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The Underlying Gendered Factors Influencing Access to and Utilization of Skilled Birth Attendance (Sba): A Case Study in Ghana

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ABSTRACT

Maternal mortality continues to be a major public health concern in Ghana where women still die from preventable maternal deaths. Several factors contribute to the high maternal mortality in the country including delay in seeking skill birth attendance, sociocultural factors among others. Pursuance to the aforesaid, the study aimed at analyzing the role of gender in accessing skilled birth attendance in Ghana. A review of relevant literature was conducted to respond to the role of gender in accessing and utilizing skilled birth attendance. The search was conducted in Web of Science, Medline, PubMed, Academic Search Complete, and Cochrane database of systematic reviews including manual search of relevant literature in articles reference list. The 12 Centre for Evidence Based Management (CEBM) guidelines were used to assess the quality of the studies. The findings revealed a power play and a significant role of gender in accessing skilled birth attendance. Among the 10 studies included in this review, half of them were from northern Ghana whiles the other half in southern Ghana. Significant element discussed among the papers reviewed included male involvement, participation in decision making processes to seek skilled delivery and the effect of women social network. Men although appreciate the importance of skilled birth attendance, they are unable to provide the needed support to their partners during labour. The decision on the place of birth is mostly taken by the elderly women in the families.

Gender indeed plays a significant role in determining women access and utilization of skilled birth attendance.

Keywords: Skilled Birth Attendance, Maternal Mortality, Access to, Utilization, Gender and Ghana.

LITERATURE REVIEW

Background

Maternal mortality remains a major public health concern globally. Available literature indicates that of the 830 women who die daily from child birth related complications globally, 99 percent occur in Lower and Middle-Income Countries (LMICs).(1)

Ghana like many African countries failed to achieve the Millennium Development Goal 5 (MDG) which sought to improve maternal health and is not on track with the Sustainable Development Goal 3.1 which is to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030. Ghana still records an unacceptably high maternal mortality ratio of 319/100000 live births.(2,3) Furthermore, regional variations exist in the maternal mortality ratio in Ghana. The northern part of the country and the Volta region are considered the most deprived and record relatively higher ratios of institutional maternal mortality of 147/100000 live birth as against 144/100000 live birth in the south.(3,4)

A number of government interventions have been implemented over the years including the free maternal health services, the National Health Insurance Scheme, capacity building in the form of training for health staff on safe motherhood, the implementation of Prevention of Maternal Mortality Programme, Safe Motherhood Initiative, Prevention and Management of Safe Abortion Programme, Making Pregnancy Safer Initiative among others.(5-8) A significant number of these interventions as reported in the literature recognized the central and important role of skill birth attendance in reducing maternal mortality in Ghana and globally. This is because research has established that, access to and utilization skilled birth attendance could reduce maternal mortality significantly by 20%.(9) Despite the position of scholarship on this subject and the afore stated interventions implemented in Ghana, access to and utilization of Skill Birth Attendance (SBA) remain relatively low(58.7%) compared to the proportion of antenatal registrants recorded in the country in 2018(79.5%).(10) This has given reason to contemplate the role of some sociocultural and economic factors such as gender-related issues. The study therefore aimed to review the role of gender and intersectionality in accessing skilled birth attendance in the country, Ghana.

CONCEPTUAL FRAMEWORK

The electronic data search strategy resulted in 200 records. A total of 115 results were found in PubMed, 40 from Academic search complete, 38 from Medline and 7 from Web of science. In addition, 10 papers were identified from other sources. A total of 137 records remained after deleting duplicates. Ninety-three (93) records were excluded after screening based on titles and seven records after review of abstracts.

Consequently, 37 full-text articles were obtained and reviewed for eligibility. Following the scrutiny, eventually, ten (10) studies met the eligibility criteria and were therefore included in the final review. The following reasons accounted for the exclusion of full-text articles from the

study; articles mainly focused on the review of an intervention or general factors inhibiting access to and utilization of skilled birth attendant and not gender roles. Generally, the role of gender in relation to access to skilled birth attendance was not assessed directly in the studies neither did the studies identify any gender variable for consideration. A flow diagram in Fig 1 highlights the study selection process.

