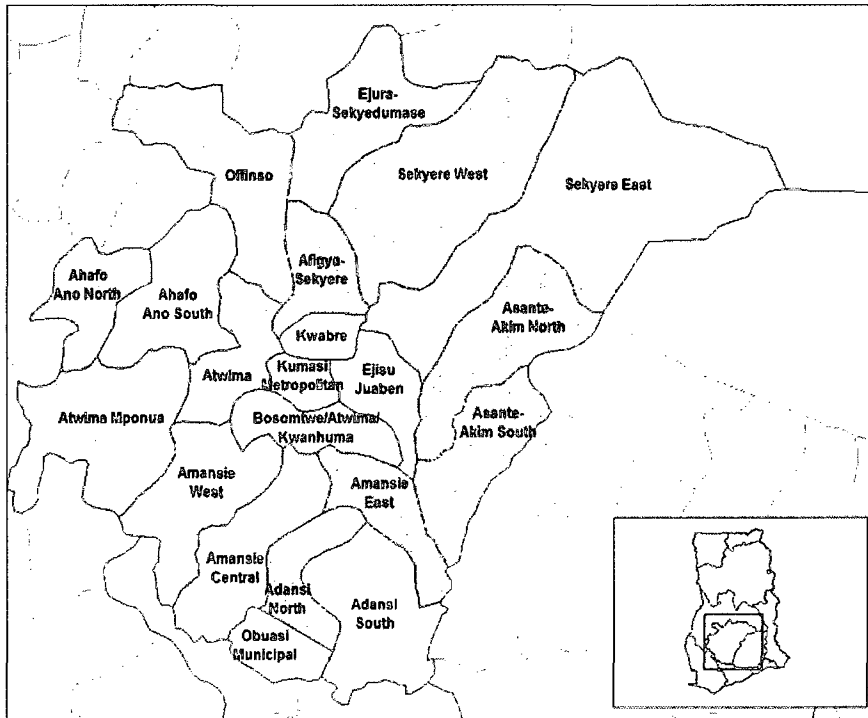
APPENDIX A

Maps of Ghana and the Ashanti Region



http://www.ghanaweb.biz/GHP/img/pics/93668109.jpg



http://commons.wikimedia.org/wiki/File:Ashanti_districts.png

APPENDIX B

Interview Guide A: Pregnant women:

1. How do you stay healthy when you are pregnant?
2. What do you believe about pregnancy and birth? For example, are you supposed to behave in a certain way? Why?
3. Is it safe to be pregnant in your village? Are there dangers?
4. Who are the important people in your village to help pregnant women stay healthy?
5. How do people in your village help when you are pregnant? Who are they?
6. Could the people in your village help more? How?

*Demographic questions: age, marital status, religion, education, occupation, first language, children (how many, ages), how many people in home, length of time in village, number of pregnancies, number of live births, due date of current pregnancy.

Interview Guide B: Community members

1. What do you believe about pregnancy and childbearing?
    a. Prompt: How do you think these ideas/beliefs originated?
2. Who are important people in the community that help pregnant women?
3. What is your role in the health of childbearing women in your community?
4. How do you help/support pregnant women in your community?
5. What do other community members do to help or support pregnant women? Who should be helping them? Why?
6. How do you keep pregnant women healthy? Are there dangers? Tell me more about them and what you do?

*Demographic questions: age, marital status, religion, education, occupation, first language, children (how many, ages), how many people in home, length of time in village.

APPENDIX C

RESEARCH STUDY

Childbearing Women in a Rural Ghanaian Community – A Focused Ethnography

I want to learn about what it is like to be pregnant or give birth in this village. Mrs. Veronica Dzomeku is helping me. I want to spend some time with women who are pregnant to learn about how your community helps pregnant women stay healthy. If you would like to be in this study please contact Heather Martin.

Heather Martin, MN Student
Faculty of Nursing, University of Alberta
Edmonton, Canada
Cell number:
027-2436718

RESEARCH STUDY

Childbearing Women in a Rural Ghanaian Community – A Focused Ethnography

I want to learn about what it is like to be pregnant in your village. I am working with Mrs. Veronica Dzomeku. I want to talk with a group of people from your village (men and women) about how community members help pregnant women stay healthy. If you would like to be in this study please contact Heather Martin.

