EXPERIENCES OF MATERNITY CARE FROM WOMEN'S AND PROVIDERS' PERSPECTIVES IN A PERI-URBAN SETTING IN GHANA

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ABSTRACT

The provision of quality maternity care is an important public health issue because a healthy pregnancy can be the basis for a mother's and child's lifelong good health. However, the global effort to reduce maternal and new-born mortality and morbidity in low-income settings has focused on access to services and has tended to neglect aspects of care. In Ghana, a free maternal healthcare delivery policy was introduced in 2008. Since then, the proportion of births that occurred without skilled services reduced from 40% (2007) to 21% in (2018). One reason women may not be accessing care is because they anticipate the treatment they receive as disrespectful or uncaring. This study aims to explore the experiences and expectations of maternity care from both women's and providers' perspectives.

Methods

A qualitative feminist approach was used in this study. A purposive sampling method was employed to recruit 20 women who had given birth in the previous 12 months at the Tema General Hospital (Tema Metropolitan District, Greater Accra Region, Ghana), and 10 maternity health professionals from the maternity ward. Semi-structured interviews were conducted between March 2018 and July 2018. Thematic analysis was used, and the data was interpreted within the context of an existing quality of care framework produced by the World Health Organisation in 2018.

Results

Maternity healthcare providers reported poor working environments in the health facilities and lack of recognition of their role, leading to feelings of demoralisation; this has contributed to the healthcare users' experiences of low quality and dehumanised care. Women revealed how much religion impacted on their decision making; they described how they would consult pastors to decide whether it was appropriate to go to the hospital, even when they were in labour. Both the mothers and midwives are religious and referred to God in terms of whether things will go well.

Women in labour lacked emotional support, experienced neglect, poor communication, as well as physical and verbal abuse. One of the more blatant issues in the Ghanaian context was a dominant discourse of the uncooperative woman, which served to allow midwives power and control over women and their bodies, using punishment for non-compliance.

Limitation

The study does not represent the experiences of women who do not attend the hospital. However, it may provide information regarding why some women may not wish or be able to attend the hospital facilities.

Conclusion

Improving the respectful quality of maternity care in Ghana requires improving workers' motivation, strengthening manpower resources and infrastructural development to ensure that professionals can achieve pride in their work. More emphasis should be placed on religion and women's education when discussing countries that are dominated by beliefs and religion. The failure to engage with this is likely to mean improvements /initiatives of positive maternity care are likely to fail.

Keywords: Quality of maternity care, Intrapartum care, Respectful care, Women experiences, Health facility.

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ABBREVIATIONS

Antenatal Care	ANC
Maternal Healthcare Professionals	MHP
Greater Accra Region	GAR
Ghana Health Service	GHS
Health Care Provider	HCP
Maternal Mortality and Morbidity	MMM
Maternal Mortality Rate	MMR
Millennium Development Goals	MDGs
Ministry of Health	MOH
Sustainable Development Goals	SDG
Tema Metropolitan District	TMD
United Nations	UN
World Health Organisation	WHO

CHAPTER 1: INTRODUCTION

1.1 Overview

As of 2018, 99% of global maternal mortality occurred in low resource settings, with Sub-Saharan Africa and Southern Asia recording 86% of the total estimated global maternal deaths (WHO, 2018) . An intervention to reduce maternal mortality and morbidity involves increasing the access to, and utilisation, of established professional healthcare facility (PHF) services. In low-income countries such as Ghana, such interventions may be impeded by poverty. To remove the financial barriers, the Ghanaian government introduced a free maternal healthcare delivery policy in 2003, which was implemented nationwide in 2008 (Aboagye et al., 2019; Anafi et al., 2018). Despite the free maternal health delivery intervention, the use of PHF services was recorded as being 44% in 2008, rising to 79% in 2018. However, the maternal mortality rate (MMR) remains high in Ghana, which was 319 deaths per 100,000 live births in 2016, compared nine deaths per 100,000 live births in United Kingdom in the same year (WHO, 2016).

Given that this major government investment has failed to make the desired impact, and that Ghana is one of the countries with the highest maternal mortality rates in the world, still driven by women failing to access services, the question posed by this thesis is: why do women not avail themselves of the free services? The present study explores these women's experiences and expectations, the perceptions of the maternal healthcare professionals (MHP), and the potential influences on women's access to antenatal and intrapartum care in Ghana. Although there is some evidence of low quality, dehumanising care at PHFs in Sub-Saharan Africa, as in Ghana (Bohren et al., 2019; Bohren et al., 2015; Bradley et al., 2016; Moyer et al., 2014), there is a paucity of studies on the drivers of women's accessing maternity care. The existent evidence of low quality and sometimes dehumanising care may partially explain this low utilisation and deter women from accessing free maternal healthcare, thus further influencing maternal mortality and morbidity (MMM). However, there may be other reasons for the low utilisation of and women's failure to access free maternal healthcare such as transport, distance, financial cost, family pressure, preference for traditional births attendance, and herbalists, advice from religious leaders and community, previous experiences of using of health facilities, the need to work, socio cultural factors, religion,

and childcare. The drivers identified will help to meet the expectations of women and address the perceptions of MHPs to improve the accessibility, utilisation and quality of the maternal healthcare services offered by PHFs. It should also be noted that improving the quality of maternity care requires a better understanding of the experiences of the women's who have received healthcare in PHFs.

This chapter presents the background to the study, the issues associated with the uptake of maternity care in Ghana, and the rationale for the study, including its aim and objectives. The general structure of the thesis is also presented.

1.2 Background of the Study

During the last decade, there have been renewed efforts to improve maternal health outcomes and reduce maternal death by focusing on the uptake and quality of care provided for women (Ratcliffe et al., 2016). Every woman, irrespective of her geographical location or social status has the right to receive dignified, respectful, and quality maternal health during childbirth (Bohren et al., 2015). The healthcare system is, therefore, expected to, efficiently and effectively, provide high quality maternity care that meets the needs and expectations of childbearing women and their families. Effective, timely maternal healthcare prior to conception, as well as during pregnancy and childbirth, could save the lives of nearly three million new-borns in high burden countries (WHO, 2016). Most maternal and neonatal deaths could be prevented by direct interventions (Simeoni et al., 2019). The evidence suggests that two-thirds of neonatal deaths could be prevented if all pregnant mothers and new-borns had access to cost-effective, direct interventions as well as receiving care from skilled healthcare providers during pregnancy and childbirth (Simeoni et al., 2019). The use of contraceptives improves women's and children's health in many ways, including reducing the maternal mortality risk, and improving child survival through birth spacing and the nutritional status of both mother and the child, together with public health interventions such as immunization, and treatment for common diseases such as , malaria, worm infestations, HIV/AIDS and tuberculosis (Ahmed et al., 2019; Wuni et al., 2017).

The benefits derived from providing quality maternity care include a reduction in maternal and neonatal mortality and morbidity (WHO, 2016). Providing effective maternity care requires countries to concentrate on increasing access to maternity care and providing safe, high quality maternity care for women (Bohren et al., 2015; Vogel et al., 2015). Additionally, countries must ensure that maternity care is available locally, and is acceptable and affordable. This would dramatically reduce the global burden of MMM (Bohren et al., 2015; Ganle, 2013) by reducing the risks and harm, preventing injuries, minimising medical errors, and increasing women's utilisation of maternity care services (WHO, 2016).

Access to skilled maternal healthcare services, especially skilled attendance at birth and timely referrals to emergency obstetric care, as well as contraceptive use, could dramatically reduce the global burden of MMM (Bohren et al., 2015; Ganle et al., 2014a). Although skilled attendance at birth has been identified as an intervention to save the lives of childbearing women and babies, in many communities in developing countries, including Ghana, 40% of women continue to deliver at home with the assistance of a traditional birth attendant (TBA) (Adatara et al., 2018; Aziato & Omenyo, 2018). A TBA, as stated by WHO, is "*a person who assists a mother during childbirth, and who initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants*" (WHO, 1992, p. 18). A study on the role of the traditional birth attendant on maternal healthcare in Ghana indicated that, in deprived communities in sub-Saharan Africa, TBAs constitute the majority of childbirth care providers, due to the unavailability of skilled birth attendants such as midwives, nurses, and doctors (Adatara et al., 2018). Home births have not been addressed nationally in Ghana. However, a fifth of all births (20%) still take place home (Asante Sarpong et al., 2016; , 2018). These births are generally supervised with the assistance of a TBA: a relative or an elderly woman from the local community (Asante-Sarpong et al., 2016). Almost 40 % of these home births are assisted by a TBA, with about one in ten births assisted by a relative or receiving no assistance at all (Asante Sarpong et al., 2016; , 2018). However, in many countries of sub-Saharan Africa, including Ghana, increasing the proportion of women who give birth in a PHF remains a challenge, as it requires the authorities to make comprehensive efforts to overcome the sociocultural, economic, geographical, and infrastructural obstacles to providing facility-based care (Bohren et al., 2015; Campbell et al., 2016). Additionally, it requires efforts to improve both the geographical coverage and quality of care for

all women in PHFs, including providing high quality, respectful care (Bohren et al., 2015; Campbell et al., 2016). However, there has been relatively little attention paid to the quality of maternity care in low-middle income countries (LMIC) as a potential reason why women may not choose to access maternity care related to pregnancy and childbirth (Chadwick et al., 2014; WHO, 2018).

Providing maternal healthcare to individuals in a safe environment, and protecting them from avoidable risks and harm has recently become priority at the national and international levels (WHO, 2017). Sadly, the challenges associated with providing effective maternal health services continues to contribute to women's failure to access care, resulting in an unacceptable number of maternal deaths globally; this is a major public health problem, especially in Sub-Sahara Africa (Campbell et al., 2016; Graham et al., 2016; Koblinsky et al., 2016).

Globally, an estimated 830 maternal deaths occur each day due to complications during pregnancy, while in labour, or after giving birth (WHO, 2016). Some 99% of these deaths occur in low and middle-income countries such as Ghana (WHO, 2018). The lifetime risk of women dying during pregnancy or childbirth in 2015 was 1 in 36 for sub-Saharan Africa versus 1 in 4,900 for developed countries which is more than a hundred times greater (Graham et al., 2016). Notably, globally, the maternal mortality rate has fallen from 385 deaths per 100,000 live births in 1990 to 216 deaths per 100,000 live births in 2015. Globally, 216 women died of maternal causes per 100,000 live births, which represents a decrease in 44% in maternal mortality compared with 1990 (Graham et al., 2016; WHO, 2016). Although this represents a decline in maternal mortality, progress towards achieving Millennium Development Goal 5 (MDG5A), which was to reduce the maternal mortality ratio (MMR) between 1990 and 2015 by three quarters (75%) and to achieve universal access to reproductive health by 2015, was slow (WHO, 2016). This resulted in the failure of many counties in Sub-Saharan Africa, including Ghana, to achieve this target.

Over the last 20 years, there has been an increasing political commitment to decreasing the number maternal deaths that occur in Ghana (Anafi et al., 2018; Ganle, 2013). Various maternal health policy interventions have, therefore, been implemented in Ghana and other African countries to reduce the mortality rates, in response to the MDGs. For instance, in 2003, Ghana launched and implemented the Free Maternal Delivery Policy. The fee-free intervention was first introduced in

four deprived regions (the Northern, Upper East, Upper West and Central Religions) and was later extended to the six remaining regions of Ghana in 2005. The free maternal healthcare intervention policy was placed under the National Health Insurance Scheme in 2008, exempting all pregnant women from antenatal, delivery and postnatal fees. Under this policy, women are allowed six free antenatal visits, free delivery in the health facilities, two postnatal visits to the clinic with their baby within six weeks and care for the new-born for up to three months, comprising an assessment of the child's health and, development and the administration of vaccinations (Aboagye et al., 2019; Anafi et al., 2018; Ganle, 2013). This policy is premised on the concept that financial barriers are a major cause of the poor access to and utilisation of maternal and childcare services (Anafi et al., 2018; Ganle, 2013; Ganle et al., 2014a).

The aim of the Free Maternal Delivery Policy in Ghana was to address the challenge of the financial barriers to service access, and so, improve the utilisation of maternity care, irrespective of the healthcare facility (Anafi et al., 2018; Ganle et al., 2014a). The free maternal healthcare has positively improved the access to and use of antenatal check-ups and supervised births (Anafi et al., 2018; et al., 2018). However, with regards to the impact of this policy on improving maternal and neonatal outcomes, there exist challenges associated with its implementation (Aboagye et al., 2019; Bonfrer et al., 2016). Studies have found that the direct costs associated with antenatal care in the public healthcare facilities of Ghana remain a significant barrier to expectant mothers' utilisation of the services offered by the health facilities. One significant issue is that free intervention does not include the transportation costs of the women (Anafi et al., 2018). Studies conducted in Ghana (Abor et al., 2011; Bosu et al., 2007; Dzakpasu et al., 2012) revealed that the implementation of this policy did help to reduce the financial and geographical barriers to accessing maternity care services, yet many women continued to fail to access them. Aboagye et al. (2019) stipulated that the communities should be the principal stakeholders in describing the disadvantaged groups that require exemptions. This current study investigates what the barriers are against women accessing such services, capturing the perceptions and experiences of women and the healthcare professionals delivering this care.

Ghana was unable to achieve the MDG 5 target of reducing the MMR by three quarters between 1990 and 2015. Ghana has consistently recorded a high maternal mortality ratio (MMR) over the

last 29 years, and the current estimates suggest that there are 308 maternal deaths per 100, 000 live births in Ghana (Ganle, 2014; WHO, 2016). The World Health Organisation (WHO) estimated a maternal mortality ratio (MMR) in Ghana of 500 in 2000, 400 in 2005, and 350/100,000LBs in 2008. Despite this progress in terms of reducing the maternal mortality ratio, there were over 800 institutional maternal deaths in 2009 in Ghana (Sumankuuro et al., 2017), meaning that the country remains far from achieving Sustainable Development Goal (SDG) three (targets 1 and 2) (Sumankuuro et al., 2017; WHO, 2016). For example, the MMR in the Greater Accra Region of Ghana was estimated to be 130/100,000 (within the period of 2016) (Klobodu et al., 2020). Globally, neonatal mortalities within twenty eight days of life has fallen dramatically during the last 15 years, with an estimated reduction from 5.1 million to 2.7 million between 1990 and 2015 (Aborigo et al., 2014). However, most of the deaths occur within the one month of life and constitute nearly half of all under-five mortalities (Aborigo et al., 2014). A study done on causes of morbidities and mortalities in two rural districts of the Upper West Region in Ghana indicated that the neonatal mortality rate in Ghana is 32/1,000 (Ghana. Ministry of Health, 2010). Indeed, it is relevant to illuminate these areas, highlighting that high death rates show that the maternal health interventions have not achieved results. At the global level, the World Health Organisation conducted a survey which involved examining the records of over 300,000 deliveries in hospitals in 29 countries and revealed that increased access to key maternal health interventions did not necessarily result in a decreased maternal deaths (WHO, 2016) . Therefore, Ghana's high maternal mortality is not only a result of the barriers preventing women from accessing maternity care, but also due to the difficulties that women encounter in accessing maternal healthcare that is safe, acceptable, and of high quality (Bohren et al., 2015). The post-Millennium Development Goals, namely the Sustainable Development Goals (SDGs) have highlighted the patchy progress achieved across the sub regions and countries of Sub-Sahara Africa in their attempt to reduce the maternal mortality rate (Graham et al., 2016). This study identified the gap in the evidence regarding what other factors may affect the delivery of safe, effective maternity care in Ghana, by exploring the experiences of the women who access the care and the maternity health professionals (MHPs) who deliver it.

It is insufficient to provide access to free maternal health services alone, as these services must provide high quality care which allows women and their families to feel safe and dignified (WHO,

2018). In some settings such as low-income countries, care can be perceived as dehumanised (Bohren et al., 2015; Bradley et al., 2016), with a prevalence of disrespectful, abusive care beginning to be documented (Bohren et al., 2015; Bradley et al., 2016). Low quality care received by women is not always a result of failures on the part of health care providers alone, but is also potentially related to a lack of staff, poor training, lack of equipment, and shortage of blood and drugs for the operation of the healthcare system (WHO, 2016). Although, at the global level, the poor care of women during childbirth in facilities has evaded the attention of the national and local health authorities, it has not the attention of women (Freedman et al., 2014). The new political and social landscape in the post-MDG era, together with the changing expectations of women, requires a fundamental shift in the strategy from a focus on access to making improvements to ensure that high quality, respectful maternal healthcare is provided (Campbell et al., 2016; Graham et al., 2016).

There is an increasing global and national commitment to addressing the right of pregnant women to receive high quality maternity care to improve their health and well-being being (Bohren et al., 2015; Bradley et al., 2016; White Ribbon Alliance, 2011). This arises from reports in the maternal healthcare literature of the disrespectful, abusive treatment of women at PHFs during pregnancy, which could be an important reason why women do not present themselves at PHFs, despite the fact that the treatment there is free. Meanwhile, according to the seven articles of the Respectful Maternal Care Charter (White Ribbon Alliance, 2011), every woman has the right to:

- be free from harm and ill-treatment (article 1);
- information, informed consent and refusal, and respect for her choices and preferences (article 2)
- privacy and confidentiality (article 3);
- be treated with dignity and respect (article 4);
- equality, freedom from discrimination, and equitable care (article 5);

- healthcare and the highest attainable level of health and right to liberty, autonomy, self-determination (article 6);

- freedom from coercion (article 7).

The healthcare environment must promote women's right to receive dignified, respectful maternity care (WHO, 2018). However, many studies indicate that many women globally experience poor treatment during childbirth, including abusive, neglectful, or disrespectful care (Bohren et al., 2015; Bradley et al., 2016). Disrespectful and abusive care, therefore, persists in health facilities, which is a significant barrier to the use of maternal healthcare services (Bohren et al., 2015; Moyer et al., 2014). Such inhumane treatment of women reflects poor maternity care practice, which constitutes a violation of their fundamental human rights, since it constitutes an abuse of the right of women to receiving dignified, respectful healthcare during pregnancy and labour (Bohren et al., 2015; White Ribbon Alliance, 2011).

Disrespectful, abusive care has been given various labels, such as 'mistreatment', 'obstetric violence' and 'dehumanised care'(Bohren et al., 2015; S. Burrowes et al., 2017). Mistreatment takes various forms, such as verbal and physical abuse, non-consenual care, non-confidential care, non-dignified care (such as shouting, pinching, scolding, slapping, and making threatening comments), and the abandonment of care (Bowser & Hill, 2010; Rominski et al., 2017). Mistreatment also constitutes neglect, detaining women in health facilities due to their inability to pay for services, discrimination due to the client's attributes (social, cultural, or economic) and healthcare professionals delivering services in exchange for bribes (Bohren et al., 2019; Moyer et al., 2014). The mistreatment of women prevents them from taking control of their birth experience, preserving their dignity, and safeguarding their physical and emotional well-being (Bradley et al., 2016; S. Burrowes et al., 2017). It further discourages women from seeking care in facilities for their subsequent births (Ganle & Krampah, 2018; Moyer et al., 2014).

Ensuring good quality maternity care is an enormous challenge faced by healthcare professionals, due to the structural and inter-personal failures (Ratcliffe, 2016; Bohren et al., 2015; Moyer et al., 2014). According to Ratcliffe (2016), at the structural level, there exists a poor supervisory, management and inadequate facility infrastructure, which interferes with the safety of women

during labour and delivery. Similarly, ineffective teamwork, a failure to apply safety standards, misdiagnosis, poor systems and processes, a poor organisational and safety culture, a lack of effective regulation mechanisms, and the inadequate training and education of healthcare providers potentially also contribute to mistreatment (Warren et al., 2017). Interpersonal communication between the client and healthcare provider is vital in shaping women's experiences and also their perceptions of good maternity care (Bohren et al., 2015; Moyer et al., 2014). Most importantly, this also shapes women's understanding about when to ask for help and when it is important to attend hospital, and how to spot risks and signs of complications and what is happening to them and their baby, so that they will engage with treatment and comply with the recommendations. Interpersonal factors, such as communication failure and individual provider bias and discrimination, also result in women failing to seek care when needed or being turned away or having to wait a long time due to a lack of staff awareness and training regarding the risks being presented to them (Pell et al., 2013; Ratcliffe et al., 2016).

The Government of Ghana, therefore, needs to shift the focus from access to maternity care to ensuring good quality maternity care, to address the needs of women and their families. This strategy would contribute towards achieving Sustainable Development Goal (SDG) 3, which is to ensure healthy lives and promote the well-being for people of all ages by reducing the current MMR of 319 deaths per 100,000 live births (WHO, 2016) in Ghana to less than 70 per 100,000 live births by 2030. Improving the quality and safety of maternity care in Ghana requires an in-depth understanding of the experience of maternity care during pregnancy, childbirth and the postnatal period, from the perspectives of both the women and the healthcare professionals who deliver this care. However, relatively little is known about the maternity health professionals and women's perceptions of labour ward dynamics (Bradley et al., 2019).This qualitative study examines the perceptions and experiences of maternity care from the perspective of women who have experienced the care, and the health professionals who deliver it. The study is focused on one particularly mixed peri-urban and rural community area of Ghana, where the mortality rate is unacceptably high. This study provides a unique opportunity to understand the underlying issues impacting maternity care delivery. The findings will inform the local service development and wider Ghanaian authorities about potential methods for improving access to, and the quality of, care, and thus policy development, to reduce the levels of maternal and neonatal mortality and

morbidity. While some studies have focused on women's experiences and satisfaction related to maternity care in Ghana (Amu & Nyarko, 2019; D'Ambruoso et al., 2005), little attention has been paid to the experiences of the maternity health professionals who provide this care and thus, to date, their voice has been missing from this discourse.

1.3 Problem Statement

Despite the huge investment made in implementing several healthcare policies, strategies and interventions aimed at reducing the death rate during pregnancy and childbirth, maternal mortality remains unacceptably high, especially in many low and middle-income countries, including Ghana. Historically, many governments focused their attention on increasing access to maternal healthcare (Ganle et al., 2014). Thus, at the end of the MDG era, the persistently high maternal mortality rate called into question the effectiveness of the policies, strategies and interventions designed to decrease this rate. Other studies and reviews (Bohren et al., 2015; Chadwick et al., 2014; WHO, 2018) have also raised concerns about the poor quality of maternity care services offered during and after childbirth in certain low-income countries. Therefore, access to, and the availability of, maternal healthcare alone is insufficient to achieve the desired goals with regard to maternal healthcare. To contribute towards saving the lives of women and new-borns, they must not only have access to maternity care services but also receive high quality, respectful maternity care, to prevent and manage more effectively the complications that may arise during pregnancy and delivery (Bohren et al., 2015; Moyer et al., 2014).

In Sub-Saharan Africa, MHPs' disrespectful, abusive treatment of women has been earmarked as contributing to the underutilisation of established PHFs (Bradley et al., 2016; Bohren et al., 2015; Warren et al., 2017). The evidence suggests that the poor physical conditions in the health facilities, unconducive working conditions, lack of or limited resources, and inadequate training and staffing levels may all contribute to the low quality, unsafe care and thus cause issues, such as the care being perceived as disrespectful or abusive. Such disrespectful maternity care practices also undermine women's trust in the healthcare system, leading to loss of reputation and credibility for the healthcare services, and discouraging women from accessing facility-based care for their delivery (Burrows et al., 2017; Warren et al., 2017). It is therefore imperative to investigate the

expectations and perceptions of women about what constitutes high quality, respectful maternal healthcare. It is also vital to explore the expectations and perceptions of the MHPs about what constitutes high quality maternal healthcare and what could be done to attain this goal.

Although, institutional and systemic failures of the healthcare system also contribute (directly and indirectly) to women's experiences of poor maternity care (Ganle et al., 2014; Chadwick et al., 2014; Burrows et al., 2017). These failures include the poor physical condition of health facilities, inadequate equipment, supplies, lack of hygiene in the maternity wards, lack of privacy and poor mechanisms to ensure accountability (Bohren et al., 2015; Ganle et al., 2014; WHO, 2018). Poor quality maternity care also occurs when healthcare providers themselves experience unfavourable conditions by the healthcare system (Bohren et al., 2015; Ganle et al., 2014). Poor remuneration and excessive workload and can lead to fatigue and further disrespect and abuse of women (Burrows et al., 2017; Warren et al., 2017). Similarly, in resource poor settings, several unfavourable factors such as inadequate staff, inadequate structures and overcrowding, lack of healthcare commodities and lack of basic equipment, contribute to poor quality maternity care (WHO, 2017).

Notably, the lack of safety culture and attitudes that overlook basic safety rules for the woman and the MHP poses serious challenges to providing good quality maternity care (World Health Organisation, 2017). Although many developing countries have developed policies that attempt to guarantee the quality and patients safety in of the maternity and healthcare in general, health facilities still have a poor quality and weak safety culture due to non-adherence to safety measures, defective processes of maternity care, lack of monitoring and supervision and disinterested management teams (Afaya et al., 2020; WHO, 2017). These factors further contribute to weakening the ability of the healthcare systems to ensure the provision of quality and safe maternal healthcare (WHO, 2017). These problems result in a vicious cycle that perpetuates the pattern of poor-quality maternity care received by women (Koblinsky et al., 2016).

1.4 Rationale for the Study

While there is growing recognition of the importance of providing quality maternity care, research on the subject in many low-income settings of Sub-Saharan Africa has not been developed. In

Ghana, for example, the majority of the research on the reasons for the high maternal death rate has focused only on access to maternity care service (Aikins et al., 2013; Amu & Nyarko, 2016; Galaa et al., 2016). Little attention has, however, been paid to the experiences of the clients and maternity health professionals regarding their satisfaction, and expectations with regard to the maternal healthcare services. Meanwhile, according to the WHO, the proportion of all women giving birth in a health facility who express satisfaction with healthcare services is an important standard for improving maternal and child healthcare (Amu et al., 2019). It is against this backdrop that the study seeks to explore the experiences of maternity care from the women's and providers' perspectives in the Tema Municipality, Ghana. Strikingly, the aspect that has been neglected particularly in resource-poor countries such as Ghana is the quality of the maternity care provided to expectant mothers. Although some studies have emphasised the need to focus on women's satisfaction with maternity care and how this can be enhanced (Afaya et al., 2020; Amu et al., 2019; D'Ambruoso et al., 2005), there is a paucity of evidence on the reasons why the care provided may be of poor quality.

In developing countries, public office holders view themselves as having authority over the public whom they are employed to serve (Bradley et al., 2016). This provides an additional drive for this study to investigate the power imbalance between the healthcare professionals and the public (e.g., women giving birth). There is also a gap in the literature on the power dynamics between the staff and clients and also between the different grades of staff in Sub-Saharan Africa (Bradley et al., 2016; Kruger & Schoombee, 2010; Moyer et al., 2014). Given the perceptions of women in African communities, the midwives/MHPs might themselves be disempowered to exercise authority through the office they hold, which may result in a lack of care and kindness displayed towards the mothers in their care (Bradley et al., 2016).

A strategy of providing more holistic care that addresses women's psycho-socio-cultural needs relies on the capacity and willingness of the midwives to provide it. Yet, until very recently, there was limited exploration of midwives' perspectives, and their voices were largely excluded from the discourse (Bradley et al., 2019). Largely missing from the literature is the voice of the midwife. What we lack is an understanding of the midwives' perceptions of the value and practice of women-centred care in Sub-Saharan Africa, yet any efforts to change the current performance and

dynamics around birth will rely on their participation. Midwives regularly face the reality of maternal and perinatal death, poor outcomes and blame, and there can be negative consequences for themselves as well as for the women in their care (Bradley et al., 2019). Overtly negative media attention, combined with the Nurses and Midwives' Council Ghana, and international advocacy agencies (e.g., White Ribbon Alliance) have left many midwives feeling unappreciated and demotivated (Bradley et al., 2016). Midwives are subject to investigation or punitive action in some instances when things go wrong (i.e., there are poor outcomes. Thus, it will be useful to gather more information about the midwives and their views (Rominski et al., 2017).

Staff shortages can lead to a heavy workload, leading to stress and fatigue, which in turn can result in staff such as midwives feeling disempowered and feeling like they are merely 'firefighting', struggling to deliver the absolute necessities, without any capacity to feel empathy for the women in their care (Bradley et al., 2016; Warren et al., 2017). This can take the form of compassion fatigue, an inability to concentrate, a feeling physically tiredness and illness, and a lack of compassion for those in their care (Yodel, 2013). Unfortunately, this lack of personal care may manifest itself as acting in a disrespectful manner. However, without understanding the power dynamics that exist within the maternity services in Ghana, this problem cannot be adequately addressed. The traditional role of women in Ghanaian society is to bear children, sell fish, and farm. Thus, women are not highly respected in the workplace (Bradly et al., 2019). Consequently, midwives and nurses, who tend to be female, already occupy a position that disempowers them from making decisions, yet they are in a position of power over the women for whom they care and may exert that power (Bradley et al., 2016). It is noted that the biggest determinant of the maternal mortality rate is the lack of access to contraception, and the consequent lack of control that women have over their body and health. The researcher was a member of the management of the Tema Hospital (Southern Ghana) used in the study area and a qualified health service administrator, local to Southern Ghana. As a Ghanaian insider, the researcher was able to understand the more subtle, underlying issues related to the cultural history of Ghana and life in the rural areas; something that an outsider researcher might struggle to achieve. Such understanding enables the researcher to offer a more realistic, nuanced interpretation of the data collected. It was thought that this would increase the study's credibility with the managers and government bodies. Within the Ghanaian community, those who are wealthier are less likely to

access public health facilities. The aim of my study was to explore the experiences of the women who are normally expected to attend the public hospital in the selected area. Women who access the public health facility are generally from poorer backgrounds and potentially more vulnerable, with less financial support. Other, more wealthy women may have their baby in the private sector and an unknown number may give birth within their community, with the support of a Traditional Birth Attendant (TBA). These other groups of women lay outside the scope of this study. This is a small qualitative study that explores the experiences of women who chose to access a public health facility, to explore their thoughts about why they chose to access the facility, what their experiences were like and what choices they planned to make in the future. This study provided a voice to this generally poorer group of women, to explore what may have influenced their choice and what they would recommend to others or chose for themselves in the future. It is hoped that the findings will inform Ghanaian health service development about how to improve the number of pregnant women accessing the public health facilities in Ghana and thus improve the birth outcomes.

1.5 Conceptual framework

The guiding framework chosen to address this topic is underpinned by the socioecological model adapted from (Bronfenbrenner, 1979). WHO (2018) and Freedman et al.'s (2014) quality of care framework for maternal and new-born health, which is explored in more detail in the literature review (section 2.4). According to Creswell (2009), a framework is any empirical theory/psychological process at a variety of levels that can be applied as a 'lens' to understand a phenomenon. The health system is measured by the quality of care it renders (Tunçalp et al., 2015). According to the framework, quality care involves the provision of care and the experience of care. Provision is broken down into evidence-based practices for routine care and the management of complications, actionable information systems, and functional referral systems (Tunçalp et al., 2015). The experience of care is broken down into effective communication, respect and the preservation of dignity and emotional support for patients (WHO, 2018). The quality-of-care framework by WHO (2018) was adopted to develop recommendations based on the lessons learned about the drivers of disrespectful and abusive care, the expectations of women, and the perceptions of MHPs on what constitutes high quality maternal healthcare and how this can be attained.

1.6 Aim of the study

The aim of this research study is to gain an in-depth understanding of the experiences of maternity care among women of low socioeconomic status who give birth in government facilities, as well as the providers' perspectives of the care provided in these facilities.

1.7 Objectives of the Study

1. To explore women's barriers to accessing maternity care.
2. To explore women's maternity care experiences.
3. To explore women's views on how maternity care could be improved.
4. To explore midwives' experiences of delivering maternity care.
5. To explore midwives' views on how maternity care could be improved to increase access to it.

1.8 Structure of the thesis

This thesis is divided into six chapters. This chapter, Chapter 1, describes the background of the study, the conceptual framework and the aims and objectives.

Chapter 2 provides a literature review, which offers a critical appraisal of the available studies related to maternal healthcare practice and the care of women within the childbirth continuum. This chapter outlines the search strategy utilised and presents the literature related to maternity care, maternal mortality, women's maternity care experiences during childbirth, health system barriers to maternity care, and health professionals/midwives' maternity care experience, and ends by outlining the drivers of disrespect and abusive care. It also offers an overview of the literature related to power dynamics and the social inequalities existing in the labour ward. This chapter ends with conclusion.

Chapter 3 details the philosophical approach underpinning constructivism as a qualitative research methodology and explains the rationale for choosing this methodology. This chapter also explains the methods used to conduct this study, including the recruitment strategy, ethical approval, data collection and data analysis. This chapter ends with a discussion on the reflexivity used within this study.

Chapter 4 presents the findings of the study related to the maternity health professionals' responses to the four main themes identified. The individual stories and voices of the midwives are presented, utilising quotations from the midwives to support the description of the findings.

Chapter 5 presents the findings of the study related to the women's responses to the two main themes identified. The individual stories and voices of the women are presented, utilising quotations from the women to support the description of the findings.

Chapter 6 presents a discussion of the findings of chapter 4 and 5 in light of the existing evidence, identifying where the literature supports these findings. It also reviews the findings in relation to the aims and objectives of the study. This chapter highlights the new information and understanding that have been discovered by this research study, explaining the original contribution that it makes to the existing evidence base. The chapter ends with a discussion of the researcher's personal development throughout the PhD research journey.

Chapter 7 provides the conclusion, highlighting where new discoveries have been made and detailing the unique contribution of this study to the existing evidence base and practice. This chapter also makes recommendations regarding future research, practice development and concludes this thesis.

1.9 Conclusion

With an estimated eight hundred and thirty (830) maternal deaths globally per day, 99% of which occur in lesser-income countries, maternal mortality remains one of the most important public health challenges facing low and middle-income countries, including Ghana. This chapter has provided a background to the research by introducing the research problem and the rationale for this study and setting out the research aim and objectives. The next chapter presents a review of the literature.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In Chapter 1, the overview of and background to the study highlighted the need to improve the present poor quality maternity care experiences of Ghanaian mothers in healthcare facilities. It also sought to establish the perspectives of the mothers and maternal healthcare professionals (MHPs) on what constitutes high quality maternal care and how this can be attained. In Chapter 1, it was highlighted that transport, distance, financial costs, family pressure, use of traditional birth attendants, and herbalists, advice from religious leaders and the community, previous experience of using health facilities, the need to work, child-care needs, socio-cultural factors, religion and disrespectful and abusive were some of the factors that deter women from accessing and utilising professional maternal healthcare services. It is therefore important to understand the challenges associated with accessing and delivering maternity care. This chapter reviews the experiences and barriers to high quality maternal healthcare in professional healthcare facilities (PHF), the expectations and perspectives of both the MHPs and patients on what constitutes high quality healthcare; and how it can be achieved. The study also investigates the poor utilization of PHF by the Ghanaian women despite free, and how to improve pregnant women's interest in accessing and utilising the PHF.

The aim of this literature review is to provide the context and rationale for the study and its findings. It also demonstrates the unique contribution that this study makes to the literature and justifies the methodological approach adopted. Section 2.2 presents the search strategy used to gather the available evidence related to the research aims. Sections 2.3 to 2.6 consider the global distributions of the maternal mortality, the regional causes and trend of maternal mortality, maternal health in Ghana, the challenges in Ghana, the WHO, 2018 and Freedman et al., 2014 quality maternal and new-born framework, disrespect and abuse during childbirth, and the categories of disrespect and abuse. Sections 2.7 to 2.11 considers the consequences of poor maternity care, the access to and use of maternity care, barriers to and use of maternity care, maternal health policies and interventions, maternity health professionals' experiences, and women's maternity care experiences. Section 2.12 offers a summary of the literature, demonstrating the gaps in the evidence base and identifying the relevance of the study's aims and approach.

2.2 Literature Search Strategy

A crucial element of a literature review is the search strategy. A good literature review, according to Carnwell and Daly (2001), includes a defined search and selection method. Traditional literature reviews have been criticised for their opaque search strategies (Wray & Wallace, 2011). To ensure relevant studies were retrieved, a systematic search strategy was utilised in this study. Published literature was searched via the University of Salford on-line system, SOLAR: EBSCO and the following databases: CINAHL, MEDLINE, PubMed & Science direct. These databases were searched separately to identify literature relating to maternal healthcare and childbirth in low and middle income countries (combined with the Boolean operator OR), using a set of terms related to the experiences of maternity care (combined with OR) and combined the two searches with the operator AND (maternal death OR maternal health OR antenatal care OR obstetric OR post-natal care OR maternity care OR childbirth or intrapartum care) AND (women's view OR barriers OR access OR mistreatment OR disrespectful care OR abusive care OR quality of care OR maternal mortality OR maternal morbidity).

A basic search of using the term' Maternal healthcare' proven to be an effective technique to determine which studies on the experience of maternal health care issues exist in this database. This search resulted in approximately 7,801 hits, 936 of which were published between 2008 to 2021.The search covered the period 2008-2021 and included studies written in English on maternity care, relating mostly to Sub-Saharan Africa, including Ghana. The publication period of 2008-2021 was selected because 2008 was the year when the free maternal health policy was widely implemented in Ghana. Consequently, there was an increase in patient utilisation of health facilities which, in turn, potentially influenced the maternal outcomes. Other literature sources were searched by hand, drawn from maternity care texts, journal/articles references, professional publications, and Ghanaian Department of Health guidance and editorials. The focus of this study is on the experiences of maternity health professionals and women regarding maternity care. To guarantee that all available material was recovered, several search terms were employed separately or in combination to search the various databases. In addition to recognising numerous terms and phrases, a technique for inclusion and exclusion was also identified.

The inclusion criteria were:

- Peer-reviewed research papers
- Published since 2008
- Published in English language in low- and middle-income countries
- All research methodologies
- Articles focusing on the causes of maternal mortality, and studies that discussed poor access and barriers to quality maternity care.

The following exclusion criteria were applied by reading the titles/abstracts/full text to select the most relevant papers to include in the review:

- Papers that were not concerned with initial women's experiences of disrespectful care OR
- Papers that were not concerned with access barriers to and the use of high-quality maternity care
- Papers not written in English
- Papers done before 2008

The initial scoping search using the keywords yielded 7,739 results. The screening of abstracts yielded the identification of 318 potentially relevant papers. Subsequently, after reading and re-screening online abstracts by using the above inclusion and exclusion criteria, excluding the most of articles on the grounds that they were not written in English, did not explore the women's experiences of disrespectful care experience, or not concerned with access barriers to, and the use of high-quality maternity care or papers done before the year 2008. In total, the electronic search process generated a total of 33 papers that met the inclusion criteria. The recovered articles were then further examined to confirm that they met the inclusion criteria outlined above, resulting in the removal of an additional six articles on the grounds that they were duplicates. Following the application of the inclusion and exclusion criteria, a total of 27 papers was selected for review (see Appendix 1). For the wider elements of the literature review, i.e., the global distribution and causes of maternal mortality (section 2.3), the literature was located through conducting a review of reviews, the World Health Organisation and government sources. The global distribution of the causes of maternal mortality.

2.3 The global distribution of the causes of maternal mortality

Globally, over half a million maternal deaths are estimated to occur every year, mostly in low-income countries. In contrast, maternal deaths are rare in the developed countries where women have access to live-saving care facilities (WHO, 2015). This section starts by defining maternal death. Maternal death is defined by WHO as: 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes' (WHO, 2017a). However, the problem with this definition is that it requires knowledge of the actual cause of death to classify the death as a maternal death. Since this information is not always accessible, a new category of 'pregnancy-related death' has been added by the WHO (2017).

Table 2.1 shows the distribution and causes of maternal deaths per 100,000 live births, the number of maternal deaths, and the lifetime risk of maternal death by region. It shows that the causes of maternal mortality are significantly higher in sub-Saharan Africa, where Ghana is located, compared with more developed countries.