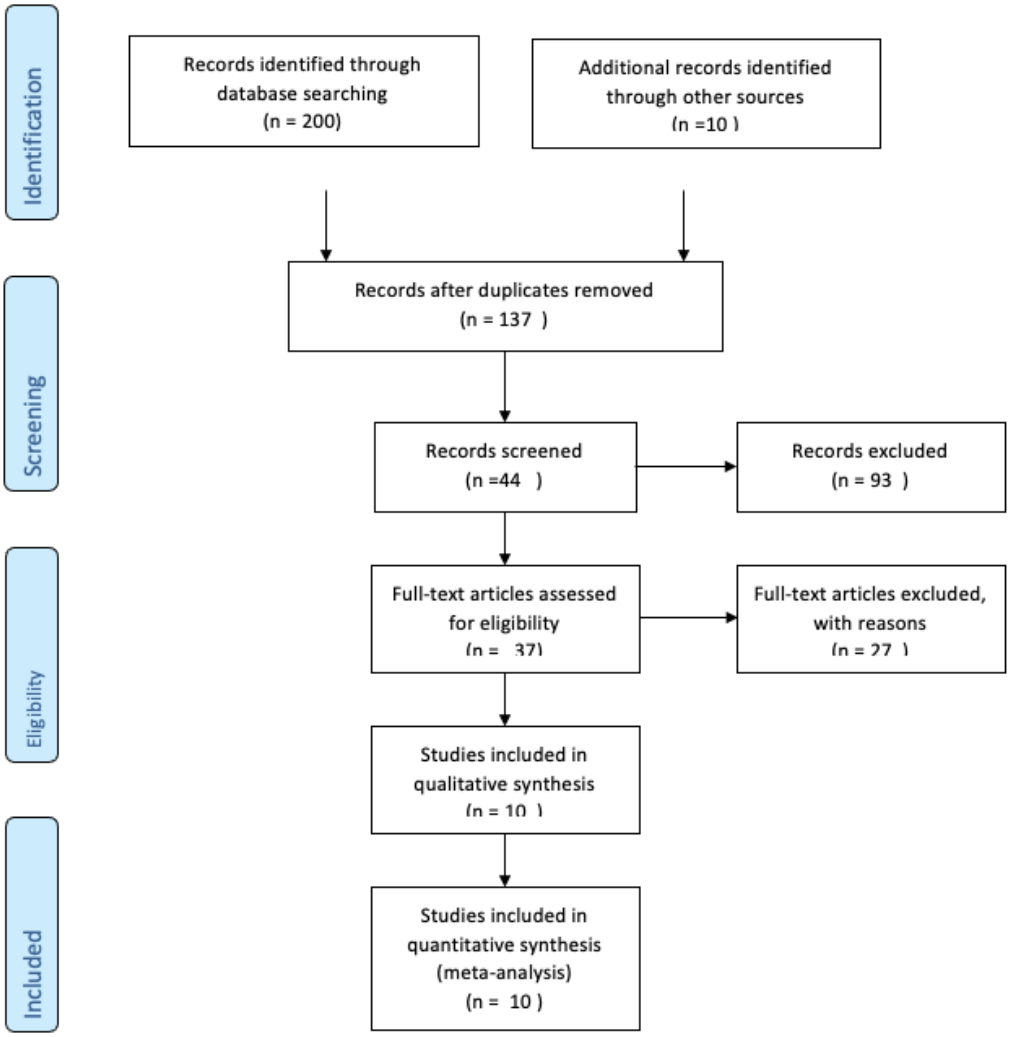

Figure 1: PRISMA 2019 Flow chart for the search process
Source: PRISMA, 2019

CONCEPTS AND DEFINITION

To provide a background to the context of the study, we provided a brief review of the concept of Skilled Birth Attendance (SBA). According to the WHO, SBA is the number of childbirth conducted by a competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards. They include professionals with the ability to provide and promote evidence-based, human rights, quality, socio-culturally sensitive and dignified care to pregnant women and newborns. It however does not include professionals without the attributes stated above.(11)

METHODOLOGY

The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA)(12) was used to guide the search and reporting of this systematic review.

The search was conducted in the following electronic databases; Web of Science, Medline, PubMed, Academic Search Complete, and Cochrane database of systematic reviews. Additionally, a manual search of eligible articles was undertaken to select relevant articles from reference list of identified articles for inclusion. The search was limited to English language articles published from 1994 to 2018. This search period is consistent with the period where there was renewed effort to fight against gender inequality following the International Conference on Population and Development (ICPD), Cairo in 1994, and subsequently the Beijing Platform for Action in 1995.