Heather Martin, MN Student
Faculty of Nursing, University of Alberta
Edmonton, Canada
Cell number:
027-2436718

Information Letter (#1) – Observations and interviews with childbearing women

Title of research study:
Childbearing Women in a Rural Ghanaian Community - A Focused Ethnography

Principal Investigator:
Heather Anne Martin RN, BSN, MN student
Edmonton, Alberta, Canada
Phone: 001-(XXX)XXX-XXXX
Cell phone in Ghana: 027-2436718
E-mail: hmartin@ualberta.ca

Co-Investigator:
Dr. Beverley O'Brien, RN, RM, PhD
Professor, 7-50 University Terrace
Edmonton, Alberta, T6G 2T4
(P)001(780)XXX-XXXX; Fax 001(780)XXX-XXXX

Mentor (on site):
Veronica Dzomeku, BSN, M'Phil
Midwifery Teaching College
Kumasi, Ghana
(P) XXX-XXXXXXX

Background: Pregnancy can be an unhealthy time for many women and pregnant women get a lot of advice from family and friends about how to stay healthy. I want to know how people living in a small village support women during pregnancy, birth and when the baby is first born.

Purpose: You are being asked to be in a study that will look at how pregnant women are supported in your community. I will ask you to talk about what it is like to be pregnant in your village. I want to spend time with you so that I can get to know you and so that I can learn what your day is like. I hope to learn about how you help pregnant women stay healthy and what could be done to make pregnancy healthier for women here.

Procedure: If you decide to be in this study, I will ask you to meet with me. I will ask to be with you during parts of your day to see what it is like to do the work that you do. I want to learn more about how you look after yourself and get care when you are pregnant. I will spend as much time with you as you like, up to 4 to 6 hours per day for about 5 days. If at any time when we are together you would like to be alone, you can ask me to leave for a while or for the rest of the day. You do not have to give me a reason. Near the end of our time together I will ask you questions about being pregnant. I will also ask what help you want from other people. This talk will not last for more than 1 hour. You can decline to answer any questions you do not feel comfortable answering.. What you say

will be tape recorded so that I can remember everything you say. You can ask me to turn of the tape recorder at any time. No one else will know what you say or even if you are talking to me. We can be in your home or anywhere you feel safe.

Project Title: Childbearing Women in a Rural Ghanaian Community – A Focused Ethnography.

Possible Benefits: The study may benefit you and your village by learning about what helps pregnant women in this community and what could be improved.

Possible Risks: Any risks to you by being in the study are minimal.

Confidentiality: If I write down something that you say, I will not tell anyone who said it. I may publish my study in a journal. It will be about what it is like to be pregnant in your village. I will share what I learn with everyone from the village but I will not tell anyone what you say. What you say could be used in a future study. That can only happen if the appropriate ethics committee approves. All of the information I collect will be kept in a locked cabinet at the University of Alberta for 7 years and only myself and my supervisor will be able to access this information.

Voluntary Participation: You do not have to be in the study unless you want to be in it. **You can stop being in the study at any time just be telling the researcher, you do not have to give a reason for stopping.** If you feel that you want to be alone when I am with you, you can ask me to leave for a little while.

Reimbursement of Expenses: to be determined

Contact Names and Telephone Numbers:

If you have concerns about your rights as a study participant, you may contact:

Kwame Nkrumah University of Science and Technology (KNUST)

Ethical Review Board.

Kumasi, Ghana

info@knust.edu.gh

+ (233) 51 60334

Please contact the individuals below if you have any questions or concerns. Contact Heather Martin if you wish to participate in this study:

Heather Martin, RN, BSN

Beverley O'Brien, RN, RM, PhD

Mentor (on site): Veronica Dzomeku, BSN, M'Phil

Information Letter (#2) – Interviews with community members

Title of research study:
Childbearing Women in a Rural Ghanaian Community - A Focused Ethnography

Principal Investigator:
Heather Anne Martin RN, BSN, MN student
Edmonton, Alberta, Canada
Phone: 001-(780)XXX-XXXX
Cell phone in Ghana: 027-2436718
E-mail: hmartin@ualberta.ca

Co-Investigator:
Dr. Beverley O'Brien, RN, RM, PhD
Professor, 7-50 University Terrace
Edmonton, Alberta, T6G 2T4
(P)001(780)XXX-XXXX; Fax 001(780)XXX-XXXX

Mentor (on site):
Veronica Dzomeku, BSN, M'Phil
Midwifery Teaching College
Kumasi, Ghana
(P) XXX-XXXXXXX

Background: Pregnancy can be an unhealthy time for many women and pregnant women get a lot of advice from family and friends about how to stay healthy. I want to know how people living in a small village support women during pregnancy, birth and when the baby is first born.