Table 2.1: Global distribution of the causes of maternal mortality

	Direct causes (1=Abortion, 2=Embolism, 3= Haemorrhage, 4= Hypertension, 5= Sepsis, 6=Other direct causes): N (%)						Total direct causes	Indirect causes (7= HIV related, 8=Pre-existing medical conditions, 9=Other indirect causes): N (%)			Total indirect causes
	1	2	3	4	5	6		7	8	9	
Worldwide	193,000 (7.9%)	78,000 (3.2%)	661,000 (27.1%)	343,000 (14.0%)	261,000 (10.7%)	235,000 (9.6%)	1,771,000 (72.5%)	134,000 (5.5%)	361,000 (14.8%)	177 000 (7.2%)	672,000 (27.5%)
Developed regions	1,100 (7.5%)	2,000 (13.8%)	2,400 (16.3%)	1,900 (12.9%)	690 (4.7%)	2,900 (20.0%)	10,990 (75.3%)	400 (2.7%)	3,000 (20.3%)	250 (1.7%)	3600 (24.7%)
Developing regions	192,00 (7.9%)	76,000 (3.1%)	659,000 (27.1%)	341,000 (14.0%)	260,000 (10.7%)	232,000 (9.6%)	1,760,000 (72.5%)	133,000 (5.5%)	358,000 (14.8%)	177 000 (7·3%)	668,000 (27.5%)
Northern Africa	490 (2.2%)	720 (3.2%)	8,300 (36.9%)	3,800 (16.9%)	1,300 (5.8%)	3,800 (17.1%)	18,410 (82.0%)	760 (3.4%)	2,800 (12.4%)	500 (2.2%)	4,000 (18.0%)
Sub-Saharan Africa	125,000 (9.6%)	27,000 (2.1%)	321,000 (24.5%)	209,000 (16.0%)	134,000 (10.3%)	119,000 (9.0%)	935,000 (71.4%)	84,000 (6.4%)	168,000 (12.8%)	122,000 (9.3%)	375,000 (28.6%)
Eastern Asia	420 (0.8%)	6,500 (11.5%)	20,000 (35.8%)	5,900 (10.4%)	1,500 (2.6%)	8,000 (14.1%)	42,320 (75.1%)	2,200 (3.9%)	12,000 (20.7%)	130 (0.2%)	14,000 (24.9%)
Southern Asia	47,000 (5.9%)	17,000 (2.2%)	238,000 (30.3%)	80,000 (10.3%)	107,000 (13.7%)	65,000 (8.3%)	554,00 (75.1%)	37,000 (4.8%)	143,000 (18·2%)	49,000 (6.3%)	229,000 (29.3%)
South Eastern Asia	11,000 (7.4%)	18,000 (12.1%)	44,000 (29.9%)	21,000 (14.5%)	8,100 (5.5%)	20,000 (13.8%)	122,100 (83.2%)	5,900 (4.0%)	17,000 (11.8%)	1,400 (1.0%)	25,000 (16.8%)
Western Asia	860 (3.0%)	2,600 (9.2%)	8,900 (30.7%)	3,900 (13.4%)	1,400 (4.8%)	4,500 (15.6%)	22,160 (76.6%)	1,200 (4.2%)	4,900 (16.9%)	650 (2.2%)	6,700 (23.4%)
Caucasus and Central Asia	250 (4.6%)	590 (10.9%)	1,200 (22.8%)	790 (14.7%)	460 (8.5%)	910 (16.8%)	4,200 (78.2%)	130 (2.3%)	920 (16.9%)	140 (2.5%)	1,200 (21.8%)
Latin America & Caribbean	6,900 (9.9%)	2,300 (3.2%)	16,000 (23.1%)	15,000 (22.1%)	5,800 (8.3%)	10,000 (14.8%)	56,000 (81.5%)	1,300 (1.8%)	9,800 (14.0%)	1,800 (2.6%)	13,000 (18.5%)
Oceania	290 (7.1%)	610 (14.8%)	1,200 (29.5%)	560 (13.8%)	200 (5.0%)	510 (12.4%)	3,370 (82.6%)	170 (4.2%)	500 (12.3%)	36 (0.9%)	710 (17.4%)

Source: Say et al. (2014).

Say et al. (2014) provide the regional and global estimates of the distribution of the causes of maternal deaths (see Table 2.1), and groups the factors that contribute to maternal mortality into direct obstetric and indirect causes. Nearly three quarters (72.5%) of all maternal deaths recorded globally were due to direct obstetric causes, while maternal deaths due to indirect causes accounted for 27.5%. Worldwide, haemorrhage is the leading direct cause of maternal mortality, associated with 27.1% of all deaths that occur during the pregnancy, childbirth, and postnatal periods. The second, third, and fourth most common direct causes of maternal death recorded globally were hypertension (14.0%), sepsis (10.7%) and abortion (7.9%), respectively. In all regions and continents, haemorrhage was the most common cause of maternal death, followed by hypertension. Northern Africa recorded the highest direct cause of maternal death due to haemorrhage (36.9%) followed by Eastern Asia (35.8%) and Western Asia (30.7%). Latin America and the Caribbean recorded hypertension as the second direct cause of maternal death (22.1%) followed by Northern Africa (16.9%) and Sub-Saharan Africa (16.0%). (Sudarmono, 2017)Larger number of deaths from sepsis are recorded in Southern Asia (13.7%), whilst Latin America, the Caribbean, and Sub-Saharan Africa recorded the highest proportion of maternal death due to abortion accounting for 9.9% and 9.6% respectively. Asia is a tropical region with a wide range of known and emerging pathogens which can cause infections that lead to sepsis and severe sepsis (Sudarmono et al., 2017). This could explain why Southern Asia witnesses high rates of sepsis.

While there exist certain differences in the statistics for developing countries with regards to the main causes of maternal death, such as haemorrhage and hypertension, overall, these remain significantly higher than those for high income countries for all causes. Ghana has achieved some improvements in its maternal healthcare by scaling up the skilled care coverage from 47% in 2003 to 55% in 2010, and 68% in 2015 (Adua et al., 2017). This improvement occurred following the introduction of free maternal care policy, therefore maternal mortalities fell to a rate of 350 per 100,000 live births in 2013 (Adua et al., 2017), then to 319 deaths in 2015 (WHO, 2016). When compared with several other West African countries, the performance in terms of reducing the incidence of maternal mortality presents a positive picture for Ghana, while the mortality rate for each 100,000 live births is still as high as 587 for Mali, 547 for Guinea Bissau, 679 for Guinea, 553 for Niger, 368 for Togo, 814 for Nigeria, and 647 for Cote d'Ivoire (Adua et al., 2017, WHO, 2016). In contrast, although Ghana's maternal mortality rate appeared to have dropped, however,

it still compares extremely unfavourably with that of developed countries, with a rate of nine per 100,000 live births for the UK, six for Australia, seven for Canada, four for Italy, six for Germany, 14 for the US (14/100,000), and five for Japan (Adua et al., 2017; WHO, 2016). Notwithstanding the wide variation between Ghana and the developed countries, the downward trend observed in Ghana has been very modest since 2010, as shown in Figure 2.1 below.

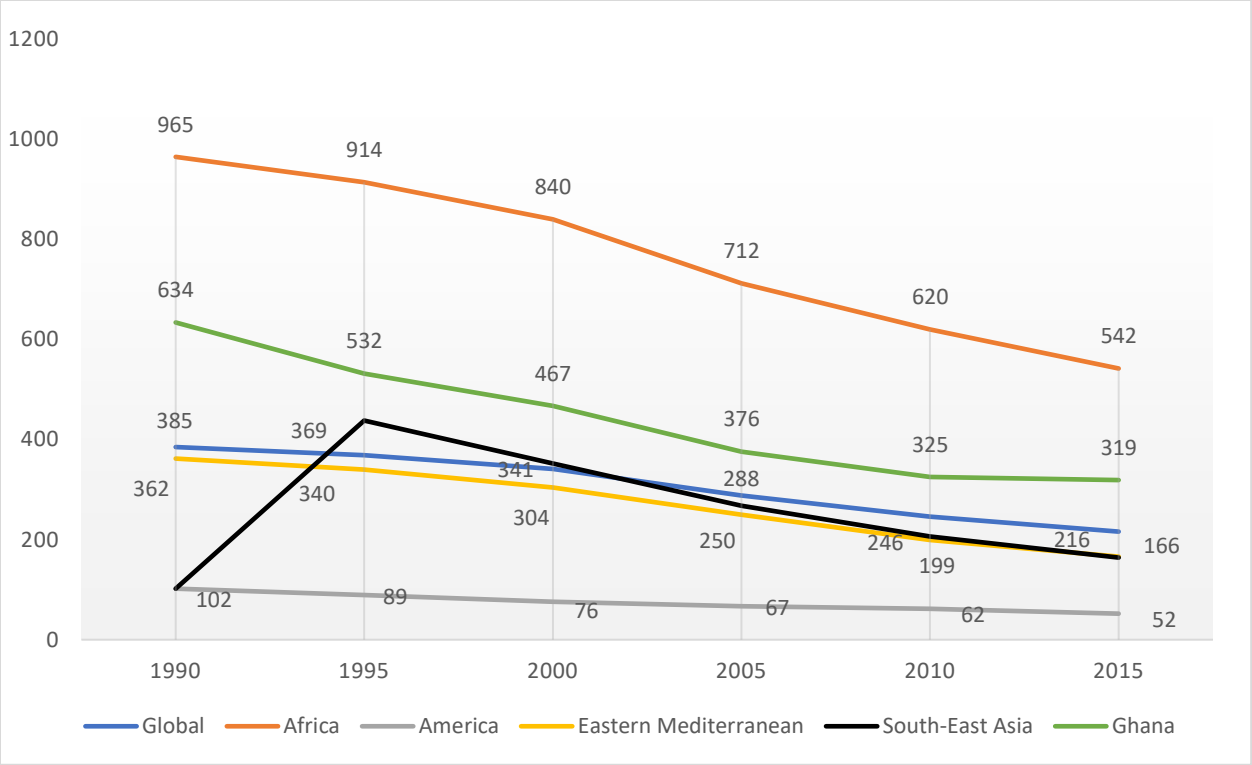


Figure 2.1: Trends in maternal mortality per 100,000 live births from 1990 to 2015 (WHO, 2016).

2.3.1 Regional causes and trends in maternal mortality

The direct obstetric causes of maternal death in Sub-Saharan Africa are mainly due to haemorrhage (24.5%), hypertension (16.0%), sepsis (10.3%) and abortion (9.6%) (Say et al., 2014). Similar findings were recorded for developing regions with haemorrhage (27.1%) accounting for the highest direct cause of maternal death, followed by hypertension (14.0%), sepsis (10.7%), and abortion (7.9%). Comparing these findings with those for developed regions, although haemorrhage (16.3%) remained the most common direct cause of maternal death, embolism

contributed (13.8%) of maternal mortality, thereby appearing to be the second cause of death, followed by hypertension (12.9%). In Ghana, a retrospective study suggests that the most frequent cause was haemorrhage (30%), followed by hypertensive disorders (14%) (Ghana Statistical Service, 2018). For this study, the verbal autopsy method (interviewing the family members or caregivers of the deceased person to collect information to determine the cause of death) was employed. This self-reported method of data collection appears to be the only one available to the researcher, but it could be considered less valid, since the families may not have understood the questions or know the actual cause of death.

The MMR, across all of the Millennium Development Goal (MDG) regions, declined from 1990 to 2015. However, the reduction rate varied significantly between the regions. Table 2.2 highlights that the MMR for Africa declined, from 965 maternal deaths per 100,000 live births in 1990 to 542 in 2015. In contrast, Norway and Sweden had an MMR of five to six, and the UK an MMR of nine. Low and middle-income countries continued to account for 99% (302,000) of the global maternal deaths in 2015, with Sub-Saharan Africa representing nearly 66% (201,000), followed by Southern Asia with 66,000 (WHO, 2016). The lowest annual rate of decrease occurred in Africa, where the MMR declined by 2.32% yearly. According to WHO (2016), the lifetime risk of maternal death in Africa is the highest (one in 37 women), followed by the Eastern Mediterranean (one in 170 women), South-East Asia (one in 240 women) and America (one in 920 women). The country with the highest MMR is Sierra Leone (1,360 per 100,000 live births), with an MMR of one in 17 (WHO, 2016). For Ghana, the MMR decreased from 634 per 100,000 live births to 319; this represents an approximate decrease of 50% between 1990 and 2015. Although Ghana was able to half its maternal mortality rate compared with other developing countries from 1990 to 2015, it failed to meet the MDGs' target 5.

Table 2.2: Trends in maternal mortality per 100,000 live births from 1990 to 2015

WHO region	MMR						% and average annual % change in MMR	Lifetime risk of maternal death: 1 in
	1990	1995	2000	2005	2010	2015		
Global	385	369	341	288	246	216	44 (2.3)	180
Africa	965	914	840	712	620	542	44 (2.3)	37
America	102	89	76	67	62	52	49 (2.7)	920
Eastern Mediterranean	362	340	304	250	199	166	54 (3.1)	170
South-East Asia	102	438	352	268	206	164	69 (4.7)	240
Ghana	634	532	467	376	325	319	50 (2.7)	66

Source: WHO (2016)

The global MMR was reported to be declining; this was particularly evident in the achievements of countries such as Equatorial Guinea, Eritrea, Egypt, and Bolivia (United Nations Population Fund, 2010). This confirms that, with commitment and appropriate resource allocation, the rate of maternal death can be reduced drastically (United Nations Population Fund, 2010). Notably, the strategies for reducing maternal deaths can produce excellent results, even in resource-poor settings (Kyei-Nimakoh et al., 2016). Examples of these strategies include free maternal healthcare services, the use of contraceptives, enacting free education policy to enable all women attain basic education, and providing regular sensitisation programmes. Considering that the 25-year period of MDG5 ended in 2015, it is therefore imperative to understand why past interventions failed to yield anticipated outcomes, given the extent of the efforts made (Kyei-Nimakoh et al., 2016).

2.3.2 Maternal Mortality: Maternal Health in Ghana

Maternal mortality has become a public health challenge for the heads of government in Ghana. Since the Millennium development Declaration of 2000, an attempt to reduce the burden of maternal and infant mortality has been key, particularly in low and middle-income countries, including Ghana (Ganle, 2013).While Ghana's rates are relatively low compared to those other sub-Saharan African countries, it is still over 10% higher than the global rate, and several times higher than that of the higher income countries (WHO 2016). Indeed, Ghana's maternal mortality ratio has remained persistently high (Galaa et al., 2016; Ganle et al., 2014). Although there was a downward trend following the introduction of free maternal health interventions, a possible explanation is that large changes are usually caused by mass societal change and family planning, such as a trend towards a smaller family size. In this section, a review of the literature related to maternal health in Ghana is presented, focusing on the causes and magnitude of the challenges, as well as discussing the interventions implemented to try to reduce maternal mortality.

2.3.2.1 Challenges of associated with maternal health in Ghana: Magnitude and Causes

As in many other low-income countries, such as Ghana, the measurement of the burden of maternal morbidity and mortality is fraught with problems which include the fact that the actual number of maternal deaths is difficult to ascertain: some deaths may not be recorded, the cause of deaths may be unknown, or it may not even be clear whether the woman was pregnant at the time of death or had recently given birth (Ganle, 2013). However, as noted earlier, the WHO's maternal mortality estimates suggest a rate of 319 maternal deaths per 100, 000 live births in Ghana, with the range of uncertainty being 216 - 458 (WHO, 2015). As noted by Ganle (2013), the high level of uncertainty makes maternal mortality rate an unsuitable way to monitor maternal mortality and the maternal health trends in settings such as Ghana, in comparison to United Kingdom for instance, where estimates suggest an MMR of nine per 100,000, the level of uncertainty being 8-11 (WHO, 2015).

Ghana's high maternal death rate among rural women, and women with lower educational background, can partly be explained by using Thaddeus and Maine (1994) 'Theory of three' delays. Delays occur when women fail to recognise an obstetric problem, such as postpartum

hemorrhage, obstructed labor, postpartum sepsis, complications of abortion, pre-eclampsia or eclampsia, ectopic pregnancy, and ruptured uterus complications. In Ghana, the first delay may occur when women do not recognise that they need medical attention (Thaddeus & Maine, 1994), or if the husband or mother is the decision maker, or they lack the money to pay for the services (Thaddeus & Maine, 1994). Maternity care has been free in Ghana since 2008 (Anafi et al., 2018; Ganle et al., 2014a), however, there is evidence to show that corruption and / or informal fees charged by the providers could serve as a deterrent to women accessing care (Anafi et al., 2018; Hsiao et al., 2019). Ganle (2013) reported that another reason for delayed care is that the woman may have sought care from a traditional birth attendant, who may have delayed her transfer to a health facility for a variety of reasons: a lack of knowledge, a reluctance to transfer the care to health professionals, the cost of the transfer, and religious or cultural beliefs.

The second delay in the 'theory of three delays' (identifying and accessing a healthcare facility) may be a result of obstacles beyond the woman's control, such as costs and transport delays. Ideally, a woman would plan where to give birth and how to get there. Some of the country's facilities, as identified in Ganle et al. (2014a)'s study are located in remote areas with unsurfaced roads. These roads may be impassable, especially in the rainy season, making it a challenge for women in labour to reach the healthcare facility. Appropriate care and transportation may also be delayed because of the challenges faced by the lower-level healthcare facilities when transferring women in labour to a higher-level facility. Although the no-cost maternity care policy has a provision that allows for women in labour to access transportation to a healthcare facility, there are a limited numbers of ambulances in the country. The providers may fail to appreciate the difficulties that women face; this leads to this secondary delay in appropriate care (Amu & Nyarko, 2016; Pagalday-Olivares et al., 2017).

The third and final type of delay is caused by a lack of professional knowledge and skills in emergency obstetric care, or a lack of resources and staffing in the health facilities, which again could lead to poor outcomes for maternal health. These findings are comparable to those of other studies conducted in Africa (Mgawadere et al., 2017). This often occurs at the health facilities, due to inadequate essential logistics, unavailability of human resources, shortages of blood and other essential treatments, the negative attitude of the staff, an inadequate emergency preparedness plan,

a lack of staff motivation, late referrals, and inadequate vehicles to cover hospital activities (Amu & Nyarko, 2016; Galaa et al., 2016). In a study conducted in Uganda, the lack of doctors, human resources challenges, and staffing levels at the hospital facilities contributed to delays in receiving the appropriate care in the hospital (Ackers et al., 2016). The relevance of the study by Ackers et al. (2016) is that it draws attention to the importance of human resource factors, which goes beyond clinically assessing obstetrics cases individually, and develops a more in-depth view of the healthcare system, as well as the factors that can impact the behaviour of healthcare workers. However, the experience or perception of inadequate facilities may link back to the first delay and could cause women to be less motivated to reach the facility. However, the actual causes of the 'Three Delays' in the different contexts or settings remain unclear (Ganle, 2013; Graham et al., 2008).

While the theory of delays according to Thaddeus and Maine, (1994) only explains three forms of delays, MacDonald et al. (2018) identified the fourth delay and explained that it is the community's responsibility for being accountable for maternal deaths. He further explained that, if there is empowerment at the community level, this can reduce the maternal death rates. The authors of this study focused on community empowerment, and so possibly neglects the wider political and cultural factors that may indeed impact on community empowerment or action.

Some empirical studies have highlighted reasons behind maternal and neonatal deaths and went further to explain what works to prevent or reduce them (Campbell & Graham, 2016; Johnson et al., 2009). For example, in Ghana, several studies have shown that women die because of obstetric haemorrhages, sepsis, hypertension, unsafe abortions, and labour dystocia and prolonged labour (Asamoah et al., 2011; Boafor et al., 2021; Deri et al., 2013; Lee et al., 2012; , 2018; Joshua et al., 2017). It is also known that 67% of Ghana's maternal mortality occurs due to direct and 27% due to indirect causes, whilst 6% are attributed to unspecified causes (, 2018).

However, less is known about what other issues could be risk factors for maternal mortality in low-income countries. There exist studies on how maternal and infant deaths could be prevented. For example, McCarthy and Maine (1992) point out that attempts to reduce maternal deaths 'must either (1) reduce the likelihood that a woman will become pregnant, (2) reduce the likelihood that a pregnant woman will experience a serious complication of pregnancy or childbirth, or (3)

improve the outcomes for women with complications' (p.23). In 2019, the WHO devised a strategy for ending preventable maternal mortality and suggested: (1) tackling unequal access to quality maternal and new-born healthcare; (2) ensuring comprehensive universal coverage of maternal and neonatal healthcare; (3) tackling the causes of maternal mortality, maternal morbidity, and disability; (4) reinforcing healthcare systems by gathering information to aid the catering to the needs of all girls and women; and (5) ensuring that the relevant bodies and individuals are accountable in order to improve the quality of care (WHO, 2019).

On the other hand, a few studies on the maternal health problem in Ghana have been conducted using a retrospective design to examine the causes of maternal deaths in different socio-demographic sets. This reflected the paucity of articles around the topic area. For example, the systematic search only located five relevant studies from Ghana (Asamoah et al., 2011; Boafor et al., 2021; Der et al., 2013; Gumanga et al., 2011; Lee et al., 2012). The studies were similar in terms of geographical locations and the use of a retrospective design. These studies are reviewed below, and the gaps in knowledge with regards to Ghana are highlighted. One of the studies conducted in Ghana found that most haemorrhages occurred in women aged between 35 and 39, at 27.5%, with 22.5% of cases occurring in women aged between 30 and 34, 20.3% in women aged between 25 and 29, and 14.5% on women aged between ages 20 and 24 (Asamoah et al., 2011).

This assertion was made without a clear explanation of what could be responsible for the variation in age. Asamoah et al. (2011) further reported that maternal mortality was inversely related to higher education levels. For example, women with only a basic education accounted for 54.9% of maternal mortality, while only 2.1% of deaths occurred among women with a higher or tertiary education. This, therefore, explains the crucial role of education in the fight against maternal mortality in Ghana. More also, the study noted a significant difference between rural and urban dwellers. While the rural women dwellers accounted for 64.1% of maternal mortality, those living in urban areas or cities accounted for 35.9% of maternal related deaths. This means that living in the city or rural areas has a lot to do with the maternal mortality. Furthermore, marital status is also a factor. Where 83.6% of the maternal mortality was accounted for by married women, only

16.4% of deaths accounted for single women. And the explanation is simple; women who are married are more likely to become pregnant than the single women.

While issues raised by Asamoah et al. (2011) represent indirect causes of maternal mortality, Boafor et al. (2021) recently explained that the main causes of maternal mortality in Ghana are hypertension at 37.3%, haemorrhage at 20.6%, Sickle cell disease and sepsis at 8.3% each, and pulmonary embolism at 8.0%. The authors showed three significant factors linked to maternal mortality at the Korle-Bu teaching hospital in Accra including: lack of a formal education [AOR 3.23 (CI: 1.73-7.61)], attending fewer than four antenatal appointments [AOR 1.93(CI: 1.23-3.03)], and undergoing emergency caesarean section [AOR 3.87(CI: 2.51-5.98)].

Similarly, Lee et al. (2012) also found that hypertension was the leading cause of maternal death (26.4%), alongside deaths due to haemorrhage, genital tract sepsis, and early pregnancy, which represent 62.2% of all-causes of maternal deaths and 87.3% of direct deaths. Interestingly, infection and Sickle cell disease represented 13.7% of all-cause maternal deaths and 61.1% of indirect deaths. The authors further noted that the distance which a woman needed to travel following a referral longer than sixty minutes was causing women to die. In this regard, the transfer decisions and transportation were a significant factor for all causes of maternal mortality. Findings according to Boafor et al. (2021) and Asamoah et al. (2011) appear to agree with Gumanga et al. (2011), in which hypertension, sepsis, haemorrhage, unsafe abortion, obstructed labour, anaemia, sickle cell disease, and malaria are reported as direct causes of maternal deaths. However, there is a little divergence in the studies: while Boafor et al. (2021) and Asamoah et al. (2011) present hypertension as the leading cause of maternal death. Gumanga et al. (2011) highlighted sepsis as the leading cause of maternal and infant death. The report showed that sepsis accounted for 19.8% of the deaths, hypertensive disorders 18.6%, haemorrhage 15.8%, unsafe abortion 11.5%, obstructed labour 5.7%, anaemia 8.7%, Sickle cell disease 5.7%, and malaria 5.0%, as the main causes of death. Interestingly, being a rural dweller was also noted as a huge factor, as over half of maternal deaths were reported to have occurred among women from the rural districts outside Tamale, while 13% were among those who were referred to the Tamale Teaching Hospital from locations more than 150 kilometres away. These studies (Asamoah et al., 2011; Boafor et al., 2021;

Deri et al., 2013; Gumanga et al., 2011; Lee et al., 2012) are comparable in terms of their study design, but partially comparable in terms of their findings.

Furthermore, Deri et al. (2013) noted that women and new-borns are still dying in Ghana, because 81% of pregnancy-related deaths happen in the community or within a day of admission to an established health facility, and just 18.5% happened the day after admission to an established professional health facility. This reflects the grave impacts of delays that is often experienced as a result of factors such as ignorance, lack of funds, transport issues, or inadequate staffing of the health facility (Thaddeus & Maine 1994). However, women's decision to access maternity care on time, and early referrals, are significant factors in reducing maternal mortality ratio.

The reviews above also show that in Ghana, it is vital that women access health facilities in a timely manner to reduce the risk of death. In most cases, haemorrhage and hypertension are the most frequent cause of maternal death in Sub- Saharan Africa, including Ghana, and even in Western countries. However, these can be cheap and easy to treat, in most cases, if the mother has easy access to the right health facilities and skilled birth staff. A likely reason as to why there is such a big gap in maternal mortality between the richer and poorer countries is because women in certain countries are a lot less likely to be in the right place, at the right time, with the right skilled attendants available. In poor resource countries such as Ghana, the burden of maternal and new-born mortality is particularly high, and a qualitative study by Ganle et al. (2014) succinctly summarises the problem as a lack of, or unequal access to essential maternity care services. Ganle et al. (2014) revealed that the fear experienced by women, hostility of maternity health professionals, extensive waiting times, poor quality care, and issues of confidentiality related to maternity care and the health system are challenges related to the utilisation of maternity care in Ghana. Although the study employed a large sample size, consisting of hundred participants and rich data based on the participants' comments, the results of the study cannot be generalised to the entire Ghanaian population, because they reflect only the people in that particular situation, within a particular geographical area. Another study by Ganle et al. (2019) investigated the prevalence of supervised delivery and the reasons for the utilization of maternity care in Northern Ghana. Ganle et al. (2019) revealed that nearly half of the new mothers gave birth at home accompanied by traditional birth attendants, disregarding the use of maternity care. This suggest that most

women might access antenatal care but be less likely to use the delivery services at the health facilities. Moreover, the incidence rate of maternal mortality, and the catastrophic obstetric complication in childbearing women are connected to factors that influence the utilisation of skilled delivery services, as well as the barriers to the uptake of skilled maternal healthcare services. Although the study provided rich data based on the participants' comments, its results may be invalid due to the issue of recall bias. The researchers made an effort to minimise the recall errors, by reducing the research timeframe to a year, but even this could be viewed as too extensive to recall the experience of childbirth. A 2017 systematic review of studies based in Sub-Sahara Africa argues that the high prevalence of maternal illness, maternal mortality, and other potentially devastating and acute obstetric complications suffered by women has generally been linked to their poor access and barriers to emergency obstetric services (Ganle, 2013; Kyei-Nimakoh et al., 2017). Indeed, responses to why women die during pregnancy in the context of the Millennium Development Goals may be centred around the problem of access. For example, Kyei-Nimako et al. (2017) argues that despite a large international focus on delivering cost-effective technical maternal health interventions, many middle and low-income countries seem unable to establish health systems that effectively provide these required solutions. Bohren et al. (2015) and Ganle et al. (2014b) expand this argument to suggest that maternal and new-born deaths result from health system failures.

However, beyond the problem of access and barriers to the uptake of maternity care as reported by few studies (Bohren et al., 2015; Ganle et al., 2014; Ganle et al., 2019), other issues emerged in other studies. For instance, Moyer et al. (2014) explored the experiences of and responses to disrespectful maternity care and abuse during childbirth in Northern Ghana, using in depth interviews and focus group discussions with women and healthcare givers, community leaders, and traditional birth attendants/healers. Most of the participants reported being neglected, physically abused, ignored, and verbally abused by the healthcare personnel. More significantly in this study is that the women felt that their traditional practices and norms were rejected; for instance, women were not allowed to take their placenta home after delivery. This may mean a lot for the women; firstly, it suggests that the patients' cultural values were not respected thus amounting to disrespectful maternity care. Nevertheless, the beliefs and values linked to reproduction influence how a culture views and regulates childbirth. Since cultures differ from

society to society, the meanings associated with phenomena differ as well. Moyer et al. (2014), therefore, concluded that the fear of abusive care, negative and unfriendly attitudes among staff form a barrier to seeking facility-based delivery by the women. A community-based study in Ghana (Maya et al., 2018) explored women's experiences of disrespect and abusive care using qualitative methods. The findings showed that most women suffered physical abuse, including slapping and beating, as well as verbal abuse. These findings are also similar to the reports of a cross sectional study (Ganle & Krampah, 2018) which investigated the prevalence of and identified the associated factors of disrespect and abuse of women by midwives in Southern Ghana. The evidence affirmed that women actually experienced disrespect and abuse during labour and childbirth. The researchers reported that about 83% of the women experienced disrespect and abuse. Women's experiences of disrespect and abusive care were present in different forms: for instance, 43% reported that they were detained care due to their inability to settle medical bills, 39.5% felt their care was not confidential, 30.8% reported abandonment/neglect, verbal abuse 25.3%, discrimination 21.3%, physical abuse 14.2%, and non-consensual care13.3%. Although Ganle and Krampah (2018) had reported findings that are quite similar to other researchers as reported above, Ganle and Krampah (2018) additionally reported another intriguing finding regarding the drivers of disrespectful and abusive care. Firstly, being HIV/AIDS positive and coming with a lower income family were the drivers of disrespect and abuse. Secondly, women who were seen by physicians experienced less abusive and disrespectful care than women who were seen by maternity health professionals. Previously, Ganle et al. (2014b) and Ganle (2015) had reported that women who experience mistreatment by midwives or other maternity care providers in a health facility setting are often less likely to use a health facility again in their subsequent childbirth. This is because women may feel discouraged from using maternity care due to the fear of being mistreated and abused by maternity health professionals. And even when they decide to attend healthcare services, they only do that very late, thereby risking complications such as pre-eclampsia or eclampsia, sepsis, and obstructed labour etc.

In conclusion, the maternal healthcare problem in Ghana comprises of complex, multifaceted issues associated with facility-based delivery. The review in this section suggests that much is known in terms of why and where maternal and new-born deaths occur. Despite this, the review also indicates that the lack of, and unequal access to skilled care services have undermined the

global and national campaigns (Ganle, 2013), whilst disrespect and abuse may also deter women from using facility-based delivery.

2.3.3 Maternal Health Policies and Interventions in Ghana:

The evidence suggests that although Ghana has witnessed some progress in terms of reducing the maternal mortality ratio, poor maternal healthcare persists (eg Ganle et al., 2014; Moyer et al., 2014; Maya et al., 2018) and appears to be linked to high maternal mortality rate. Some previous findings (Ganle, 2013; Kyei-Nimakoh et al., 2016) suggest that the early years of Ghana's post-independence period were marked by considerable policy and programmatic measures, as well as some progress in lowering maternal morbidity and death. For instance, following the Millennium Development Goals of 2000, Ghana developed a 'Reproductive Health Strategic Plan' (2007-2011) with six high level objectives under its Safe Motherhood Policy, the first of which is to reduce maternal mortality and morbidity (Ganle, 2014; Kyei-Nimako et al., 2016). The strategies for attaining this first objective aimed to improve access to comprehensive and basic essential obstetric care, improve the capacity of the family and community members with regards to home-based life-saving skills, increase the proportion of deliveries overseen by skilled attendants, increase the antenatal and postnatal care coverage and improve equity, content, and quality of services, and ensure the availability of comprehensive abortion care services as permitted by law (Ganle, 2013; Kyei-Nimakoh et al., 2016).

Over the years, Ghana has introduced and implemented various policies and interventions that aim to improve maternal and child healthcare delivery in the country. These include the MDG Acceleration Framework, Safe Motherhood initiatives, Family Planning Services, Reproductive Health Services Policies and Standards, Prevention and Management of Unsafe Abortion Comprehensive Abortion Care Services, Mother to Child HIV transmission, and Adolescent Standards and Protocol (Kyei-Nimako et al., 2016). A significant measure was the introduction of the free maternal healthcare policy through the national insurance scheme. The aim was to improve equity of access and reduce the financial barriers to accessing maternity care services for all pregnant women (Anafi et al., 2018; Ganle, 2013). The evidence shows that the introduction of free maternal healthcare has increased the utilisation of services and reduced the number of home

births (Ghana Statistical Service, 2018). Similarly, the national health policy initiative implemented by Ghana, called the Community-based Health and Planning Services system, aims to increase the geographic access to maternal and child health services (Kyei-Nimakoh et al., 2016; Nyefene et al., 2018). Another significant measure is the Campaign on Accelerated Reduction of Maternal Mortality rate in Africa (CARMMA). This was initiated in 2009 by the African Union, designed to assist African nations achieve Millennium Development Goals (MDGs) four and five related to reducing child and maternal mortality, through the Partnership for Maternal Newborn & Child Health (2011).

Although abortion has been legal in Ghana under certain circumstances since 1985, the integration of safe abortion into Ghana's reproductive health policy did not occur until 2003, and it was not until 2006 that comprehensive abortion care services, as permitted by the law, became one of the five components of the objectives to reduce maternal morbidity and mortality in the 2007-2011 Ghana Reproductive Health Strategic Plan, including contraceptive use (Ghana Statistical Service, 2018). Unsurprisingly, misunderstandings exist with regards to the legality of abortion in Ghana. In practice, the law tends to be interpreted as prohibiting abortion, so the availability of abortion care is limited (Ganle, 2013). Patchy progress has been made in terms of reducing the maternal mortality rate (MMR). Ghana was unable to achieve MDG target 5, which was to reduce the MMR by three quarters (75%) between 1990 and 2015 (Afaya et al., 2020; Ganle et al., 2014b). According to the World Health Organisation (WHO) report 'Trends in Maternal Mortality: 1990-2015', the MMR dropped in Ghana from 760 per 100,000 live births in 1990 to 570 in 2000, then to 308 in 2017. This represents a halving of the MMR over 27 years (i.e. from 1990-2017), compared to neighbouring countries such as Nigeria, where the MMR stood at 917 in 2017. However, although acknowledging that there has been significant reduction in the neonatal, infant, and under-five mortality rates in Ghana, the report notes that it was unlikely that the 2015 target would be achieved, unless efforts were made to scale-up and sustain child survival interventions. Considering the above assessment, Ghana has made only some progress in reducing maternal mortality and improving maternal healthcare. Some researchers have attributed this to the failure on the part of policy makers to identify and tackle the other category of determinants: i.e., the socio-cultural determinants (Yarney, 2019). Socio-cultural practices and the factors that influence maternal death in Ghana have been identified as including the low socio-economic status of

women, early marriage and childbearing, poor dietary practices, and taboos surrounding pregnancy (Yarney, 2019). Others believe that the poor education for women, poverty, unaffordability, and inaccessibility, as well as socio-cultural factors act as barriers to rapid progress in this area (Ganle et al., 2019; Yarney, 2019). What remains unclear is the exact nature of these barriers, why they affect progress, and the importance of each within Ghanaian society.

Kye-Nimako et al. (2017) discussed the problem as one of access. Hospital-based studies in Sub-Saharan Africa, including Ghana, show that the maternal death rate remains high, attributed to the poor staff knowledge and skills, and poor staff interpersonal relationships in maternal health services. It can be argued that more research is needed on the supply-side barriers, particularly in the rural Ghanaian context.

Ghana's free maternal healthcare policy was first introduced in the four most deprived regions of the country (Northern, Upper East, Upper West, and Central) in September 2003, and was extended in April 2005 to Ghana's remaining six regions (Anafi et al., 2018; Ganle, 2013). In the past, health financing in Ghana relied on user-fees to cover recurrent costs for public health facilities (Ganle, 2013). Thus, out-of-pocket was the order of the day.

Under the policy, women are entitled to a 'Maternal Benefit Package' which includes six free antenatal visits, additional medical visits to the outpatient department (OPD), free delivery at a health facility, including all emergencies and complications arising from the delivery, two postnatal visits within six weeks, and care for the new-born for up to three months, including various immunisations and extra care for low weight babies, babies born to HIV-positive mothers, and babies with other special needs (Anafi et al., 2018; Ganle, 2013). In 2005, the free maternal health policy was integrated into the National Health Insurance Scheme (NHIS) funded through value added tax and levies, contributions from the Social Security and National Insurance Trust, and premiums paid by individuals (Scieber et al, 2012; Ganle, 2013). Under the NHIS, pregnant women are exempt from contributing regular annual premiums, but still entitled to the maternal benefit package described above (Ganle, 2013; Witter et al., 2007). It is expected that the free maternal delivery policy will reduce both the financial barriers to access and inequities in the access and use of maternity care, thereby leading to an increase in the proportion of women accessing and using the service, particularly supervised delivery in a health facility setting (Ganle,

2013; Kyei-Nimakoh et al., 2017). However, the quality of maternity care has been compromised, therefore putting pressure on the healthcare professionals in healthcare institutions (Ansu-Mensah et al., 2020). More research is needed on the effects of free maternal delivery on the health professionals' burnout and fatigue.

2.4 Underpinning theory and models

Theory can be defined as the structuring of a set of concepts to form an explanatory framework for an identified phenomenon (Langer & Lietz, 2014). Theories provide an explanation of the ideas related to a research area, offering a wider understanding of the topic, and strengthening the basis for selecting a research problem (Abend, 2008). Various theories and frameworks have been developed through which the abuse of women within a maternity healthcare context can be understood. Here, these theoretical models are discussed in relation to our understanding of women's maternity care. In this section, I will introduce three theories and models that underpinned my study of maternity care experiences. The first is the socio ecological model, while the two following models consider quality.

2.4.1 Social-ecological model

A framework known as the social-ecological model will now be discussed in terms of its applicability for examining the usage of facility-based maternity care provision. This framework derives from sociology, psychology, behavioural science and health science (McLeroy et al., 1988). The model views individuals as existing within social systems, and asserts that how they interact with their surroundings has an impact on the health outcomes they experience (Schiamberg & Gans, 2000; Stokols, 1992). This view, therefore, suggests that variables related to behaviour, the environment, and biology interact across a person's lifetime to impact their wider health and wellbeing (Smedley & Syme, 2000). In practice, this framework is applied less to focus on a specific set of people making a particular health-related decision, but rather to utilize social processes which impact upon individuals' health decision-making, in order to encourage decisions which, lead to better health outcomes (Stokols, 1992). In addition to the framework's impact on health-related behaviour at a given level, interventions may be implemented that are specific to

that level. On the other hand, some researchers consider it extremely important to conceptualise the levels within this model, rather than simply applying an intervention (McLeroy et al., 1988).

Following Brofenbrenner's (1979) work, McLeroy et al. (1988) specify five levels with a strong potential to have an impact in terms of health outcomes, level related to individuals, the interpersonal domain, communities, organisations, and policies (see Figure 2.2). However, the debate continues regarding how this should be conceptualised operationally, and the number of levels present (Sallis et al., 2015). Individuals' history and characteristics, including their age, attitude, behaviour, and knowledge make up the individual level, related to potential disrespect and abuse (Krug et al., 2002). At an interpersonal level, the phenomenon is influenced through social systems by the person's relatives and friends, neighbours, and work colleagues (McLeroy et al., 1988). When considering disrespect and abuse, the interpersonal level explores which relationships carry a higher risk for both, being subjected to and perpetrating disrespect and abusive behaviour. Intervention methods at this level of the model may comprise altering the attitude and norms of groups and promoting social support. The aims of the intervention at this level include impacting people's skills, knowledge, and beliefs (Krug et al., 2002). At the organisational/institutional level, the significant components include the network of communications, management style, and structural and cultural aspects of the organisation. The strategies for intervention at this level may centre on incentivisation initiatives, and consulting about processes. This level is analogous to the interpersonal level, except that it focuses on the organisational, rather than social setting (McLeroy et al., 1988). At the level of the community, healthcare provision and social services are involved, as is both formally and informally recognised leadership practice. The prevention of disrespect and abuse using this level of the model may involve techniques which influence the context, both physically and socially: for example, using conflict resolution, coalitions within communities, empowering and developing communities, and media promotions. Community-level intervention strategies aim to enhance healthcare provision, empowering groups which are vulnerable or deprived. The final level in the model relates to public policies, including taxation, law, regulatory bodies, media promotions, and shifts in the political environment (McLeroy et al., 1988).

Although the social-ecological model has been widely applied to examine influential factors regarding health behaviour, as well as how the various levels interact, it has been suggested that it suffers from certain limitations. For example, it can be challenging to identify the potential for specific factors across the levels to have an impact in relation to a specified health behaviour (Sallis et al., 2015). Moreover, the implementation of health-promoting or healthcare-improving interventions through this model might present practical challenges, due to the multifactorial, interactive nature of the levels (Stokols, 1996). Stokols (1996) suggests that the interventions should be restricted to a maximum of two levels concurrently. The social-ecological model has been subject to continuing adaptation to suit specific contexts to extend our understanding of the different variables affecting health-related behaviour and perceptions, and has, for instance, been effectively applied to examine highly complex topics, such as elder abuse, through a broad lens (Norris et al., 2013). It has also been applied to study variables impacting social inequity and health inequality (Parker & Aggleton, 2007). Based on this, the social-ecological model could be usefully applied in this work to identify variables which are viewed as contributing to the prevalence of poor care.