Initial search terms identified on the topic were used for introductory search on Google Scholar and modified to suit the databases used. The under listed search terms were eventually used for the study; [#1(Gender OR Sex OR Female OR Male OR Feminine OR Masculine OR Gendered) OR #2 (Use OR Utilize OR Seek OR Access OR Utilization OR Utilisation OR Accessibility) OR #3 (Education OR Sex OR Age OR Religion OR Socioeconomic Status OR Residential Area OR Disability OR Intersectionality OR Intersection OR Marital Status OR Ethnicity OR Tribe) AND #4 (skilled delivery OR Supervised delivery OR Skilled birth OR Obstetric delivery OR Skilled birth attendance) AND # 5 (Ghana OR Republic of Ghana OR Ghanaian)]

The study included qualitative, quantitative and mixed studies that reported on gender dynamics in relation to skilled birth attendance. To this extent, the review included both primary studies and systematic reviews. Non-peer reviewed journal articles, commentaries, editorials, policy statements were excluded. For inclusion therefore, a study must be an empirical one demonstrating entirely or at least relate one gender variable to access or utilization of skilled birth services in the Ghanaian setting.

The focus of the study is on women and men in the reproductive age in Ghana and their experience in seeking maternal health with emphasis on skilled birth attendance from the community through to the health facility level.

The review included both quantitative and qualitative empirical studies. Specifically, the review included studies that examined the relation between gender and intersectionality factors (that is age, education, religion, ethnicity, socioeconomic status and residence) and access to or utilization of skilled birth services *(i.e skilled birth is the number of women who delivered in a specified time period by a trained health provider*

The place of delivery during labor was reviewed in line with the role of gender dynamics. We also reviewed the experiences of both men and women in this study in relation to skilled birth attendant.

Using the eligibility criteria, articles were systematically reviewed manually to eliminate duplications. Following the elimination of duplications the remaining articles were assessed for inclusion through a sequence of screening titles, scrutinizing abstracts and finally reviewing full-text of articles. This review was conducted by NA and was repeated by AMS to ensure

reliability. The extraction of essential elements of the included articles was conducted by NA using a pre-designed form made up of the following study characteristics; the name of the author, region, objectives, study design, variables, key findings and conclusions. To ensure consistency, a second reviewer (AMS) repeated the process.

The Centre for Evidence Based Management (CEBM) guidelines(13) were used by the reviewers to assess the quality of the studies included in the review. CEBM has 12 questions and all 12 questions were used to guide the reviewers to assess quality of studies included taking cognizance of validity, reliability, and relevance of the findings. The assessment was carried out by two reviewers considering availability or otherwise of all the 12 items. However, a third reviewer was involved where there were major discrepancies. The two reviewers had to do the assessment to minimize the subjectivity in assessing the included papers. Each paper was subjected to four criteria: 3 for highest score, 2 moderate score, 1 lowest score, 0 criterion not met and not applicable. Based on the 12 guidelines, studies were cumulatively assessed out of 34. Low quality if a paper scores below 50%, moderate quality 50-79% and high quality 80% and above.

DATA ANALYSIS POCEDURE

The Cochrane Consumer and Communication Review Group (CC &CRG)(14) was used to guide the studies included in the review with same or different study designs and different interventions. This approach is largely narrative synthesis since the results had to be described and integrated into the full review. The guidelines has four major steps in narrating the synthesis for the review. Step one involves developing a theory of how the intervention works, why and for whom. Step two involves developing a preliminary synthesis of the findings of included studies. Exploring relationships in the data within and between studies is the third step and the fourth and final step is assessing the robustness of the synthesis.

Strength and limitations of the study

To the best of the authors' knowledge, this review is the first of its kind to examine the gendered factors influencing access to Skilled Birth Attendance (SBA) in Ghana. As such the review pulls together relevant literature that provides insights into the health seeking behavior of women especially regarding SBA using gender lens.

The review is however limited in its conclusions following the limited number of studies available regarding this subject in Ghana and the number of administrative regions covered. However, the number of regions covered was somewhat cured, following the cross-cutting nature of the eligible studies between the north and the south. The evidence pulled together from both northern and southern part of Ghana with varied contextual underpinnings provided more insight.

FINDINGS AND DISCUSSIONS

Characteristics of included studies

Key findings that characterized the included studies are outlined in table 2 in the annex. Four studies(15-18) used qualitative methods to explore the factors influencing women access to and utilization of skilled birth attendants. on the other hand, three studies(19-21) were descriptive in nature, one study for mixed methods(22), baseline survey(23) and ethnographic study(24). The studies were generally exploratory in nature and mainly focused on establishing

an association or otherwise between the identified gender variable and skilled birth attendants. All studies except one mainly relied on primary data from their study population (22). All ten articles included in the study were conducted in Ghana between 2006 and 2018. Four out of the ten studies were carried out in northern Ghana(15,18,21,23), four (4) in southern Ghana(17,19,20,24) and two of the studies looked at districts in both northern and southern Ghana(16,22). Participants included in all ten studies ranged from women in reproductive age, traditional birth attendants, pregnant women and lactating mothers, men with pregnant women, married men aged 18 years and above, community leaders, health workers, mother to mother support group, compound heads, household heads.

