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Beyond Proximity: A Qualitative Analysis of Socio-Cultural Barriers to Maternal Health Service Uptake in Rural Communities of Ghana's Greater Accra and Central Regions

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Abstract: Despite significant national efforts to improve maternal health, Ghana continues to face challenges in reducing maternal mortality, with disparities concentrated in rural areas. While geographic and economic barriers are well-documented, socio-cultural factors remain less quantified yet critically influential. Methods: This desk review synthesizes current qualitative data from the Ghana Demographic and Health Survey (GDHS), the Ghana Maternal Health Survey (GMHS), and program evaluations from the Ghana Health Service (GHS) and its partners (2018-2023). The analysis focuses on thematic findings related to gender norms, cultural beliefs, and community practices in rural Greater Accra and Central Regions. Findings: Key socio-cultural barriers include: (1) male-dominated decision-making power, limiting women's autonomy to seek care; (2) deep-seated cultural beliefs privileging Traditional Birth Attendants (TBAs) and perceiving pregnancy as a natural state; (3) pervasive mistrust in the formal health system fueled by fears of disrespectful abuse, Caesarean sections, and HIV testing stigma; and (4) the influential role of older female relatives in reinforcing traditional norms. These barriers persist despite relative geographic proximity to health facilities in some areas. Conclusion: Improving maternal health outcomes in rural Ghana requires a paradigm shift beyond infrastructure investment. Policy and programming must explicitly integrate community-level socio-cultural interventions, including male engagement, respectful maternity care training, and the respectful integration of traditional systems, to build trust and empower women.

Keywords: Maternal Health, Socio-Cultural Barriers, Rural Ghana, Health Equity, Qualitative Research, Traditional Birth Attendants, Gender Power Dynamics.

I. INTRODUCTION

Ghana has made substantive progress towards improving maternal health, exemplified by the expansion of the Community-Based Health Planning and Services (CHPS) initiative and policies like the free maternal care program. However, the national maternal mortality ratio (MMR) remains high at 263 per 100,000 live births (GDHS, 2022), with significant rural-urban disparities. The Greater Accra and Central Regions present a compelling juxtaposition: both contain affluent urban centers but are also home to remote, underserved rural and coastal communities where health indicators lag.

Research on access to maternal health services has traditionally focused on the "three delays" model, emphasizing geographic and financial accessibility. However, utilization rates remain suboptimal even where facilities are physically present and services are nominally free. This indicates that the first delay—the decision to seek care—is profoundly influenced by socio-cultural factors. This article analyzes the current socio-cultural barriers to maternal health service uptake in rural communities of the Greater Accra and Central Regions, drawing on recent qualitative data to inform more effective, culturally competent interventions.

II. METHODS

This study constitutes a qualitative desk review and synthesis of existing data. Sources included:

- ✓ National Surveys: Thematic analysis of qualitative insights from the Ghana Demographic and Health Surveys (GDHS 2014, 2022) and the Ghana Maternal Health Survey (GMHS 2017, 2022 Preliminary Report).Ghana Health Service (GHS)
- ✓ Documents: Program evaluations, operational research reports, and community assessments from the CHPS program, the Adolescent Health Strategic Framework, and the Ghana Essential Health Interventions Program

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- ✓ Partner Agency Reports: Qualitative data from UNICEF Ghana, WHO, and World Bank reports and project evaluations (2018-2023) focusing on maternal health and community engagement in the specified regions. The analysis employed a thematic approach to identify, extract, and synthesize recurring socio-cultural themes across these data sets.

III. RESULTS: THEMATIC ANALYSIS OF SOCIO-CULTURAL BARRIERS

3.1. Patriarchal Power Structures and Constrained Agency

Qualitative data consistently reveals that a woman's decision to seek care is seldom hers alone. The 2022 GMHS notes that in rural districts, only approximately 60% of women participate jointly in healthcare decisions. Men control the financial resources required for transport and unofficial fees, and their permission is often a prerequisite for seeking care. UNICEF assessments describe how men often view pregnancy as a "woman's issue," leading to a lack of financial prioritization for antenatal visits unless emergencies arise.