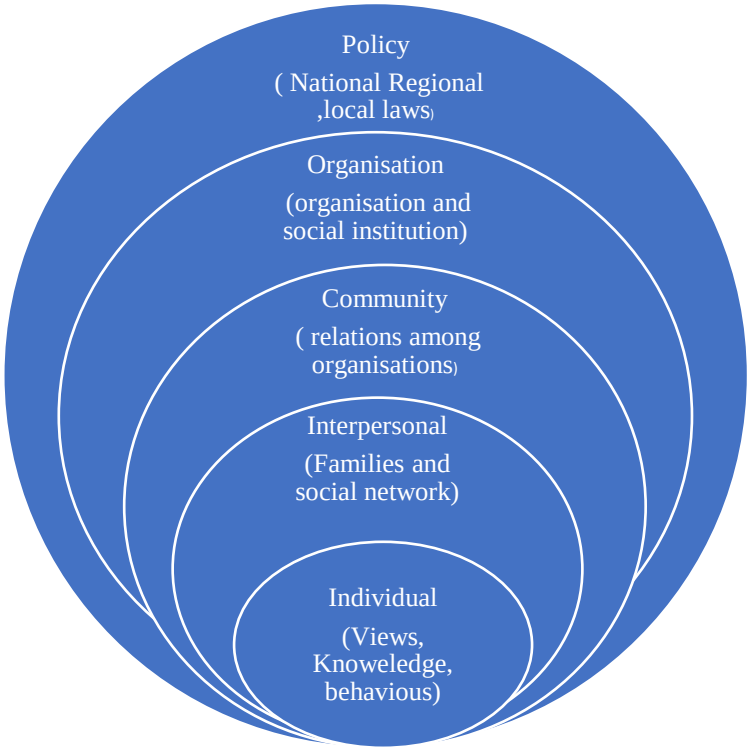


Figure 2.2: Sociological Model adapted from Brofenbrenner (1979).

The following two models consider the quality of maternal and newborn healthcare. Quality in healthcare can be defined as consistently satisfying the patient by providing efficacious, effective, and efficient healthcare services according to the latest clinical guidelines and standards which meet the patient's needs and satisfy the providers (Mosadeghrad, 2014). Since quality is a complex, multi-dimensional concept, there is no universally accepted definition of it (Mosadeghrad, 2014; Van den Broek & Graham, 2009). This is because it has different meanings and interpretations for different stakeholders (i.e., healthcare providers, managers, clients, and the healthcare system) and in various contexts (Mosadeghrad, 2014; Van den Broek & Graham, 2009).

2.4.2 WHO Quality of Care Framework

The WHO have devised strategies to operationalize the key elements. The aim was to use the components and experiences of care key to maternal and newborn health in facilities (WHO, 2018). The framework is proposed within the structure of the health system and focuses on the assessment, improvement and monitoring of maternal and childcare. Quality of Care is the degree to which health services offered to a person or larger population yield positive health outcomes (WHO, 2018). To accomplish this, health services must be effective, safe, efficient, people-centred, fair and timely. The quality of care in facility-based childbirth reflects the available supplies, physical infrastructure, management, and skilled workers, with the knowledge and ability to manage pregnancy and childbirth. However, the quality of care is predisposed to complexities that would need immediate interventions (Tunçalp et al., 2015). The framework (see Figure 2.3) has eight domains and proposes that pregnant women and newborns require care services from readily available, motivated, and competent human resources in health facilities (Tuncalp et al., 2015). Health services should also include practices for emergency and routine care, and systems should be in place for proper record-keeping and timely referral across various levels of care. The experience of care should involve effective communication with the women and their family members about the services. Care for women should be provided with respect, and their dignity upheld, as well as their rights and expectations. The necessary physical resources should meet women's needs while providing them with access to emotional and social support. Despite the framework's emphasis on facility-based treatment, Tuncalp et al. (2015) emphasise the role of service users and community members in determining their individual health needs and

preferences. Community engagement is crucial because women's and community members' perceptions of the quality of maternity care influence their decision to utilise the services (Bohren et al., 2014).

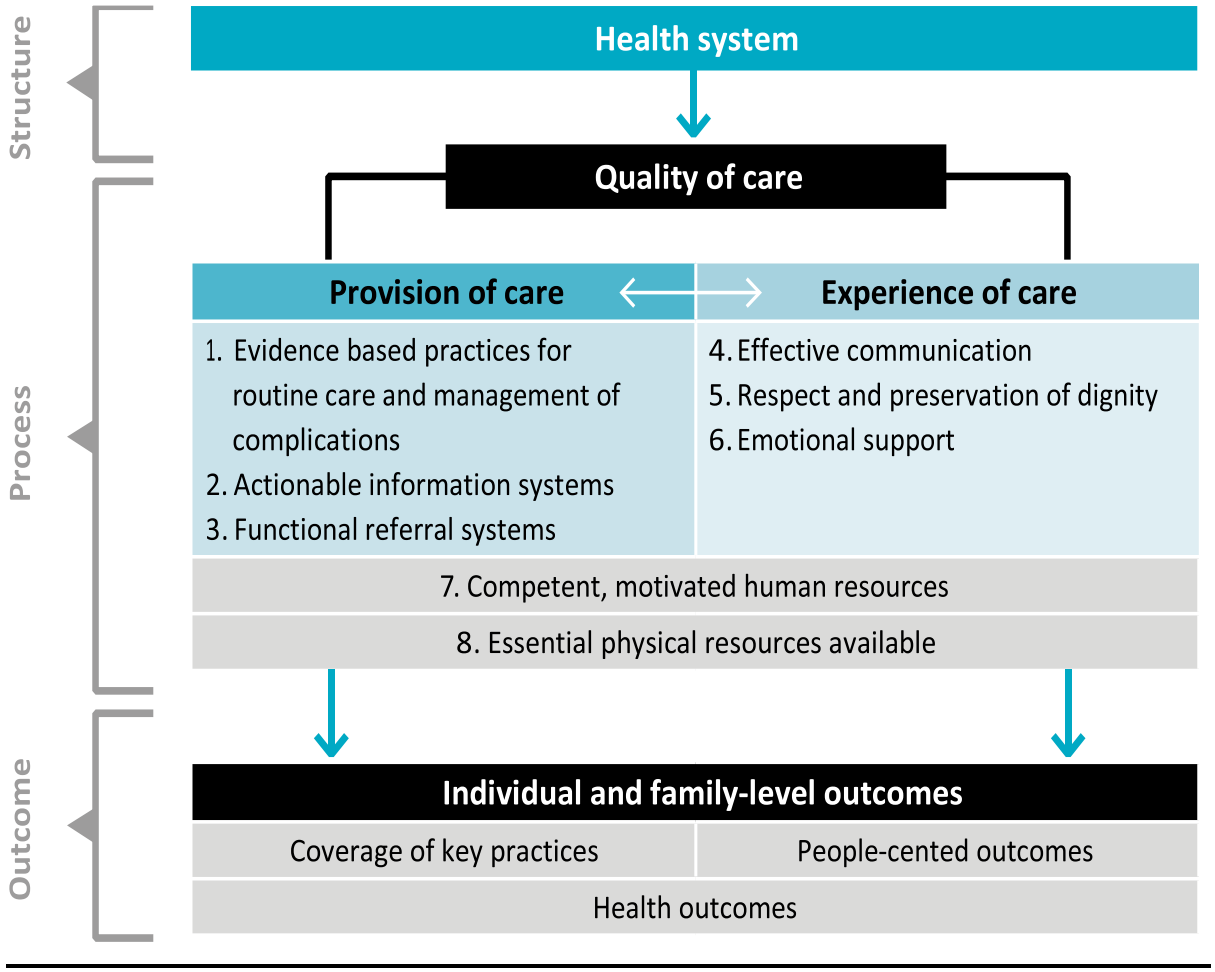


Figure 2.3: The WHO quality of care Framework for maternal and newborn health (WHO, 2018).

2.4.3 Freedman et al. - Maternal and Newborn Quality Framework

Another framework for Quality Maternal and Newborn Care was proposed by Freedman et al. (2014), within the structure of the health system. This framework focuses on the planning, implementation, and assessment of maternal and newborn health services. According to Freedman et al. the quality of maternal health and newborn care begins with what women need, their expectations and wishes during pregnancy and childbirth. However, the fact that a woman

struggles to push during the final stages of labour reminds us that health systems often reflect the deeper dynamics of power and inequity that shape the broader societies in which they are embedded (Freedman et al., 2014). This includes chronological sequences of action to expand the coverage of clinical interventions to reduce maternal and newborn mortality and morbidity. The WHO (2018) argues that, within the reconfiguration of maternal and neonatal care, every individual has the right to receive available, non-discriminatory, accessible, quality, acceptable and universal care. Thus, low quality care can mean that the standard of care as recommended by the World Health Organization is not being delivered. Freedman et al. (2014) expound that disrespect and abuse detract from women's right to the acceptable standard of care proposed by WHO (2015) and are problematic. A possible explanation is that the health systems are not conforming to international standards. Freedman et al. (2014), however, suggest that disrespect and abuse arise due to the situation in a maternity facility and interactions that are perceived as humiliating and not dignified during childbirth. Disrespect and abuse can be considered within three core levels – the individual, structural, and policy levels (Freedman et al. (2014) (see Figure 2.4). At the individual level, disrespect and abuse comprise behaviour and actions that local consensus views as disrespectful and abusive. Classified under the structural level are elements such as poor conditions in the healthcare systems, including understaffed health facilities and overcrowded maternity wards, which are viewed as disrespectful and abusive by both women and midwives. It also includes poor practices resulting from deficiencies in the health system and these being regarded as the norm. The policy level consists of deviations from the national and global standards of high-quality care and aberrations from the human rights of an individual which include the right to equitable, accessible, acceptable, safe and available care (Bohren et al., 2015; Freedman et al., 2014). The framework (see Figure 2.4) has been grouped into three major levels; namely, the individual, structural and policy levels, including six domains.

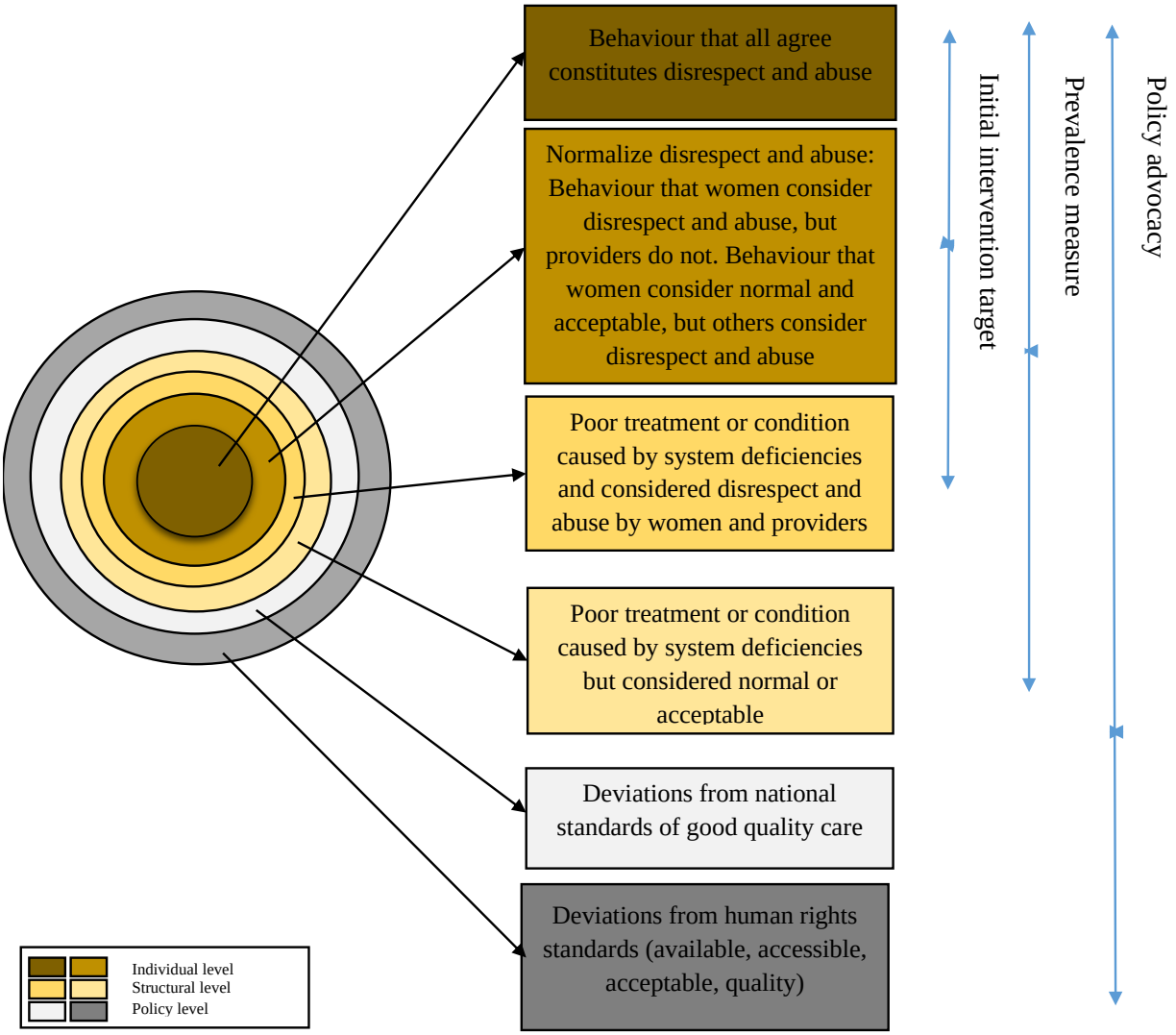


Figure 2.4: Freedman et al. (2014) maternal and newborn quality framework

The theory and models above frame the quality of care in the context of disrespect and abuse. Therefore, the next section will review the different types of disrespectful care.

2.5 Disrespect and abuse during childbirth

Different authors have used various terms to describe the disrespectful and abusive care received by women when attending maternal health facilities (Bohren et al., 2015; Burrowes et al., 2017), including ‘mistreatment’, ‘obstetric violence’ and ‘dehumanised care’. It is challenging to define the disrespect and abuse meted out to clients because they interpretate differently based on the setting, time, birth outcome and individuals’ perception and expectation (Bohren et al., 2015; Bowser & Hill, 2010; Burrowes et al., 2017). However, Bohren et al. (2015) pointed out that there is no worldwide definition of disrespect and abuse in maternity facilities, given the multi-dimensional nature of the term and various notions used to characterise it. According to Brüggemann et al. (2012), abuse in healthcare is described as patients' subjective perceptions of encounters with the health-care system that are characterised by careless incidents, in which patients suffer and believe that they have lost their humanity. Nonetheless, it must be acknowledged that structural and cultural circumstances frequently unwittingly foster and legitimise occurrences. Consequently, health-care abuse is deleterious to patients, as well as, presumably to personnel and health-care system as a whole (Bruggemann et al., 2012).

Indeed, Freedman et al. (2014)’s study found the significant differences that were observed between setting, time, birth outcome, personal expectations, and subjective experiences in a study of childbirth (McMahon et al., 2014). The previous discussion (Bruggemann et al., 2012; Freedman et al., 2014) as well as Bowser and Hill (2010) define disrespect and abuse as noncompliance with the WHO's norm of positive birth experiences, high-quality care, health-care facility circumstances, or health-care professional acts that women perceive to be damaging or infringing their fundamental right to health. According to Bruggemann et al. (2012), this might include any subjective experience during maternity care that women and midwives view as harmful or as a violation of women's human rights.

2.6 Categories of disrespect and abuse

The classification provides the cornerstone for study on this subject, as different studies (Bowser & Hill, 2010; Bohren et al., 2015) have mentioned varied forms of disrespect and abuse. For example, one study (d'Oliveira et al., 2002) divided healthcare violence into four categories: physical violence, verbal abuse, neglect, and sexual abuse. Physical abuse, according to their categorization, can take many forms, including being slapped, beaten, or denied pain medication. Verbal abuse includes things like humiliation, threats, yelling, and scolding, whereas neglect involves women being left alone with their children in maternity centers (Bohren et al., 2015).

Another study used individual interviews and structured group discussions with stakeholders, to create seven categories of disrespect and abuse in facility-based birthing (Bowser & Hill, 2010). Physical abuse, non-consented care, abandonment, non-confidential care, discrimination, non-dignified care, and incarceration in health facilities are some of the categories (Bowser & Hill, 2010). These disrespect and abuse categories are based on ethical and human rights principles (White Ribbon Alliance, 2011), and they support the combination of many forms of disrespect and abuse recorded in the literature. According to Bowser & Hill (2010), the categories of disrespect and abuse are related, since a single incident of the phenomena might exhibit many classifications. Despite these flaws, Bowser and Hill's categorisation has served as the foundation for subsequent research on maternity care disrespect and abuse (Okafor et al., 2015).

In a separate study, Bohren et al. (2015) used a mixed-methods systematic review to create an evidence-based typology of the mistreatment of women who give birth in health facilities. The seven dimensions of mistreatment described by these authors include physical abuse, verbal abuse, sexual abuse, failure to meet professional standards of care, stigma and discrimination, health system constraints and limitations, and toxic relationships between women and providers. According to Freedman et al. (2014), abuse and disrespect are key issues that have been identified at the health-care system level. These issues were further expanded by Bohren et al. (2015) who identified seven main domains in which abuse of women in childbirth occurs, ranging from inadequacies in health systems and facilities to relationships between women and health professionals (Freedman et al (2014). This confirms the claim by Freedman & Kruk (2014) in

which lack of accountability of the health system was identified to be responsible for the quality crisis.

Table 2.3: The categories of Disrespect and Abuse.

Categories of disrespect & abuse	**Examples**
Physically abuse	Women are slapped, beaten, pinched or hit, or severe force or restraint is used while giving birth
Non-confidential care	Failure to keep sensitive patient data private, including medical data, HIV status and age
Non-dignified care	Deliberately humiliating, blaming, scolding/shouting or threatening to perform a c-section
Non-consensual care	Consent not obtained for medical interventions, e.g. caesarean sections, episiotomies, and blood transfusions
Abandonment and neglect	Refusing to let a birth partner attend, disregarding labouring mothers in the second stage, and failing to intervene when a life is in danger are all examples of poor decision-making.

Discrimination	Denying necessary care because of ethnicity, class, illness or age.
Detaining women within a healthcare facility	Detaining women who cannot pay their medical bill

Categories from Bohren et al. (2015).

2.6.1 Nonconsensual care

Every woman has the right to decide whether or not to consent to use a maternity care service (Bowser & Hill, 2010). This assertion appears to have been defiled in one study based in England in which the women complained that they did not feel able to give informed consent when undergoing a caesarean section (Redshaw & Hockley, 2010). Ordinarily, one would think that the practice in England would be different from non-Western countries. For example, in Malawi, women stated that the health workers examined them without seeking their approval (Kumbani et al., 2012). Even when the consent of the women was sought, the health workers often failed to provide them with detailed information of the benefits and risks of a particular medical procedure (White Ribbon Alliance, 2011). This kind of behaviour suggests that the maternity professionals are in charge, as they demonstrate authoritative knowledge over women (Bradley et al., 2016). In Ghana, a quantitative study on the prevalence and factors of the mistreatment of women by midwives in facility-based services found that the women experienced nearly 13.3 percent of non-consensual care (Ganle & Krampah, 2018). In another study based in Ghana, the student-midwives reported that they had not requested consent from the women when examining them in the health facility (Rominski et al., 2017). Lack of informed consent reflects a practice that falls below the effective communication recommendation of WHO (2018), as shown in (figure 2.3), which undermines the achievement of positive birthing experiences.

2.6.2 Verbal abuse

Verbal abuse is another important finding that resonated in almost all the reviewed studies. Most women in Ghana reported being verbally abused by health providers, and this was found to affect the health and well-being of both mothers and the babies (Ganle et al., 2014; Moyer et al., 2014). Significantly about finding is the fact that most of the verbal abuses were committed by nurses and midwives, potentially because the nurses and the midwives have more contacts and interactions with the women during maternity care (Bohren et al., 2015; Ganle et al., 2014; Pell et al., 2013). The forms of verbal abuse identified in many studies includes rudeness, harsh language, ridicule, 'name-calling,' insults, and condemnatory comments, as reported in Tanzania (McMahon et al., 2014), and Ghana (Moyer et al., 2014; Ganle & Krampah, 2018). However, evidence from these studies suggest that some demographic factors can play a huge role in the abuse of women. For instance, a study in South Africa Chadwick et al. (2014) reported that women from poor socio-economic backgrounds, migrants, and those from ethnic minorities experienced derogatory slurs during delivery. Similarly, studies from Brazil (Aguiar et al., 2013), Ghana (Moyer et al., 2014), and Tanzania (Mselle et al., 2013) uncovered other categories of demographic factors: for instance, adolescents and unmarried women have also reported being subjected to humiliating, derogatory remarks regarding their sexual activity from health professionals. Such insensitive remarks were cited more often by adolescents and unmarried women because in many countries, particularly in resource-limited settings, where custom and tradition frowns on women who give birth outside wedlock (Bohren et al., 2015).

2.6.3 Physical abuse

Few studies (McMahon, et al., 2014; Moyer at al., 2014; Bohren et al., 2015) reported that women were physically abused by health care workers, especially doctors, nurses, and midwives during childbirth. The most frequently reported forms of physical abuse include hitting, pinching particularly on the thighs, and slapping using either an instrument or the hand (Bohren et al., 2015; Mselle et al., 2013). However, in some cases, some of the actions of the healthcare professionals, such as pinching or slapping on the thighs which were recounted as abuse by the women, may not really mean an intended abuse, but an effort to stimulate the women to push during labour to

prevent death of their babies and other complications. Nevertheless, there were also some instances when such actions appeared to be in excesses. For example, a study conducted in Ghana by Ganle & Krampah (2018) and Moyer et al. (2013) reported that healthcare workers physically abused women by hitting, slapping, kicking, and beating them, supposedly in order to get them to push during delivery. Such practices were considered unprofessional which had serious negative implications on uptake of maternal care services. Moyer et al. (2013) reported fear of being physically abused prevented women from attending or returning to the healthcare facility to access maternity care. Nevertheless, the results on indication of physical abuse documented during childbirth and delivery are related among the studies, as the research designs, methodology, and the geographical locations of these research may have differed. However, despite these differences, physical abuse is reported to occur in the established professional facilities.

2.6.4 Discrimination

Discrimination is an issue of concern that was largely reported by many studies(García-Jordá et al., 2012; Janevic et al., 2011; Warren et al., 2017). In a qualitative study conducted among the largest minority group in Europe (the Roma), women perceived discrimination when using maternal healthcare, and this was found to be higher among Roma (35%) in Hungary compared with non-Roma (4.4%) (Janevic et al., 2011). Very significantly about these findings is the fact that ethnic background, race, and socio-economic status played a huge role in the discrimination the women experienced during childbirth at the facility. Worldwide, women of lower socio-economic standing report feeling discriminated against due to their lower income level. Women residing in rural or slum areas, with lower socio-economic status in Afghanistan Rahmani and Brekke (2013), and South Africa (Chadwick et al. (2014) who reported cases of discrimination also felt that such maltreatment was because of their poverty, as they were unable to pay or bribe health workers for maternity care services. This is a perception that may be borne out misconception, biasness, or wrong interpretation of health professional's approach. However, a qualitative study conducted in Tanzania by (McMahon et al. (2014) reported a finding that validated the findings of Rahmani & Brekke (2013) and Chadwick et al. (2014). The study revealed that women with higher social standing received preferential maternity care by having easy access to maternity supplies and services at facilities, compared to women from remote areas (McMahon

et al., 2014). This study was not able to explain what defines higher social standing. However, the studies of Ganle (2013) and Moyer et al. (2014) threw more light on the issue and explained that women of lower class such as poor women, women with lower educational background, and financially dependent women were the most likely to experience discrimination when they visited health facilities to use maternal health services (Ganle, 2014; Moyer et al., 2014). This explains why such class of women would avoid health care facilities and prefer to patronize traditional birth attendants (Ganle & Krampah, 2018; Ganle et al., 2014a; Munabi-Babigumira et al., 2019). This is partly because the fear of being discriminated against discourages women from using health facilities in many resources – poor countries, such as Sierra Leone, Ghana, and Tanzania (Ganle & Krampah, 2018; McMahon et al., 2014; Oyerinde, 2013). Additionally, age presented as a significant factor that encouraged discrimination in the health facilities (McMahon et al., 2014, Mselleet al., 2013). The women also perceived that health workers discriminated against them due to their age, especially unmarried pregnant adolescents, or older women of high parity (McMahon et al., 2014; Mselleet al., 2013). This shows that health professionals allowed cultural or personal beliefs to control their sense of professional responsibilities. They should be concerned more about the safety of their clients than using personal beliefs against them.

2.6.5 Neglect

Neglection is an issue of serious concern that was largely reported by many women in some studies (Chadwick et al., 2014; Ganle et al., 2014; Moyer et al., 2014). Neglect happened when health care workers snubbed and ignored the concerns of the women during labour and delivery (Chadwick et al., 2014; Ganle et al., 2014; Moyer et al., 2014). The implications of such negligence were delay in getting satisfactory maternity care, and poor or lack of support during delivery, which made them perceive health workers to be insensitive to their condition. Even in high-income countries such as the UK, when women interacted with midwives, they were made to feel as if they were a burden to them (Redshaw & Hockley, 2010). Healthcare services were perceived by the women to be devoid of empathy, with some of the women concluding that the health professionals were not interested in their condition (Chadwick et al., 2014).

Similarly in Africa, being neglected at health facilities for long periods before being attended to has been reported in Ghana by (Moyer et al., 2014) and Tanzania by (Mselle et al., 2013). Also, women had to wait for long hours before they were referred to the next higher-level of health facilities in Uganda (Ackers et al., 2016). The long hours of delay were due to indecision on the part of nurses and midwives to promptly consult doctors to refer women in labour after realising that spontaneous delivery was not possible Uganda (Ackers et al. (2016), Ghana (Ganle et al. (2014) and Tanzania (Mselle et al., 2013). This explanation of reason behind delays and negligence at the health facilities is quite appreciated, however, the studies failed to point out the issue poor training among the nurses and midwives which made them not to know when to consult the doctors or refer patients to higher facilities. It also failed to point out that there is a communication gap between the midwives, nurses and doctors. Mselle et al. (2013) only included women who had a fistula and they reported delays due to access to doctors & midwives/nurses not making decisions. They also reported that many of these women did not attend the facilities at all or until very late which would obviously impact on the time available and the chances of delay in getting help. Such long periods of neglect lead to complication and death of the woman (Galaa et al., 2016; Ganle et al., 2014a). Unfortunately, some women experienced extreme forms of neglect by delivering at health facilities with no skilled birth attendants present at the time of delivery in South Africa (Chadwick et al., 2014). This was as a result of skilled birth attendants being preoccupied with other responsibilities (Chadwick et al., 2014; Mselle et al., 2013). The lack of accountability and sanctions when such poor treatments are reported by women makes them feel helpless to seek redress for disrespectful and abusive treatment received from health professionals (Warren et al., 2017).

2.6.6 Poor Communication

Poor interpersonal relationship between women and midwives can be due to language barriers and the wrong interpretation of information when women communicate with health workers (Bradley et al., 2016; Pell et al., 2013). Ineffective communication is a huge problem to attaining positive birthing experience (see Figure 2.3) and defies the WHO (2018) recommendations. When women experience this challenge, they do not get the required information on the medicines provided or maternity procedures to be performed (Bradley et al., 2016). When health professionals do not

communicate adequately on the risks and benefits of procedures to be performed during such difficult times in the life of a woman, it increases their fear of the procedure which complicates their condition (Dzomeku, 2011). Notably, rural dwellers in low-income countries, who are predominantly uneducated, are more likely to be discriminated against than the urban dwellers using the same healthcare facility (Ganle et al., 2014). The reason may be because the rural women who are largely uneducated may fail to comprehend some basic information (or instruction) and thus may also explain why the healthcare providers decline taking questions from the women. Instead of demeaning treatments, it could be more helpful and reassuring to assist the women comprehend the instruction being given by the healthcare provider. By providing proper communication, irrespective of the social status of a birthing mother, this would not only entreat the women to continue using healthcare services but also prevent deaths and policies must be re-enacted to enforce this (Kruk et al., 2018).

Women's descriptions in a qualitative study based in South Africa found that their inability to obtain information about their own health and their newborns enraged the maternity health professionals and left the women unhappy with the maternity care. Another study showed that women were disappointed with their doctors' degree of communication with them (Bohren et al., 2015). The women were dissatisfied with their health advice, and in other cases, were not given information on care procedures. It may be argued that accessing to information from maternity health professionals assists women to participate actively in the labour birth process, by placing women at the centre of the care plan, and interventions are used, acknowledging that supplying women with the knowledge and information they require enables them to manage their own health and make informed decisions about their treatments and care, as well as supporting them in improve their health and wellbeing by giving them the best opportunities to live their lives. Some MHPs, however, contend that women's lack of access to information during maternity care may be associated with the maternity health professionals busy schedule (Aguiar et al., 2013).

In addition, the lack of proper communication within the health facility among physicians and also between physicians (Madula et al., 2018; Mannava et al., 2015) pose a serious problems and is further demonstration of power and authority at the expense of the expectant women. Seeing themselves as lords over the healthcare users, doctors and midwives find it difficult to

communicate properly with and to the women (Bradley et al., 2016; Kruk & Freeman, 2014). For example, in Malawi a qualitative investigation was conducted to examine the nature of the communication on the maternity ward, identify the facilitators and barriers to healthcare provider-patient communication, and understand how these affects maternal healthcare (Madula et al., 2018). The results showed that the healthcare providers may verbally abuse pregnant women and either not answer or refuse to listen to their questions. The results also showed that there can be other non-verbal communications problems due to the patients' lack of verbal competency, perhaps due to disability, gender issues or memberships of multilingual communities (Madula et al., 2018).

2.6.7 Poor supportive care

Women in Jordan experienced poor supportive care since they felt that the health providers failed to provide them with the attention that they needed in order to feel supported and adequately cared for (Hatamleh et al., 2013; Redshaw & Hockley, 2010; Anguir et al., 2013). This lack of supportive care makes the women feel anxious (Redshaw & Hockley, 2010). Another important aspect of supportive care to which woman have a right is the presence of a birth companion, such as family member or husband (Hatamleh et al., 2013; Oyerinde et al., 2013; Redshaw & Hockley, 2010; Aguiar et al., 2013). However, many women have been found to have been prevented from being accompanied by their companion of choice during the delivery (Aguiar et al., 2013; Garcia-Jorda et al., 2012). Being able to have a companion in labour is recommended by WHO (2018) for a positive birthing experience (see Figure 2.3). The lack of a companion during delivery can make women feel disempowered and frightened (Bohren et al., 2015) and would make them less likely to attend if concerned about facing their labour alone. A study in Ghana found that the mistreatment during childbirth experienced by women was due to a lack of supportive care by the midwives (Maya et al., 2018; D'Ambrousse, 2005).

2.6.8 Lack of autonomy

Women in Jordan felt that they were being stripped of their dignity during childbirth due to health care workers failing to seek their consent to perform procedures on their bodies (Hatamleh et al.,

2013). Also, the woman's consent was not sought before exposing her body to many healthcare workers and large groups of student nurses, midwives and doctors in Brazil (Anguir et al., 2013) and the UK (Redshaw & Hockley, 2010). In Ghana, Ganle et al. (2014) found that some women were not given the right to decide their preferred position (squatting or kneeling) for the delivery and were forced to deliver in the supine position which they felt was undesirable since it rendered them passive. In a study based in Cuba, the reason given by the healthcare professionals for insisting that women deliver in the supine position was because they had not received training on how to deliver babies with the mother in a position other than lying down and felt uncomfortable about allowing women to decide their preferred birth position (Garcia-Jorda et al., 2012).This is an example of how a lack of knowledge, professional development and clinical supervision can lead to poor practice which affects a woman's choices and experiences of childbirth. It is possible that a woman who has experienced such care may not return to the healthcare facility in the future. All of these experiences fall below the quality maternal care recommendations of WHO (2018), as shown in Fig. 2.3

2.7 Consequences of poor maternity care

The evidence suggests that an experience of poor maternity care can have adverse effects on women and their newborn, either directly or indirectly, as well as the community at large (Asefa and Bekele, 2015; Bohren et al., 2015).

2.7.1 Impact upon women's health

The period of labour and childbirth can be joyful experience for many women (Ganle et al., 2013), although others find it painful (Beigi et al., 2010). A lack of access to pain relief during labour or episiotomies can cause women to suffer extreme pain. In some healthcare settings, such as Iran (Beigi et al., 2010) and Cambodia (Dawson & Homer, 2013), denying women pain relief during labour is linked to their inability to fully for their medical services in full. Women who have experienced disrespect and abuse in the form of slapping or hitting can also suffer both psychological and physical pain (Bohren et al., 2017). Another issue worthy of discussion is the existence of post-traumatic stress disorder (PTSD) which may be unrecognised for the MHP and

women in the Ghanaian context. A study on how to prevent post-traumatic stress disorder following childbirth and traumatic birth experiences in the Netherlands indicated that PTSD arises when a person has been exposed (directly or indirectly) to or threatened with death, actual or threatened serious injury or sexual violence (de Graaff et al., 2018). These authors stipulated that this traumatic experience ushers in a variety of symptoms (re-experiencing, avoidance, negative cognition and mood, and hyperarousal), which should persist for at least 30 days before a diagnosis of PTSD can be ascertained (de Graaff et al., 2018). The women in this present study may be affected by this, which will impact on their mental health and that of their children. They may not return for another birth if affected by PTSD; for example, if they experience flashbacks.

In Ethiopia, a study found that most women felt unhappy because the midwives did not communicate to them the condition of their newborn or the progress of their labour (Asefa & Bekele, 2015). Similar findings suggest that mistreatment can make women feel upset and disturbed during the period of childbirth or destabilised, because pregnancy makes them vulnerable (Balde et al., 2017; Bohren et al., 2017). These findings show that experiencing disrespect and abuse does affects not only women's reproductive health but also their overall wellbeing (Schroll et al., 2013). Schroll et al. (2013) agreed that the women perceived that experiencing disrespect and abuse could have adverse consequences for their children.

To conclude, this section suggests the women's experiences of disrespect and abuse can have long-lasting effects on their health, physically, emotionally and psychologically. Much research is needed in this area.

2.8 Access and Utilization of maternal care services

One of the guiding concepts of the newly proclaimed European Pillar of Social Rights is that everyone has the right to timely, affordable, preventive and curative care of high-quality healthcare (Allin & Masseria, 2009).This implies that access to healthcare should be effective for every individual: it should be supplied when individuals need it, through a geographically even distribution of healthcare facilities, professionals, and policies that minimize waiting times. Costs should not deter anybody from accessing the necessary healthcare (Baeten et al., 2018).

In the context of Ghana, free maternal healthcare service is available to all women in all the government hospitals and all other private accredited facilities in the country. The concept of access ties directly with the (WHO, 2018) guiding principles on availability of essential physical resources for pregnant women in all areas in Ghana, regardless of their geographical or socio-economic status. An effective and appropriate referral system is considered as an element of access, since some conditions during the intrapartum phase of labour might require the services of a specialist or critical care that may not be available at the primary healthcare centres.

Strikingly, the empirical evidence suggests that there exist substantial disparities in the maternal health indicators related to aspects such as women's place of residence (rural/urban), socioeconomic status and others, which are indicative of unequal access to healthcare (UNFPA et al., 2014). The strategy for preventing pregnancy-related ill-health and associated adverse outcomes requires the provision of regular, holistic care to childbearing women, particularly during childbirth. This is crucial, since this is where the highest incidence of adverse maternal health events occurs. To provide comprehensive care, it is imperative to identify and remove any factors that hinder maternal healthcare access and utilisation. The term 'access' can be described using three interrelated dimensions: availability, affordability, and acceptability (Kyei-Nimako et al., 2017). Thus, other authors have suggested that efforts aimed at promoting equity of access need to be considered in the wider context of these dimensions. However, Ganle (2013) draws attention to the fact that healthcare may be organized or provided in a way that creates access barriers to potential service users, such as pregnant women, in the context of maternity care services. Similar reviews have suggested that individuals may have various needs, interests, and expectations due to the contextual influences on the obstacles to healthcare access from the viewpoints of different groups (Kyei-Nimako et al., 2017). It can be argued that equity of access can be measured as the availability, utilisation, or outcomes of the maternal healthcare services (Gulliford et al, 2003; Ganle, 2013; Kyei-Nimako et al., 2017). Although significant studies have been conducted on the barriers to obstetric care services (Ganle, 2013; Kyei-Nimako et al., 2017), for the purpose of the present study, the review was focused on the barriers to the access and utilisation of the maternity care.

2.9 Barriers to and utilisation of maternal care services

Empirical studies, particularly in several low-income country contexts, such as Ghana, have identified several factors as barriers to accessing and utilising maternity care (see Ganle, 2013; Kyei-Nimako et al., 2017). To each specific barrier I now turn.

2.9.1 Individual family and community level

2.9.1.1 Financial and Transportation costs

Bowser and Hill, (2010) noted that a lack of financial resources among women and their families results in disrespect and abuse during childbirth. The inability of the women and their family members to pay the fees, bribes and other medical bills during maternity care results in disrespect and abuse at health facilities. Although bribery or informal fees are unacceptable in health facilities, the majority of the women mentioned the need to pay a bribe to the maternity health professionals to receive key aspects of services in Uganda (Ackers et al., 2018), among Roma (Janevic et al., 2011), and in Tanzania (McMahon et al., 2014). A 2019 systematic review based in Sub-Sahara Africa argues that bribes/ informal fees were found to be one sort of financial barrier that has significant effects on access to healthcare (Hsiao et al., 2019).This is particularly true for less wealthy patients who depend more on public services and are hence more open to bribery (Peterman et al., 2011). Patients who frequently have to pay a bribe at the point of care may decide to put off getting treatment until they are much sicker (or may decide not to get treatment at all), or they may decide to rely on traditional or spiritual healers or unofficial drug dealers who may make their condition worse (WHO, 2012).

In other studies, paying illegal fees or bribes to receive medical care is a particular type of financial barrier that has important implications for access to and use of maternal healthcare in Ghana (Dzakpasu et al., 2012; Ganle et al., 2014; , 2018). In Benin, Banke-Thomas et al. (2020) contended that the financial cost was a major barrier to access for all women. Others also point to the fact that, hidden, corrupt, unofficial and other costs associated with institutional deliveries are potential barriers to women accessing and utilising maternity care (Ganle et al., 2014b; Schaaf & Topp, 2019). Empirical studies to health professionals in Ghana and Tanzania, found that those who felt

more mistreated by their managers and the system, or who lacked the fundamental tools needed to do their jobs were more inclined to mistreat patients, including pressuring them to make unofficial payments (Aberese-Ako et al., 2014; Tibandebage & Mackintosh, 2005). Apenkro (2020) noted that the corrupt practices within Ghanaian medical care include the absenteeism of healthcare employees and bribery to elicit medical services. Corruption in the health sector is well-known in Ghana due to the lack of effective policies, and lack of transparency and trust, which culminate in ineffective public service rules and a lack of accountability mechanisms ((Agbenorku, 2012). The most common types of corruption in the maternal health sector are informal payments to caregivers, absenteeism during contracted hours, and the taking of bribes in exchange for the provision of aspects of care. The table below shows the types of corruption together with their meaning and effects on the individual and household.

Table 2.4: Forms of corruption

Types of corruption	Definition	Impact
Informal Payments	Payments said to be greater than the official fees made to health providers for services that are supposed to be free	Serves as a barrier to accessing maternity care; undermines equity in access; increases the financial burden on women and their families
Absenteeism	Stealing time by not working one's contracted work hours	Reduces access to and the provision of maternity care services
Bribes	Money or items of value promised or given in	Bribes can result in high costs for the women and their relatives accessing the care.

	exchange for the provision of care	

Schaaf and Topp (2019) note that informal payments are considered as money or in-kind payments made to healthcare providers for a service to which women are entitled under the government interventions, and this misuse of entrusted power for private gain is viewed as corruption. However, Mæstad and Mwisongo (2011) reported that, in countries where free maternity policies are guaranteed, women are still charged fees. The authors further noted that, in Tanzania, despite the free delivery services intervention, 62.5% of women were asked to pay for delivery services at public facilities. Similarly, in Ghana, nearly half (48.3%) of women were asked to pay for antenatal care services and 40.8% for drugs, whilst 41.7% of the women were asked to pay for laboratory services (, 2018), even though the free maternity care policy has been in place since 2008. In another study in Ghana, Anafi et al. (2018) reported that some women were asked to pay to access maternity care. However, the women confirmed that the direct medical care associated with delivery was free in public clinics and hospitals for women registered under the National Health Insurance Service scheme (Anafi et al., 2018). Although the maternal healthcare service in Ghana is now free to all women, the women were still asked to pay for services such as laboratory tests, drugs, and consultation fees. Parkhurst and Ssengooba (2009) agreed that informal payments were barriers to the access and use of maternal health services, especially when such services were believed to be free.