The gendered variables which were predominantly examined in the studies included; women network of information and instrumental support during labour(18,24), social roles (24), male involvement (17,18,20) , social norms (15,21,24), power hierarchies (15), men inclusion in supervised delivery(19) and social networks.(15,23) Skilled birth attendance variables included facility delivery(16) , place of delivery(15,21), supervised delivery(15) , child birth(21,22,24) , safe motherhood services(19) and pregnancy related services.(16,23)

Apart from two studies(16,22) that used two different regions covering about three districts in each region, all others were specific to a particular region. Three studies(15,18,23) used two or more districts within the same region to draw the study conclusion. Whereas three studies (19,20,24) each had their scope focused on single communities, three other studies(17,18,22) worked in about five to seven communities. As such, we did not have studies of national character.

Quality assessment

Table 1: Quality rating of studies included

SN	Rating criteria	Included studies and quality rating									
		Ref #1	**Ref #2**	**Ref #3**	**Ref #4**	**Ref #5**	**Ref #6**	**Ref #7**	**Ref #8**	**Ref #9**	**Ref #10**
1	Study addressed a clearly focused question / issue	3	2	3	3	3	3	3	3	3	3
2	The research method (study design) appropriate for answering the research question	3	3	3	3	3	3	3	3	3	3
3	Method of selection of the subjects (employees, teams, divisions, organizations) clearly described	3	3	3	3	3	2	2	3	3	3
4	Sample obtained introduce (selection) bias	1	1	2	0	0	3	2	1	1	2
5	Sample of subjects representative with regard to the population to which the findings will be referred?	2	3	2	2	3	3	3	3	3	3

6	Sample size based on pre-study considerations of statistical power	3	3	2	3	3	3	3	3	3	3
7	Satisfactory response rate achieved	3	3	3	3	3	3	2	3	3	3
8	The measurements (questionnaires) likely to be valid and reliable	3	3	3	3	3	3	3	3	3	3
9	Statistical significance assessed	NA	NA	NA	0	3	0	NA	NA	NA	0
10	Confidence intervals given for the main results	NA	NA	NA	0	0	0	NA	NA	NA	0
11	Confounding factors that haven't been accounted for?	NA	NA	NA	3	0	0	NA	NA	NA	0
12	Can the results be applied to your organization?	3	2	2	2	3	3	3	3	3	3
	Total out(Percentage)	24(89%)	23(85%)	23(85%)	25(69%)	27(75%)	26(72%)	24(89%)	25(93%)	25(93%)	26(72%)
	Overall rate	High	High	High	Moderate	Moderate	Moderate	High	High	High	Moderate

Male involvement in skilled birth attendance

The key variables used in male involvement include men accompanying their wives to health facility, gender and husbands' roles during child birth. In this review, five studies (17-20,24)

reported on male involvement in maternal and child health and their relation to access and utilization to skilled birth attendants. While three studies (18-20) reported on men accompanying their wives/partners to the health facility to seek skilled birth attendants, the other two studies (17-24) examined the social roles men play during childbirth. Regarding accompanying wives/partners to seek skilled birth, majority 56%(17) and 55.5%(24) of the respondents did not accompany their wives/partners to the health facility to deliver in their last pregnancy. When respondents (men) were asked if they would accompany their wives/partners to seek skilled birth, only 21.9% affirm they would accompany their wives/partners to deliver in the health facility in their subsequently delivery(24). Enablers of male involvement in delivery services included partner's educational level, marriage type, living arrangement and number of children. Male involvement is significantly higher among men with tertiary education (100%) than those with no education (0%). Similarly, male involvement tends to be significantly higher among women in monogamous marriages (49%) than polygamous marriages (0%). Significant male involvement was also reported among men with a child or more (58%) than men without children(43%)(20). It was however reported that despite this low level of participation in supervised or skilled delivery, most men knew the importance of skilled delivery yet relatively low level of participation was observed. About 69% recounted supervised delivery being safer for mother and child (69%), helped to avoid and/ or address complications during delivery (17.9%). Ganle and Dery cited masculinity and male role conflict, cultural beliefs and practices, health service related factors and high cost associated with accompanying women to seek child birth services as the reasons for men unwillingness to accompany their wives/partners or encourage them skilled birth services although they appreciate the importance of skilled birth services(18). Besides accompanying their wives/partners to health facilities to deliver, Jansen(24) revealed that men played significant roles to facilitate skilled delivery such saving money for safe delivery of their wives/partners (100%) and arranging transport for their wives to visit the health facility for skilled care(84.4%). Regarding the social role of men during child birth, one study (24) reported on paying for the cost of hospital expenses as the dominant role of men during child birth. However, Bougangue and Ling(17) reported on varied male involvement in childbirth including directly sending women to deliver at health facility and using female relatives and co-wives among others based on what is considered a gender norm for men. The study further revealed that it was a taboo for a man to accompany the wife to access childbirth services instead, they assigned their mothers or sisters in a patriarchal society and mothers-in-law and sisters-in-law in the matriarchal society.