3.2. Cultural Beliefs and the Primacy of Traditional Care

A fundamental barrier is the perception of pregnancy as a natural life event, not an illness requiring medical management. This belief fuels a preference for Traditional Birth Attendants (TBAs), who are trusted, culturally embedded, and affordable. The 2022 GDHS reports that 10% of births are assisted by TBAs or other untrained personnel, a figure that rises in specific rural districts. Beyond trust, fear of spiritual harm ("the evil eye") in hospital settings leads some women to conceal pregnancies and delay antenatal care initiation.

3.3. Mistrust and Fear of the Formal Health System

A powerful and recurring theme in GHS community feedback reports is mistrust, stemming from two sources:
Disrespect and Abuse (D&A): Women report being shouted at, chastised for cultural practices, and treated harshly by clinic staff. A CHPS evaluation in Ada West quoted a woman stating, "Why will I go to the clinic for them to insult me?... I prefer to stay with my ‘ayana’ [TBA] who speaks to me kindly." This abuse is a significant deterrent to facility-based delivery.

Fear of Medical Procedures: Qualitative studies, such as those from the Kintampo Health Research Centre (2019), document a profound fear of Caesarean sections, often perceived as a death sentence ("wo abawaba wo mogya mu" - they have written your death in your blood). Similarly, mandatory HIV testing creates fear of stigma and marital discord, leading to late or skipped ANC.

3.4. The Influential Role of Intergenerational Female Kin

The authority of mothers-in-law and grandmothers is a critical social determinant. Their advice, rooted in tradition, often supersedes that of health workers. They advocate for traditional postnatal practices and may discourage hospital delivery unless a complication is evident, acting as powerful gatekeepers of cultural norms.

3.5. Stigma and Secrecy Surrounding Adolescent Pregnancy

GHS Adolescent Health program data identifies a distinct barrier for young pregnant girls: intense stigma. Fear of shaming from family, community, and health workers drives adolescents to seek risky clandestine care from chemical sellers or TBAs, resulting in dangerously late engagement with the formal health system.

IV. DISCUSSION

The findings illustrate that socio-cultural barriers are not peripheral concerns but central determinants of maternal health service uptake. These barriers render policies like free care less effective, as cost elimination does not address deep-seated fears, power imbalances, and cultural preferences.

The persistence of TBA use is not a failure of policy but a symptom of the formal health system's failure to be accessible, trustworthy, and culturally competent. The data suggests that successful models are those that bridge these two worlds rather than dismissing traditional systems.

Furthermore, the pervasive fear of D&A indicates a critical need for systemic reform within health facilities. Training on Respectful Maternity Care (RMC) is not a soft skill but an essential component of quality care and a catalyst for improving utilization.

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V. CONCLUSION AND RECOMMENDATIONS

This analysis demonstrates that improving maternal health in rural Ghana requires moving beyond a narrow focus on clinical service provision to embrace a broader, culturally informed community-health system engagement strategy. To this end, we recommend:

1. Implement Targeted Community Engagement: Design programs that actively involve men, community elders, and religious leaders in dialogues about maternal health to shift harmful social norms and promote supportive decision-making.
2. Invest in Respectful Maternity Care (RMC): Mandate and fund continuous RMC training for all maternal health staff, coupled with robust community feedback mechanisms to hold facilities accountable.
3. Formally Integrate Traditional Practitioners: Develop a structured policy for training and collaborating with TBAs as community-based liaisons for health promotion and timely referral, acknowledging their trusted role.
4. Create Adolescent-Friendly Services: Establish confidential, non-judgmental services and outreach programs specifically designed to meet the needs of pregnant adolescents and reduce stigma.

By addressing the socio-cultural architecture that shapes health-seeking behavior, the Ghana Health Service and its partners can ensure that physical access to care translates into timely and willing utilization, ultimately closing the equity gap in maternal mortality.

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