Further, some studies have shown that patients were often unable to distinguish between official fees and informal payments, and often incurred a combination of both (Afsana, 2004; Perkins et al., 2009). The distinction between gift - giving and informal payments can be blurred. A study in Bangladesh reported that forceful demands for informal payments were made following the provision of care (Afsana, 2004). Several studies have reported patients paying to ensure a continuous, interpersonal relationship with the provider; for more personalized care, for higher quality clinical care, for a shorter wait time, and for more comfortable care ((Baji et al., 2017; Karibayev et al., 2016). Unfortunately, informal payments or corruption are a catastrophic out-of-

pocket cost associated with an illness event, particularly in the event of labour and delivery complications (Jeffery & Jeffery, 2010; Perkins et al., 2009).

Other authors have categorised the financial cost into direct and indirect costs, which potentially act as a barrier to the access to and the use of maternity care (Anafi et al., 2018; Dahab & Sakellariou, 2020). These authors further noted that the direct costs are associated with the direct medical care incurred by women when accessing maternity care. The indirect costs include the expenses incurred by the women, such as transport to and from the facility, tips, food, gifts and other payments with accessing care (Anafi et al., 2018; Dahab & Sakellariou, 2020). In South Sudan and Mozambique, the direct and indirect cost of maternal care was found to be a recurring barrier to accessing care (Munguambe et al., 2016; Wilunda et al., 2017). This was also highlighted in Ghana by Anafi et al. (2018). In Uganda, Ackers et al. (2018) found that corruption and under-hand dealings among the healthcare providers were associated with long waiting times, neglect, and relinquishments. Accordingly, while 'little presents' help individuals to obtain medicines and supplies, corruption delays the decision to seek care by increasing the costs associated with it, and also increasing patient dissatisfaction (Ganle, 2013). In Tanzania, Abuya et al. (2015) found an association between bribery and neglect in health facilities in Tanzania. Married women had a lower risk of detention for the non-payment of bribes and hospital bills compared to the unmarried ones because of the perception that they come from a more financially stable household. However, unmarried women usually lack access to funds since many are not financially independent, and do not receive support from a partner or companion Abuya et al. (2015). Similar findings are also documented in Kenya where the participants viewed bribery as disrespectful, though most of the men felt that it facilitated the privileges and timely care their spouses received (Warren et al., 2017). In Ghana, Bohren et al. (2019) found that the staff asked the women or their companions for a bribe, informal payment, or gift in return for having received timely care, adequate attention from healthcare providers, and medication (Bohren et al., 2015), and Uganda (Ackers et al., 2018). Although there exist similarities between these studies within the Sub - Sahara African context, they lack transferability to the UK context.

Transportation - related barriers have been found to influence the access to and uptake of maternity care, for instance, in Ghana (Ganle, 2014; et al., 2018). Related to transportation is the distance to

the health facilities which can be a combination of the geographical distance, and the mode, time, and costs of travel (Ganle et al., 2019). In Ghana, Ganle et al (2019) found that bicycles and donkeys were used to transport pregnant woman in labour. The authors further noted that the women and their families were most likely to make decisions about the use of maternity care in light of factors such the mode of travel, time required for the journey, the cost of travelling to the facility, as well as the degree of difficulty of arranging an appropriate means of transport.

Transportation paucity is a barrier to accessing care especially in rural settings in low-income countries (Ganle, 2014; , 2018). This is also true even in high income countries: in Canada for example, Heaman et al. (2015) found that the problem of transportation was a hindrance to accessing maternity care services. However, Ganle (2014) noted that women, particularly in remote parts of Ghana, face difficulty not only due to the high user-fees or outright unavailability of transportation, but also from the inappropriateness of the types of transport available. More recently, a study in Ghana found that the distance between the villages and health facilities, and the high costs of transportation represent an impediment when it comes to accessing a health centre to give birth (Ludovica Barbi et al., 2021)). The distance from the nearest health facility and the unavailability of transport are negatively associated with delivery in a hospital (Ganle et al., 2019). A Gambian study reported that a lack of transport or need to pay for other means of transportation significantly contributed to the non-use of maternity care services (Lowe et al., 2016). In Uganda, Munabi-Babigumira et al (2019) also reveal that the lack of transportation sometimes led to delays in the referral of expectant women to higher-level facilities.

In Haiti, Barnes-Josiah et al. (1998) describe how women in impoverished settings may choose not to visit a formal health facility even when medical attention is urgently needed, when faced with a crucial trade-off between balancing the time lost in terms of domestic labour and childcare, the transportation costs, services, meals, bribes, and fees, and as well as the emotional stress of travel, with the dubious benefits of unproven care. Other studies have found that considerable distance, lack of transportation, and bad roads are less of a deterrent to women seeking maternity care if they are experiencing major difficulties, or if the target facility or care provider has a good reputation for providing exceptional treatment (Anson, 2004; Ganle, 2013).

2.9.2 Socio-demographic Factors

The barriers to access and the uptake of skilled birth attendants are associated with socio-demographic factors, although there are predisposing factors that may differentially affect different women's ability to access and use skilled maternity care services (Fosu, 1994; Ganle, 2013). Ganle (2013), (, 2018), and (Yarney, 2019), found that socio-demographic factors, such as maternal age, education, husband's education, exposure to the media, marital status, household income/wealth, women's employment, and parity are important determinants of accessing maternity care. Ganle (2013) suggested this, noting that, in some cases, even when a strong association has been reported, such as a positive relationship between education and the use of skilled birth attendants, the extent and nature of this relationship is not uniform across different social settings.

Membership of a minority ethnic group has also been found to be a barrier to accessing and using maternity care. In Serbia and Macedonia (Janevic et al., 2011) and South Africa (Chadwick et al., 2014), indigenous women are less likely to have skilled attendants at their delivery (Ganle et al., 2014; Ganle et al., 2019).

2.9.3 Socio-cultural Factors

The socio-cultural beliefs, preferences and practices of women and communities have been linked to barriers to access and use of maternity care (Ganle et al., 2014b; Mukabana & Emali, 2019). For example, Pfeiffer and Mwaipopo (2013) and Dako-Gyeke et al. (2013) find that traditional birth attendants are noted to enjoy patronage due to their high sensitivity to the sociocultural norms together with their greater ability to incorporate psychosocial care into their services compared to the modern health facilities in Tanzania and Ghana, respectively. More recently, a study in Ghana also found that the traditional practices, and common beliefs, such as the list of items that women need to bring with them when giving birth in a facility, like a new white dress which is worn for three months after the delivery to signify the victory of life against death, are extremely important, but less obvious and not cited in other studies (L. Barbi et al., 2021). A possible explanation could be that some pregnant women attend a health facility for delivery but never return home, which makes it understandable that those who do survive wear a white dress as a sign of victory over

death. However, cultural beliefs can vary from community to community and region to region, so more studies are needed to explore whether other communities or regions of Ghana have similar traditions (Barbi et al., 2021).

In Ghana, the results of a mixed method study show that it is a taboo for women from certain families to give birth in a health facility and that newborn babies must be presented to the 'traditional gods' before they can access essential newborn care services, including immunisation, due to perceived repercussions in the form of the death of either the woman or the child (Boah et al., 2020). Ganle et al. (2019) also found that women's religious beliefs prohibited health facility delivery, as did their belief that there were norms in her community that did not support health facility delivery. This is an aspect that my study has explored.

Religion shows variable patterns of association. For instance, mixed method studies in Ghana, find that Muslim women are less likely to use reproductive and sexual health services compared to Christian women (Ganle, 2015; Ganle et al., 2019). Similarly, in Nigeria, Olusanya et al. (2010) found that people belonging to the Muslim or African Traditional religions (a general term for traditional African beliefs and practices)(Mills et al., 2008) tended to use services less often. Ganle et al. (2019) stipulated that Christian woman (90, 86%) were more likely to use supervised delivery services as compared with those who profess Islamic (76, 54%) and traditional (18, 51%) faith. It can be argued that there may be certain religious laws restricting the Muslim women from using the maternity clinics. Other studies, Gyimah et al. (2006) in Ghana also indicated a high uptake of institutional delivery services by Christian women compared to women who profess an Islamic or traditional faith. Similar findings were also previously reported by Stephenson et al. (2006),who noted that this may be due to the cultural/religious restrictions placed on women within certain households or communities which prevent them from leaving their home or seeking care. In Ghana, a cross-sectional study (Yarney, 2019) found a link between a preference for herbalists, the use of herbal medicine, traditional birth attendants, religious practices, childbirth-related taboos and maternal mortality. However, other authors have challenged the idea that childbearing women and relatives in the remote areas in Ghana have a strong preference for accessing spiritualists and herbalists for maternity care, even when maternity care services are available (Moyer et al., 2014). In another retrospective cross-sectional study, Ganle et al. (2019) identified

the associations between supervised delivery and the factors that influence the use of supervised delivery services in a district of Ghana. According to the findings, the factor that most strongly independently predicted supervised delivery was religion ($p < 0.01$). There exist similarities between both studies (Yarney, 2019; Ganle et al., 2019) in terms of the geographical location and use of a cross-sectional design, but other factors may also have influenced the research process. For example, in the former study, antenatal women were the participants while, in the second, the particpants were postpartum women who had given birth within a year of the data collection (Ganle et al., 2019). Oyerinde et al. (2012) report, in Sierra Leone, beliefs in destiny, religious teaching regarding faith in divine healing, as well as the cultural preference for a home delivery among certain ethnic groups, and the non-use of skilled care. Interestingly, very few studies, including the two studies on Ghana mentioned above, explore how issues within the Muslim culture or Traditional African religious beliefs act as barriers to the use of maternity care services. In this regard, Ganle (2014) and Ganle et al. (2019) suggest that research is needed on religion and traditional beliefs that deter access to and the use of maternity care (Ganle, 2014; Ganle et al., 2019). Indeed, it is unclear how these religious and traditional beliefs deter women from accessing care, and little attention has been paid to how the beliefs/traditions of Christianity or other traditional faiths can deter women from accessing care. This is an interesting aspect that my study explored.

Other barriers include women's low social status in their community in Ghana (Ganle et al., 2015) and women's lack of decision-making autonomy within their family in northern Ghana. Women lack skills for employment and may be stigmatized both in their community and at the health facility for becoming pregnant. Men's disapproval is a major barrier to women's use of maternity care services (Ganle et al., 2019; McNamee et al., 2009). Considering the above factors, the results suggest that, although the maternity care delivery services may be free of charge in Ghana, several socio-demographic, health system and socio-cultural factors still deter women from utilising such services.

2.9.4 Social inequality

Gender, defined as the socially-prescribed and experienced dimensions of femininity and masculinity in society, is evident in the diverse ways in which individuals engage in health behaviour (Johnson et al., 2009). Due to the gender inequality, the factors that lead women to avoid using healthcare facilities, for example in rural Zambia, are often based on their lack of decision-making autonomy regarding childbirth and dependence on their husband and other family members to make the final decisions (Sialubanje et al., 2015).

In terms of the educational and relational inequalities, women see midwives as possessing the necessary skills and expertise, even when things go wrong (Bradley et al., 2016), and only prefer to attend a healthcare facility if this happens (Prytherch et al., 2013). The MHPs are often fearfully respected by expectant mothers who thus find it difficult to approach them to ask for help or to ask questions (Angelshaug, 2013). This situation creates a considerable social distance between the expectant women and the MHPs. In Malawi, the midwives were characterised by the researchers as being fluent in English and educated compared to the illiterate women whom they served (O'Donnell et al., 2014). Due to this educational inequality, the illiterate women may feel embarrassed, and inferior compared with the "highly-educated" midwives, thus widening the relational inequality even further.

Another form of inequality is conceptual/virtual inequality, borne out of a personal concept/belief in the virtual existence of a certain inequality. For example, when considering why the intrapartum healthcare services fail to attract women to visit the clinic, it is argued that the cultural norms and traditions place women in lower positions of power, combined with an inability to make independent decisions (Ganle et al., 2015; Nyefene et al., 2018). It may also be due to previous negative experiences at healthcare facility with impolite midwives (Nyefene et al., 2018; Ganle et al., 2015). Some rural women in Ghana perceive the traditional birth attendants as being more competent than professional midwives, probably because they feel less pressured by these unskilled midwives ((Apanga & Awoonor-Williams, 2017; Kyei-Nimakoh et al., 2016). Another reason is that the traditional birth attendants and women share similar economic, literacy and social

power levels, and thus can communicate their problems and feelings relatively freely, without any fear of embarrassment.

Since the traditional social inequality creates a power imbalance, where someone must give the order (Bradley, 2018), women and healthcare specialists prefer healthcare service systems where the majority of the healthcare providers are male (Ganle & Dery, 2015). Since they drive most of the family decisions, involving men in the service could enhance the campaign for educating women about the importance of receiving professional maternal healthcare services. Although the maternal healthcare service in Ghana is now free, this information has not trickled down to the uneducated (or less educated) and rural dwellers (Ghana Statistical Service, 2018). An additional solution outside healthcare is to reduce the poverty level generally and raise the formal education achievement among women and their husbands alike.

2.9.5 Service provider factors

2.9.5.1 Negative attitudes of staff

Negative attitudes among healthcare workers and the poor treatment of expectant mothers by healthcare workers acted as a deterrent to women seeking maternity care from health facilities in a hospital in Kenya (Oluoch-Aridi et al., 2018; Warren et al., 2017), Uganda (Munabi-Babigumira et al., 2019) and Sierra Leone (Oyerinde et al, 2013). More recently, a study in Ghana reported that disrespectful care, including disrespect for women's privacy, was a major barrier to them accessing and using maternity care services (Maya et al., 2018; Moyer et al., 2014; Rominski et al., 2017). In Sierra Leone, the maternity care facilities were not used due to a fear of having to wait in long queues to be seen (Oyerinde et al, 2013).

The health system is linked to the quality of care. In Uganda, Munabi-Babigumira et al. (2019) find that poor quality care serves as a deterrent to the use of maternity care. In Tanzania, Mselle (2013) find that, in some cases, based on a desire to provide more accessible health facilities, the lack of trust between women and the healthcare providers has also been identified as a barrier to accessing and utilising care. In Uganda, Munabi-Babigumira et al. (2019) find that caregivers' relationships with mothers create mistrust and worsen the inequity of care. In Haiti, Barnes-Josiah

et al. (1998) found that the impression of caregivers' relationships with mothers create mistrust and inequity of care deters women from accessing and using maternity care services. In Sierra Leone, Oyerinde et al. (2013) find that a lack of trust in the skills and practices of maternity care providers discouraged access to maternity care services.

2.9.5.2 Poor staff training

Poor education and training can lead to poor maternity care experiences. Aguir et al. (2013) suggested that health workers may develop abusive practices and behaviour during their training. For example, during their training in health institutions in Ghana, student-midwives reported witnessing high levels of disrespect and mistreatment of women (Rominski, 2017). Women in Guinea blamed the behaviour and attitude of inadequately qualified midwives for their experiences of disrespect and abuse (Balde et al., 2017). In a separate survey, Peruvian women claimed that poor health-care professional training and a lack of understanding of respectful treatment contribute to the persistence of negative attitudes and behaviour (Montesinos-Segura et al., 2018). This is likely to encourage maternity health professionals (MHPs) to distance themselves from women, as the health professionals believe that delivering medical treatment is more important than developing a positive relationship with the expectant women. As a result of holding such ideas, disrespectful and abusive actions are more likely to persist (Jewkes et al., 1998; d'Oliveira et al., 2002; Yakubu et al., 2014).

2.9.5.3 Power Dynamics and power control

Since time began, the battle for supremacy has existed. In the legendry 'Animal Farm', George Orwell noted that '*all animals are equal, but some animals are more equal than others*'(Orwell, 1945, p. 112). This reflects a natural example of the power imbalance between different types of animals. Typical of the society where the maternal health professionals and expectant women reside, African politicians are seen as being more equal than the electorate; they display the imbalance of power in the way they run for public office, use public funds, flaunt the national laws and finally create rules to protect themselves when they are out of office. Freedman and Kruk (2014) highlighted the phenomenon as a reflection of a healthcare (political) system that is facing a crisis in terms of both quality and accountability (Freedman & Kruk, 2014). This hierarchical,

potentially corrupt system seems to have an indirect impact on the health professionals working in these healthcare facilities. The abuse of power displayed by those employing and managing them leads to the disempowerment of health staff (Bradley et al., 2016; Freedman & Kruk, 2014). They have no control over their working conditions or the resources available to enable them to care for the women and their family. This disempowerment can create stress and burn-out, which in turn impacts on the health staff's ability to show compassion (Yoder, 2010; Bradley et al., 2016). This phenomenon is known as 'compassion fatigue' (Joinson, 1992) and may help to explain why the midwives working in such facilities are often reported as being disrespectful and abusive to those in their care (Yoder, 2010). These power imbalances and inequalities reflect the deeper dynamics of power and inequity that shape the broader society in which the MHPs and expectant women are embedded (Freedman & Kruk, 2014).

To some extent, the MHPs work hard to control healthcare, as well as the type (and quality) of the services offered. The MHPs respond to the healthcare assessment questions of expectant women as if they are doing them a favour rather than their job (i.e. they provide feedback to pregnant women as a privilege), which leads to poor communication between MHPs and pregnant women. This falls below the effective communication requirement of WHO (2018) to ensure a positive birthing experience (see Figure 2.3). The power imbalance between doctors and midwives may also influence the type and level of healthcare treatment received expectant women in healthcare facilities. Notably, this power imbalance is reflected in the doctor/midwives' attempts to assert their professional identity and take charge of both the women and the birth process (Bradley et al., 2016). The MHPs attempt to transform the woman-centred care to MHP-centred care. Further, doctor-doctor, doctor-midwife and midwife-midwife confrontations and poor communication about patients' treatment may significantly hamper medical progress and potentially undermine the quality of the care (potentially impacting on the morbidity and mortality outcomes) (Taran, 2011). The MHPs devote efforts to maintaining their power and control by positioning birth as a medical event, to secure their own cultural, social and societal status. This includes placing women under the control of healthcare policies and knowledge (Bradley et al., 2016).

2.9.5.4 Maternal Health Professional (MHP) attrition

In Sub-Saharan Africa, primary healthcare worker attrition contributes to the progressive reduction of care quality provided by the healthcare worker due to exogenous reasons. The typical factors influencing worker attrition include pay, feeling overworked or stressed, moving away, death and illness (Kruse et al., 2009). In Ghana, there are frequent delays in payments, meagre salaries, a lack of promotion and lack of increment in their salaries for prolonged periods for midwives (Banchani & Tenkorang, 2014). Healthcare workers who are subjected to this kind of lack of respect may, in turn, inflict a lack of respect or abuse on patients, lackadaisically engage in duties, or be absent from work. The breakdown in the accountability of a health system that results in disrespectful and abusive care not only affects its service users but also the professionals whom it employs as service givers (Freedman & Kruk, 2014).

2.9.5.5 Wider Society influence

The power dynamics and inequalities described above can be highlighted as a reflection of the deeper dynamics of power and inequity that shape the broader societies in which the MHPs and pregnant women are embedded (Freedman & Kruk, 2014). Low quality care results from a transitional breakdown in the respect and care in the wider society infiltrating the medical healthcare system. Records abound on the disrespectful and abusive dispositions of political office holders, who may be schoolmates of the MHPs, and their societal affluence, flaunting of laws and court orders, corruption and nepotism. Being embedded in the same society, MHPs also translate these dispositions into a display of power and the gaining of societal affluence and fearful respect. In short, disrespectful and abusive care is a signal of a health (and political) system in crisis; for example, a crisis of quality, accountability and sanctions (Freedman & Kruk, 2014).

2.9.6 Health systems and policies

2.9.6.1 Lack of enforcement of policies

Inadequate policies in healthcare facilities are reported to contribute to disrespectful maternity care. In many settings, including Ghana, maternal health policies that protect women's right to the standard respectful maternity care are missing or poorly implemented (Bowser & Hill, 2010). Even where these policies exist, women lack a knowledge of their rights and responsibilities when accessing maternity care. In some instances, there are no procedures laid down to lodge complaints, and no mechanism for addressing complaints. Janevic et al. (2011) suggested that women who had experienced abuse at the hands of maternity care professionals wanted to complain, but there were no redress systems in place to enable them to do so. Moyer et al. (2014) affirmed that a lack of redress schemes for women to lodge their complaints is one of the reasons why disrespect and abuse still exist in health facilities in Ghana. A weak redress system hinders women and other community members from taking action to deal with disrespect and abuse in Kenya (Warren et al., 2017). Bohren et al. (2015) stated that the lack of a redress system and sanctioning of professionals for engaging in disrespect and abuse left women feeling reluctant to seek justice. However, in Ghana, the Patients' Charter, like all equivalent documents around the world, was published by the Ghana Health Service, which was meant to protect the rights and the responsibilities of the patients (Yarney et al., 2016). The aim was to ensure accessible, equitable and comprehensive healthcare of the optimum quality within the available resources of the country, respect for the patient as an individual who has a right to participate in his or her healthcare plan decisions, and a right to be protected from discrimination stemming from culture, ethnicity, language, religion, gender, age, type of disability or illness, (Yarney et al., 2016). However, some of the reasons accounting for this are a perceived fear of receiving unfair treatment if they complained or sought clarification, the women's lack of knowledge about the existence or contents of the Charter and the lack of an ineffective system of redress for lodging and addressing complaints (Warren et al., 2017; Yakubu et al., 2014). Although patients' rights and responsibilities are spelt out in the Patients' Charter in Ghana, the patients and their families are unaware of their rights and sometimes unaware of the legal process. These barriers led to the repeated occurrence of disrespectful and abusive practices in health facilities. Inadequate policies

in healthcare facilities is reported to contribute to disrespectful maternity care. In many settings including Ghana, maternal health policies that protect women's right to the standard respectful maternity care are missing or poorly implemented (Bowser & Hill, 2010)). Even if these policies exist, women lack knowledge on their rights and responsibilities when using maternity care. In some instances, there are no procedures laid down to lodge complaints, and no mechanism of addressing complaints. Janevic et al. (2011) suggested that women who experienced abuse from maternity health professionals wanted to complain, but there were no redress systems in place to do so. Moyer et al. (2014) affirmed that a lack of redress schemes for women to lodge their complaints is one of the reasons disrespect and abuse still exists in health facilities in Ghana. A weak redress system hinders women and other community members from taking actions to deal with disrespect and abuse in Kenya (Warren et al., 2017). Bohren et al. (2015) stated that the lack of a redress system and sanctioning of professionals on disrespect and abuse left women feeling reluctant to seek justice. However, in Ghana, the patients' Charter like all equivalent documents around the world was published by the Ghana health service which was meant to protect the rights and the responsibilities of the patients (Yarney et al., 2016). This was to ensure accessible, equitable and comprehensive healthcare of the optimum quality within the available resources of the country, respect for the patient as an individual who has a right of choice in his or her healthcare plan decisions, the right to be protected from discrimination stemming from culture, ethnicity, language, religion, gender, age and type of disability or illness, the role and responsibility of the client or patient for personal and communal health via promotive, preventive, and basic curative strategies (Yarney et al., 2016). However, there some reasons accounting for this are perceived fear of receiving unfair treatment if they complained or seek clarification, women have no knowledge of the existence or the contents of the Charter and the lack of or ineffective system of redress for lodging and addressing complaints (Warren & Abuya, 2017; Yakubu et al., 2014). Although patient's rights and responsibilities are spelt out in the patient's charter in Ghana. However, patient and their families are unaware of their rights and sometimes do not know the legal process. These barriers led to a continuous occurrence of disrespectful and abusive practices in health facilities.

2.9.6.2 Inadequate infrastructure

The inadequate infrastructure in health facilities contributes to poor maternity care. The poor conditions and unavailability of a physical structure places pressure on the existing services, leading to overcrowding. This leads to women giving birth on the floor and sometimes without the necessary support from MHPs (Bohren et al., 2017). A shortage of hospital equipment, such as beds, curtains and partitions for undertaking vaginal examinations during labour and childbirth, violates the service users' privacy (Bowser & Hill, 2010). In sub-Saharan Africa, studies have shown that many of the healthcare facilities are in a state of collapse and the basic infrastructure allows little room to ensure patient privacy (Solnes Miltenburg et al., 2018). Further, in low-income countries, like Ghana, the low government spending on healthcare systems leads to a poor infrastructure and lack of equipment and drugs ((Fauveau et al., 2008). This phenomenon reduces the quality of the healthcare system. For example, health workers in rural facilities in Ghana have been reported as being more de-motivated by the poor availability of resources and drugs than their counterparts in the urban facilities ((Alhassan & Nketiah-Amponsah, 2016)). Some of the instances of reports received from midwives in Ghana include:

Most of our equipment is not in good shape at all. Most of the wheelchairs are broken, which has made the movement of patients in and out of the operating theatre very difficult for us. At times, there is frustration all around you because, when you go to the storeroom to request surgical gloves, you're told the stocks have run out (Midwife) ((Banchani & Tenkorang, 2014, p. 6).

The frustration over malfunctioning equipment, and a lack of equipment or it being "out-of-stock" may lead MHPs to experience stress, burnout and compassion fatigue.

2.9.6.3 Human resource

One reason for the lack of skilled healthcare professionals in the health systems in sub-Saharan Africa (and probably other low and low-middle income countries, such as Ghana) is the brain drain (Prytherch et al., 2013) . The austerity measures have had a devastating effect on the functioning of the health system. However, the brain drain in the form of internal and external migration (Ackers et al., 2016; Bradley, 2018) and general poverty has compromised the primary healthcare

provision in many low-income countries, particularly in rural areas, where a significant percentage of the population lives (Bradley, 2018). There are various factors that have serious consequences for the performance of high quality care, including staff shortages or the poor distribution of the existing health workforce (Brown et al., 2011), as well as inadequate skills in basic and emergency obstetric and newborn care (Lobis et al., 2011).

For example, the estimated rate of expatriation in 2000 for medical doctors born in Ghana but working in OECD countries was 31.2%, and 24.9% for nurses (Dumont & Zurn, 2007).The emigration rate of nurses from Ghana is 18.1% higher than that of Tanzania and 24.6% higher than that of Burkina Faso (Dumont & Zurn, 2007). Where there exist staff shortages, the facility managers default to using generalist nurse-midwife cadres, who lack midwifery-specific skills required effectively to administer care to women within the culturally and emotionally sensitive arena of childbirth (Fauveau et al., 2008). Hence, the use of different types of health professionals carrying out maternity care tasks creates challenges due to the lack of standardised training and poorly defined roles (Kyei- Nimako et al., 2016). The inadequate number of skilled midwives is because the few individuals were interested in the profession, and enrollment in midwifery training programmes was limited (Banchani & Tenkorang, 2014), and also due to the lack of qualified health professional resulting from the inadequate training capacity or international brain drain (emigration), which are exacerbated by the often more disastrous impact of the internal brain drain and high rates of absenteeism and rampant dualism (Uganda. Ministry of Health, 2010, p. 20). In Ghana, many doctors invest in studying for a master's degree in business administration or public health planning in a quest to obtain a higher managerial position, such as hospital director. Thus, most of the doctors in the consulting room are now managing the hospitals, which creates shortages in the consulting rooms and facilities. This has been echoed elsewhere in Uganda (Ackers et al., 2016). However, other authors in Ghana have associated the shortage of midwives to the aging population of midwives, economic migration and the inadequate training of qualified personnel (Banchani & Tenkorang, 2014). Midwives provide the majority of the skilled maternity care services in Ghana so the maternal health workforce must consider the recruitment, retention, and equitable distribution of midwives. However, a shortage of maternity health professionals creates a stressful work environment for MHPs who become overworked, burnt-out, and likely to display unprofessional attitudes and behaviour towards women (Ganle et al., 2014; Bohren et al.,

2015; Warren et al., 2017). The overstretched MHPs become frustrated, unable to carry out their normal duties effectively, provide poor maternity services, and sometimes only do what they consider the minimum to promote maternal and child survival (Bowser & Hill, 2010). Balde et al. (2017a) further stated that, due to understaffing, trainees, described as hot-tempered, less compassionate and unempathetic, are often required to provide care for women in Guinea. In another study, the impact of delays and absenteeism on maternal and neonatal outcomes in Uganda indicated that the sole factor contributing to delays and their associated adverse outcomes for mothers and babies in Uganda is the failure of doctors to be present at work during their contracted hours with any degree of regularity or predictability (Ackers et al., 2016). The authors note that the costs to the public purse are enormous and suggest that a failure to acknowledge and respond to this sensitive problem will ultimately undermine all other interventions (Ackers et al., 2016, p. 1152). Although these constrains in the healthcare systems do justify some of the poor care that is prevalent in the maternity care in Ghana, it should not encourage the perpetuation of disrespectful care. Hence, (Kruk et al., 2018) pointed out the need for local, national and international stakeholders to work together and address the drivers of disrespect and abusive in maternity care settings. In addressing the understaffing problems, the lack of opinion recognition in the decision-making and lack of recognition of skills must be considered.

2.9.6.4 Stress

The stress of healthcare workers has been associated with poor quality care, including the provision of disrespectful and abusive care during childbirth, in both the developed and developing world. However, there are no excuses for disrespectful and abusive care, including an excessive workload or stress (Hall & Mitchell, 2017). In the literature, some authors suggest that the ability of healthcare professionals to provide respectful care is compromised by administrative overload, over medicalisation and the organisational structure which detract from continuity of care and lead to stress and burn-out (Morad & Parry-Smith, 2013). Additionally, in Ghana, delays in the payment of salaries are also frequent so many MPHs find other ways to complement their income (Banchani & Tenkorang, 2014). This could lead to a lackadaisical attitude towards work, stress and a lack of commitment among the MHPs. The problem with stress is that a midwife who is providing compassionate care at one moment might be overwhelmed by unmeetable demands in the next and

lash out at the women she is attending (Mselle et al., 2013). To summarise, where the working conditions are poor, healthcare workers may experience stress, exhaustion, and frustration, which in turn can lead to "compassion fatigue" in reation to the treatment of pregnant women (Wesson et al., 2018). On the other hand, increasing the staff-patient ratio is a certain way to reduce stress and disrespectful care (Yoder, 2010; Bradley et al., 2016).

2.9.6.5 Motivation and Incentives

The MHPs have also reported that pay that is inadequate to meet the basic cost of living is a demoralising parameter that demotivates their caring services (Brodie, 2013). Also, the MHPs frequently lament their poor working environment, citing underpayment and long work hours (Solnes Miltenburg et al., 2018). Hence, the impact of the incentives received by the MHPs in low-income countries, like Ghana, as a motivational factor to enhance their respective performance in terms of delivering high quality care services is debatable (Alhassan & Nketiah-Amponsah, 2016; Prytherch et al., 2013). It has been reported that the quality of healthcare received in Ghana is better in the urban areas than in the rural ones (Alhassan & Nketiah-Amponsah, 2016), possibly due to the higher remuneration received by the staff working in the urban centres.

For MHPs deployed in challenging and isolated working areas (with poor facilities), the courage (i.e. motivation) to return there in the future includes supportive supervision that allows the free, open discussion of, and reflection upon, their challenges, distress and concerns, without any fear of consequences (Brodie, 2013). This type of support should allow midwives to discharge their care duties without engaging in disrespect and abuse (Brodie, 2013). In Tamale metropolis in northern Ghana, the midwives complained that motivation was lacking in the profession; for example, the midwives agreed that their salaries were too meagre, their payment was frequently delayed, and they had not witnessed any increment in their salaries for a long time (Banchani & Tenkorang, 2014). As a result, most of them found a second job to supplement their income. Thus, the staff will be very tired due to two jobs and no doubt caring for a family, selling clothes and caring for animals.

2.9.6.6 Compassion fatigue and burnout

There are situations when healthcare professionals appear helpless and angry due to the stress of witnessing traumatic or devastating illnesses or patients' conditions deteriorate, resulting in feelings of guilt or distress (Yoder, 2010). This phenomenon is known as compassion fatigue (Joinson, 1992). MHPs, especially in developing countries where the doctor-patient ratio and midwife-patient ratio could be exacerbating their compassion fatigue, they need extra support (e.g. staff, resources), and should be consulted on how to improve their general working conditions, enabling them to take more control over their own role. In terms of leadership and management, the structure and involvement of the MHPs who actually care for the expectant women should be improved. Other issues worthy of discussion are the ethical stress and vicarious trauma arising from witnessing high levels of mortality and morbidity. A study conducted in seven countries, including Belgium, on the moral distress experienced by nurses indicated that this is mainly associated with difficult care situations and a sense of burnout, which impacted on their professional position (Oh & Gastmans, 2013).

The study of compassion fatigue is not prominent in the African maternal healthcare literature, but widely available on developed countries, such as the USA (Yoder, 2010). Compassion fatigue decreases productivity (Cocker & Joss, 2016). The major drivers of compassion fatigue have been described as the convergence of secondary traumatic stress and cumulative burnout, a state of physical and mental exhaustion caused by a depleted ability to cope with one's everyday environment (Cocker & Joss, 2016). Feelings of anger, stress and exhaustion may be caused by a heavy workload, the environment, the poor infrastructure, and low staffing levels. Such situations may have led to disrespectful or abusive care being provided by some healthcare professionals.

On the other hand, burnout refers to a situation in which an MHP cannot achieve his or her own care goals, which also results in frustration, a sense of loss of control, increased wilful efforts, and diminishing morale (Yoder, 2010). Burnout also includes the expenditure of energy, effort and time on work without adequate time or a suitable environment (including resources) in which to recover physically and emotionally (Filby et al., 2016)). The participants in a study conducted by Kruse et al. (2009) described burnout as feeling overworked, stressed and tired. Midwives were more likely to experience higher levels of burnout if they had low control over the decision-making

and their work pattern, and/or were working at a low grade, and for longer hours (Smith et al., 2009). Both compassion fatigue and burnout are major themes that influence low and unsafe quality of care. However, these are not commonly reported in the African maternal healthcare literature and, therefore, require detailed attention.

To conclude this review of the literature on the barriers to the access to and uptake of maternity care, a few issues have been highlighted. The majority of the research has been conducted on the barriers to women accessing care. Each barrier, however, differs from context to context. What is required is context-specific research to investigate the significance of these barriers and how these work to deter women's access. Research is also needed on the factors that facilitate access (Ganle , 2013).

2.10 Maternity health professionals' experiences of maternity care

Many authors have reported health-care workers' contempt and maltreatment of pregnant women (Aguiar et al., 2013; Moyer et al., 2014). Health workers in Brazil, for example, confirmed the prevalence of the disrespectful treatment of women from pregnancy until delivery (Aguiar et al., 2013). Threats and carelessness, on the other hand, were not seen as acts of abuse towards women, but rather as a way of asserting power over them. In South Africa, however, maternal health workers utilise violence against women to maintain control over them (Jewkes et al., 1998). According to Warren et al. (2017), health professionals' disdain and mistreatment of pregnant women might be either intentional or unintentional. In Nigeria, maternity health experts claimed that they had seen a colleague mistreat women in hospital (Bohren et al., 2017). They indicated that slapping was used to gain compliance and ensure a safe childbirth because women were often recalcitrant and unwilling to cooperate during labour. They believed that women's disobedience could imperil the life of their unborn child, and hence such measures were required. The maternity health experts, on the other hand, stated that they did not plan to mistreat women during childbirth, but that occupational stress occasionally led to such situations (Bohren et al., 2017).

In Ghana, a qualitative study examined the perceptions and experiences of student-midwives regarding disrespect and abuse during childbirth (Rominski et al., 2017). The participants understood the value of respectful maternity care, according to the authors, which involves treating

every woman with dignity, regardless of her capacity to pay her medical bills or her history. During their placement at health facilities, they claimed to have seen their fellow midwives and nurses mistreat and abuse women. The student-midwives believe that, in some cases, it is vital to perform disrespectful acts during childbirth to rescue a mother and her child. Other research has shown that health personnel will go to any lengths to save a mother and child, which is often perceived as disdain and maltreatment. As a result, healthcare providers believe that harsh measures are necessary to compel compliance, particularly from mothers who are recalcitrant during childbirth. Disrespectful methods, such as slapping women, were not seen as dehumanising by health professionals, but rather as a way to save a woman and her child during childbirth (Jewkes et al., 1998; Rominski, 2017; Bohren et al., 2016; Bohren et al., 2017; Warren et al., 2017).

Research in Tanzania highlighted health workers' contempt and maltreatment of women with HIV while displaying their understanding of women's entitlement to confidential care ((Sando et al., 2014)). Women's HIV status has little bearing on the provision of care services, according to their comments. However, a handful of the medical professionals stressed the importance of isolating HIV-positive women. Non-discriminatory treatment was not always the institutional norm, and the maternity health professionals ascribed the shift in practice to the normalisation of HIV, as well as supervision and training on HIV prevention (Sando et al., 2014). Despite several limitations, the study's use of a mixed-method approach (interviews with postpartum women, observations of labour, and in-depth interviews and structured questionnaires with health professionals) is one of its strengths, which may have increased the quality of the findings.

In Nigeria, maternity health practitioners admitted to seeing a colleague mistreat women in health facilities (Bohren et al., 2017). Because the women were generally obstinate and resistant during labour, they saw actions like slapping them as an essential means of gaining their compliance and ensuring a safe delivery. They believed that women's disobedience could imperil the lives of their unborn child, and that hence such measures were required.

Staff demoralisation and bad attitudes towards women are also caused by ineffective staff management (Bowser & Hill, 2010). Nurse-midwives in Tanzania, according to Mselle et al. (2013), have voiced their severe unhappiness about their working conditions, describing a scenario of disempowerment in the form of a lack of supportive supervision and motivation. The majority

of nurse-midwives believe that health and social care professionals, particularly those who are inexperienced or poorly-trained, provide poor quality care during childbirth due to a lack of proper supervision (Mselle et al., 2013). With a lack of competent supervision, health personnel may work at their leisure, resulting in conditions that are disrespectful, such as long wait times, negligence, and abandonment. Furthermore, the maternity health professionals indicated that some of them were forced to work in maternity facilities as a sort of punishment, rather than because of their expertise (Mselle et al., 2013). Effective healthcare professional supervision is especially important in contexts when health professionals are disempowered by the health system.

Finally, with regard to the maternity health professionals' perspectives on disrespect and abuse in facility-based delivery, the methodological issues of the studies, such as the operational definition, the kinds of disrespect and abuse evaluated, research aims, data collection technologies, and study settings, may be inconsistent. Furthermore, the majority of the research focused on maternity health perspectives and experiences during labour and delivery, with little attention paid to postpartum care. Disrespect and abuse have received little attention in Ghana.

2.11 Women’s experiences maternity care

Several authors have recently documented the experiences of women in maternity care institutions. Despite the efforts of stakeholders around the world to enhance maternal health, the data from these researches paint a grim picture. During maternal care, women have experienced a variety of disrespectful and abusive actions and procedures. Women in Debre Markos, Ethiopia (Burrowes et al., 2017) recounted experiencing verbal abuse and non-consenual care during labour and childbirth, physical abuse, discrimination, neglect, abandonment (Warren et al., 2017), with discrimination and verbal abuse being reporter in Iran (Mohammadi et al., 2017).

Women's opinions and experiences of disrespect and abuse in maternity facilities have also been documented in other studies. Warren et al. (2017) discovered that multiparous women in Kenya felt dehumanised when they left alone to give birth, due to their previous maternity experiences. Some of the women, on the other hand, believed that the MHPs' acts were not designed to harm them (Warren et al., 2017). Furthermore, Warren et al. (2017) discovered that women experienced physical abuse during labour (slapping, pushing, and beating) but assigned various interpretations

to the MHPs' acts. Some women, particularly the younger ones, believed that being slapped by MHPs was justified because it ensured their cooperation with and focus on the childbirth process (Warren et al., 2017). It is worth noting that the women in the latter study gave birth either in a health institution or at home, whereas Schroll et al. (2013) included individuals who had previously experienced abuse. The findings may have been influenced by methodological considerations, which limited the extent to which they could be compared to other investigations.

According to d'Oliveira et al. (2002), violence committed against women in health institutions is frequently planned; nevertheless, some scholars have recently suggested that incidents perceived as abusive are not always designed to hurt women (Bruggermann et al., 2012). McMahon et al. (2014) used interviews with women and their partners, community health workers and public opinion leaders to investigate the experiences and responses to disrespectful maternity care and maltreatment during childbirth in Tanzania. All of the participants described experiences of disrespectful care that were similar to Bowser & Hill's current categories of disrespect and abuse (2010). Another noteworthy finding in their study is that the women felt abandoned, ignored, and verbally assaulted during their labour, despite the fact that many of them expressed satisfaction with their experiences. It is likely that many of them were unsure about which occurrences to label as disrespectful or abusive. Furthermore, because the authors included women who had given birth some months prior to the trial, recall bias may have been an issue (McMahon et al., 2014).

Finally, the women's experiences and views of disrespect and abuse in healthcare facilities reveal the existence of disrespect and abuse. Disrespect and abuse have been the subject of numerous studies in Sub-Saharan Africa. On the other hand, very little research has focused on Ghana. This is a gap that the current study attempted to fill. The majority of research has concentrated on labour and delivery in maternity care, ignoring prenatal and postnatal care.