Participation in decision making in relation to skilled birth attendants

Decision-making is an essential component in accessing supervised delivery. Variables measured included decision making during child birth and power hierarchy in relations to deciding on place of birth. Although the pregnant woman carries the pregnancy and in most cases is in the position to make the decisions regarding her place of birth, she is required to follow the advice of the elderly women who are mostly family members(22). Four studies reported on decision making during child birth(15,21,22,24). Jansen in her ethnographic study reported that, the decision on the place of birth in Kwame Danso was mainly made by older female relatives (woman's mother, mother in-laws etc). The study noted that these older women usually used rational judgements to arrive at their decision on the place of birth considering the risks factors, interests and advantages related to their cultural, spiritual and social system (24). This account corroborates that of Moyer et al.(15) and Yidaana and

Issahaku(21) where mother in-laws and husband make decisions regarding place of birth. The power to make the final decision at the household irrespective what it maybe, is in the hands of the compound head. It is believed that he owns the family members and is obliged to take decisions for them. The study however points to the fact that such practices are waning away. Women can now make such decisions all alone and may consult the husband.(15) Respondents who delivered at home in Yidaana and Issahaku study noted that they delivered at home because it was the decision of their mother-in-laws. Some women especially teenagers were however happy to have delivered at home because they were saved from public ridicule since they were not married and people would be questioning them of the father of their babies. For the married women, the explanation is usually that other women delivered at home and so, there is no need going to the health facility to deliver.(21) Again, Atuahene et al(19) reported that more than a quarter of the men (37.1%) said their mothers-in-law decided on the place of delivery, 30.9% indicated that both they (men) and their wives/partners jointly chose the place of delivery with only 0.8% of the men said their wives/partners made the decision all alone. Ganle et al was in unison with all other studies which noted that although women sometimes desire to seek skilled birth services, their limited decision making autonomy, physical mobility and lack of independence influence their choice of place of birth.(22)

Effect of social network on skill birth attendants

Women networks provide varied levels of influence on women decision to seek the services of skilled birth attendants. Two studies reported on women social network in relation to accessing skilled birth services(23,16). Social network variables such as sex, education, experience, relationship type and communication were measured by Dougherty et al(23), age, marital status, education, occupation and place of delivery were measured by Cofie et al.(16). Average network size reported was 8 people made up of blood relations (constituting more than half), in-laws and friends (at least two-thirds of network members).(16)

Cofie et al. in their finding pointed to the fact that women who had facility delivery and most women with unintended home birth received information and immense support from their network members to deliver at the health facility. Network members of facility births worked together to facilitate women use of health facility delivery. Among women who had unintended homebirth had their network members advocated for them to have facility delivery, but failed to mobilize resources quickly for the women's facility delivery. However, women who opted to deliver at home do not provide the needed support to have them deliver in the health facility. Instead, their supported is rather slanted towards home delivery.

However, network members of homebirth provided support oriented towards ensuring safe homebirth for women.(16) Dougherty et al on the other hand reported that the characteristics of women networks, network size among others influence women use of health facility and skilled birth attendant. Women with social contact significantly influenced facility birth and skilled birth attendance. Pregnant women who participated in women's groups were more likely to have a facility birth. It was also revealed that the network size a woman had and discussed with about pregnancy and childbirth influences her place of birth.

Accessing facility birth and use of skilled birth attendant was associated with communication with males and those having less education. Women who reported more frequent communication with the social network partner have a higher chance of accessing the same

services. Again, women naming experienced partners as network members was positively associated with having a skilled birth attendant (AOR=1.36, p<0.01). Naming friends and naming a health professional were positively associated with facility birth (AOR=4.23, p<0. 01; AOR=8.02, p<0.01, respectively) and having a skilled birth attendant (AOR=3.89, p<0.01; AOR=8.08, p<0.0, respectively).