Purpose: You are being asked to be in a study that will look at how pregnant women are supported in your community. I will ask you to talk about pregnant women in your village and how you help them. I hope to learn about how you help pregnant women stay healthy and what could be done to make pregnancy healthier for women here.

Procedure: If you decide to be in this study, you will meet with me to talk for about 1 hour. I will ask you questions about pregnant women in your village and how they are supported. You can decline to answer any questions you do not feel comfortable answering. What you say will be tape recorded so that I can remember what you say. You can ask me to turn of the tape recorder at any time. No one else will know what you say or even if you are talking to me. We can in your home or anywhere you feel safe.

Possible Benefits: The study may benefit you and your community by learning about what helps pregnant women in this village and what could be improved.

Project Title: Childbearing Women in a Rural Ghanaian Community – A Focused Ethnography.

Possible Risks: Any risks to you by being in the study are minimal.

Confidentiality: If I write down something that you say, I will not tell anyone who said it. I may publish my study in a journal. It will be about what it is like to be pregnant in your village. I will share what I learn with everyone from the village but I will not tell anyone what you say. What you say could be used in a future study. That can only happen if the appropriate ethics committee approves. All of the information I collect will be kept in a locked cabinet at the University of Alberta for 7 years and only myself and my supervisor will be able to access this information.

Voluntary Participation: You do not have to be in the study unless you want to be in it. You can stop being in the study at any time just be telling the researcher, you do not have to give a reason for stopping.

Reimbursement of Expenses: to be determined

Contact Names and Telephone Numbers:

If you have concerns about your rights as a study participant, you may contact:

Kwame Nkrumah University of Science and Technology (KNUST)

Ethical Review Board.

Kumasi, Ghana

info@knust.edu.gh

+ (233) 51 60334

Please contact the individuals below if you have any questions or concerns. Contact Heather Martin if you wish to participate in this study:

Heather Martin, RN, BSN

Beverley O'Brien, RN, RM, PhD

Mentor (on site): Veronica Dzomeku, BSN, M'Phil

Consent Form

Project Title: Childbearing Women in a Rural Ghanaian Community – A Focused Ethnography

Principal Investigator:
Heather Martin RN, BSN, MN Student
Cell in Ghana 027-2436718

Co-Investigator:
Dr. Beverley O'Brien, RN, RM, PhD
(P)001(780)XXX-XXXX

Mentor (on site):
Veronica Dzomeku, BSN, M'Phil
(P) XXX-XXXXXXX

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and been given a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to leave this study at any time, without having to give a reason ?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to the information?	☐	☐

Project Title: Childbearing Women in a Rural Ghanaian Community – A Focused Ethnography

Statement of person giving consent:
I have read the description of the research or have had it translated into language I understand. I have also talked it over with the interviewer to my satisfaction. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.

This study was explained to me by:

____

I agree to take part in this study:

____
SIGNATURE/THUMB PRINT of participant

____
Printed name

Date:____________________________

Statement of person obtaining informed consent:
I have fully explained this research to
________________________________ and have given sufficient information, including about risks and benefits, to make an informed decision. I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator or Designee__________________________ Date
____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT.

Research Assistant/Transcriber/Interpreter Confidentiality Agreement

Project Title: Childbearing Women in a Rural Ghanaian Community – A Focused Ethnography

I,___________________________________, know that the information collected in this research project by Heather Martin is personal and I agree to treat all materials in a confidential manner. In particular, I will respect the participants' confidentiality by not talking about the information provided by the participants with people who are not associated with the research project. I will ensure that all research materials are securely stored.

______________________________________ _______________________

Signature of Research Assistant/Transcriber/Interpreter Date

______________________________________ _______________________

Signature of Principal Investigator Date