2.12 Conclusion, Research Gaps

Based on the foregoing review of the related literature, maternal death is defined as the death of a woman while pregnant or within 42 days of the termination of her pregnancy, irrespective of the

cause of death (WHO, 2017). Reducing maternal mortality has been at the top of the global health agenda for the last 30 years. However, the burden of maternal mortality in low-income countries remains significant (Ganle et al., 2014). This chapter reviewed and evaluated the empirical research literature related to maternal healthcare access in order to identify the research gaps in the literature and provide a context for addressing such gaps. This concluding section aims to illuminate the specific knowledge and research gaps identified by this review, and the ways in which the research reported in this thesis will aim to contribute towards filling these research gaps.

Arguable, enough is known to inform global action to ensure safe childbirth (Ganle, 2013; Ronsmans et al., 2006). However, this review has highlighted many social, psychological and environmental issues that can also impact on maternal mortality and morbidity. This review highlights the need for further research on these issues, particularly in the rural areas of Ghana where women are more reluctant to access maternity health facilities and more at risk of poor outcomes for both themself and their baby.

Contributing to the maternal healthcare access and barriers debate more broadly, this research aims to make a significant contribution to the empirical research literature on maternal healthcare access. In relation to the empirical research literature, this study focusses on the gap in the literature; namely, the limited research evidence on how demand-side financing interventions impact on the accessing of and barriers to maternity care, and the concomitant call by several researchers for more empirical research on and evaluation of the interventions used to date to generate a better understanding of both their impact and the factors which may operate to undermine them (Ganle, 2013; Witter et al, 2010).

As one of the studies that have attempted to define and investigate the issues related to accessing and the barriers to accessing maternity care in Ghana within the context of the healthcare delivery policy setting using qualitative research methods, this research uniquely contributes to the empirical research literature. As discussed earlier, the Ghanian government has, in recent years, adopted a policy stance aimed at reducing the barriers to accessing and using maternity care services, including the introduction of the free maternal healthcare policy in 2008. Against this background, it is remarkable, as Ganle et al. (2014) and Kyei-Nimako et al. (2016) have observed, that Ghana continues to register a high MMR. Thus, it is imperative for empirical research to be

conducted to understand both the impact of the policy on access decisions as well as the barriers to accessing care. It is unknown how these operate in contexts. This study, therefore, intends to fill this research gap.

Compounding the problem is the near exclusive focus in the existing literature on clinical, and individual factors, neglecting, in the process, disrespectful care, social inequality, and the community and state-level factors that may limit access and affect the rates of service utilization in various ways (Ganle, 2013). Yet, the factors influencing maternity care access and utilization often operate at various levels: individual, household, and community (Ganle, 2013; Yarney, 2019). Arguably, these issues demand more contextual, multilevel, and polyvalent analyses (Babalola & Fatusi, 2009). With a more situated, multilevel examination of the barriers to maternity care access in Ghana, exploring how they interact to slow down the access and use of maternity care offers us an opportunity to produce findings that may respond to this research gap and inform the maternity care strategy and practice.

From a methodological point of view, some researchers have offered critiques on the nature and design of the previous research on access and the barriers to access, as well as the quality of evidence such studies have produced ((Essendi et al., 2011; Parkhurst et al., 2006). For Parkhurst et al. (2006), existing studies that focus on the users of the services have tended to be quantitative surveys, identifying statistical correlations of use, including socio-demographic elements, such as income, education, and age. Important as this type of studies are, they cannot illustrate how decisions are made at a grassroots level, or the key enabling factors behind these decisions (Ganle, 2013). However, Ganle (2013) extends this further, arguing that, to understand the barriers to maternal healthcare services in sub-Saharan African women, many studies have focused on individual, household, community, and health system-level barriers. From these studies, a lot has been learnt. The data used in these studies were collected using quantitative measures that could be said to ignore the direct views and accounts of those who use, or choose not to use, these services (Ganle, 2013).

Commenting on the current research evidence on the use of and barriers to accessing maternity care, Ganle (2013) explicates the problem as follows: there are few qualitative studies of women's views or experiences of maternal and child healthcare in developing countries. In advancing our

knowledge on access and the barriers to access to maternity care in Ghana, therefore, the experiences and views of women and midwives are missing, and it is also critical to pay attention to the local policy practices (Ganle, 2013; Shanker et al, 2008). This present study aims to deploy qualitative methods to address these issues. This literature review has placed these aims in context, and the following chapter will examine the research design and methodology adopted.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the process of the research and how the methodological decisions and choice of data collection tools were made. The chapter also discusses the choice of the study design and feminist approach, research setting, data collection method and ethical considerations. Subsequently, it documents the ethical and institutional approval. The final section presents the recruitment and sampling technique, ethical dilemmas or issues and the method employed for the data analysis.

3.2 Research Paradigm

A research paradigm is an all-encompassing system made up of interconnected practice that explains the nature of an enquiry, based on three fundamental dimensions, namely: epistemology, methodology and method (s) (Denzin & Lincoln, 2008). A researcher's philosophical stance is central to the choice of methodology, since research involves looking for new knowledge (Guba & Lincoln, 1994). The research philosophy is demonstrated based on an individual's 'worldview' which influences the perceptions of the relative importance of reality (Creswell, 2014; Munhall, 1989).The philosophical worldview which underpins this study is constructivist, since it relies on human participants providing their views of the situation which they form, or construct, in their own mind. The study is constructivist, since it will focus on the participants' lived experience (Creswell, 2014; Guba & Lincoln, 1994). These experiences are constructed through interaction with others and through historical and cultural norms (Creswell, 2014; Munhall, 1989). The study, therefore, seeks to understand the subjective experiences of the participants who have experienced delivery in the maternal health care system. However, constructivists make their values explicit, which can be criticised for being subjective and unscientific (Doucet et al., 2010; Stebleton et al., 2012). The researcher's role as a participant and facilitator can influence the findings if they interpret them in line with their own values (Doucet et al., 2010). Further, the focus of a constructivist study emerges through the interactions between the researcher and the participants. Accordingly, this approach to research would not be useful for a researcher who has a

predetermined study focus or research question that is inflexible (Doucet et al., 2010; Stebleton et al., 2012). Further, the tendency to align the methodology with a researcher's own values and experiences makes it essential that the researcher is aware of this and employs reflexivity at all stages of the research process.

3.3 Feminist Perspective

Feminism developed as part of considerable movement that was striving to challenge the traditions, methodologies, and priorities in all aspects of life. The movement "*began a widespread call for a major reassessment of concepts, theories, and methods employed within and across the academic disciplines*" (Hesse-Biber, 2002, p. 57). Hesse-Biber and colleagues contended that, "*research conducted within a feminist framework is attentive to issues of difference, the questioning of social power, resistance to scientific oppression, and a commitment to political activism and social justice*" (Hesse-Biber et al., 2004, p. 3). Many authors have focused on different definitions, views and perspectives of feminist theory.

Feminism can be considered as an ideology and a social movement concerned with gender and improving the lives of those disadvantaged by gender inequality. Wood (1994) argued that feminism means different things to different people, which may account for the many variations that occur, highlighting specific parts of women's lives, which help to distinguish one type of feminism from another. Other authors have defined Feminism as "*a world view that values women and that confronts systematic injustices based on gender*" (Chinn & Wheeler, 1985, p. 74). Using the feminist lens entails one looking at individuals, groups, families, and organisations in their social, political, economic, education, ethnic, and cultural contexts. The connection between these contexts creates the potential for oppression that is rooted in gendered relationships (Lay & Daley, 2007). According to Oakley (1980), childbirth stands uncomfortably at the junction of the two worlds of nature and culture. She asserts in a seminal study that the male domination of childbirth became the 'norm' in the 20th century, particularly within the Western world, with the introduction of men as the doctors leading the medicalisation of childbirth, transforming it from what was traditionally a female-controlled, community-based activity into a male-controlled medical event (Oakley, 1980). She further noted that all of these factors, together with the changes in society,

resulted in birth becoming the outcome of the institution rather than something over which the mother had some control, which could be considered a loss for mothers. Oakley argued that there is disjunction between the medical paradigm of childbearing and women's lived experiences, as women are stuck between medical myths and the social reality. Nonetheless, Oakley viewed the broader cultural context of motherhood and proposed that women might regain control over their own reproduction. Although Oakley's study made a remarkable contribution, it has some limitations. The study failed to include men in their position as fathers, pro feminists, involved in the process of childbirth, medical practitioners and shapers of society. In addition, the study depicts a picture of pessimism and the study period of five post-natal months was short, so a research period that included a full pregnancy might have improved the knowledge gained.

Traditionally, many societies portray women as passive victims of their biological gender, or their own social context; where they are regarded as weaker beings (Alzahrani, 2016). In a seemingly male dominated world, women are often regarded as subordinates (Klocke, 2008). Yet feminists conceptualise these gender issues differently; women have been depicted as seeing no way of voicing their thoughts and feelings within their interpersonal and cultural contexts, as this move into silence protected mothers from what they experienced as a cultural and interpersonal invalidation and dismissal of their feelings (Mauthner, 2002) . The nature of my study is designed to uncover the presence of oppression and its manifestation in the lives of the participants; hence, it relates to feminist social research. Lugones and Spelman (1983) explained that feminist research is a response to the manifestation and institutionalization of male dominance over women in a society where women have been either left out of or subjected to demeaning and disfiguring ways. The system of social structures and practices in which men dominate, oppress and exploit women (Klocke, 2008), is one of the most defining characteristics of feminist ideology. A feminist often argues that women suffer more than men, are poorer than men and are discriminated against in all welfare policies (Ernslie & Hunt, 2008). In the opinion of Hussain and Asad (2012), feminism refers to the assumption and claim that women should have the same rights, powers, and opportunities as men. In past centuries, women were often regarded as weaker vessels compared to the opposite sex (males) by society, hence making them a vulnerable group (Anyalebechi, 2016)). Given these assumptions, feminists argue that women are often not truly represented in studies and are determined to have a distinct methodology of research that they call feminist

(Alzahrani, 2016). Therefore, feminist research focuses on the experiences of women in natural social settings with the aim of making women visible, raising their consciousness and empowering them (Hollway, 2015)

Although proponents of feminist theory claim to have developed specialist research methods and techniques, critics are of the opinion that these methods of research already existed and were well used, so their development had nothing to do with feminism (Hussain & Asad, 2012). It is noteworthy that feminists have long been trying to answer the question of what constitutes feminist social research. In the opinion of Maynard (1994), feminists believe that there is a distinctively feminist mode of enquiry, on the grounds that there are certain characteristics which are claimed to be the main features of feminist research that are distinct from traditional social science research. These include researching women's issues and focusing on gender relations. Maynard (1994) opined that feminist research is carried out by a woman and draws on the experience of women living in a world where they are subordinate to men. However, most scholars do not specify that it must be a woman conducting the research. Klocke (2008) argued that men need to be "menists", supporting women in their feminist work while allowing feminism to work on them, challenging themselves and other men to end patriarchy. The way forward for feminist theory and practice could be a catalyst for liberating both men and women from their restrictive gender roles and the system of patriarchy (Klocke, 2008).

Feminist research has been distinguished from other types of research on four distinct grounds, which include: focusing on gender relations; the validity of personal experience as opposed to the conventional emphasis on scientific methods; rejecting hierarchy in the relationship between the researcher and the researched; and the emancipation of women as the goal of the research (Gelling, 2013). Hammersley (1992) challenged the basis of the feminist methodology and criticized the basic components on which feminists laid their foundation, concluding that the arguments in support of a feminist methodology do not establish it as a coherent, cogent alternative to non-feminist research. He further argued that many ideas on which the feminist methodologists draw are also to be found in the non-feminist literature. However, there is an overwhelming recognition that the feminist approach has brought substantial gains to the development of social research

through the positive and creative production of knowledge and so should not be undermined (Ramazanoglu, 1992).

The main purpose of this thesis is to explore the experiences and expectations of maternity care from women's perspectives. Feminism is considered an appropriate epistemology and methodology to underpin this research. Bloom (1998) asserted that the feminist methodology helps to identify a more personal, reciprocal and interpersonal relationship between the researcher and participant, in which the lives of the women participants are the focus of the research. However, in accounts of the previous experiences of women of male-female interactions, there are always cultural norms concerning the role of men and women, regarding the power differential. In the opinion of Gelling (2013)when dealing with a topic of this nature, researchers should adopt a feminist approach which influences what questions they ask and how they make sense of their data. Bloom (1998) and Reinharz and Davidman (1992) identified many feminist methodologies that could be used to underpin studies of this nature.

Feminism has a view on woman's role in childbearing. Mauthner (1999) suggested that this perception involves a different approach to research through prioritizing and legitimizing women's own accounts and linking women's private lives and public conditions and constraints. Feminism sees women's maternal experiences as much wider than non-feminism and would consider a cultural, gender issue, institutional and societal approach to gender difference as part of the factors that influence their experience. As this study seeks to understand more fully how women experienced their maternal care service and what they expect, these widening factors are helpful. Although the aim of the feminist's approach is to put an end to the oppression of women and attain social equity (Klocke, 2008), the politics of patriarchy have suppressed women's voices and dominated the social discourse and action to the benefit of men and detriment of women. Thus, it may be problematic to be a man in this patriarchal society, as a researcher, interviewing women and struggling to define the male role in feminism (Klocke, 2008). Some feminists have concluded that feminism will not thrive if men are excluded (Banyard, 2010; Bartky, 1998). Schacht and Ewing (1997) and Hebert (2007) argue that men must be included for feminism to achieve the 'critical mass' of supporters necessary to effect widespread social change. Others have also argued that, because men are part of the problem of patriarchy, they must also be part of the solution.

Although men are the principal agents preserving and supporting sexism and sexist oppression, such oppression can only be successfully eradicated if men are compelled to assume responsibility for transforming their consciousness and the consciousness of society (Hooks, 2000). Other feminists campaign for the inclusion of men, arguing that to exclude them contradicts the feminist values of equality and inclusiveness (Falkof, 2007; Schacht et al., 2004)..

3.3.1 Positioning myself

Maher and Tetreault (1993, p. 188) conclude that positionality can refer to "*gender, race, class, and other aspects of our identities as markers of relational positions rather than essential qualities*". In this research, I have adopted this idea of positionality to explore the complex nature of class, gender and ethnicity in the participants' stories, although positionality can also relate to the impact of my own identity on the research process. Banks (1998, p. 4) argues that "*the biographical journeys of researchers greatly influence their values, their research questions, and the knowledge they construct*". Throughout the process of my research, my own positionality has created obstacles within the interview conversation as well as general contact with the Ghanaian women participants in my study. Being a man, married, and from Ghana were all significant elements that informed the interviews, subsequent discourse, and fieldwork. Although I recognise that such a dichotomy can be problematic, the gender perspective I describe here uses an essentialist understanding of the terms "male" and "female" (Berliner & Falen, 2008). Feminist scholars believe that a researcher's gender, ethnicity, and socioeconomic rank have an impact on his or her relationship with the people being studied, as well as the research results (Gilbert, 2008; Maynard, 1994). Gender identity plays a critical role in the research process, according to feminists. This account could be explained by feminists based on the understanding that men and women have different positionality because they experience life differently (Maynard, 1994); thus, a shared gender identity between the researcher and the researched aids the development of a positive rapport in the interview situation. Cross-gender interviews, on the other hand, it is frequently claimed, while they may cause challenges and complications (Finch, 1984), may reveal essential elements that would otherwise go unnoticed in same-gender research (Falen, 2008). It is suggested that gender identity is one of the topics that considerably influences the interactions between a researcher and the researched (Gilbert, 2008); and that gender identity is one of the

issues that greatly influences the interactions between a researcher and the researched (Gilbert, 2008; Kane & Macaulay, 1993). Feminist researchers support this notion; their main focus in methodology is for researchers and the researched to have close, non-hierarchical relationships based on shared identities and experiences (Oakley, 1981). Although feminist scholars acknowledge how race/ethnicity, social class, and culture may impact the research relationship (Finch, 1984; Oakley, 1981), they also acknowledge that these factors may influence the research relationship (Collins, 2002; Phoenix, 1994). Indeed, traditionally, women's research has been dominated by female researchers (Berliner & Falen, 2008). Because of different life experiences and knowledge (Maynard, 1994) and the perceived or actual power differential between male researchers and female participants, this methodological concern of feminist research calls into question the authenticity of research about women conducted by male researchers (Jones, 2018). Aside from the methodological issue, an interview arrangement like this is also politically delicate (Berliner & Falen, 2008). Male researchers are discouraged from conducting research on women because of these reasons and environmental variables (Berliner & Falen, 2008). Gender sensitivities prevented me from discussing some childbearing difficulties connected to their maternity care experiences as a man interviewing female participants in my fieldwork. Because it appeared that the women found it difficult to communicate their feelings and thoughts with me concerning personal parts of their maternity care and birthing, I was limited with regard to what I could ask them about and what they could share with me, at times. As a result, while male academics conducting research on women face challenges and complexities, these challenges can help researchers to gain information that is informed by a holistic understanding of gender, that includes both the male and female perspectives (Falen, 2008). My Ghanaian national and cultural identity, on the other hand, provided certain advantages in my research. Our shared identity allowed the participants to feel that we had a bond, feel more confident about my intentions, and regard me as more trustworthy. It also helped me to gain a better understanding of the ideas and experiences of the Ghanaian women. Furthermore, speaking the same language as the interviewers made it easier for me to connect with them. As a result, my national and cultural identities aided my fieldwork. Furthermore, I learnt from this research that the research subjects might have an impact on the research process if a researcher's identity or positionality is related to, or a part of, the research topic (Takeda, 2013). My positionality as a man undertaking research on women's

experiences of maternity care could be perceived as problematic, undesirable (Kelsky, 2001) negative attributes, that impacted on the interview and impeded the neutrality of my position as a researcher. However, it could also be viewed as positive and desirable as, with a man interviewing women within a male dominated society, the women may have shared their experiences with someone whom they felt might have the power to change things within their society and be able to influence other men. In conclusion, this draws attention to how insiderness and outsiderness are entwined in my research, and how such categorization ignores the complexity of our identity and place in the research process (Takeda, 2013) .

3.4 Qualitative approach and Rationale

Denscombe (2007) characterised qualitative research as a term that consists of many social research approaches. However, it is a field of inquiry that has been adopted in a variety of different disciplines, including education, social science, psychology, history, medical science, anthropology, and organisational studies (Braun & Clarke, 2013). Qualitative inquiry refers to observing, analysing and interpreting attributes, patterns, meanings and characteristics. These characteristics may include face-to-face research conducted in naturalistic settings, with an emphasis on in-depth description and understanding the participants' views or meanings (Braun & Clarke, 2013). Qualitative research comprises an interpretative, naturalistic approach to the world (Denzin & Lincoln, 2005). The qualitative researcher studies things in their natural settings, making sense of phenomena with regards to the meanings that people bring to them (Denzin & Lincoln, 2005). In contrast, the quantitative methodology focuses on an objectivist approach to social science and generally uses experimental methods to control for bias in order to establish objective facts and causes of behaviour (Denscombe, 2007).

Patton (2002) suggests that the research methodology should be selected according to the purpose of the individual research study and therefore qualitative, quantitative and mixed methods (both qualitative and quantitative) can be appropriate for different research projects. In qualitative studies, researchers aim to gather an in-depth understanding of human behaviour and offer explanations that influence behaviour; meaning is constructed in the researcher-participant interaction in the natural environment (Denzin & Lincoln, 2005).

A quantitative approach was declined in favour of qualitative research for this study because quantitative research seeks causal determination, prediction and the generalisation of the findings. The aim of this study is to gain an in-depth understanding of the experiences of maternity care from the women and providers' perspectives. According to the principal investigator, the parts of the studied phenomenon are intricately interconnected and can only be explained by considering the phenomenon in its entirety (Denzin & Lincoln, 2005). Recognizing the political, social, and cultural context in which maternal health care is delivered, it was deemed that a holistic approach to the design of the study was the most appropriate methodology to adopt in order to understand and gain an in-depth perspective from the perspectives of women and health providers.

When investigating complex social or human phenomena that cannot be reduced to isolated variables, a qualitative design is appropriate (Denzin & Lincoln, 2005). The holistic approach aligns with qualitative methodology and seeks to gain a better understanding of individuals or events in their social context (Denzin & Lincoln, 2005). The significance of the individual experience according to the philosophy and characteristics of qualitative research in order to make sense of and interpret phenomena in terms of the meanings people give them within their social context (Denzin & Lincoln, 2005). Because little research has been conducted on the perceptions and experiences of maternity care professionals and mothers about the quality of maternity care services in the Tema Metropolitan District (TMD) in the Greater Accra Region, a qualitative research methodology was the most appropriate choice for this study.

3.5 Research Setting

3.5.1 Profile of Ghana

The study was conducted in West Africa, specifically Ghana (see Appendix 3). Ghana is situated about 750 km north of the equator on the Gulf of Guinea with a total land area of 238,305 square kilometres. Ghana is bordered on the south by the Gulf of Guinea, to the north by Burkina Faso, to the west by Cote D'Ivoire (Ivory Coast) and to the east by Togo. Administratively, the country is divided into 16 regions with 216 districts, with an estimated total population of 28.8 million (United Nations Department of Economic and Social Affairs. Population Division, 2017). Ghana

is in the category of lower-middle-income countries) (Schieber et al., 2012). There are however significant variations between the sexes, regions, urban-rural areas, and districts. Ghana is a multicultural, multi-ethnic, multi-religious, and multi-party constitutional democracy, characterised by civil society (Ganle, 2013).

Nationally, the number of deliveries of babies in clinical facilities increased from 54% in 2007 to 79% in 2017 whilst, during the same period, the number of home births decreased from 45% to 20% (Ghana Statistical Service, 2018). While this shows a significant improvement in facility-based deliveries, however, still 20% of babies were delivered at home. The reasons could be lack of access in terms of (transportation, cost), a preference for home birth, a lower perceived need for institutional childbirth and perceived poor quality and uncaring care from maternity care providers in healthcare facilities (Ghana Statistical Service, 2018).

Ghana is situated within a marginalised economy and a politically unstable region of West Africa. The maternal mortality rate has remained persistently high. Available studies show that Ghana was unable to achieve the MDG5 target, which is now SDGS target 3, despite the implementation of the free maternity care intervention policy (Schieber et al., 2012).

3.5.2 Organisation of Ghana's health care system

Ghana's healthcare system is organised and supervised by the Ministry of Health (see Table 3.1). At the national level, the Ministry of Health is responsible for policy direction and facilitates the implementation of policies by all agencies. In addition, the Ministry aims to improve the health for all people living in Ghana through effective and efficient policy formulation, appropriate resource mobilisation, and the monitoring and regulation of the delivery of health care by different health agencies (Dery, 2017). These agencies are: the Ghana Health Services, Christian Health Association of Ghana, National Health Insurance Authority, Mental Health Authority, National Ambulance Service, National Blood Service, and the teaching hospitals, universities, research institutions, etc (Dery, 2017).

The Ghana Health Service is the implementing body responsible for the delivery of primary and secondary care services in Ghana, including monitoring and evaluation. Health services delivery

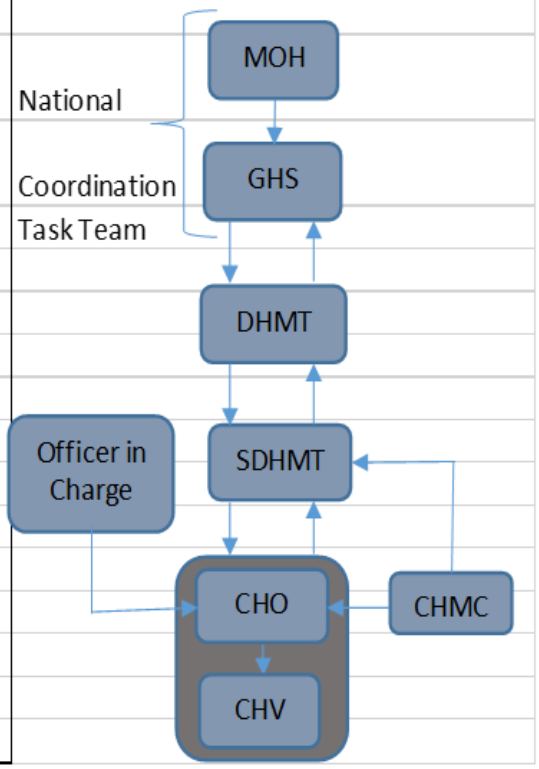
in Ghana consists of the Community-based Health Planning and Services zones, sub-district, district, regional and the national levels. At the community level (level A), the Community-based Health Planning and Services provide primary health with the support of the community leaders and community participation (Community Health Service Country Profile, 2017; Dery, 2017). The sub-district level (level B) is made up of health centres, health posts and clinics.

The district level (level C), is responsible for planning, organising, and programme development, and supervises and coordinates the activities of the sub-districts, with a district hospital acting as the first referral point for all of the sub-districts. The district level is made up of both private and public health service providers. Both the district and sub-district level provide basic maternal health care (e.g. antenatal, delivery and postnatal care) (Dery, 2017). The activities of the districts are also coordinated and supervised by the Regional Health Administration and the regional hospital acts as the secondary level and the referral point that supports the districts. At the national level, the teaching hospitals, psychiatric hospitals and other tertiary level facilities act as referral centres (Dery, 2017).

Over the last two decades, the health sector has undergone various reforms and interventions to address the overwhelming challenges facing the health sector (Kyei-Nimako et al., 2016; Dery, 2017). Significantly, these reforms and interventions aimed to improve equity of access to quality maternal health care services. This includes the primary, secondary and tertiary levels and encouraging private sector participation and inter-sectoral collaboration (Dery, 2017). In spite of this progress, the health sector continues to face challenges related to access to quality maternal health care services, with poor outcomes across the geographical locations (Dery, 2017) in terms of the doctor to population ratio (1:8481), midwives to Women in Fertile Age ratio (1:1374), nurse-population ratio (1:542) (Nsiah-Asare, 2017). Notably, Ghana's maternal and child mortality rates remain unacceptably high; this may be due to the fact that the past reforms and interventions having not yet yielded the anticipated outcomes.

Table 3.1: Structure of Ghana's health delivery system

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships*
	MOH		
National	GHS	Specialized Hospitals	National
	National Coordinating Task Team		Coordination Task Team
Level C (District)	DHMT	District Hospitals	
	SDHMT		
Level B (Sub-District)	Health Center	Health Centre	
	Officer in Charge		
	CHMC	CHPS	
Level A (Community)	CHO	Compound/CHO	
		CHV	



MOH- Ministry of Health

GHS-Ghana Health Service

DHMT- District Health Management Team

SDMT- Sub-District Health Management Team

CHPS-Community Health Planning Services

CHV- Community Health volunteer

CHMC- Community Health Management Committee

CHO- Community Health Office

Source: (Egan et al., 2017)

3.5.3 Justification for Choice of the Tema Metropolitan District in Ghana

Ghana was chosen as the study site because the researcher comes from Ghana; hence, familiarity with the research setting, and context influenced the choice. Also, as a manager in the health service, the need for the research was apparent. Familiarity is important since it ensures easy access to data and the data collection processes as well as the smooth negotiation and resolution of certain

ethical dilemmas that may emerge during the research (Ganle, 2013). In addition, in order to explore the needs of women and the maternity health professionals in this area, it is essential for the researcher to have a detailed knowledge of the country, cultural, organisation of the services, and language in order to analyze the data and apply the findings to the local setting. The study was conducted in the Tema Metropolitan District in the Greater Accra Region of Ghana (See Appendix 3). Greater Accra Region is located in the south-eastern part of Ghana, along the Gulf of Guinea. Tema Metropolitan District is a coastal district located 30 kilometres east of the national capital, which is Accra.

3.5.4 Research Participants

The study population consists of two groups; namely, women who recently gave birth in a public health facility, and maternity professionals (midwives and doctors). For the purpose of this study and simplicity, midwives and doctors are referred to as maternity health professionals (MHP) in the study. Women who have 'recently delivered' refers to mothers who have given birth in the health facility within the last twelve months, since the experience will be fresh in their mind. In the Ghanaian community, the wealthier you are, the less likely you are to access a public health facility. The scope of my study was to recruit women who attended the public hospital in Tema municipality, as these women were generally poorer and thus more likely to have less autonomy and negative birth outcomes. I wanted to give these women a voice and find out about their experiences. Including the wealthier women in the area who attended private health facilities or women who attended other services for birth such as Traditional Birth Attendants or herbalists/spiritualists was not within the scope of my study, as a lone researcher. I recruited women who accessed the public hospital at a certain point in time, as a window onto what the women were feeling and experiencing, to give me an insight into why some women fail to attend the hospital for antenatal care, to give birth, or both. Women who access the public health facility are generally from poorer backgrounds and are potentially more vulnerable, with less financial support, being dependent on their husband or family to pay for their transport and medicine and offer guidance and advice about where to access maternity care and other social/cultural and spiritual support. These women are often marginalized and lack opportunities to share their thoughts and feelings. This study intended to give these women a voice in order to inform policy

makers about what may help to improve their attendance and the quality of maternity care in public health facilities. An additional key aspect of this study was to explore the role that poverty plays in how women access and achieve maternity care. This study aimed to identify the needs of these women by listening to their narratives, thus giving them a voice that was previously unheard or ignored.

3.6 Recruitment and Sampling

In this research, a purposive sampling technique is used to ensure that the participants had experience of the phenomenon of giving birth in government facilities, against the backdrop of poverty being studied (Creswell & Poth, 2016). In terms of MHPs, this was purposive selection, based on the participant's role in the institution, the knowledge of the area of study and the researcher's evaluation and perception of the relevance of that role and knowledge to the research topic (Kumekpor, 2002) whilst, for the women, the strategy for the sampling and recruiting was a combination of purposive and snowball sampling techniques. Snowball sampling is a type of purposive sampling, where the researcher recruits a participant based on their eligibility to partake in the study, and the participant then recommends other prospective participants that meet the inclusion and exclusion criteria of the study (Denscombe, 2007). The limitation of this approach is that it may be subject to bias; that is, participants with many friends are more likely to be selected and possibly likeminded about their choice of maternity care and place to give birth (Bowling, 1997).

Another issue was how to access the mothers in the study communities. This resulted from the fact that the researcher had contact networks in the communities. The researcher discussed with the elders of the community, who recommended him to the chief and the assembly woman who represent the people in the local government and constitute the gatekeepers of the community, being highly respected and vested with authority. Gatekeepers can positively influence the research process by facilitating the smooth running of research activity to completion (McFadyen & Rankin, 2016), whilst acknowledging that gatekeepers can be problematic for researchers, as they have the power to limit or restrict access to sites (McFadyen & Rankin, 2016). The researcher contacted the chief and the assembly woman who represented the local people in the community,

introducing the purpose of the research, and asking for permission to conduct the research in the Ashaiman Tema community. After the chief and the assembly woman had agreed, visits were made to the women in the Tema community. Women were recruited from Ashaiman in the Tema geographical area; an area characterised by poverty, poor housing and overcrowding.

The researcher introduced the research and the purpose of the research to the mothers. There was a brief presentation (20 minutes) about the project to the women in a Ashiaman community in Tema metropolitan. This presentation was for potential participants who had used Tema general hospital and wished to participate. The researcher approached the women and verbally informed them of the study's goal and pertinent ethical considerations, after which their participation was solicited. The participant information sheet (Appendix 4) was given to the participants to help them to understand the goal of the study and allow them to ask questions. All eligible participants were given a consent form (Appendix 6) to sign as proof of their agreement. The researcher and the women agreed on a date, time, and location for the face-to-face interview session after consulting with each participant. The researcher also addressed any participant queries or concerns. However, some potential participants were identified through the assistance of the nurses in the hospital. The interviews took place at the mothers' home and the hospital, based on the participant's preference and convenience. Before each interview, the researcher double-checked that all of the participants had signed and returned the consent form. To make the participants feel more at ease about sharing their experiences, the interview method was described. According to Descombe (2007), creating a comfortable environment assists the researcher to develop a good relationship with the participants, allowing for a more in-depth revelation of their experiences.

The majority of the target population speak Twi as their main language. I acknowledge that many languages are spoken in Ghana, and the Tema municipality lies within the Greater Accra Region, which is cosmopolitan in nature. The region houses people from diverse social and cultural backgrounds throughout the country (Yarney, 2019). I considered the language issue but, after careful investigation of the area and discussion with the community leaders and health professionals, I found that the women and staff communicated commonly in Twi. As I also speak Twi, it seemed sensible to use this language to ensure that I captured not only their words but also the meaning of their responses effectively.

3.6.1 Inclusion Criteria

The inclusion criteria for the mothers taking part in the study were:

- Women who have delivered in the public health facility within the previous twelve months in the Tema metropolitan
- Mothers who were living in the catchment area of the study.
- Women aged eighteen to forty-nine years who gave birth at home were excluded.
- Mothers who were able to speak in English or Twi fluently.

For the health care providers:

- Maternity care professionals such as midwives and doctors from health facilities, who have worked in this role for a minimum of five years.
- Health professionals who were fluent in English.

Exclusion Criteria

The exclusion criteria:

For the mothers

- Mothers who were under the age of eighteen because minors need the consent of their parents
- Women who gave birth at home.
- Unable to speak English or Twi.

For Healthcare providers:

- Health professionals not working in the catchment area.

- Health professionals who had had less than five years' experience.

3.7 Sample Size

In the methodological literature, there is an argument concerning sampling and sample sizes in qualitative research (Denscombe, 2007). A sample should be neither too small nor too large, since the size depends on the purpose of the research (Sandelowski, 1995). Further, the researcher decides when to stop collecting information (Morse, 1991). Braun and Clarke (2013) suggests that the most appropriate sample size is achieved through decision and experience, considering the purpose and scope of the study, the quality of the data to be collected, the study design, and the availability of resources. This study aimed to interview ten maternity professionals (midwives and doctors) and twenty new mothers. Originally, forty new mothers consented to participate in the study. However, some of the interviews were not useful because they did not generate sufficient data. When considering saturation, I could only use the ones with sufficient data.

It was anticipated that this would generate the required data to address the study's research objectives and questions, although it was also acknowledged that there would need to be some flexibility in terms of increasing or decreasing the numbers according to the needs of the study. However, the appropriate sample size in this study is thirty (ten maternity health professionals and 20 new mothers), considering the aim of the study.

The preliminary analysis occured concomitantly with the ongoing data gathering and allowed the further exploration of different thoughts in the subsequent interviews. This method continued until data saturation was reached. Data saturation can be described as information redundancy (Lincoln and Guba 1985), the point at which no new information, codes or themes emerge from the data, at which point the data are said to be saturated (Braun & Clarke, 2021). In my situation, data saturation was reached in the study, where no new information was gathered regarding the women's maternity care experiences, acknowledging that this area of inquiry was no longer explored after interview 15. The researcher ensured that the saturation point was reached while in the field before the data collection ended.

3.8 Methods of Data Collection

The major source of data in qualitative research is captured through in-depth conversations in which the researcher guides the informant to describe freely his or her understanding or perceptions, without leading the conversation (Patton, 2002). In this study, semi-structured interviews were considered the most appropriate tool for collecting the data (Green & Thorogood, 2018). One-to-one, semi-structured interviews were used since they have the potential to uncover the interviewee's perspective on the topic. Green and Thorogood (2018) defines semi-structured interviews as aiming to find out what is in someone else's mind. The process of one-to-one interviews enables the researcher to engage with the data actively, identifying and analysing the issues that emerge (Patton, 2002). Therefore, a data collection method that would allow relevant issues to become evident from the participants' stories was required. This approach offered the flexibility to establish and explore new issues in greater depth, based on the mothers and health professionals' perceptions and experiences about the quality of maternity care. Undertaking semi-structured interviews requires using an interview guide with probes that cover all of the research objectives (Green & Thorogood, 2018). (See Appendices 7 and 8). This type of interview enables the collection of in-depth, rich data, thus providing opportunities to uncover personal perspectives and viewpoints (Braun & Clarke, 2013).

Interviewing, in the opinion of Brewer (2010), is an approach where information about people's way of life, thinking and the way in which their lives are affected by something can be effectively generated. The purpose is to discover the respondents' feelings, perceptions and thoughts (Brewer, 2010), which is fundamental to the research aim. An interview guide was used to ensure that the interview stayed on track, but to allow some flexibility for both the researcher and the participant.

The semi-structured interview approach was chosen in order to provide more flexibility for both the participant and the researcher (Braun & Clarke, 2013). This enabled the participants to lead the discussion when they wished to and build an argument around their understanding of the issues and events, as well as enabling the researcher to explore unexpected issues as they arose without leading the discussion. Other qualitative methods, such as focus groups, were discounted because the experiences being explored could be considered as very sensitive and personal. Mothers may

be less likely to share their experience with others (D'Ambruoso et al., 2005). Also, health professionals may be less likely to share their experiences with other health professionals or lower ranking staff due to the sensitive nature of the topic. Therefore, the sharing and exploring of sensitive topics was more suited to an individual, rather than a group setting, as the participants may be unwilling to discuss such issues in a group.

Semi-structured interviews were used to conduct this study, whilst acknowledging that interviews consume both time and financial resources (Patton, 2002). In order to allow for this, plenty of time was arranged for each interview and they were audio recorded to ensure the accuracy of all of the data collected. Each interview took place within the communities of the interviewees at a convenient place, based on the participant's preference. Each interview lasted approximately 30-60 minutes, as recommended by DiCicco-Bloom and Crabtree (2006). The researcher conducted the interviews with new mothers with the assistance of a female chaperone who observed the interviews. The chaperone was recruited by the researcher to help him to coordinate and conduct the interviews. She was locally recruited from the community, based on her secondary school certificate, fluency in English and the local language, and familiarity with the research participants. Her presence was to protect, comfort and assist the mothers being interviewed by the researcher, whilst also providing a source of legal protection for the researcher in case of sexually harassment or being accused falsely by the participants (Anyanwu et al., 2013). The partners of the mothers may also have been more accepting of a man who was accompanied by a chaperone. Despite the significant strengths of the use of chaperones, Anyanwu et al. (2013) argued that some participants may object to the presence of a third party when being interviewed by a researcher, as this may create a barrier to expressing themselves freely, and their confidentiality is compromised (Anyanwu et al., 2013), even if the female chaperone signs a confidentiality agreement (see appendix 12). This scenario did not occur during the interviews as all of the mothers were accommodating and willing to be interviewed, even in the presence of a chaperone.

The instrument used focused primarily on exploring the health professionals and women's experiences about the quality of maternity care, their interaction with the services, and the barriers to accessing and using the services. Prior to the commencement of the data collection, the research tool was pre-tested on both the health professionals and the mothers. The researcher engaged in a

constant review of the questions and the interview process to ensure that they were trustworthy and were eliciting the right answers to the right objectives (Ganle, 2013)

3.9 Ethical Considerations

Researchers working with human participants must obtain ethical approval from the relevant School Ethics Committee before they begin their research. The University's Research Ethics Committee aims to ensure that all research involving human subjects, and/or their data is conducted in such a way as to minimise the risk to both the participants and researchers, and that best practice is followed at all times. In accordance with the University's Ethics Committee, the ethical procedures followed for this study were discussed with the supervisory team before an ethics application was submitted. A research ethics application form was completed and approved by my supervisors prior to its submission to the relevant ethics committee. Subsequently, ethics approval was granted on the 17TH October 2017 (HSR1617-174).

3.9.1 Informed Participant Consent

Informed consent is an ethical and legal requirement for research that involves human participants. The informed consent of each participant is also a necessary condition for conducting any research, and a signed consent form should be obtained from each participant before he or she takes part in a study. In this research, each individual participant was asked to sign a consent form (Appendix 6: consent form for both the women and MHPs). The participants were approached by the researcher to obtain their consent to participate in the study, after which they were required to sign a written consent form prior to the interview. Consent was also sought to take notes and audiotape the interviews. The participants were assured that their non-participation or withdrawal from the study at any stage without giving an explanation would not incur any negative consequences and would not affect their role/job (in the case of MHPs) or treatment (in the case of the women). The respondents were provided with a Participant Information Sheet in advance (see Appendices 4 and 5 for both the women and MHPs, respectively), which contained detailed information about the study and so enabled the participants to make an informed decision. They were then allowed up to 24 hours to decide if they wished to participants in the study or not. To ensure that the women who

could not read and write understood the study, the Participant Information Sheet and consent form (see Appendices 4 and 6) were read to the participant in the local language (Twi), after which they were required to give their consent by a thump print.