However, women in this study did not prioritize communication among themselves, with their partners or family members about pregnancy-related issues but rather health professionals for such information. The paper further reported that women who discuss pregnancy-related care with their female and educated network partners were less likely to access a birth facility or a skilled birth attendant.(23)

DISCUSSIONS

The role of gender in accessing skilled birth attendance is increasingly becoming prominent in maternal and child health discourse. Unfortunately, not so much gender studies have been conducted to unravel the influence of gender in access and utilization of skilled birth attendance. This review set out to pull together evidence on the underlying gendered and intersectional factors influencing access and utilization of skilled birth attendance in Ghana. As such, identified gender and skilled birth attendance variables from ten (10) studies were used. The main thematic areas discussed in this review include male involvement, participation in decision making and social network. The findings from the studies revealed that almost all the major stakeholders regarding access and utilization of skilled birth attendance including pregnant women, husbands, mother-in-laws and TBAs among others appreciate the importance of utilizing skilled care during child birth.(17,18,20,24) The literature emphasized the importance of factors such as partners level of education, marriage type, living arrangement among others as essential determinant of male involvement in maternal health services especially skilled birth services (20) Craymah et al.(20) further points to the fact that most women still require the permission of their partner/husband to seek skilled care at birth, unfortunately, most of the men do not involve themselves in maternal health services especially child birth. Jansen(24) on the contrary highlighted economic, spiritual and social factors as the three main factors influencing male involvement in skilled birth attendance. Jansen noted the lack of money to pay for transport and skilled care expenses by men as significant determinant of their involvement in skilled care services. According to Jansen “the role of the husbands in childbirth was described as paying the cost for antenatal, the delivery and all expenses for the health and education of the children” Men who adhere to this cultural norm spend their time fending for the family than to follow their wives to the health facility to deliver. This accounts corroborates the of Atuahene et al.(19) where long waiting hours, lack of time to accompany partner, poor attitude of health staff and maternal health services exclusively focused on women were some of the reasons influencing male involvement in delivery services. The study however like other studies disagreed that long distances to health facilities, cost of services, lack of information were barriers to male involvement to delivery services.

The studies also revealed that women are rarely involved in decision making at the household and as such the choice on the place of birth is mostly in the hands of husbands/partners, mother-in-laws or both.(15,19,22) This mirrors the extent to which women carry the pregnancy but have little or no say about their own health. Mothers-in-law and husbands that support home delivery do not understand why they have to carry a delivery they can conduct

at home to the health facility through challenging moments. A number of reasons such as women economic dependence on men, lack of education, women in polygamous marriage and women general submissive nature(15,24) make them lack the decision making autonomy or to participate in decisions at the household level regarding access to SBA. A number of factors are taken into account by husbands and mother-in-laws in considering the place of birth. These factors include transport availability, cost of delivery, cultural beliefs and the norm that all other women delivered at home and as such they should also deliver at home. And so, avoiding transport and delivery cost and altercations with health providers at the health facility mother-in-laws or husbands usually opt for home delivery. The literature however points to the fact that women who are educated, economically independent and younger generation tend to have some level of autonomy in decision making or participate in decision making at the household level.

RECOMMENDATIONS

Following the available evidence presented above, we conclude that gender and sociocultural factors play a critical role in women access to and utilization of SBA. The decision to seek skilled care and place of delivery as reported in the studies is most times taken by the elderly women within the family, household heads and women partners. It was also revealed that although majority of men know the importance of SBA, they are unable to accompany their partners to the health facilities to access such services. Maternal health services including SBA is considered the preserve of women.

The findings of this study therefore provide relevant information to unpacking the underlying factors influencing access to and utilization of skilled birth attendance (SBA) in Ghana using the gender lens for consideration by all stakeholders in planning maternal health interventions. These insights are critical in determining which policy direction the government should pursue in the fight to reducing maternal mortality. Besides the aforementioned, the study is a bridge to the knowledge gap regarding the underlying causes of maternal mortality in the community using a gender lens.

It is also recommended for policy makers that they provide women with the capacity building to empower them. This will enable them provide quality services to their clients. Regular training and certification of such women practitioners is also recommended to serve as motivation. Training programmes should be tailored and customised to suit their level of education, cultural beliefs and location.

Finally it is recommended for future researchers to conduct further investigation on the level of satisfaction of such women service providers using a different research deign to cover the entire country. Findings from such a study could give room for generalization for the entire country and give policy makers the opportunity to make informed decision for policy review if such a policy do exist.