3.9.2 Anonymity and Confidentiality

Confidentiality is based on the fundamental principle of respect for anonymity (Denzin & Lincoln, 2011). In this study, the information sheet addressed issues of anonymity and confidentiality. As noted above, this was carefully read out to the women participants, in the relevant language (Twi). It was acknowledged that the data collected would only be used for the purpose of this study, hence complying with the Data Protection Act (2018) (Spencer & Patel, 2019). The participants' identity was kept confidential by the researcher and the research supervisors. The interviews took place at the convenience of the participants' homes and offices. Only myself and my research supervisors had access to the taped/digitally recorded information, that was stored using codes rather than names, to maintain confidentiality. The audio tapes and digital files were coded by numbers and listed. The list was stored with the participant's name in a locked drawer in the University office to maintain confidentiality. The participants were assured that, within the thesis and any subsequent publications, they would be referred to using pseudonyms (Braun & Clarke, 2013). As agreed in my approved ethics proposal, I adhered to these procedures in order to maintain the confidentiality of those who participated in the study

3.9.3 Protecting participants: addressing risks and discomfort

In this study, the risks, potential hazards or adverse effects to the participants were considered. The participants may have felt uncomfortable about revealing their personal experiences about maternity care. In order to explore these issues in further depth, it was important to highlight to the participants that they would remain anonymous within the study report as they might be reluctant to speak out, due to a fear of reprisals. The participants were informed that, if they had any distressing experiences during the discussion, they could access free support from the psychology department of the hospital. Further, the participants were informed that their confidentiality and anonymity would be maintained within the findings reported to the local

maternity service leaders/managers of the Ministry of Health and the Ghana Health Service. All of the participants were informed that any accounts regarding serious malpractice or serious criminal activity, such as theft, bribery or maltreatment by the staff, would have to be reported to the hospital's senior management team or the authorities. However, since the purpose of this research was to gain in-depth experiences of maternity care, it was essential to give the participants the opportunity to recount their maternity care experiences in a safe, confidential environment.

Additionally, as it was anticipated that the interviews might cause psychological distress to the participants due to the nature of the study's topic, the researcher was prepared to signpost them on how to obtain support from the other healthcare professionals from the Psychology Unit of the health facility (e.g., counselling), if needed. There were no potential risks or harm identified during the interview process for this study.

3.9.4 Approval to conduct interviews with Maternity health professionals

Research committees need to satisfy themselves that the subjects involved in, or affected by, the study will not be harmed, and that all of the participants are treated fairly. The research proposal to conduct interviews for this research were submitted to, and approved by, the Post-Graduate Research Ethics Panel for the Schools of Health and Society and Health Sciences of the University of Salford (HSR1617-174) (see Appendix 9). After gaining the University of Salford Research Ethics Committee approval, the Medical Director of the Tema General Hospital was approached to gain permission and approval so that the research could be conducted within the hospital as part of the study. This official permission was obtained after the researcher wrote formally (see appendix 8) to the Medical Director of the Tema General Hospital, introducing himself and the research and requesting permission to interview specific health professionals. Following this request, approval letters were given to the researcher to conduct the interviews at Tema General Hospital (see appendix 10). The invitations to participate were sent by hand, through notices on boards within the departments of Tema General Hospital. The maternity health professionals were given written information about the study, including: an Information Sheet (Appendix 5) on the aims and scope of the project, and a Consent Form (Appendix 6). For all of the potential participants who wished to participate, a date and time were arranged for them to take part in the

face-to-face interviews. The most convenient place for the interview to take place was agreed in their offices and the training unit of the hospital.

3.9.5 Method of Analysis

The thematic analysis approach proposed by Braun and Clarke (2006) was used for this study, which aims to interpret/analyse complex textual qualitative data (Braun & Clarke, 2013). Thematic analysis is the most commonly used approach in qualitative research; it has been noted to be the most useful tool for capturing the complexities of meaning within textual data, as it provides a framework for identifying, analysing and reporting patterns in data (Braun & Clarke, 2006; Braun & Clarke, 2013). The strength of thematic analysis is that it is not bound to one theoretical position as is interpretive phenomenological analysis or grounded theory (Braun & Clarke, 2013). Therefore, it is argued that it has the flexibility to provide a detailed, yet complex account of data, as required for qualitative research. However, an approach without a clear framework for analysis would undermine the rigour of the research (Braun & Clarke, 2006). The use of thematic analysis is congruent with the values and assumptions of the constructivist paradigm, which underpins this study.

Speziale et al. (2011) identify theoretical flexibility and demonstrate how it can be applied within various paradigms of qualitative data analysis, further identifying thematic analysis as a foundational form of data analysis which can be applied when analysing complex qualitative data. This approach begins with coding, and progresses from a basic description to identifying patterns, organising the findings and interpreting the data. Holloway & Todres (2003) argue that thematic analysis has been historically considered an approach that can be applied in different analytical traditions rather than being a specific approach. However, Braun & Clarke (2013) contend that it is now universally considered a method in itself (Braun & Clarke, 2013). Like other qualitative approaches, such as grounded theory, thematic analysis requires the researcher to be involved in establishing an in-depth interpretation of the data (Holloway & Todres, 2003).

Thematic analysis focuses on identifying and describing both implicit and explicit ideas within the data as themes and goes beyond counting explicit words or phrases (Braun & Clarke, 2013). Consequently, codes are normally developed to represent the identified themes and linked to the

raw data, which are then marked for analysis as times passes. The strength and flexibility of thematic analysis makes it a useful research tool that can yield a rich, complex analysis of the data through its theoretical freedom and, following the coding of the text, themes can be generated through abstraction (Braun & Clarke, 2013). A theme provides insights and interpretation into the patterns found in data, information or phenomena (Braun & Clarke, 2006; Braun & Clarke, 2013).

A theme can also be used to represent or capture important issues about different concepts that can provide meaning to the data set (Braun & Clarke, 2013). A theme may be derived directly from the manifest or latent level. At the latent level, a higher level of abstraction can be used to represent a phenomenon (Braun & Clarke, 2013). A theme can be inductively generated from the raw data or deductively from an existing theory (Braun & Clarke, 2013). The most important point, however, is that a theme is used to capture relevant aspects of the data set in relation to the research question under investigation (Braun & Clarke, 2013). In this study, the themes were inductively generated from the raw data set (the experiences of mothers and health care professionals) and deductively from the prior existing theory (see section 3.8).

Thematic data analysis in this study considered the following steps, as proposed by Braun & Clarke (2006); familiarization with the data set and transcribing interview data, generating the initial codes, searching for themes, reviewing themes, naming/renaming the themes and presenting and reporting the findings (Alhojailan, 2012; Maguire & Delahunt, 2017). Other authors, such as Nowell et al. (2017) and King (2004), agree with the six steps of Braun & Clarke (see Table 3.1). Arguably, it is the most influential approach in the social sciences, its theoretical freedom and probably offers a clear, usable framework for conducting thematic analysis (Nowell et al., 2017). Although the theoretical freedom provides a flexible approach, it can be modified to suit the needs of many projects, providing a rich, detailed, yet complex account of the data (Braun & Clarke, 2013; Braun & Clarke, 2006; King, 2004). Despite this significant strength, flexibility can lead to inconsistency and a lack of coherence when developing themes derived from the research data (Holloway & Todres, 2003; Nowell et al., 2017). Consistency and cohesion can be promoted by applying and making explicit an epistemological position that can coherently underpin the study's empirical claims (Holloway & Todres, 2003).

3.9.6 Analysis of interview data

The recorded interview data were transcribed, examined and interpreted using thematic analysis. Thematic analysis is commonly used in qualitative research but may take many different forms (Alhojian, 2012; Maguire & Delahunt, 2017). The process of Braun and Clarke (2006) was applied flexibly to this study's research questions. The process started during the early phase of the data collection by actively looking for issues related to the research questions in the data, thinking about the patterns of meaning, and reflecting on the experience of collecting the data (interviews). The endpoint of this analysis process was the reporting of the final themes. The analysis phase involved an iterative process of constantly moving back and forth between the data set of the analysis, data items and the coded extracts of data.

Table 3.2: Thematic Data Analysis Process

	Phase	Description
1	Familiarisation with the data.	Transcribing if necessary, reading and re-reading the data and noting initial ideas and comments.
2	Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3	Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4	Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5	Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6	Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Source: Braun and Clarke (2006, p. 87).

1. Familiarisation with the data

Familiarisation with the data began during the initial stages of the field exercise and continued through storing the audio recordings of the interviews and transcription process. The data collection exercise was conducted by the researcher, as it is vital that researchers immerse themselves in the data to familiarise themselves with the depth and breadth of the content (Braun & Clarke, 2006; Braun and Clarke, 2013; Nowell et al., 2017). The investigator had a notepad in which the initial ideas and key themes emerging from the interviews were noted to ease the initial coding and also clarify the entire data set.

This process continued with the transcription of the verbal data (in both English and Twi) from the audio-recorded interviews – accounting for all verbal and non-verbal utterances, as well as adding appropriate punctuation in order to retain the information from the verbal account (Attride-Stirling 2001; Braun & Clarke, 2013). The researcher needed to think about the theory and find a suitable method. The principles of analysis are the same regardless of the category used: data collection;

transcription of data; reading and understanding the data; developing a data coding system; and linking codes to form overarching themes or categories in order to produce an interpretation or conclusion (Carter, 2004). Attride-Sterling Thematic Network Analysis and thematic analysis may share some similarities, being a similar to the six steps approach but incorporating thematic networks able to incorporate different levels of themes from basic (in text) to sub-ordinate and main themes using the thematic networks in text to illustrate this development and analysis. Arguably, thematic analysis is the most influential approach in the social sciences and healthcare research. In healthcare research thematic analysis are widely employed to provide a comprehensive understanding of patient's experience. Although, Attride-Sterling Thematic Network Analysis are used in healthcare projects.

For analytical method, the Attride-Stirling Thematic Network Analysis shares many similarities with the well-known grounded theory method, but its theoretical basis is based on Toulmin's (1958) argumentation theory. Toulmin (1958) argues that argumentation theory seeks to provide such a structured method to analyse negotiated settlement processes. It explores the connections between explicit statements and implicit meanings in people's discourse by defining and elaborating the typical, formal elements of arguments (Attride-Stirling, 2001). Whiles with Thematic analysis is theoretically flexible because it permits the search for and identification of patterns without necessarily subscribing to or adhering to a particular framework (Braun and Clarke, 2006). This implies that thematic analysis can be utilised within a variety of theoretical frameworks, such as constructivism and realism.

It provides the interview transcripts with a coherent structure (Braun & Clarke, 2006).This yields meaningful themes and a deep understanding of complex phenomena. This allows the researcher to demonstrate data interpretation and illustrate findings with interview quotes (Rice & Ezzy, 1999). It has been criticised that there is a lack of transparency in the thematic analysis process. This is due to the fact that studies do not always demonstrate how themes relate to the original data; rather, studies report that themes emerged (Braun & Clarke, 2006). Thematic analysis presented a method of analysis that was not tied to a specific theoretical perspective, and it could be applied to a variety of theoretical frameworks, it was deemed advantageous (Robson, 2011). As a novice researcher, it provided a method for organising the huge amount of data collected by

examining the data and coding to determine how frequently they occurred. I chose Thematic Analysis because of its theoretical freedom which provides a flexible approach, it can be modified to suit the needs of many projects, providing a rich, detailed, yet complex account of the data. In addition, enabling the researcher to explore issues across different demographics, including health professionals and women from differing backgrounds and situations. Able to explore individual issues within the wider context of maternity care, explore for serendipity, develop innovative ideas and apply these to practice. Which the Attride-Sterling Thematic Network Analysis could not have offered me as a novice researcher that theoretical flexibility approach.

Thematic Analysis provides a toolkit for researchers who wish to do rigorous and even advanced analyses of qualitative data, while focusing and presenting them in a manner that is readily accessible to non-academic groups. And, as a qualitative analytic approach that is very simple to acquire and does not require substantial theoretical commitments, it works well for research teams in which some members are more qualitatively experienced than others. In the end, the choice of analytic approach will depend on a multitude of factors, such as the topic of the research, the research question, who conducts the research, their research experience, the intended audience(s), the theoretical location(s) of the research, the research context, and many others. Some of them are somewhat fluid, while others are more rigid. We ultimately argue for a deliberate, reflective, and exhaustive approach to qualitative research. TA provides a tool that can serve these functions well, but not all functions. It can be utilised extensively for health and well-being studies, but it must also be employed prudently.

Before transcribing the interviews, the researcher took the time to listen to each voice file in turn. This was followed by the formal transcription of the voice notes into text. The transcription was done verbatim into English, taking care not to miss a word. For the interviews in Twi, a sample were checked by an independent translator then the transcripts were compared by listening to the audio again. The researcher agreed with the way that the other translator did the translations, as this was almost the same. In total, 19 transcripts were in Twi, which were translated straight into English from the audio in Twi due to the inability of the researcher to write in Twi. The independent translator checked a sample to ensure that the translation into English was accurate and that the original meaning was preserved as far as possible.

As part of the initial phase of familiarisation with the data, the text transcriptions were read meticulously and examined against the voice recording to ensure the accuracy of the texts. The entire text data were read three times for each interview. On the second reading, the researcher began taking notes and drafting inception ideas for the coding.

2. Generating initial codes

All of the transcribed interviews were uploaded to NVivo 11 qualitative data analysis software for coding. NVivo helps researchers to manage and organise data and facilitates the analysis of data, identification of themes, gleaning of insights and development of conclusions (Denscombe, 2007). Critically, NVivo requires the researcher to code the data and develop the themes or categories. Therefore, it is argued that the data analysis is principally subjective (an underlying philosophy of the constructivist paradigm) and allows the researcher to engage more meaningfully in the analysis process (Sotiriadou et al., 2014). Sotiriadou et al. (2014) stipulated that, because software such as NVivo 11 requires the researcher to derive the list of codes and rules for attaching these to the data, there is a lot of bias involved. The initial coding performed during the introductory stages of the familiarisation informed the direction of the subsequent coding. The codes were arranged under the various research objectives to ensure the generation of coherent themes that emerged under the respective objective areas. The coding entailed the listing of interesting ideas and topics in the data that the researcher identified as relevant elements that could be examined in a meaningful way under the various objective areas. When relevant data were identified, I highlighted the text, then dragged and dropped the highlighted text into parent nodes created in NVivo. The coded text quotes were described briefly by their meaningful arrangement into segments (Tuckett, 2005) based on the research questions of the study. All of the text in the actual data extracts were considered in the initial coding, and different nodes were used to designate potential patterns in the data. The coding was performed by taking all of the individual transcripts into consideration and going through the entire text transcriptions for each interview. It was an important step, leading to the theme generation; hence, optimal time and attention were dedicated to this stage. All of the data from the various interviews were coded and collated to begin the theme identification or assignation.

3. Searching for themes

At this phase, the collated codes were carefully examined and sorted into potential themes. This was combined with identifying the major theme categories and sub-themes that fit into the major themes for each research objectives (Braun & Clarke, 2006; Braun & Clarke, 2013). In doing this, the relevant extracts that were collated at the coding stage were assigned to identify the sub-themes. This formed part of the key analysis process as different codes was carefully analysed and combined to form a major theme (Braun & Clarke, 2013; Braun & Clarke 2006). At this stage, the NVivo (version 11) tool was employed to sort the different codes into themes by creating child nodes under each parent node. The parent nodes became the major themes that had sub-themes; i.e., the child nodes under each theme. All of the codes were exhausted – used or employed as major or sub-themes – while unrelated codes were grouped into a temporary node named miscellaneous for further review and possible discarding if they did not fit anywhere. All of the codes were developed into a collection of major themes and sub-themes, with related extracts of data that were coded to them.

4. Reviewing the themes

At this stage, the initial themes and sub-themes were refined via a process of reviewing both the coded data extracts and the whole unit of analysis. Initially, the themes were reviewed against the coded data extracts (Braun & Clarke, 2006). The themes were identified by bringing together components or fragments of ideas or experiences, which are often meaningless when viewed alone (Nowell et al., 2017). The themes are not dependent on quantifiable measures but rather on whether they capture something important in relation to the overall research question (Braun & Clarke, 2006; Nowell et al., 2017). The flexibility of thematic analysis allows the researcher's judgment to determine the themes in a number of ways; however, it is important that researchers are consistent during the analysis process (Braun & Clarke, 2006; Nowell et al., 2017). Nowell et al. (2017) suggested that it is essential that the data collection process, coding, organisation and analysis are described in detail for the reader to judge from the data. Once the researcher was satisfied with the thematic map, having a clear idea of the various themes in the map and their coherence, and the general story elicited about the data, the next phase commenced with the themes' definition and naming.

5. Defining and naming the themes

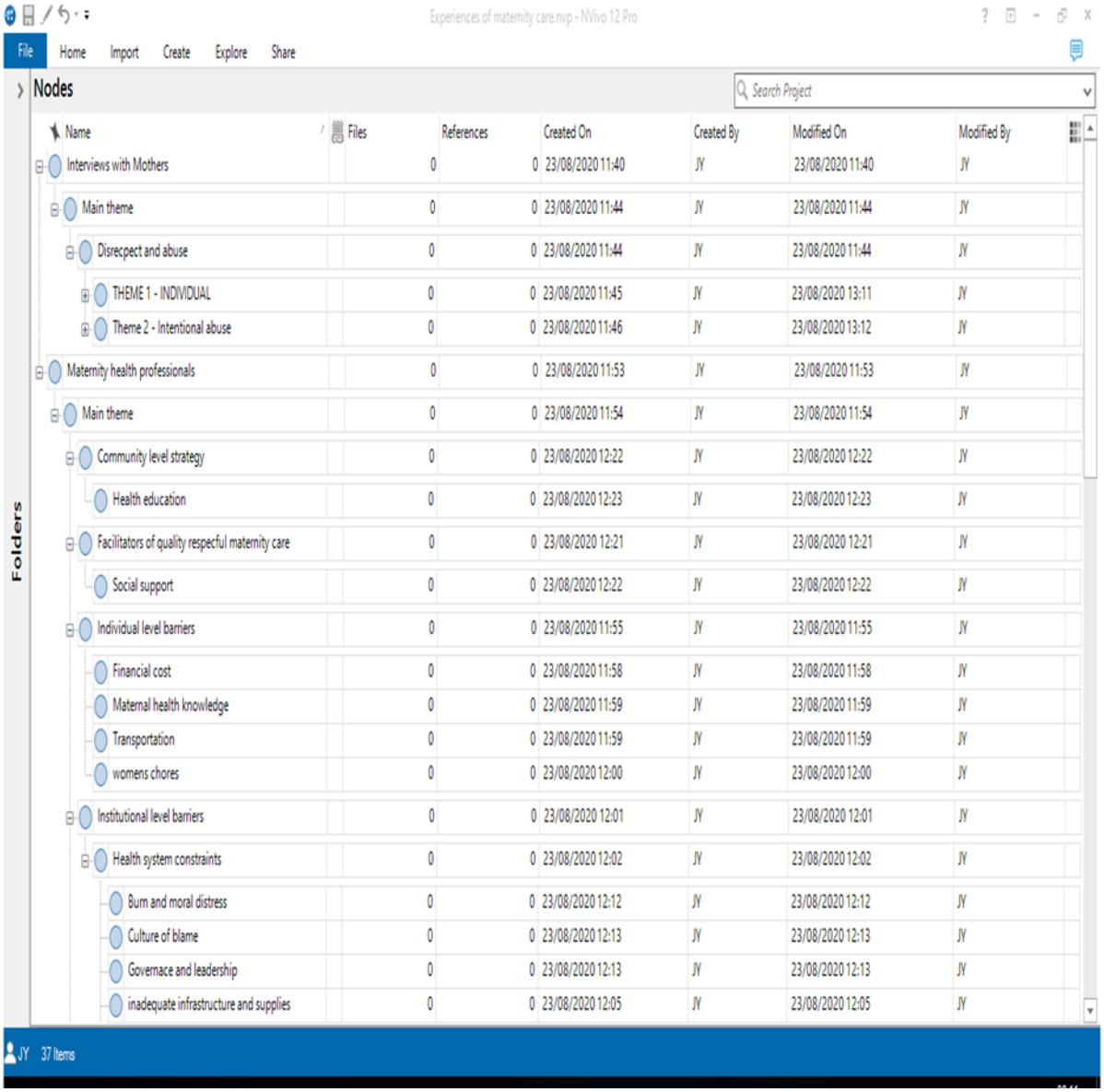
The themes were defined and refined for the purpose of the analysis. This was done by identifying the relevance of each theme, and the part of the data that the individual themes captured (Braun and Clarke, 2006; Newell et al., 2017). For each individual theme, the researcher conducted a detailed analysis, identifying the story that each theme tells (Braun & Clarke, 2006; Nowell et al., 2017). Braun & Clarke (2006) stipulated that the themes' names must be punchy and give the reader a sense of what the theme is about. Data may be included under multiple themes, with some overlap between the themes (Nowell et al., 2017). During this stage, the researcher considered how each theme fitted into the overall story of the entire data set in relation to the research questions (Braun & Clarke, 2006; Nowell et al., 2017).

6. Producing the report

The final write-up of the report began at the stage when the researcher had established the themes (Braun & Clarke, 2006; Nowell et al., 2017). This final part of the thematic analysis entails writing up the report after thoroughly identifying the theme. A detailed report was written on the findings. The report included data extracts that are brief, logical, and coherent, and that support all of the themes. The data extracts capture the essence of the themes and demonstrate the story being told based on the research question, according to Braun & Clarke (2006).

The results chapters in this study include thorough descriptions of what each theme implies as well as accompanying data extracts to clarify their meaning. The themes that emerged from the semi-structured interviews with maternity health professionals are presented in chapter four, while the findings from the semi-structured interviews with new mothers are presented in chapter five.

Figure 3.1 shows the coding created in NVivo 11 that plots women's and provider's experiences of maternity care.



Name	Files	References	Created On	Created By	Modified On	Modified By
Interviews with Mothers	0	0	23/08/2020 11:40	JY	23/08/2020 11:40	JY
Main theme	0	0	23/08/2020 11:44	JY	23/08/2020 11:44	JY
Disrecpect and abuse	0	0	23/08/2020 11:44	JY	23/08/2020 11:44	JY
THEME 1 - INDIVIDUAL	0	0	23/08/2020 11:45	JY	23/08/2020 13:11	JY
Theme 2 - Intentional abuse	0	0	23/08/2020 11:46	JY	23/08/2020 13:12	JY
Maternity health professionals	0	0	23/08/2020 11:53	JY	23/08/2020 11:53	JY
Main theme	0	0	23/08/2020 11:54	JY	23/08/2020 11:54	JY
Community level strategy	0	0	23/08/2020 12:22	JY	23/08/2020 12:22	JY
Health education	0	0	23/08/2020 12:23	JY	23/08/2020 12:23	JY
Facilitators of quality respectful maternity care	0	0	23/08/2020 12:21	JY	23/08/2020 12:21	JY
Social support	0	0	23/08/2020 12:22	JY	23/08/2020 12:22	JY
Individual level barriers	0	0	23/08/2020 11:55	JY	23/08/2020 11:55	JY
Financial cost	0	0	23/08/2020 11:58	JY	23/08/2020 11:58	JY
Maternal health knowledge	0	0	23/08/2020 11:59	JY	23/08/2020 11:59	JY
Transportation	0	0	23/08/2020 11:59	JY	23/08/2020 11:59	JY
womens chores	0	0	23/08/2020 12:00	JY	23/08/2020 12:00	JY
Institutional level barriers	0	0	23/08/2020 12:01	JY	23/08/2020 12:01	JY
Health system constraints	0	0	23/08/2020 12:02	JY	23/08/2020 12:02	JY
Burn and moral distress	0	0	23/08/2020 12:12	JY	23/08/2020 12:12	JY
Culture of blame	0	0	23/08/2020 12:13	JY	23/08/2020 12:13	JY
Governace and leadership	0	0	23/08/2020 12:13	JY	23/08/2020 12:13	JY
inadequate infrastructure and supplies	0	0	23/08/2020 12:05	JY	23/08/2020 12:05	JY

Figure 3.3.1: Coding – Nvivo11

3.10 Reflexivity

Constructivist research suggests that, since research is value-laden, researchers must be self-reflective about how they influence the research process and how it influences them (Corbin & Strauss, 2014). Understanding and reflecting upon how their personal background influences the data collection is critical in making sense of and interpreting the mothers and health professionals' accounts of the quality of the maternity care provided at the health facilities. This will increase the readers' confidence in the credibility of the outcome of the research. It also highlights the potential power relationships between the researcher and research participants, that might shape the data being collected (Braun & Clarke, 2013). Therefore, it is important to address reflexivity and possible biases and how these problems might be avoided or reduced.

I qualified as a health service administrator in 2012, having completed a master's degree in health service management at the University of Ghana. I have worked as a health service administrator at Tema General Hospital in the Greater Accra region of Ghana. Since 2013, I have been involved in the administration and management of the hospital. In 2014, I commenced a specific leadership role as a key member of the maternal mortality audit committee, with responsibility for auditing maternal deaths in both the hospital and the Tema community. In the process of auditing maternal deaths in the community, I became interested in the reason for the unacceptably high rate of the maternal mortality in the Greater Accra region, specifically in the Tema community, despite there being a free maternal health delivery intervention aiming to increase equality of access to skilled birth attendance and reduce the maternal mortality rate in the country.

Although, as a novice researcher, the initial idea to undertake this research emanated from my experiences as a committee member of the maternal mortality audit committee for the hospital and the community, being responsible for the auditing of maternal deaths in the hospital and the community in general motivated me to undertake this research. For the purpose of this research, I considered myself an insider researcher (Le Gallais, 2008), with access to the past and present histories. Such shared experiences offered me a sense of belonging to a group, sharing the same culture, language, values and attitudes (Le Gallais, 2008).

Bonner and Tolhurst (2002) characterised the insider researcher as an integral part of the social group under study. I benefited from all of the advantages of understanding the culture being studied and having a shared language and collective identity. This facilitated an effective flow of social interaction, promoting a rapport with the participants, enabling access, knowing how and where to collect the data, and showing empathy towards the participants (Bonner & Tolhurst, 2002). However, I was aware that these insights might jeopardise the trustworthiness of my findings (Le Gallais, 2008). For instance, midwives and doctors may respond to me as a boss, being participant health workers from the area where I had previously worked as a health administrator. During the interview process, some of the midwives asked if they were giving the right answers. I replied that only their views on the subject mattered. However, they were uncomfortable as they wanted to help me to obtain adequate data. This demonstrates that there are dangers for insider researchers concerning their dual role as researcher and employee (Le Gallais, 2008). In a patriarchy driven society context, the response of the female dominated midwifery profession can also be influenced when questioned by a male who had worked as a hospital administrator. In addition, my personal involvement in the area and proximity to the setting might have impacted on the validity of the research. However, I ensured via my recruitment and explanation to the participants that their answers would remain confidential, that I was not there as a manager and would not be reporting back to their managers about them. I aacknowledged that, when interviewing only a small number of staff from one workplace, one must take care to ensure that the participants cannot be identified easily by managers who read the study report. Further, the interviews were conducted away from the clinical area, or at a location that was convenient to the participants, so they did not feel threatened by the presence of their manager or other staff.

Brannick and Coghlan (2007) counter such claims by emphasising the value of the rich, complex knowledge which the insider possesses regarding the systems of the institution, of which I am a member. As such, this rich, complex knowledge helped me in the research I conducted at the General Hospital and the Tema community. My insider knowledge of the research location, as someone from Ghana, with a good understanding of the culture, a previous employee of the hospital and experience, created a mutual familiarity with the buildings, staff and women. This was necessary in order to seek out common ground and establish a research relationship. I also

acknowledged my multiple roles which include researcher, former employee, a man, a father and a committee member of the maternal mortality audit.

My previous experience aided my role as the researcher in this study in many ways, however, I was also aware that my prior knowledge and values might influence the research process in a negative way. Prior to the data collection, I considered my own opinions related to the barriers to maternity care delivery before the interviews took place and recorded these in my fieldwork diary for reflection during the data collection and analysis. I was again conscious that I might improperly steer the interview conversation in a direction to satisfy my own interest. To address this, a semi-structured interview schedule was developed to allow the interview conversation to cover certain areas in greater depth and dismiss others, according to the participant's responses (Appendixes 7 and 8). As a result, my own beliefs, experience, skills, understanding and values may have influenced this study; however, I have used reflection as a method for mitigating this potential bias. As I took up this PhD research, I saw myself getting close to a group without a shared history (Le Gallais, 2008). I had to acknowledge that I was also acting as an external person, in a powerful position, going to interview women and maternity health professionals. In a patriarchal society such as Ghana, the social structure system places men in a position of dominance over women. I am not a midwife, a woman or a doctor. Therefore, as a man, supposedly in a powerful position, this could be considered a positive thing. As a researcher, I was offering them an opportunity to talk to a person who was obviously an outsider, a person whom they may have perceived as having the power to make changes, which they might see as helpful. So, my powerful positionality can be positive as well as negative. My position as a health service manager, and a man, gives me a certain status that may make it difficult for the staff and women, who see themselves in a subordinate position. I reflected on the initial interviews and ensured that the questions were more open, less value laden, less presumptuous and more nuanced (Hoskins, 2015). Further, I talked at length with the participants about their experiences of maternity care, focusing on suspending my values and assumptions, and listened and responded more carefully, thoughtfully and sensitively during the interviews. Sometimes, this might have meant trying to give the 'right' answer rather than the honest answer. I acknowledged that this could affect how the women and midwives talked to me during the data collection. However, I tried my best to mitigate against that, and tried to reduce the power imbalance by reassuring the participants that I was not acting on behalf of the hospital

managers. I also ensured that I interviewed them in a comfortable, safe place, away from their work environment. Again, I reassured them that the interviews were confidential and that I would not share the information with their manager, so they hopefully felt safe to share information with me. However, the midwives were able to discuss their work experiences using medical and professional terminology as I was able to understand or find out the meaning of these terms. Some of these medical terms were difficult for me to understand but I read around the use of the terminology myself. When interviewing the women, I had a female chaperone from the local area, who was there to make the mothers feel more comfortable throughout our conversations. I understand that, in one sense, I was in a powerful position, but this could have been seen as positive. I acknowledge there may have been a power issue, but that power gave me an opportunity as an outsider to listen to what people were saying without bias (their views and opinions).

The researcher was involved in formulating and implementing policies. Policies and decisions were usually made without considering the views of the mothers. However, since I have listened to the mothers' views, through the data collection, I now know that this will shape my management contributions in the future when making decisions and developing policies at a management level. The two-dimensional view of the insider/outsider position regarding the research stance should be encouraged for the richness it provides. The researcher was partly an insider researcher by virtue of my previous role as a health service administrator, who is from Ghana and knowledgeable about the country's culture. This insider/outsider role was helpful as it allowed me to consider the benefits of critically examining my past and present, my experience, beliefs, values and professional and social identity (Le Gallais, 2008).

An ethical dilemma was how to manage the participants' expectations about the research as well as how to recognise and compensate the participants for their time. I opposed monetary payment to individual participants due to a fear of inducement. However, all of the research participants were provided with non-alcoholic drinks and snacks. I explained to the participants and leaders of the study community that the research was meant for academic purposes. In Tema, the women had high expectations that this research would lead to a change in the way healthcare workers treat them whenever they seek care. Even the health professionals in Tema community hoped that this research would improve their working conditions and the poor infrastructure. I was required to be

honest about what I could do to try and make this research impactful and improve things, but also realistic that the nature and complexity of the challenges and barriers were too great to be solved through my recommendations made based on this research alone.

Storytelling is the natural home of narrative, and the most familiar context of storytelling for most of us. It is this familiarity that enabled the women to feel comfortable and take control of telling their stories (Harlow, 2009). Nevertheless, this was challenging at times. Not only does narrative interviewing assume the capacity for reflexivity and that there is a story to be told (Birch & Miller, 2000; Etherington, 2007), but also that the story will have a coherent sequence and plot (Frank, 1995). With the attention on the views of the women's maternity care experiences, it could be argued that the uniqueness of their maternity care experiences suggests a need for reflexivity to enable women freely to share the details of their particular experiences (Birch & Miller, 2000; D'Ambrouso et al., 2005). Originally, forty women consented to participate in the study. However, twenty of the women gave entirely monosyllabic answers. The women implied that they had been satisfied with their treatment. Despite probing with questions from the interview schedule, they seemed reluctant to expand on their answers. They may have been embarrassed to discuss their birth stories with a man or hospital manager or they may have genuinely struggled to articulate their experience and feelings. It is possible that they had never been asked their opinion before, had some form of difficulty with cognitive processes or even feared reprisals from the midwives or their relatives if they made any derogatory comments. This left twenty new mothers and ten maternity health professionals' interviews for analysis

Interestingly, most of the participants were keen to participate in the study and ready to share their experience of pregnancy care and labour with me as the researcher. However, they were unable to elaborate on their own stories. The interlocutors are first encouraged to tell a longer narration about their own experience. The women can structure the narration according to the criteria that they themselves find relevant; the memory process is supported and frequently the process of self-understanding have already taken place (Rosenthal, 2003). Following that, within the interviews conducted I offered more structure by asking questions. Providing these prompts was useful, yet the women still had total control over their own stories. Despite using prompts to try to stimulate further discussion, some of the women still struggled to offer any further thoughts or comments.

Even when I asked specific questions about explicit issues, their responses were often short and seemed to lack consistency and depth; thus, these interviews unfortunately had to be discarded. Other authors have contended that the requirement for reflexivity may make a narrative approach inappropriate for those participants who may be developmentally immature (Harlow, 2009).This view led me to question if a more structured approach may have made the research more accessible for some members of the participant population. However, I also recognised that my concerns regarding the quality and depth of the data produced were based upon what I considered to be a 'good or successful interview' (Birch & Miller, 2000). I had anticipated hearing stories of disruption and grand narratives of tragedy. I assumed that the stories consisting of short responses and lacking in depth illustrated an absence of quality data. However, this denies the tellers' understanding of their own story and background. The keenness of some women to participate who then struggled to explain their experiences is an interesting issue. It may indicate that another method of exploring their thoughts and experiences may be needed. This issue would need to be considered by future researchers when undertaking research within this setting.

3.11 Ensuring Research Quality Criteria

It is widely acknowledged that quality in qualitative research is the only way in which researchers can convince themselves and their readers that the research findings are worthy of attention (Guba & Lincoln, 1985). However, qualitative research is often criticised for a lack of scientific rigour, most notably consisting of anecdotal evidence, biased by the researcher, and lacking in generalisability. However, these criticisms assume that quantitative and qualitative approaches to research should be judged by the same criteria of ensuring the validity and reliability of their findings despite their different philosophical positions. Guba and Lincoln (1985) argue that trustworthiness is characterised by the criteria of credibility, transferability, dependability, and confirmability, to parallel the conventional quantitative assessment criteria of validity and reliability. Arguably, the criteria vary within different approaches, such as phenomenology, ethnography, grounded theory and feminist inquiry. The researcher has chosen the widely accepted and recognised criteria introduced by Guba and Lincoln to showcase trustworthiness in this study. In addition, my supervisors have undertaken quality checks (the supervisory team checked and

agreed with the themes), and an independent translator was appointed to check a sample of the interviews that were translated from Twi to English.

3.12 Conclusion

This chapter has discussed the rationale for the methodological approach and method of analysis employed for this study. The methodology is congruent with the aims of this study: to gain an in-depth understanding of the experiences of maternity care from the women and providers' perspectives. The significance of the providers and mothers' experiences, the philosophy and characteristics of qualitative inquiry and therefore, it is contended that a qualitative approach grounded in the constructivist paradigm is justified to uncover new understandings, experiences and knowledge related to maternity care from the women and providers' perspectives. The following two chapters present the empirical findings; firstly, related to the interviews with the MHPs (Chapter 4) and then to those with the mothers (Chapter 5).

CHAPTER 4: DATA ANALYSIS AND FINDINGS (MATERNITY HEALTH PROFESSIONALS)

4.1 Introduction

This is the first of two chapters on the findings from the interviews and deals with the perspectives of the maternity health professionals (MHPs). One objective of this research was to gain an understanding of MHPs' experiences regarding the barriers, facilitators and possible ways to improve the maternity care services in Ghana, with the aim of identifying the factors that hinder the access to and use of skilled maternal health services in the context of Ghana's free maternal health care intervention policy. To document MHPs' experiences, 10 semi-structured interviews (see appendix 8) with professionals in the Tema community in the Greater Accra Region of Ghana were conducted between March 2018 and June 2019. Chapter three describes the methods in full and this chapter begins the process of reporting the findings derived from the data analysis.

This chapter specifically aims to examine the factors at the level of the health system that undermine access to and the provision of quality and respectful maternity care. Nine females and one male who were registered midwives and two doctors, ranging in age from 35 to 59 years of age, participated in the study. All of the participants were experienced, with between five and 32 years of experience. Six of the ten participants held a bachelor's degree in nursing. All of the participants were employed at Tema General Hospital. This facility is considered one of the nation's referral hospitals for maternity care services. The participants will be identified throughout this chapter using pseudonyms (see Table 4.1) along with demographic details of each participant.

This chapter details the findings, using four main overarching themes (Figure 4.4). These main themes will be illustrated using quotes from the maternity care professionals to support the analysis and examples of critical commentaries. In Chapter 6, these main themes will be discussed with reference to the relevant literature.

Table 4.1: Demographic data, experience and qualifications of the participating healthcare professionals.

Pseudonyms	Age in Years	Years of Experience	Rank	Qualification
Felicia	50	23	Matron	Midwife/degree in psychology
Lilly	47	18	Senior midwife	Degree nurse
Maggi	29	5	Senior Staff Midwife	Diploma in midwifery
Claire	33	8	Midwife	Midwifery
Conrad	59	32	Gynaecologist	Specialist obstetrician gynaecologist
Elspeth	57	25	Gynaecologist	Consultant
Gloria	46	20	Senior midwife	Midwife
Joyce	34	10	Midwife	Midwife
Emma	38	12	Midwife	Midwife
Sophia	35	15	Midwife	Midwife

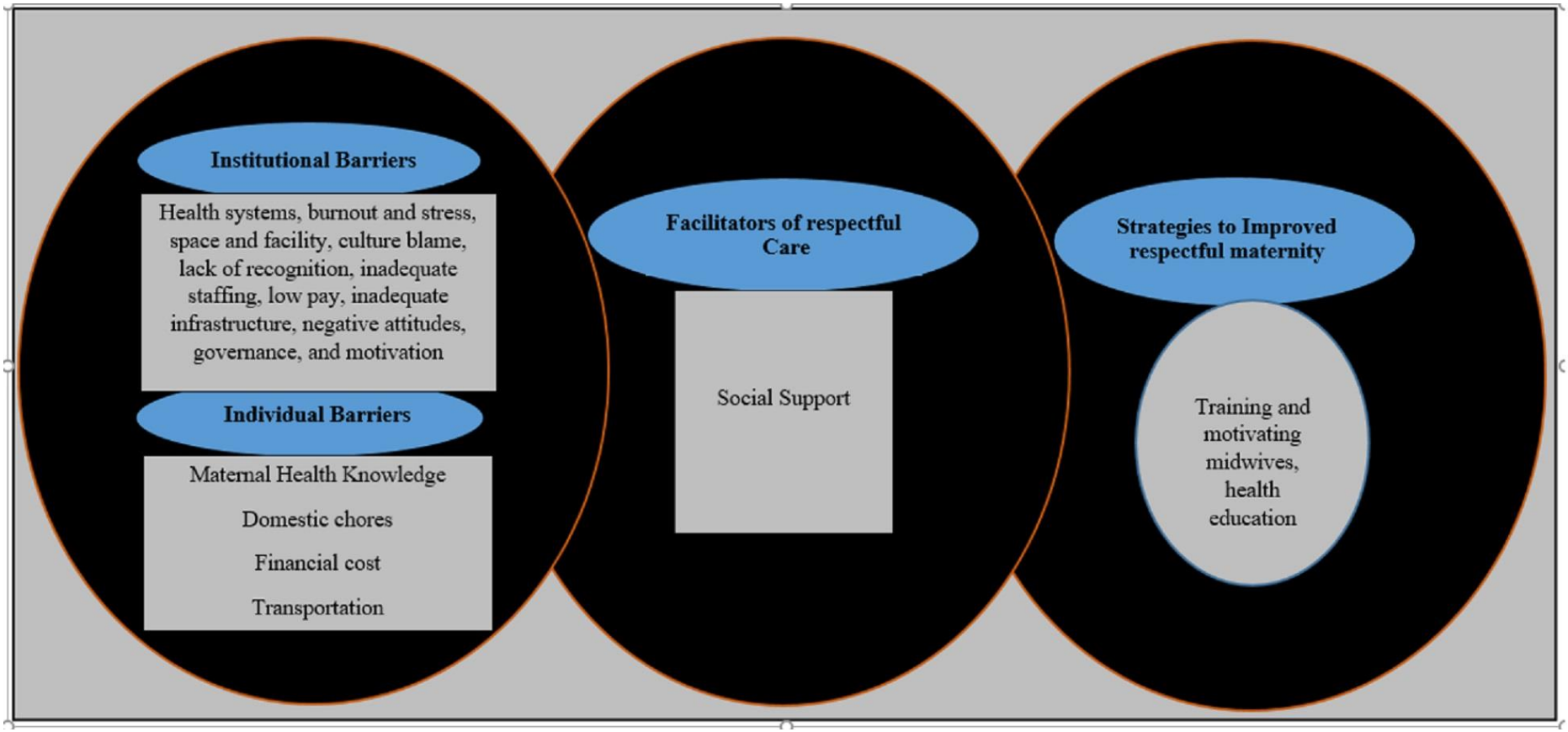


Figure 4.4.1: Mind map main themes (Blue) and sub themes (Grey)

Sets of themes were analysed in the context of the individual, institutional and systematic barriers to the uptake and delivery of maternal healthcare. The themes and sub-themes in this analysis are grounded in data (outlined in Chapter 1 Section 1.2) which seek to gain an understanding of health professionals' experiences regarding the barriers and facilitators of maternity care. They are also grounded in data.

4.2 Theme 1: Individual-level barriers

The study reveals that several barriers which militate against women using maternity care services exist at an individual level. This theme captures maternity health professionals' perceptions of what the barriers are to individual women using maternal care services. The following sub-themes, which include financial cost, maternity care knowledge, transportation and women's domestic chores, are used to support the theme.

4.2.1 Financial Cost

The interviews revealed that almost all of the health care professionals perceived that financial constraints were a dominant barrier that prevented pregnant women from accessing maternity care, as echoed in the individual participants' interviews captured below. For instance, Maggi stated that financial constraint was a major barrier that hinders pregnant women from utilising antenatal and postnatal healthcare services. Maggi admitted that the antenatal care service is covered by health insurance, but that there are some services, including lab investigations, scans and some essential drugs, which are not covered by the insurance and have to be paid for. In light of this, Maggi believes that the majority of the pregnant women avoid accessing antenatal services due to their inability to afford the cost of the aspects of the services that are not covered by health insurance. Maggi explained: *Sometimes too, factors from the home maybe finances and all that. When she comes there are certain things she will need to do. Antenatal I know is covered by health insurance but your labs, your scan, some of the labs and your scan is not covered by health insurance so if the person is not financially good the person may not come.*

Avoiding receiving or non-adherence to professional advice were associated with a lack of funds. From Beatrice's information, it is clear that women do not deliberately seek to avoid accessing antenatal care services. Being financially handicapped or dependent appears to exert

a great influence on whether to utilise the available antenatal services. In other words, pregnant women utilise the antenatal services more if they are financially independent or have a supportive spouse. Similarly, Beatrice explained:

There are cases where you ask them to do a scan so we can see the position of the baby. We even give advice some of them and asked them for admission they don't come because they will tell you they don't have money or their husband refuses to give them money. Conrad mentioned that poverty was one of the major factors hindering pregnant women from attending antenatal care. This is because poverty could mean little or no education, and a lack of finances and other material resources. This could be true, given that the first two participants mentioned a lack of money as the reason for the lack of take up of antenatal care among pregnant women.

4.2.3 Transportation

Transportation remains a crucial and determining factor for successful health care delivery. This was clearly demonstrated in this study, with some participants expressing how it hindered the utilisation of antenatal care services by pregnant women. The lack of an effective, affordable transportation system to and from the health facilities was perceived by Felicia to pose a major barrier to pregnant women accessing services. This is one of the contributing factors that limits the access to and utilisation of maternal care services by financially impoverished expectant mothers. For instance, Felicia stated that:

The women have challenges related to transport...money for transport, all those things come in.

While inadequate and ineffective transport has been noted to be the major barrier to accessing antenatal care services in Tema, Claire noted that this problem might be worse in the shanty communities, where there are few or no access roads. Compounding this issue also is the fact that there is high level of poverty in the shanty communities, hence making it more difficult for the women to afford the cost of the transportation even when it is available. The fact that I knew the area meant that the MHPs did not have to describe the issue in detail. MHPs will know the transport challenges that the women may face and are implying through these

responses that these issues all contribute to why women may not attend for antenatal care and childbirth. It may be that the MHPs assumed that the researcher, coming from the area, would already know about the transport challenges and so did not describe them in detail within their responses. Claire concluded that:

What happens in the community is that, there, some of the women have challenges related to transport.

4.2.4 Maternal knowledge

The maternity health workers thought that what may hinder optimal access to and the utilisation of maternal care services by pregnant women is ignorance about the importance of antenatal care. Also, they explained there are other important health issues which pregnant women appeared to be ignorant of due to their lack of formal education. The participants individually expressed their views on this.

Women did not attend for maternity care or to give birth at the hospital's delivery facilities. Maggi believes that the underlying cause of the low utilization of the maternal care service is the low educational status of the women and their lack of health education. Having been in the practice and interacted with pregnant women over the years, Maggi appears certain that most of the women lack the basic knowledge that would help them to access and use such a service. Indeed, she drew out the contrast between the apparent lack of knowledge of the patients attending Tema General Hospital compared with those attending private facilities: by juxtaposing her experiences from both private and public clinics, Maggi was of the opinion that the women whom she had met in the private clinic appeared more enlightened because they would have done some reading in advance. Arguably, the midwives play a big role in educating and enlightening this class of pregnant women on the importance of maternity care. While this might be important, the participants acknowledged the time constraints involved in trying to explain everything to their patients and the staff reported being unable to do this. For example, Maggi explained the challenges related to illiteracy:

'*What I have also noticed is that most of them are not really educated. If we go to the private hospital or even outside, you realise that, before the patient comes in, she has read a lot about what is going to happen to her, what you are going to do to her and everything.*

Similarly, Felicia felt that a lack of education is responsible for women being unable to take a decision to utilise the maternal care services available to them. In this participant's opinion, a lack of education could mean not attending school or failing to obtain adequate information about the availability of such services and their importance. Ignorance is seen as the major reason why these women do not utilise the maternal care services.

'Well, sometimes, I feel that it's just the education. The person doesn't know why she's—I mean the need to come to clinic. Some kind of ignorance makes women not come to hospital or they will stay home to give birth.'

Similarly, Conrad took the view that most of these women are educationally disadvantaged, hence, it is difficult for them to understand the signs and symptoms of the complications associated with pregnancy and take them seriously. This leads to them failing to present to professionals for help and, even when they do, they arrive very late. However, it might be argued that this is related to the education of the partner and relatives, as they will influence the woman's ability to attend a maternity clinic. Conrad concluded that root cause is a lack of education on the part of the women.

Poor educational status, some of them don't take the signs and symptoms of complications seriously and they come…er...too late.

4.2.5 Women's domestic chores

The midwives interviewed perceived that women prefer to give birth at home to allow them to continue their family responsibilities, such as childcare. It was mentioned that women, especially those with other young children at home, do not necessarily have a choice about being admitted to health facilities as they could not leave their existing children at home with no one for care of them. For instance, Beatrice and Elspeth were familiar with some of the situations in which pregnant women had refused to be attend antenatal care of be admitted to give birth, due to their other responsibilities at home, such as family commitments, having young children at home who needed care and employment demands. Women are occupied with thoughts about looking after their existing children while pregnant, because of which most of them turn reject appointments or refuse to be admitted. Having someone to help them to look after their existing children could be an encouraging factor for women, especially those with life-threatening conditions, to enable them to be admitted to hospital. The midwives assumed that the researcher understood what chores the women must perform; for example, working at home, growing vegetables to see, overseeing the safety of their existing children and cooking for the household. As Beatrice explained:

They wouldn't want to stay! Yes, most of them complain, especially the women who have no one to take care of their other children at home and can't be admitted when there's no one to take care of them [Beatrice].

Similarly, Elspeth described a female who refused to be admitted as follows:

We asked a client who was supposed to be admitted in January. She was detected as having high BP in January, and she refused [Elspeth].

4. 3 Theme 2: Institutional level barriers

4.3.1 Health systems

The MHPs made several references to the health system-related challenges that constrained their ability to provide effective respectful maternal care services to expectant mothers, including the inadequate infrastructure and supplies, understaffing, burnout and moral distress,

lack of motivation, low pay, the lack of recognition, governance and leadership and the culture of blame.

4.3.1.1 Inadequate infrastructure and supplies

Half of the MHPs mentioned the inadequate infrastructure, such as the lack of space, theatres, beds, and other medical equipment and supplies in the hospital maternity departments, as a problem. The participants reported that the limited physical space and hospital facilities limited their ability to provide high respectful and compassionate care. The following illuminates the health workers' comments.

For instance, Conrad admitted that the antenatal service in their hospital offers little respect and compassion for the women and attributed this to the inadequate amount of space. An insufficient number of beds on the maternity wards, such as the labour and postnatal wards, was a challenge facing the health facility due to the lack of space. Because of this, women often had to wait for a long time to get a bed and, even when they got one, it was always difficult to achieve the needed privacy due to a lack of space. Conrad stated that problem of space for surgical theatre is an issue:

We don't have much space for theatre services [Conrad].

It was very difficult for the mothers and maternity health professionals to walk around in the labour room, due to the limited space. Beatrice also mentioned the heat. There was no air conditioning, and overcrowding could make it oppressively hot, especially during the dry season, when the daytime temperature can rise above 35°C (95°F).

The space, you know, how to even walk through. The atmosphere, you can understand, even currently, the heat that we are experiencing on the ward is very demotivating [Beatrice].

Noticeably, Felicia mentioned that a lack of physical space can prevent pregnant women and mothers being admitted to the health facilities. In extreme cases, mothers are asked to go home to manage their obstetric condition, such as high blood pressure, due to a lack of space. A condition which might require admission for immediate medical attention to save the life of the woman and unborn baby in the UK is left, instead, for husbands and families to manage.

We do not have the space here in our setting in Tema General for, for instance, hypertension management. So, if it's not that too high in that patient, and you think that it can be managed at home, you ask her to bring a supportive person, so it could be her sister, her mother, her husband, and then you give them the education together because sometimes she herself might be illiterate [Felicia].

In these circumstances, women feel discouraged from attending or perhaps decide not to attend due to having been turned away previously or hearing from other women that the hospital does not have enough room. Joyce, one of the maternity health professionals, stated that:

No space to come for admission, the space is small [Joyce].

Beatrice recognised that the limited space prevented MHPs from providing good quality care to women. In addition, the lack of space also limited their ability to provide privacy to mothers and babies, which is fundamental to respectful maternal care. For example, the maternity wards are mostly open, making it difficult to protect the privacy of women during labour and childbirth. The maternity theatre is congested, as several other procedures take place at the same time. This further reduces the space and makes the environment unconducive for both the pregnant women and health professionals. Beatrice explained that this could reduce the health professionals' performance, resulting in low quality care:

"*We have just one maternity theatre for caesarean sections, and in this maternity theatre, we have other gynaecological procedures being performed*" [Beatrice].

Similarly, Maggi echoed that the poor infrastructure was a serious issue that had a considerable bearing on the care rendered by professionals or received by the women. Even in the limited space available, there were many other procedures and activities being carried out at the same time. When emergencies arose, it becomes very distressing for the professionals to render the kind of care that the women needed. While this might affect the women, the health professionals were also worried because they felt that they themselves did not receive sufficient support to render the needed care. Maggi explained the challenges related to the infrastructure as follows:

"The infrastructure is something that worries us a lot; for instance, here in the referral centre, we have just one theatre that does maternity cases. It does emergency CS and elective CS. When you go to the ward, there are a lot of people" [Maggi].

Emma recognises that the lack of physical space and poor physical layout of the maternity wards also limited the maternity health professionals' ability to provide high quality, respectful maternity care. Emma stated that a larger physical space and properly laid-out maternity wards in the hospital would help the maternity care professionals to provide high quality care to mothers and work freely on the wards.

"I would say that, as you can see, this hospital is generally congested in terms of its infrastructure; the bed capacity is less than it should be" [Emma].

Having one theatre in which to carry out other types of gynaecological procedures in this situation limited their performance. Without the space to care for the women, they were unable to provide the emergency care required or the women were not being seen until their condition has deteriorated considerably, thereby increasing the mortality and morbidity rates among both women and babies. Also, women may be sent home inappropriately and be unable to return or be transferred to another hospital in time. A lot of factors are considered before providing a mother with emergency care. It was reported that priority was given to first-time mothers over other pregnant women in the case of life-saving situations. A pregnant woman might have a life-threatening condition requiring immediate treatment where another childbearing woman, who arrived at the facility earlier, might require the same urgent care. The MHPs said that priority was often based on the number of children the women already had. First-time mothers needing urgent care were prioritised over other pregnant women, thereby creating significant inequality and making appropriate care a lottery. Emma felt that they could have saved all of these mothers and their babies at the same time if they had had the appropriate facilities. Beatrice discussed how challenging managing emergency situations was due to the lack of theatre space and how this resulted in low morale among the midwives. She described situations in which they were simultaneously helping patients in labour and triaging those ready for delivery. Beatrice used this opportunity to discuss how she had managed very difficult emergency situations and how challenging this was for them, impacting on staff morale adversely:

*"And so, you may face two emergencies at once. Let me just say foetal distress, when those babies need to be delivered within the next ten minutes. You are sure to just help only one, the one who came first...you know you have to really tease out and see which one we can help now at the expense of the other. By the time you come back, you may have lost the other baby, so it's quite hectic. The infrastructure is just inadequate" [*Beatrice*].*

The inadequate infrastructure and understaffing sometimes create a dilemma for the health professionals, who must decide whom to attend to first, despite the fact that all of the women on the ward need immediate attention. Unfortunately, the health professionals were always unable to help all of the patients at the same time because of the poor infrastructure and understaffing. In light of the above, pregnant women and their babies are sometimes neglected, which leads to complications and death. Also, this is an example of ethical stress, as having to make such decisions will take a toll on the health professionals' mental health, such as in the form of post-traumatic stress disorder (PTSD). This has a long-term impact on the maternity health professionals' mental health problems, motivation to attend work, stress/compassion fatigue, etc. It can lead to increased absenteeism, reduced productivity and profits and increased costs to deal with the issue, as well as psychological effects, like anxiety and depression, loss of concentration, and poor decision-making. In addition, it is understandable that women and the community, on hearing about this lack of beds and resources, may consider it safer to seek care elsewhere, such as from TBAs, spiritualists, herbalists and quack doctors, who are able to offer them more personalized care, despite their lack of training on how to manage maternity-related emergencies.

4.3.1.2 Human Resources

From the data in this study, inadequate or low staffing in the public maternity units in Ghana has been identified as a major barrier impeding quality care. The midwives individually narrated how the understaffing compromised the safety of the mothers and infants in their care, and resulted in stress and fatigue, as midwives must constantly assume an extra workload to cover many service areas, including conducting multiple deliveries. This apparently resulted in poor quality care and the neglect of clients.

Here, Maggi admitted that they shout and scream at women because of the frustration, stress and burn out that they experience when discharging their duties under these challenging conditions. For example, Maggi admitted that she is extremely stressed and feels overwhelmed due to being expected to carry out tasks that lie outside her scope of expertise.

Maggi described how she sometimes felt very scared, probably because she felt that she lacked the skills required to conduct a breech delivery. This may have affected how she reacted to or cared for the women. Maggi admitted that she does shout at the women, which she excused this by saying that the volume of work is so great that it leads to anger. These words are key, as they express a feeling of abandonment and being abused by the system. The midwives are left to cope, with only one doctor available, if that. This means that, due to their overwhelming workload, the maternity health professionals feel stressed, which leads them to pass on their negative emotions to the patients. Maggi expressed her frustration about her overwhelming workload:

"We were just two midwives on duty that day. I think me and then the other midwife who was on duty did our best to deliver the babies because a breech delivery is a very difficult delivery sometimes and you need skills to do it. Sometimes, you feel frustrated because you need more hands. Yeah, unknowingly, you might transfer aggression to the client" [Maggi].

Lily recognised that the doctor/nurse ratio is a problem in the healthcare sector, affecting the effective and efficient health care delivery. The World Health Organization recommends a ratio of 2.30 midwives/doctors per 1,000 people. In Ghana, the doctor/midwife ratio is about 1.04, which shows a shortfall of 1.26. As a result, if the health facilities are properly equipped and staffed, maternal problems can be efficiently and effectively managed. In this regard, Lilly acknowledged the importance of human resources, but felt powerless and disempowered due to the amount of human resources currently available to her. She explained:

"Then, human resources is another factor...When it comes to nurses, midwives, when it comes to midwives and doctors, now there is just one doctor who is on duty, and when you came here this morning, it is just two midwives who are on duty" [Lilly].

Similarly, Beatrice's responses demonstrated that there was only one obstetrician. The attitudes and absenteeism of the doctors in failing to show up for their contracted hours thus contribute to the understaffing of the hospital wards, which cuts across all fields. Only one doctor always has to take care of all of the theatre cases. This could be overwhelming and indirectly affect the midwives on duty, whom she said are always under pressure due to the volume of work, which affected their ability to explain things and be patient, and so their interactions with the women and their families. Hence, some midwives resort to shouting at women to do something and so upsetting or offending them. Beatrice struggled to refer to her own team when discussing this behaviour and the poor practices, feeling uncomfortable about the behaviour of staff (presumably including themselves), instead shifting the blame for the poor practice onto others.

"He is this same doctor, and then you will have one in theatre who is doing the theatre cases that come in. And so, it is just terrible. It's terrible" [Beatrice].

Sophia admitted that she had witnessed clients being abused by colleagues but, instead of condemning this or reporting the offenders, she made excuses for them in order to protect her colleagues rather than the clients under their care. In all cases, the abuse of patients by staff is unprofessional and unacceptable, and should be highly condemned by every professional.

Sometimes, I see my colleagues doing things that are unacceptable, but they are human. I don't think any midwife would intentionally abuse a pregnant woman or mother but sometimes the pressure and when you have a headache, and you have to go and buy your own medicine [Sophia].

While the problem of understaffing was noted to be a challenge, Felicia pointed out that there was always a way around this. Due to their poor salary, midwives are always eager to work overtime to increase their income. Unfortunately, employers appear unwilling to pay for this overtime, as their aim might be to maximise profits. Hence, midwives prefer to go elsewhere to do overtime and earn more money. This strongly indicates that the government is be aware of these challenges which are affecting the maternal care services but turning a blind eye to the situation.

"You get overtime; everybody will do it because some staff go and work. else where when they finish here, they go and do extra work so, if you can work extra hours, you work four hours and get something. Everybody would stay here and not go and work elsewhere. So, if I feel that my salary is not good, and there is a job somewhere that pays well, I will leave the government system and go, which will create a shortage of staff here. Do you understand? So, if there are like 1,000 women, we are only two midwives taking care of these 1,000 women, Do you understand? In that case, the work cannot be done well and we all know what can happen" [Felicia].

Most of the participants mentioned the suffering and challenges that the understaffing has posed for health professionals. Beatrice digressed slightly to consider the impact of this on the pregnant women. Understaffing increased the wait time for women, which discouraged a lot of women from attending antenatal care. This is arguably true, given that other participants have mentioned that, in most cases, only two midwives oversee a very large number of pregnant women.

"The wait time. They come, they have to wait and wait and wait…erm…to get the needed care. As I said earlier on, the staff...they don't match the number of clients. The ratio is so bad. There are not enough staff, an acute shortage. Some have retired, and none are coming in. Meanwhile, the number of clients rushing in to seek the service is so high, and that, you know, discourages them from accessing the care" [Beatrice].

The shortage of doctors has put midwives in the position of having to do the job of the doctors. Here, the question of safety and quality care arises, as the midwives are undertaking roles and responsibilities on which they have not received any training. Task-shifting is a practise used in Ghana within health facilities to help to mitigate the impact of the insufficient number of health workers. Given the scarcity of doctors, midwives seemed to offer an alternative, who now undertake the doctors' roles in hospitals. However, staff members are occasionally assigned tasks that are beyond their level of training and the scope of their job description. The staff members rarely receive adequate training on how to carry out these additional tasks. Beatrice's responses demonstrated that these extra tasks are an opportunity to learn new skills, but it can be argued that they are also stressful and burdensome. Nevertheless, Beatrice is concerned about the low salary that midwives receive. She is of the opinion that their salary

should be upgraded as a motivator instead of paying doctors high salaries, who do little or nothing in the health facilities. Beatrice described how midwives might be empowered:

In this environment, we don't have a lot of the doctors around. Obstetricians, we don't have many, and so midwives are to be empowered (promoted), even at the lower level, to be able to carry out certain procedures that hitherto should have been done by a doctor [Beatrice].

4.3.2 Burnout and Moral distress

The complexity of rendering care in an under-resourced setting and the negative impacts of this were discussed under this theme. The maternity health professionals described feeling burnt out in the course of discharging their duties. According to WHO 2019, burnout is a syndrome thought to be caused by chronic workplace stress that has not been managed. It has three dimensions: feelings of energy depletion or exhaustion; increased mental distance from, or feelings of negativism or cynicism about, one's job; and decreased professional efficacy. Understaffing, a lack of motivation and the heavy workload on the labour ward hugely contributed to how the particpants felt about their job. Burnout is characterised by a high degree of emotional tiredness and a loss of personal identity. Due to the paucity of resources, the midwives appeared to be constrained, which negatively affected the standard of care they rendered to their clients. In this study, the maternity health professionals experienced: energy depletion or exhaustion; extreme mental distance from their job; feelings of pessimism or scepticism about their job; and decreased professional efficacy. They sometimes faced situations that they were unable to manage under such poor resource conditions, resulting in the death of a mother and/or her baby. These unexpected tragedies all contributed to the stress and burnout experienced by the midwives, as illuminated during the interviews by Maggi:

'Sometimes, too, the pressure on the midwife is too much' [Maggi].

Beatrice recognised that there was a lot of pressure in the course of discharging their duties, especially under such a poor resource setting. The pressure was such that they were forced to work outside their sphere of expertise. Given the poor infrastructure and resources, the health professionals are, by virtue of their licence, expected to be responsible for their actions and inactions. Working under such circumstance can create immense pressure and burnout. Beatrice concluded that:

And you know those are some of the demotivating, you know, issues, that you encounter when you are on duty. And so, we lost that baby. And so, we realised that if the infrastructure or system had been in place, the theatre would always be ready, available to assist, and we would have saved this baby [Beatrice].

The midwives felt more frustrated and morally distressed when they lost babies because they could not help as much as they were supposed to, owing to the paucity of resources. Most of the issues they encountered at work, such as their excessive workload, working outside their sphere of expertise, the poor infrastructure, their inability to render high quality care due to the paucity of resources, etc., demotivated them. They blamed the death of the baby on the poor infrastructure and wished that things would improve in the facility to enable them to perform their job well. Following this distressing incident, the midwives experienced intense moral distress frequently, as they perceived a more negative ethical climate in their care setting. The midwives were compelled to act in ways that they perceived as not being in the patient's best interests and were exposed to negative ethical climates. Lilly described the huge work pressure that midwives face:

In this place, the workload is too hard for the midwife. The number of midwives taking care of the clients is not all that equal because at least one midwife can take care of about ten clients and we have two [Lilly].

Similarly, Elspeth described the pressure arising from the work:

In my view, our biggest challenge is the workload [Elspeth].

The participants find themselves in very difficult situation, leading to a lack of motivation.

4.3.3 Conditions of service

A lack of motivation was identified as a major concern among the midwives interviewed. They claimed that, although they worked in poor, unsupportive, overcrowded environments, with limited equipment, supplies and personnel, their work was never appreciated by their supervisors. This, according to the interviewees, impinges on their morale and demotivates them when discharging their duties.

It is apparent from the following quote that Claire felt disappointed by the poor salary and lack of recognition from their employers. Pay was seen by the midwives as an indication of appreciation for their work and effort when facing such difficult circumstances. They seem to feel this might be something that they expect or are hoping for to help them to provide for their family. The midwives felt that their salary was significantly different to that of other midwives working in other countries, such as the UK, US, Canada and Australia. Strikingly, this has led to some trained nurses and midwives leaving Ghana in search of greener pastures in these so-called highly paid countries.

"I don't know if it's yet to come or before I entered midwifery. Maybe, if they were getting some allowances, I can't tell but [laughter] but nothing like allowances for anyone" [Claire].

Motivation, in whatever form, is one thing that the health professionals would welcome, as this would enable them to stay strong in their job. Although the circumstances surrounding their job are challenging, the midwives appeared to be even more demoralised by the fact that the management displays no appreciation or recognition for the good work they do. As Felicia explained:

"We are not being motivated. Even yesterday the theatre people were saying that we are not been motivated" [Felicia].

While the maternity health professionals receive a monthly salary, Sophia felt that it is insufficient and wished other forms of allowances to be considered that would serve as a motivator. Nothing is motivating about their job, as there is no any form of welfare package for the staff. Midwives who are dedicated to their job only do it on the ground that they wish to obey the golden rule of life. Sophia echoed the disparities between the allowances for the midwives on the maternity ward and the emergency department nurses:

"This is why some nurses working in other departments, like the emergency ward, are more motivated than those on the maternity ward. Allowances? No. It is just our salary, so we are not motivated. Even when you are sick, you have to buy your own medicine. The hospital doesn't do anything to support our welfare. We work because we are touched. So, you do unto others as you would want them to do unto you. As I sit here, if I have a headache, I have to buy my own drugs from the pharmacy. There is nothing like motivation at all" [Sophia].

While Gloria agreed with the others, she added that the staff's safety is not guaranteed, as the midwives are sometimes beaten up by the patients' relatives, without any form of protection from the hospital authorities. The midwives felt vulnerable, which was bound to make them feel nervous/anxious and defensive if they thought that a woman or her partner may threaten them. Things like this demotivated the staff from doing their best at work. Also, Gloria mentioned that other wards frequently get motivated by the hospital authorities, despite the fact that these wards are less busy than the maternity ward. The health workers are rewarded or appreciated in the form of takeaways and drinks for period of time, such as three months. It can be very demoralising when midwives see other nurses, who do not work as hard as them, being appreciated more. Gloria echoed how some departments are rewarded quarterly, unlike the maternity department:

"There is no motivation. Sometimes, we come on the night shift around 11:30pm. We workday in day out and there's no security at night. A patient's relative once attacked a health worker. People in other places are motivated every three months. Our maternity ward is always busy compared to other wards. The government added something small to our salary and that is it" [Gloria].

However, other midwives seemed interested in trivial issues, such as the failure to provide hot drinks, water and takeaways for night staff, which made them feel unvalued, while recent drops in other benefits had serious, unintended consequences for the care of women. Clearly, if their basic needs are unmet, such as hydration or food, to enable them to perform well, they are unlikely to be able to concentrate, become unwell, suffer from headaches, etc., resulting in human error and impacting on safety and the quality of care that they provide to women.

Bad. That one I will say it is bad. It is not the best. [Lilly].

4.3.4 Low Pay

The majority of the midwives stated that they felt that the salary of obstetricians and midwives hinders the effective delivery of maternal care. To supplement their income, health workers sometimes take other jobs in addition to their job at the health facility, which could also lead to long working hours in a bid to pay their bills, thus leading to burnout and fatigue. This could affect the individual's performance in their main job. Felicia described how, if there had been proper policies in place for extra duty allowances in general or at Tema General Hospital in particular, there would be no need for her and her colleagues juggle bank shifts elsewhere. Felicia's words implied a gradual shift in her attitude, until eventually she felt sufficiently confident to say:

You get overtime. Everybody would have done it because some staff go and work. When they finish here, they go and do extra work, so if there is something like you can work extra hours, you work some four hours and you get something, everybody would stay here and not go and work anywhere else [Felicia].

The midwives felt that their low salary and lack of incentives sometimes led to a lack of motivation and poor performance, absenteeism, and increased rates of having more than one job. Their low salary forced the health professionals to take on extra jobs in order to increase their earnings. The participants confirmed that this extra work contributed to the understaffing in the facility. Apart from the low staffing, those who engage in many jobs also often experience burnout, which indirectly affects their performance in their main job. Thus, human factors may affect the care and safety of the women. The midwives often come to work very tired, very late, perhaps leave work before they should get to another job, etc.

Beatrice stated how low and demoralised she felt about going to work whenever she remembers the low salary, which does not give them the needed financial security. Hence, the staff always feel unmotivated about going to work or doing their best in the job.

Beatrice appeared to be worried about paying her bills:

"You are coming to work, and your morale is so low. So that aspect, you know, and financial wise too, you know, it's so demotivating" [Beatrice].

Joyce had also worked on the hospital wards for several years and reflected on how the doctors also often have more than one job. Moreover, she admitted that, due to the country's high standards of living, they all must undertake extra duties to meet their financial demands:

"From the medical point of view, doctors feel that they need to do extra work to meet their financial obligations, so you find a lot of people also working outside the hospital to make more money. Of course, some of it is also due to greed…er…I would say that, but generally speaking of financial remuneration its more that, you know, the expenses keep rising and rising in our country" [Joyce].

Joyce's comment shows that the issue of taking on extra jobs outside one's main job cuts across every profession. While some are doing this to pay their bills, others (presumably the more senior staff) are engaging in it out of greed. However, speaking from her experience, the participant admitted that their financial remuneration is generally poor and hardly matches their expenses, as the prices of commodities in the market continue to increase.

4.3.5 Lack of recognition

The results from the interviews show that there is no form of recognition system in place for acknowledging and appreciating health staff's good performance at work. This, according to the interviewees, impinges on their morale and demotivates them regarding the discharge of their duties. For instance, Maggi described how staff were not even given a verbal '*good job*', even when '*doing something exceptional'*:

In the hospital setting, the motivation is bad…Because we are not motivated by anything at all, nothing at all, not even a 'good job' when maybe you think you have gone out of your way to do something exceptional...you don't even get a 'good job', so for motivation as part of the hospital's policy no. I don't think that is good [Maggi].

While some health professionals go out of their way to provide care, others feel disappointed that nobody recognises or appreciates them for work well done. In such situations, people might feel demotivated to do their best. Joyce linked this lack of motivation to a decreased tendency to provide good care, which she recognised could lead to a patient not returning for subsequent deliveries:

It affects the nurses like the midwives, so definitely the kind of care that they would provide to the patient wouldn't be as good as if they were motivated so, if I don't provide good care to the client, then next time she may decide not to come here or she may decide not to go for my services because I don't provide good care but, if I was motivated, I am sure that make me provide good care to the client and so, next time, she would come back [Joyce].

This was an emotive account of how the understaffing of health facilities, coupled with tge poor working conditions, often led to stress, overwork and a lack of enthusiasm among the few healthcare providers in the system. In other words, compassion fatigue and workplace stress are major contributors to occupational illness, poor productivity, and human error. This leads to increased sick leave, high staff turnover, poor organisational performance, and a possible increase in accidents due to human error. A variety of minor illnesses, as well as psychological effects like anxiety and depression, loss of concentration, and poor decision-making, affect the quality, safety and health of maternity health professionals. This in turn affects the safety and quality of care of the women as well.

This indicates that the participants felt that better pay would give them more status and perhaps prevent them from being forced to take other jobs to make ends meet. They felt that their status within the hospital hierarchy was low and unrecognised, with the status of the midwifery profession being low in general. They felt very bitter that no one seemed to notice the work they are doing, and sought recognition and rewards. In the interview data, the midwives reported that they were replacing medical staff by doing tasks that they have not been trained to do. They also raised the issue of safety, related to them being so tired. Tiredness meant that they were less able to make crucial decisions, and this inability to concentrate on their tasks impacted on human factors, particularly in the context of providing quality intrapartum care services. A particular emphasis was placed on doctors' superior status and the lack of recognition of the midwives' contributions. Midwifery students in Ghana, for example, were aware that they were not respected. Some doctors may look down on nurses and midwives. In some situations, midwives felt they had a low status in the obstetrics team and that their opinions were constantly ignored by the physicians.

The shortage of doctors mean that doctors receive much higher salaries but are often absent during their contracted hours. This means that a substantial portion of their medical work is

being left to midwives, who subsequently suffering from high stress levels and burnout in large numbers. The midwives mentioned that they are no systems for auditing their practice; e.g., how many births, the outcomes of the births and the use of improvised to work on the maternity ward. Despite these circumstances they still seem to care and wish to do a better job; for example, to reduce the waiting times.

4.3.6 The culture of blame

There is a prevailing culture of blame in these established professional settings. The maternity health professionals were blamed for every poor outcome. The midwives felt particularly strongly that they took the 'direct hit' for any adverse outcomes regarding the women or children. They also expressed a fear of being blamed for outcomes that they largely thought were as result of non-compliance by the women. For instance, Beatrice said:

Sometimes, they think that…erm…the staff should have done something better, something more to help them and they put all the blame on the staff but, when you go into the issue, you investigate and go deep down into the issue, you realise that it's just an institutional failure, and not the staff, who have actually caused, you know, whatever negative outcomes that come up. Yes, so…erm…the clients are sometimes unhappy with the care they receive. They are not happy. Sometimes. But it is equally not our fault as well. It is the system. The system is not very effective [Beatrice].

While the midwives thought they were doing their best for the women in their care, they expressed frustration, anger and disappointment at how these women blame them for every poor outcome of the care service. Blaming or thinking that the midwives did not do enough to solve their predicament was a strong sign that the women were unappreciative of the midwives' care services. The midwives, on the other hand, believe that most of the things that these women try to blame on them are not actually their fault but a result of system failure.

4.3.7 Governance and leadership

Weak management and a lack of accountability regarding a clean environment, human resources, sufficient equipment, commodities and drugs for health providers to do their work effectively, an inefficient duty roster that does not maximise the staffing ratios leading to a high workload, and ineffective supervision to ensure adherence to the standards of care are

some of the identified drivers of disrespect and abuse that are tied up in the context of each facility culture. The management should be held accountable for their neglectful behaviour. This would serve as a control mechanism to put the management back on track. For example, one midwife reported that doctors skip their duties (either they do not turn up or take long breaks) because of a lack of adequate supervision, resulting in new mothers feeling abandoned. Some of the participants complained that the poor supervision of human resources resulted in absenteeism and staff serving as locums elsewhere. In such situations, the cases are not investigated so that the perpetrators might be punished so they get off scot-free. In this environment, people are not held accountable for their actions. Thus, there is a lack of or an inadequate leadership style to drive and change the organisational goals and strategies. In effect, when there is little or no supervision of healthcare workers, it is possible that female patients will not receive the required level of maternity care because the system for supervising them is lacking.

People have to raise more money through other means which usually means doing work outside as a locum and the rest. Now, definitely somebody losses when people are rushing or dodging work in one facility in order to be able to complete their tasks in another facility [Elspeth].

The need to raise more money to pay personal bills is the reason why some health professionals decide to take on an extra job. This arrangement is seen as one of the major causes of the understaffing in the facility. Unfortunately, this situation was allowed to continue unchecked, and continued to have devastating effects on the health system and clients.

Having only one doctor to attend to multiple cases was found to cause of the long wait time for emergencies to be attended to and the poor service that the female patients receive. The maternity professionals reported that the shortage of staff delays women's receiving of care. Claire described how a single doctor covered several wards, and could only be in one place at a time:

One doctor fulfilling a role for 24 hours, he's here, he's the same person attending to the OPD pregnant women and gynae cases, the same person attending to the labour ward, antenatal,

post-CS, post-delivery…one person, sometimes, an emergency walk in, then we the midwives do our part. We need the doctor to check so that we take the next initiative but there are other emergencies that he is attending to and, when you think about it, he can't leave immediately and come and attend to your case, so sometimes it delays matters in some ways [Claire].

Due to the lack of experts, the facility had to rely on the decisions of personnel with fewer skills, even when complicated cases that required the services of experts arose. This has led to or further complicated the clients' problems, meaning that some of the deaths they recorded in that facility were actually avoidable if the right staff had been available to do the right thing at the right time.

The practice of leaving less qualified members of staff unsupported to deal with emergences led to misdiagnoses and cases of incorrect or over medication, thereby harming patients and putting patient safety at risk. Elspeth stated:

It is very exhausting, so I would say the numbers are a real challenge and so we are forced to rely on less well-trained personnel or house officers to take a lot of the initial decisions so there may be lapses which means that, occasionally, this leads to other things. A patient can be misdiagnosed because of the lower skill level of the trainee doctors. You know, a lot of doctors come with different levels of skills [Elspeth].

Beatrice advocated the empowerment of midwives:

In this environment, we don't have a lot of the doctors around. Obstetricians, we don't have many, and so midwives are to be empowered (promoted), even at the lower level, to be able to carry out certain procedures that hitherto should have been done by a doctor [Beatrice].

The poor supervision of facilities also leads to the poor forecasting of supplies and commodities, staff attendance and quality assurance. The majority of the midwives reported that the physical conditions of the facilities are a good example of how health system failure affects usage; for instance, pregnant women lack privacy when they visit the maternity clinic. Some of the midwives noted that, during the women's treatment and delivery, the facilities lack adequate equipment and supplies. They reported a poor supply of drugs and supplies, and insufficient commodity management, as well as a lack of equipment. They reported that women

often had to share a bed or were given a mattress on the floor without any privacy, due to the lack of beds. This also contributed to disrespectful care.

We have tbeds but the beds are not beds that you can adjust for the delivery because, before you finish, you are having back pain or something so all of the beds are there, but not good beds, appropriate for delivery [Lilly].

The poor and incorrect equipment on the maternity ward was noted to be a big issue, which hindered the midwives from carrying out their duties. Having to use equipment such as beds that cannot be manipulated by the users to suit their procedures was seen to have caused pain not only to the midwives but to the pregnant women as well.

The post-delivery area was just a small place and you could get two, three women in one bed [Beatrice].

The baby is already coming and the beds nearby are all full so you have nowhere really to send the woman so, sometimes, either we put the woman on the examination couch. If the woman can't walk to the examination couch, we'll do the delivery on the floor [Claire].

Sometimes, professionals have to deliver babies on the floor due to the lack of bed spaces. This is unprofessional but cannot be blamed on the health professionals because it is not their responsibility to equip the hospital. The hospital management, and by extension the government, are responsible for doing that. Professionals sometimes compromise their standards not because they choose to but because they have to do whaterver is possible to help pregnant women, even when the resources are scarce. The professionals wanted many changes to be made to the hospital arrangements but none of these changes can be achieved without the commitment of those in charge. Those in authority are responsible within the organisation for ensuring that their employees fulfil their responsibilities. At the same time, the midwifery managers desire their organisation to be successful, with good quality midwives who will provide high standards of care for pregnant women.

Beatrice, Lilly and Joyce all reported that they felt disempowered as they could not help to improve the situation to make things work, since they were not in the position of power. They admitted that, from time to time, they write to the management, reminding or telling them about the conditions of the ward and the need for more hands in the unit.

We don't have much choice over these factors. All we can do is to report the situation at hand, and then offer recommendations, which we've been doing every quarter. We put in our request for more staff, more hands on deck, but…er…we are still waiting to receive a favourable response from the authorities [Beatrice].

No, we don't have any control [Lilly].

I do have a little control—not all but some [Joyce].

4.3.8 Negative attitudes

The midwives were aware that the health facilities were sometimes not very welcoming and that women were reluctant to attend them because of the disrespectful attitudes among some of the staff. They reported that these manifested in women not being greeted or properly attended to when they arrived on the labour ward. The midwives acknowledged that, sometimes, poor care resulted in women delivering their babies alone. When asked about their attitudes, the midwives tended to say that it was not they who abused the women but other staff. They acknowledged that some midwives are not always patient and kind to the female patients. Consequently, this resulted in patients feeling offended when the midwives lost their patience, which might deter them from accessing maternity care in the future. The tendency to attribute poor performance to other staff is illustrated by Felicia's comments:

Some staff develop attitudes that so, when some patients come, they will just be doing… because, you know that, at the end of the day, she knows that she will go and get her salary and she will not stress herself to do any work [Felicia].

Although institutional failure was the dominant theme reported in this study, Claire pointed out that the negative attitudes of some staff members at times hampered the antenatal care services. There was a view that some staff members hate to work and feel less concerned about patients' care because they believe that, at the end of the month, they will receive their salary. This could mean that nobody monitors the activities of the staff at work. There was an implication that it was accepted that the staff tend to behave how they wish, to the detriment of the female patients and their children.

Claire noted that some midwives not only show a lackadaisical attitude towards their duties but also shout at the female patients at the slightest provocation or when trying to make them

do something. An example of this was given by female patient who refused to lie on her left side because of the pain. This was unprofessional, as shouting at a patient or speaking to them in a disrespectful manner can amount to abuse and deter them from using the facility again in future.

She doesn't really like working. She will sit at the table and shout, shout at the client [Claire].

However, when discussing their own poor behaviour, various excuses were offered, such as the intolerable pressure, while it was claimed that others behave in this way because they do not like working. Rather than admitting that they themselves had a own poor attitude towards their work, the participants claimed that being rude or shouting at patients was unintentional, leading to the female patients feeling offended when the midwives lost their patience and deterring them from accessing maternity care again in the future. The midwives sometimes acted impulsively due to burnout and frustration with their job. Working in an atmosphere like this with so much pressure triggered how they acted towards the patients. There were instances where the maternity health professionals had a desire to do their best to help the patients, but the workload was always too great and prevented them from doing their best.

Sometimes, when you are barraged by activities and that makes you feel tired, you can appear rude to people but that may not be the case. Yes! Sometimes I want to do my best, but I became angry and shout hey! I am coming, but I'll think and say it is not their fault. Again, the pressure is too much [Sophia].

Because, when they come, whatever you tell them, someone who just decides not to listen to you will do whatever she feels like doing [Maggi].

4.4 Facilitators of high quality maternal health care

While the issues hindering the delivery and utilisation of antenatal care services were the dominant theme mentioned by most of the health care professionals interviewed, some of the participants also acknowledged several facilitators that could improve the provision and utilisation of maternal care services during pregnancy, childbirth and postnatal care. The following sub-themes further explained the participants' comments on this.