Annex

Table 1: Characteristics of included studies

Author	Region in Ghana	Objective	Study design	Gendered variables discussed	Results and conclusion
1Cofie et al 2018 (PLoS ONE)	Northern and Central Regions	To explore how women's network social support influences facility delivery	mixed methods evaluation 3 districts NR 3 districts CR A community in each of the districts	Information support from social network in relation to pregnancy and delivery Instrumental support during labor and delivery	Women who had facility births and unintended homebirth received advice to use facility-based pregnancy and or delivery care from their network members. Homebirth on the other hand did not receive such advice from their network members Network members of facility births worked together to facilitate women use of health facility delivery. Network members of unintended homebirth did not make arrangement in time to get women to a health facility for birth delivery Network members of homebirth provided support oriented towards ensuring safe homebirth for women It is normative for mother inlaws, mothers, and grandmothers to advise women and provide suggestion on how to experience safe pregnancy and delivery. Women who had good relationship with husband are advised to deliver at health facility
2Jansen 2006 (International Nursing Review)	Brong Ahafo Region	To explore why pregnant women do not make use of supervised deliveries in the modern institutions	Mini ethnographic study	Social roles in accessing skilled delivery services	Husband's role in childbirth was to pay for the costs of antenatal care, the delivery and all expenses. Where the man cannot pay, the pregnant woman is expected to pay Pregnant women are expected to strictly follow the advice of their older

					female relatives during child birth. TBAs by their beliefs and social status in the community, they are obliged to conduct home
3 Moyer et al (2013)	Upper East Region	To explore the impact of social factors on place of delivery in northern Ghana	A qualitative study 2 districts zoned into 5 sub-districts and further divided into clusters 12 clusters were selected from each zone	Shifting Social Norms Regarding Place of Delivery Power Hierarchies in the Community	All respondents are appreciating the importance of supervised delivery. Several women disagreed that they needed permission to seek delivery services at the health facility. However, another group think that the decision to seek facility delivery is not entirely theirs to make but husband/partner or family member. The woman relies on the husband/partner or family member to organize a means of transport to take her to the health facility The study points to the fact that important decisions regarding delivery, some women consult with their mothers in-law and husbands, who may in turn consult with compound head. The compound head is the final decision maker who may also consult a spiritual leader. The study however added that this practice was not universal as some women make the decision to go to health facility alone with some compound heads also denouncing the role of spiritual leaders.
4 Atuahene et al (2017)	Greater Accra	The purpose of this study was to describe the level of men's inclusion in maternal and safe-motherhood services and to assess the	A descriptive cross-sectional quantitative survey One community (Chokor)	Men's inclusion in supervised delivery Barriers to men's inclusion in safe motherhood services	Men who accompany their wives to the health facility are more likely to have them access supervised delivery More than half (55.5%) of men did not accompany their wives/partners for delivery in the health facility. And only 21.9% indicated they will accompany their

		barriers of men's involvement.			wives/partners to the health facility to deliver in the future. Knowledge was not a problem. Most men knew the importance of supervised delivery. Long waiting hours, poor attitude of health providers, no time to accompany wife/partner to health facility and the fact that some maternal health services focus mainly on women. Men disagreed that distance, cost of services, lack of information/knowledge about maternal and safe motherhood services, shyness to take part in maternal services, and dissatisfaction with services in health facilities were barriers to their involvement Decision in relation to place of birth; About 37% said their mothers-in-law decided, 30.9% said both they and their wives/partners jointly decided with only 0.8% said their wives/partners made the decision alone
5 Dougherty et al (2018)	Upper West Region	To explore whether women who access birth facilities and receive antenatal and postpartum care services are more likely to communicate	Descriptive survey Baseline 3 districts in UWR 9 communities	Social network effect, frequency of discussion on pregnancy-related services	The characteristics of women networks, network size among others influence women use of health facility, and skilled birth attendant. Women with social contact significantly influenced facility birth and skilled birth attendant. Minimal differences recorded between one social partner and those with none. Women who participated in women's groups were more likely to have a facility birth. It was also revealed that the network size a woman

					spoke with about pregnancy and childbirth influences whether she had a facility birth and skilled birth attendant Women who discussed pregnancy-related issues with friends or health worker were more likely to access a birth facility and skilled birth attendant than those who discuss with their partners. Accessing facility birth and use of skilled birth attendant was associated with communication with males and those having less education. Women discussing pregnancy-related care and those receiving advice were less likely to access a birth facility or a skilled birth attendant. However, women who reported more frequent communication with the social network partner has a higher chance of accessing the same services. Women in this study did not prioritize communication among themselves, with their partners or family members about pregnancy-related issues but health professionals for such information
6 Craymah et al. (2017)	Central Region	To assess male involvement in MHC and associated factors at Anomabo in the Central Region of Ghana	cross-sectional study in Anomabo	Male Involvement in MHC Services Partner level of education, marriage type, living arrangement	Some 35%, 44%, and 20% of men accompanied their partners to antenatal care, delivery, and postnatal care services, respectively. Male involvement in antenatal care and delivery was influenced by sociodemographic (partner's education, type of marriage, living arrangements, and number of children) and

					enabling/disenabling (distance to health facility, attitude of health workers, prohibitive cultural norms, unfavourable health policies, and gender roles) factors. male involvement in MHC was signifcantly higher among respondents in monogamous marriages (antenatal: 39%, delivery: 49%) than those in polygamous marriages (antenatal: 0%, delivery: 0%).
7 Bougangue and Ling (2017)	Central Region	The main objective was to provide opportunity for men to share their views about involvement in various aspects of maternal health care, ranging across pregnancy, delivery and postnatal care.	Qualitative study One district 5 communities	Traditional gender role expectations	The study shows varying involvement of men, some were directly involved in feminine gender roles; others used their female relatives and co-wives to perform the women's roles that did not have space for them. They were not necessarily indifferent towards maternal healthcare, rather, they were involved in the spaces provided by the traditional gender division of labour. Amongst other things, the perpetuation and reinforcement of traditional gender norms around pregnancy and childbirth influenced the nature and level of male involvement.
8 Ganle et al. (2015)	Ashanti & Northern Regions	The purpose of this paper is to examine how intra-familial decision-making affects women's ability to access and use maternal health services.	Mixed method 2 different regions One district each 3 communities in each district	Women's autonomy and maternal health-seeking behavior Women's participation in maternal healthcare decision making	Findings suggest that decision-making regarding access to and use of skilled maternal healthcare services is strongly influenced by the values and opinions of husbands, mothers-in-law, traditional birth attendants and other family and community members, more than those of individual childbearing women. In 49.2 %, 16.2 %, and 12.4 % of cases in which

				Women's relative freedom of movement and access	women said they were unable to access maternal health services during their last pregnancy, husbands, mothers-in-law, and husband plus mothers-in-law, respectively, made the decision. Women themselves were the final decision-makers in only 2.7 % of the cases. The findings highlight how the goal of improving access to maternal healthcare services can be undermined by women's lack of decision-making autonomy through complex processes of gender inequality, economic marginalisation, communal decision-making and social power.
9 Ganle and Dery (2015)	Upper West Region	The purpose of this paper is to explore the barriers to and opportunities for men's involvement in maternal healthcare in the Upper West Region of Ghana.	Qualitative study One region Two districts 7 communities	Men's perceptions of the importance of skilled maternal healthcare Men's involvement in maternal healthcare Barriers to men's involvement Masculinity and male role conflicts Cultural beliefs and practices	Findings suggest that although many men recognise the importance of skilled care during pregnancy and childbirth, and the benefits of their involvement, most did not actively involve themselves in issues of maternal healthcare unless complications set in during pregnancy or labour. Less than a quarter of male participants had ever accompanied their wives for antenatal care or postnatal care in a health facility. Four main barriers to men's involvement were identified: perceptions that pregnancy care is a female role while men are family providers; negative cultural beliefs such as the belief that men who accompany their wives to receive ANC services are being dominated by their wives; health

					services factors such as unfavourable opening hours of services, poor attitudes of healthcare providers such as maltreatment of women and their spouses and lack of space to accommodate male partners in health facilities; and the high cost associated with accompanying women to seek maternity care. Suggestions for addressing these barriers include community mobilisation programmes to promote greater male involvement, health education, effective leadership, and respectful and patient-centred care training for healthcare providers.
10 Yidana & Issahaku (2014)	Northern Region	This paper sought to establish sociocultural impediments to the use of health facility as the most ideal place of delivery among a cross section of women in the northern part of Ghana.	A descriptive cross-sectional study One district in NR	The Decision of Significant Others	The results suggest a positive relationship between increasing maternal formal education, household income and possibility of delivering at a health facility. However, social and cultural factors have been noted to exert a greater impact on the choice of delivery sites. In view of this, the paper suggests a modification of traditional practices to suite current happening. In addition to the above, there is also the need for deployment of resources needed to combat home delivery, or even if at, make it safer.

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