4.4.1 Social support

Social support was noted to play a crucial role in encouraging women to utilise the service. The most common strategy for navigating maternity care was for women to be accompanied by a birth companion, usually a family member. The companion's role was to care for the woman in ways in which the health system could not; for example, in instances when women refused to be admitted or undergo a caesarean section in the health facility.

In addition to performing caring tasks, these companions lessen the sense of abandonment, so the woman is not physically and/or emotionally alone. Additionally, companions may provide protection and support for the mother. In Ghana, the family members and husbands fulfil these roles. For instance, some maternity clinics in Ghana encourage the family members, including males, to become involved in the maternal health care. Beatrice described how involving significant others can achieve positive outcomes:

When you identify them, you want to admit and manage them but you know they wouldn't want agree to it so now we go the extra mile, to involve the significant others in their lives, like their husbands and other relatives. We involve them in the care, so that…erm…at the end of the day…erm…we can have a good outcome [Beatrice].

It was recognised that it is sometimes difficult to convince women to attend antenatal care and give birth at the hospital. This had led to a new intervention to start involving significant others in the women's admission and the delivery. This idea has yielded good outcomes. The participants argued that allowing a family member to accompany the pregnant women at the hospital made them to feel at home and gave them a sense of security.

Felicia's comment shows that a support person was not necessarily a member of the woman's family but could be her spiritual leader or significant other. The woman is given the right to chose whom she wants to come to the hospital with her, so perhaps she feels encouraged and supported by seeing her close relatives or significant others beside them in the hospital.

Sometimes, you would have to call a support person. If the pastor wants to come, let the pastor come. If the husband, sometimes you have to bring their mother and things and bring them all together and speak to her and then we accept, so these are a few areas [Felicia].

Gloria and Sophia pointed out that, due to the population served by the hospital, most of the female patients were uneducated. This lack of education was also associated with a tendency to forget or struggle to understand the instructions given by the health professionals, so the support person was able to remind the women about their medication and appointments.

We recommend that she brings a support person and we talk to all of them. Some are illiterate so she may forget something, so if they bring two people or even one, these can remind her of her medication or when her appointment is to return to the hospital [Gloria].

We ask that she brings a support personm so it could be her sister, her mother, her husband, and then you give them the information together because sometimes she herself might be illiterate [Sophia].

While the idea of bringing a support person appeared to have worked, the health professionals always recognise the importance of educating both the client and the support person because sometimes the persons they rely on might also be illiterate. Nevertheless, on the labour ward, because of the open nature of maternity wards, health facilities do not allow women to have the social support of a birth companion while giving birth. This means that a woman will probably give birth surrounded by midwives and doctors with whom she is unfamiliar. The evidence suggests that women value and benefit from having a support person present during their labour and delivery. This assistance may include emotional support (a constant presence, reassurance, and praise) as well as information about the labour's progress. It may also include suggestions about coping techniques, comfort measures (comforting touch, massage, warm baths/showers, encouraging mobility, and promoting adequate fluid intake and output), and speaking up on the woman's behalf when necessary. Concerns have been raised that the experience of labour and delivery has become dehumanised due to a lack of continuous support. These could have a negative impact on the quality, outcomes, and experience of care during labour and childbirth. During labour, supportive care may improve the physiological labour process as well as women's feelings of control and confidence in their own strength and ability to give birth. This may reduce the need for obstetric interventions and strategies while also improving the experiences of women. In addition to these practical benefits, Maggi described how being seen as a supportive health facility led to other benefits, such as an awareness in the community that women were being cared for properly there and even that the staff could be friendly and 'laugh with them'.

When they think that the facility is accommodating, that we take good care of them, we laugh with them, the social aspect [Maggi].

4.5 Strategies for improving the quality of maternal care

Based on the healthcare providers' experiences and accounts of what facilitates pregnancy and childbirth, this theme presents a number of solutions that were proposed by the women and healthcare providers interviewed for this research. At the level of the healthcare system, the participants in this study proposed a number of strategies for improving maternal health care. The aims of the proposed strategies are, first, to counter and correct the negative aspects of the maternal healthcare system in Ghana.

4.5.1 The Training and Motivation of Midwives

Over half of the maternity health professionals interviewed described the problem of the poor maternal health care in Ghana as two-fold: the limited number of trained qualified personnel, such as nurses, midwives and obstetricians, to provide care at the community level, and the poor remuneration. As a remedy, these participants recommended that more midwives should be trained, remunerated and motivated to deliver a respectful, high-quality service to the patients.

In Maggi's opinion, increasing the work force within the antenatal clinic and improving the infrastructure are key to salvaging the situation. Increasing the work force must cut across all professions in order to reduce the health professionals' heavy workload and enhance patient care.

We need more staff in all aspects in antenatal, clinic, the labour and then post-delivery as well and with the doctors, too, their time and, every day, if we could also get additional infrastructure, this could also help to improve maternal health [Maggi].

The Ghanaian Government appears to be failing in its responsibility in terms of staff employment. Conrad noticed negative impacts on care delivery, which he believes the government should address in order to improve the services for mothers and babies. Conrad stated that the government should intervene:

We talked about the fact that the government needs to give us adequate staff [Conrad].

While Felicia noted the need for a larger workforce, she emphasised more skilled staff. Apart from the shortage of maternity health professionals, a lack of skills appears to be a big issue within maternity care, as it limits their ability to provide high quality maternity care. For example, some midwives who were trained years ago may need to attend retraining or refresher courses to provide good quality maternity care.

In fact, we really need the workforce to be high. The workforce should be skilful. The workforce should be high [Felicia].

In contrast, when discussing unskilled health professionals, Sophia admitted that, in her personal assessment, they are not competent enough to carry out their work. This particular issue demotivates the few competent maternity health professionals and decreased productivity in relation to inputs and output. Having more skilled staff would improve their lives and well-being and, at same time, improve maternity care.

Ha ha! It is a difficult question. From my own perspective, we are not good at all but it depends on the person [Sophia].

Beatrice and Felicia take the view that all is well when one is well-motivated in terms of salaries/remuneration and career development, although much of their attention is on money as a way of motivating them to work hard, regardless of their career development within the organisation. The group described how this impacted on their work:

Extent that they are motivated in a way that, when you are doing something, you will not even look at your back because you know that, when you do any extra thing alongside with yours, you will be motivated so I think that is what they can do. They should look at the motivation side…so I think the human resources and then the motivation should arise to help the midwives to work hard [Beatrice].

if there is something like you can work extra hours, you work some four hours and you get something, everybody would stay here and not go and work anywhere else [Felicia].

In all of the above recommendations, there were emotive accounts of how the inadequate staffing of the health facilities, coupled with the poor working conditions, often led to stress, fatigue, overwork, burnout and moral distress. For example, there were reports of inadequate staffing resulting in losing mothers and babies in health facilities.

4.6 Community-level strategies

4.6.1 Health Education

Almost all of the maternity health professionals suggested that women should be educated about the components of maternity care as a strategy for improving patient care in maternity hospitals. Women should be informed about the steps to be followed in order to obtain the care they require at the facilities. They went on to suggest that the way to make progress is to increase the health education campaigns using the radio and community durbars to educate women about the need to attend antenatal care and hospital delivery.

Women can obtain this information from antenatal clinics, radio adverts, and social centres like churches, according to the health professionals: almost all the midwives reported that many of the women in the district remained ignorant about health issues, including maternal health.

Sophia took the view that the hospital should step up rigorous educational activities to save the lives of the women and their unborn babies before they fall into the hands of spiritualists, Traditional Birth Attendants and quack doctors. She pointed out that herbalists and native doctors were convincing some pregnant women to access their service as an alternative to the professional service. Replacing professional care service with herbalists or native doctors' services could mean that such women are acting in ignorance. In addition, if they hear stories from the women who attend hospital about there being no staff, beds or resources, poor care and women not being listened to, they may feel that this alternative type of care is a better option for them. It is like a vicious cycle: the women who go to hospital are more likely to be attending due to obstetric complications after receiving care from herbalists, Traditional Birth Attendance (TBA), spiritualists, etc. These women and their babies are more likely to suffer mortality or morbidity, and so will believe that the hospital is also not a safe place in which to access maternity care. This could also mean a lack of health education for women at the community level. Sophia was of the opinion that well-equipped health centres are needed in every community, with skilled staff, who should continuously educate women about the

importance of accessing professionals' services rather than those of herbalist or native doctors. Midwives could make door-to-door visits in the local area to conduct antenatal clinic risk assessments, and encourage women to attend hospital. However, most midwives do not wish to work in the rural areas due to the poor social amenities, such as the lack of drinking water, electricity, or schools for their children. Sophia described how the situation might be changed:

We need more education because they want a simple way. Some herbalists or native doctors go to the houses of pregnant women and take care of them. They think it is quicker and more convenient as they come to their doorstep so we should educate them and not keep quiet. The hospital should be well-equipped with human and material resources so that, when they come, we would be able to give them high quality care. Good training, good midwifery practices, and evidence-based interventions should be implemented in order to do our best to help them. We should be hardworking in order to help the women when they come to us. We should ensure that we educate the public so that, when women become pregnant, they will access the antennal care services. Some of them do come but some also go for herbal treatment and other things [Sophia].

Whilst the importance of educating women and the public is acknowledged by the maternity health professionals and how this affects women's maternity care experience, Felicia and Maggi suggest the importance of emphasising the need for women to access antenatal care in time. It is important to assure them that the midwives are available to support women throughout their maternity journey, from the antenatal to postnatal periods, by providing them with person-centred care and giving them the information they need for their health and wellbeing. Felicia and Maggi took the view that educating women to access antenatal and maternity care would improve the pregnancy outcomes.

We discussed educating the general public about the need to attend ante-natal clinics and attend hospitals. Not stay at home…ah…till it becomes…er…too dangerous or too late [Felicia].

If we begin with the antenatal section, they gave more education so at least the public health people can go out there and give more education on the need for them access antenatal care. The attitude of the staff when women attend antenatal clinics, they need to explain things to

them more to understand why they have to come and then the way they talk to them, take care of them when they come to hospital when it comes to labour too when they come in labour the staff, too, the way we take care of them when they come [Maggi].

The midwives reported that the way to achieve respectful, high quality maternity care is to involve the 'Men of God', the media and communities in general in promoting the maternal health care campaigns. They felt that the pastors and imams are significant to women in the communities. This is because most pregnant women go to them after they have visited a hospital. As a result, they felt that the women could be educated through the churches, mosques, markets and media about maternal healthcare. Beatrice took the view that involving 'Men of God' in maternity care would go a long way towards improving the pregnancy outcomes in the community:

Facility organised a workshop for all pastors…erm…and imams on maternity health care. We dubbed it…erm…"Men of God for maternal health"; where we invited them, and then we spoke to them about the maternity services, about the need for pregnant women to access the services. Because more often than not, they come with a complication. You tell them how to manage it, and then they will tell you our pastor says we should do ABC, and then they will rush to their pastor, and then come back in a very bad state [Beatrice].

Recognising the significant influence that the religious leaders have on women, the health professionals decided to speak through them. Women hold their religious leaders in high regard and follow their advice. Religious leaders could be educated about pregnancy, the associated obstetric complications and the services available to them to avert such complications arising, such as postpartum haemorrhage, obstructed labour, postpartum sepsis, complications related to abortion, pre-eclampsia/eclampsia, ectopic pregnancy, and ruptured uterus. The reason for the religious leaders' involvement is because an average Ghanaian woman is believed to respect her pastor or imam so much that she will readily accept his advice. It is expected that the pastors and imams, if they had a better understanding of these complications, would pass it on to the female members of their congregation and advise them to attend antenatal clinics.

"Education should be done in our churches, hospitals, markets and wherever there is a gathering. You can't predict the outcome of a labour. The baby may be born safely, but the mother may start pouring with blood" [Gloria].

The midwives' frustration was often triggered by the fact that women did not know what to do. The midwives in this study said the way forward is to provide health education in the community and recommended communal places, such as churches, schools, hospitals and market places, as the best places for health education to take place. Joyce described how little some women knew about maternity care, saying '*they don't get it*':

"For me, I see that some people look like they haven't even had a basic education so, whatever you tell them, they still do not see the need to come. She doesn't know that she has to come. Its for her health that she has to come. No, they don't get it" [Joyce].

While the majority of the midwives see health education as an important tool for changing the attitude of the pregnant women towards becoming more accepting of and utilising maternal care services, Felicia takes the view that most women would not still listen to anyone, no matter what they are told. This is anchored on the fact that these women lack a basic education and it would seemingly be difficult to convince them to see the necessity of attending an antenatal clinic. In Felicia's opinion, education is a requisite for an improved utilization of antenatal care. She believes that a woman's understanding of pregnancy and its associated complications determines how she handles her health, pregnancy, and choice and location of care. Hence, while it may be impossible for every woman to receive a formal education, it is imperative that every woman receives health education through their midwife or community nurse to place her in control of her own health. Felicia gave an emotive account of women's health-seeking behaviour:

"I still say education. I mean, how the patient herself still takes the whole…erm…understands her own health in relation to pregnancy or any disease, if the woman doesn't really see that I have a problem or pregnancy is a serious thing" [Felecia].

According to Gloria, the inability of women to read or write or understand instructions constituted a huge challenge for midwives. Basic education is required in order for the women to understand what is happening in order to make things slightly easier for the health professionals. Unfortunately, this was lacking. The high level of women's illiteracy was seen as the cause of their negative attitude towards professional help. Providing information to women about important assessments was crucial in supporting them to make an informed decision. For example, many women refused to take oral iron and Sulphadoxine-Pyrimethamine due to their unpleasant taste, side effects and their lack of knowledge of the

importance of the need to avoid anaemia and malaria during pregnancy. Even when the health facilities have information and illustrated posters to aid the women, helping them to make informed decisions was challenging. Gloria described how the problem of illiteracy impacted on women's maternity care experience:

"It becomes a challenge for us and, sometimes, I have a problem, so you know that everybody should at least have a basic education to be able to understand, read and you yourself know what is happening so that we won't have too much difficulty. This kind of ignorance means that women don't come to the hospital or stay at home to deliver, despite the complications" [Gloria].

The forgoing is a representation of the perspectives on one strategy - the need for more health education - that the majority of the healthcare providers sampled proposed. In searching for an explanation for the persistently high maternal mortality as well as level of skilled maternal healthcare services access and utilisation, these healthcare providers reasoned that most of the damaging factors lay with the women themselves. Specifically, women's limited health knowledge and backward beliefs were implicated for their non- or insufficient attendance at clinics to receive adequate antenatal care, as well as home deliveries.

Beatrice mentioned the education initiatives that the midwives had been engaging in with the media, in communities, in schools, and so on. Beatrice described how she interacted with the 'Men of God' and the entire communities:

The interaction we had with the men of God, and the communities. So, you know, education, education, yeah, is the way forward. We had…erm…some sessions with the media, with the radio stations especially in this environment, this community, to talk about maternal health issues and the need for every woman who misses a period to attend hospital for care, and so that has helped in a way. That has increased the number of women who access the facility and so education, media education…erm…our community health nurses go into our communities, go into the schools, go into the churches, go into the market, they go into the communities, to give education and health talks on maternity health services [Beatrice].

In the communities where the health awareness initiative was organised, Beatrice confirmed that there was a change in the women's attitude towards antenatal care. Those communities where such awareness-raising took place recorded more pregnant women attending antenatal clinics. As a result, health education was seen as key to changing women's attitudes towards antenatal care. The media, community nurses, churches, schools and markets were important tools for achieving a higher take-up of maternity services.

4.7 Conclusion

In this chapter, the main themes of this study have been discussed in line with the available evidence, highlighting the significant findings and considering their importance in relation to the aims of this study. This qualitative study sought to gain an understanding of the maternity health professionals' experiences regarding the barriers and facilitators and how to improve the maternity care services in Ghana. The poor perceptions of care quality and evidence of negative attitudes among the maternity health professionals are important barriers to pregnant women seeking care.

By assessing the inadequate infrastructure, understaffing, motivation of midwives, burnout, moral distress, culture of blame, and negative attitudes, among other factors, the chapter suggests that women's past positive and negative experiences of receiving skilled hospital maternity care provide an opportunity both to improve the content, quality and effectiveness of respectful care, and to draw useful lessons to help to ensure that high quality care is provided along with skilled facility delivery and post-delivery care services.

The chapter also showed how the priorities of the maternity care professionals differed and/ or were in line with those of the women. These divergences and alignments might have implications for how maternity care services are conceived, organised, and delivered to women, and also affect the choice of strategies pursued to address the low uptake of and barriers to accessing maternity care. The following chapter examines the experiences of the pregnant women and new mothers, to compare their perspectives with those of the professionals.

CHAPTER 5: DATA ANALYSIS AND FINDINGS (MOTHERS)

5.1 Introduction

The previous chapter investigated the barriers and facilitators regarding high quality maternity care from the perspective of the health professionals delivering the services. This next chapter of empirical findings covers the perspectives of the female patients. One of the objectives of this research was to explore women's experiences, perceptions and expectations of the maternity care services in Ghana, with the hope of identifying which factors hinder the access to and use of skilled maternal health services and whether or not the women are satisfied with the care they received.

Originally, forty women consented to participate in the study. However, half of the women struggled to think of what to say when asked about their maternity care experiences; hence, interviews were not useful because they did not generate sufficient data. The participants may have been embarrassed to discuss their birth stories with me as a male or researcher/hospital manager. They genuinely struggled to articulate their experiences and feelings. It is possible that they had never been asked their opinion before, had some form of difficulty with cognitive processes or even feared reprisals from the midwives or their relatives if they made any derogatory comments. For these reasons, 20 interviews were discarded because they contained only monosyllabic responses, or *'it was OK',* to all of the questions posed about their experiences. This meant that only 20 interviews were included in the analysis.

To document their maternity care experiences, 20 semi-structured interviews with women who had delivered a healthy baby within the previous 12 months were included (see chapter three for the methods). This chapter reports the findings of the study, which are based on the women's accounts about their experiences of receiving skilled antenatal, intrapartum, and postpartum care services in the Tema Metropolitan district of Ghana.

Table 5.1 summarises the demographic characteristics of the 20 participants. They ranged in age from 18 to 49 years. Most of the women had little or no formal education, however, a few indicated that they had completed some or all of their secondary education. One participant

reported having a higher than secondary education. Most of the participants were Christian, two were Muslim, and all were from one of the communities in Tema municipal District.

The women's monthly income ranged from 300 to 500 Ghana cedis (£42-£69), generated by selling things. These participants seamstresses, traders and hawkers. Those who are married did not declare their total household income because they could not specify how much their husband earned. Those who were unmarried and had given birth out of wedlock struggled to take care of their children. Most of the women had between one and three children. For some of the women, the pregnancy under discussion was their first one (Bell, Martha, Godly and Linda), and the maximum number of children was six (Kasia). Linda said that she had used both traditional and orthodox medicine during her pregnancy but none of the other women reported using traditional medicine.

Table 5.1: Demographics of each participant

Pseudonyms	Age in years	Employment	Monthly Income GHC/£	No. of Children	Education	Partner	Religion
Felicity	30-35	Hairdresser	400/55	3	JHS	Husband	Christian
Bell	30-35	Media personnel	500/69	1	SSS	Husband	Christian
Rosalinda	30-35	Trader	400/55	2	JHS	No Husband	Christian
Edith	30-35	Seamstress	400/55	3	JHS	Husband	Christian
Camilla	20-25	Unemployed	_	2	JHS	Husband	Christian
Margaret	30-35	Unemployed	_	3	JHS	Husband	Christian
Jackie	30-35	Businesswoman	500/69	3	O'Level	Husband	Christian

Agnes	35-40	Trader	500/69	5	JHS	No Husband	Christian
Dela	40-45	Trader	400/55	5	JHS	Husband	Christian
Kasia	30-35	Seamstress	500/69	6	JHS	Husband	Muslim
Martha	20-25	Student	_	1	Tertiary	No Husband	Christian
Linda	30-35	Seamstress	400/55	1	JHS	Husband	Christian
Ursula	30-35	Trader	300/42	2	SHS	Partner	Christian
Mary	20-30	Unemployed		1	SHS	Husband	Christian
Rita	35-40	Seller	400/55	3	JHS	Partner	Muslim
Destiny	30-35	Seller	300/42	2	JHS	Husband	Christian
Godly	35-40	Trader	300/42	1	JHS	Husband	Christian
Priscilla	30-35	Trader	400/55	2	JHS	Husband	Christian
Perpetual	30-35	Trader	500/69	3	JHS	Husband	Christian
Theresah	30-35	Trader	500/69	4	JHS	Husband	Christian

JHS – Junior High School

SHS - Senior High School

No Husband- Not Married

Husband – Married

Almost all of the 20 women included in the analysis perceived that they had received a mixture of poor and good care during their facility-based delivery. Most felt dissatisfied with their care overall. The thematic analysis resulted in the main themes being identified, which will be outlined below and discussed in detail along with the sub-themes, using quotes to support the explanation of these findings.

The themes that emerged from the semi-structured interviews (see appendix 6) on the challenges and barriers that women face when accessing maternal health care services included: the financial and transport costs, informal requests for payment, and spirituality. However, the findings reported related to the care in the health facility also cited disrespect and abuse through negative verbal communication, physical abuse, stigma and discrimination, non-confidential care/a lack of privacy, abandonment/neglect, as well as positive care. The themes were analysed at the individual and institutional levels rergading the uptake and delivery of maternal healthcare.

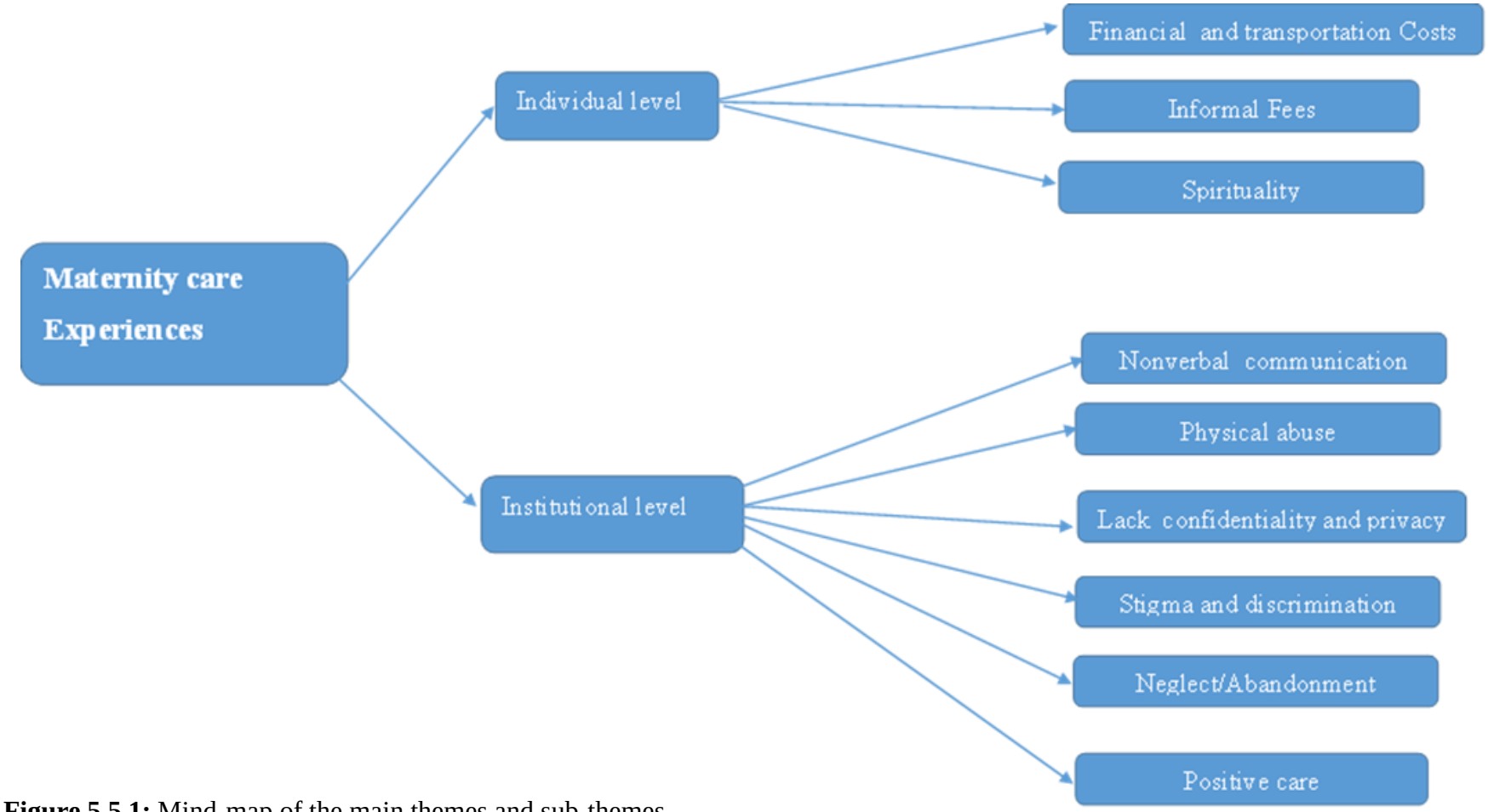


Figure 5.5.1: Mind-map of the main themes and sub-themes

5.2 Theme 1: Individual/community level barriers

Under the individual/community level barriers, the themes that emerged from the women's interviews related to their perceptions of the barriers to maternity care shall be discussed, including the financial and transportation costs, spirituality and informal fees.

5.2.1 Financial and Transportation Costs

Financial problems were recognised as a contributing barrier to accessing antenatal care, with almost all of the participants specifying a lack of money to pay for transportation and other medical expenses as the reason why they decided not to attend or miss clinic appointments. It is apparent that most of the women in low paid jobs were reluctant to take time off work to attend clinic appointments.

Looking at the cost of transporting herself to and from the hospital, meals and other things, Linda always felt discouraged to attend antenatal care. As she mentioned, the modest expenses incurred (*GHC* 23 cedis) is greater than any of the women earned per day, as table 5.1 shows (*GHC* 20 cedis). Lacking sufficient funds to cover these expenses represents a huge barrier to these women taking up antenatal care. Also, regarding transportation, the cost was not the only problem faced: having to travel some distance in order to access public transport was also stressful and time consuming. These financial and transportation issues were described by Linda:

I only had a problem with my travel costs, which is from Afienya to Ashiaman. It was GHC4 (£0.50) with the public bus "trotro", my return journey was GHC 13 (£1.90) every day. Sometimes my meals were a problem because GHC 10 cedis (£1.40) was not enough for me (Linda).

Edith noted the enormous challenges which they faced when trying to access antennal care services. However, in her comment, she demonstrated a level of resilience as she decided not to be deterred by these challenges. By implication, this shows how much she valued such care services and was unwilling to give them up, despite the challenges. While her resilience can be admired, her comment contains valuable information about the delivery and uptake of antenatal services. The distance to health facilities is an important factor to be considered in the delivery of care services. While some individuals may be able manage the stress of travelling a long

way to access care services, others may not, which might deter the utilisation of facility-based delivery services. Distance can be a combination of geographical distance and the mode, time, and cost of the travel. The geographical distance from Afienya to Ashiaman is 12km while that from Afienya to Tema General hospital is approximately 19.5 km.

It's far from home for transport. It's difficult, but we put in effort at everything, so it is not that bad. Those challenges are normal. I could wake up as early as 4:00am and get here by 6:00am. I normally wake up early due to the distance from the hospital to my home. I use trotro (public buses). I take two trotro (Edith).

While others spoke of a lack of funds, the deplorable state of the roads, and the distance, Bell added the issue of the exorbitant cost of transport. It appears that drivers deliberately hike up their prices to extort the women. Unfortunately, it appears that the government fails to regulate how much the individual transporters charge travellers.

Is it not easy! Sometimes drivers charge more due to the traffic [Bell].

For Kasia, having six children made it more difficult to navigate the hurdles of providing childcare while still attending antenatal care. The lack of family care was highlighted as a problem. Although her husband sometimes called a taxi for her, this was not a regular occurrence. On the days when her husband was unable to pay for a taxi, she ended up trekking to the facility for about two hours. This would be very stressful for a pregnant woman and might discourage her from attending appointments.

At times, my husband hasn't got a car so sometimes he books a taxi for me but there are days when I walk for about two hours. Remember, I am also a mother of six [Kasia].

In her interview, Godly appeared to be aware of the importance of antenatal care and seemed keen to utilise the services. However, like the other participants, Godly admitted that her only challenge is transportation, and she might miss her appointments due to an ability to afford her transport fare.

Yes, please, that is the only hindrance, I mean the transport [Godly].

Edith admitted that she lacked knowledge about conception and delivery and that was the reason why she liked attending antenatal clinics, because of what she gained there. She feels that it is a shame when she is unable to attend due to an ability to pay for the transport and other things. She is aware of the service and its importance but handicapped due to transport issues.

Because I don't have knowledge on all aspects from conception to delivery, so I am forced to come here for that vital information. Because of this, when you don't have money to come to the hospital, it's sometimes a shame because you might miss out on good information [Edith].

Having been told that the service is free to them, Bell and Ursula were concerned that there are certain aspects that are not covered by the insurance; for instance, transportation, meals, scans and medication. Therefore, affording these aspects of the service became an issue for them. In Bell's opinion, one can receive the best care one can afford the cost, which includes being able to pay for transport, scans, meals and medication. Unfortunately, Bell believed that she could not afford these things due to her financial constraints:

We are told it is for free but there are some things we have to pay for because they are not covered by the insurance. Besides, if you want the best care, you have to pay for it [Bell].

Ursula described how some prescribed medicines are purchased outside the hospital:

It is free of charge during antenatal care unless certain prescriptions that are not in the hospital, so you have to buy such drugs at drugstores [Ursula].

Losing one's child because of an inability to afford the services could be highly traumatic. It appears that the existing insurance did not help very much, given that the cost of the medication is not covered. If long-term medication is required for the wellbeing of either the child or mother, it will become a difficult situation if the individual cannot afford it. Kasia felt that her baby died because she could not afford to pay for the medication that could have saved her child's life.

I would like to start with the government. I had my first child in 2008. Health insurance was relatively new, so I paid for my maternal healthcare. In 2010, I had my second baby, and didn't pay anything because I was insured, I only gave GH₵ 20.00 to the nurses as a gift. In 2013, I couldn't pay for the drugs that the hospital prescribed so I lost the baby. In 2015, I didn't pay anything. Getting your folder on time at the hospital requires paying some money [Kasia].

After observing what some women and their babies go through, Kasia felt that the government needs to do more to help them. Declaring a free antenatal care service does not appear to be enough, given that other aspects of care/responsibilities must be paid for and, unfortunately, most women cannot afford to do so. This led to some of the women taking decisions that may have harmed themselves or their baby. For a mother to leave her baby and disappear, it means that she must have felt that she was unable to care for her baby, perhaps due to her mental health issues or a perceived inability to care for the baby financially. This seems like a crime against humanity and requires government intervention, as Kasia pleaded. Furthermore, an expectant mother going to give birth without any baby clothes shows her intense financial difficulties.

I once had to give my baby's dresses to a woman who came to the hospital to deliver without anything. A woman once left her baby at the hospital gate because she didn't have any money. The government should intervene [Kasia].

The socioeconomic and gender disparities in health status can be significant. Women living in the remote parts of the Tema communities, as well as those from poorer households or with less education, face constraints in accessing services. These are compounded by the degree of the women's control over the family income and the locus of the decision-making regarding their health care. Some of the women were unaware how many weeks pregnant they were and relied on discussions with their husband and mother to decide if they needed to go to hospital or not. The husband then needs to be prepared to pay for tests, medicines and other supplies.

This was a clear demonstration of how women are disempowered, as they lack control over their own healthcare, are uninvolved in the decision making, and have no choice regarding where they give birth or when to seek medical attention. In Malawi, nearly one-third of women's health-care decisions are made by the husband, with only about 18.6 percent making their own decisions. In effect, the husbands control their wives' lives completely. Thus, a woman must obtain her husband's permission to attend hospital and to pay for transport and

other hidden costs. These issues were clearly highlighted in this study as the reasons why women may fail to attend the health facility during pregnancy or labour.

Some husbands may genuinely be unable to afford to pay the transport and other medical expenses. Indeed, some women revealed that their husband acknowledged the importance of maternity clinic visits, but that they are financially constrained. Thus, women have to forgo the maternity clinic and take herbal medicines, which are cheaper and sometimes even free This threatens the health of both the mother and her child. Linda highlighted:

Hahaha, my husband tried his best to cover the transport and other expenses and, when he was unable to get me money, I postponed the review date to the following day. The only problem was when I travelled to the village where I could only call the midwives for advice and take herbal medicine back home because I could not access the prescribed drugs [Linda].

Kasia clearly shows that she is financially dependent. If her husband cannot afford to pay for her antenatal care, she cannot attend for it. This is typical of an African patriarchal society, where men dominate women. This arrangement does not grant woman the freedom to decide. The participants explained that they have had to miss appointments because their husbands did not have any money to give them. On occasion, Linda had to take herbal medicine as a substitute for her medication because she could not afford to pay for her prescription.

There were days when my husband didn't have enough money for me to pay my midwife, so on such days I wouldn't come [Kasia].

Depending on her husband for money was problematic for Kasia as, on the days when her husband did not have any money to give her, she could not attend her antenatal appointment. Poverty among the women is a huge barrier that hinders their access to antenatal services.

5.2.2 Informal fees

Previous researchers have investigated requests for informal fee payments by MHP, with examples of women being detained in the health facility due to an inability to pay, and requests for unofficial fees to be paid in return for care. In this study, there was no evidence of detention in the facility due to an inability to pay, although some of the women mentioned requests for the payment of informal in return for key aspects of care. In most cases, this was in the form of bribes, thus creating a financial burden for the women.

While the government has declared free maternal care for women of child-bearing age, Kaisa recounted how often her midwife tried to extort money from her during each visit. This unofficial request for money not only put her under pressure but also felt embarrassing, especially on the occasions when she did not have enough money to pay the midwives. Kasia sometimes overstretched herself in order to meet the financial demands of the midwife and so avoid receiving disapproving looks. Regrettably, there were occasions when Kasia had to miss her appointment because she did not little or no money to offer and, at the same time, did not wish to feel embarrassed or be confronted by the midwives because she could not meet their demands.

Kasia felt embarrassed about being coerced to pay her midwife a certain amount (GH₵ 20.00, £2.79), which she felt to be insulting.

My midwife often demands money. There are days when I don't come to the hospital because I would feel very shy giving her GH₵ 20.00 (£2.79) so I usually wait till my husband has enough for me to give her. I respect her and I don't also like her facial expression when I don't have the money to give her [Kasia].

Her emotional account uncovers many of the unprofessional attitudes among some health professionals, which appear to be continuing unabated. The health professionals' approach to women was seen as disrespectful. The pregnant women were sometimes disregarded, disrespected, ignored or even denied care services because the professionals felt that they were poor, with poor clothing, and no money to offer them as a bribe. Linda sometimes felt maltreated and humiliated because individuals in the queue behind her often-received treatment before her because they bribed their way through with 10 cedis. The poor attitudes of the casual health workers also added to her feeling of humiliation, such as when she discovered that the cleaner of the maternity ward has thrown her slippers into the bin because they were perceived as dirty and old and so unfit to be in the maternity clinic.

So, as I said, your looks sometimes determine the way you are treated. Sometimes, too, when they ask for like 10 cedis (£1.40) and you are able to pay, you can skip ahead in the queue. Cleaners can also throw away our slippers when we leave. Sometimes, when you are unable to pay the 10 cedis (£1.40), you are not treated well, regardless of your health status, I reckon [Linda].

The demographic data in table 5.1 show that Kasia is relatively better off than some of the other women interviewed, and has a husband, which also affords her a higher status. Kasia, in particular, seemed to know how to pay to get the best out of her midwife, and conversely could face her midwife when she has not got any money to pay for special treatment. This description implies a giver and a receiver, whereby the woman is willing to pay for key care and the receiver is willing to take her money. In effect, those who cannot afford to pay like Kasia can are then are neglected or do not benefit from this special care.

When you come here with money, you are given preferential treatment and, if you come with your husband, then you are treated as special. When I gave birth, I had a problem with my leg so I couldn't walk and usually I would call my midwife to inform her I would be coming, and she would tell me to come on time. She sometimes skipped breakfast to attend to me, knowing that I would pay her after that [Kasia].

While the participants discussed how they used to offer money previously in the form of appreciation to the midwives for assisting them during and after the delivery, it now appears that the midwives are beginning to see such gestures by mothers as their right. According to Kasia's comments, payments that were previously seen as appreciation have become a condition for receiving care in current practice.

After a delivery, I usually feel weak, due to over bleeding, so I would have to be carried with the baby to the ward. I delivered around 6am, I would be too weak. We used to show appreciation in any form to the nurses who carried us to the wards with our babies but, now, you only receive such services after you have paid GH₵10.00 (£1.42) [Kasia].

This view contrasts with the belief among the general public that a pregnant mother does not have to pay anything in order to access antenatal, perinatal or postnatal services. Kaisa was shocked at how much she was expected to pay at the hospital. Fees were also charge for prescriptions and tests, which conflicts with the government's declaration that all maternal care is now free.

The public have been told that maternity care is free. Some of us come without money and encounter unexpected bills to buy drugs and do this and that so, if it is not free, let us know so that we can come prepared and our husbands will be aware of the situation [Destiny].

In this study, the various charges are described, from small amounts for urine pots and blood tests to large amounts for tubal ligation so the women appear to be being exploited and forced to pay for services that are supposed to be free. There are different practices, depending on the specific hospital's culture. Despite the fact that some mothers were registered with the National Health Insurance, they provided their own pints of blood to be given after delivery when the hospital is short of blood, yet were still charged a sum of money which was a burden to them and discouraged from presenting themselves at and using the facility-based maternity service. Kaisia, Edith and Godly described how the MHPs exhorted money from them:

When you come here, you have to bring a urine sample but sometimes people come to the hospital to take sample and it costs 0.20pesewas (0.028 pence) [Kasia].

I pay 30 pesewas (0.042pence) and sometimes pay an extra 1 cedi (0.14pence) for the container to urinate in and then 50 pesewas (0.071 pence) to get my urine tested [Edith].

For my convenience, I pay 30 pesewas (0.042pence) and sometimes pay an extra 1.70 cedis (0.24 pence) to get my urine tested [Godly].

Agnes also mentioned the illegal charging of fees:

The little things about money should be looked at but, for me personally, I have a health insurance card and I brought my own blood and still paid 600 cedis (£90) [Agnes].

In the quote below, it is apparent that Bertha might have experienced birth trauma, and even post-traumatic stress disorder, and must have felt terrified about returning to that same hospital again.

I told myself and husband that I wouldn't come to this hospital again because I lost a baby here and I was also verbally assaulted. I went to a private hospital, but I had to come back here to face my fate because they charged GH₵ 500.00 (£80) [Bertha].

Due to the continuing exploitation occurring in the health facilities Bertha chose not to visit the hospital again. Apart from the unofficial fees being demanded from the women, she also stated that she was verbally abused and lost her baby at that hospital.

It is evident that most hospitals do not provide urine bottles, so the midwives gather used ampoules, clean them and then sell them to the women to generate additional income:

'With a health insurance card, you would not pay but, without the card, you would pay but we pay for urine testing [Margaret].

Thus, the financial burden is placed on the mothers accessing the facility-based services. In most cases, official receipts are given for payments, which are a genuine costs, but official receipts are not given for some of the payments by the pregnant women, and can be considered bribes.

However, the women seemed to accept that attending hospital generally means that they will need to pay for things. Strikingly, almost all of the interviewees thought that women who arrive at hospital unprepared for this were foolish or naïve. Those who did not hold this attitude had themselves been caught out without money. This corruption is condemned but accepted, as the women want to receive treatment and avoid being detained at the hospital, sleeping on the floor, due to an inability to pay what they are considered to owe.

5.2.3 Spirituality

Religion constitutes a significant barrier to the access and use of skilled maternity care. Women may fail to access and use skilled maternity care services due to their religious beliefs. The question arises: what impact does religion have on women's decisions to access maternity care? The discussions with the women revealed that religious beliefs affect the access to and use of maternal and new-born healthcare services via the concept of faith healing, prayer, asking the pastor for advice, religious doctrine, keeping healthy, as well as the social support networks provided by religious groupings. The belief that pregnancy and birth outcomes are completely in the hands of God is a significant issue affecting how the women in this study view the need for maternity care. They generally viewed maternity services as secondary to religious practices. This clearly affects their view of everything, so it is important to highlight how much

religion impacts on their decisions and the protective measures that they undertake with regard to their pregnancy.

Linda appears to have become so attached to her pastor that he is her first point of contact whenever issues arise regarding her pregnancy. Although she did not state that she fails to access professional services, the fact that her pastor is her first point of contact whenever she feels concerned about her pregnancy arguably means that seeking professional help is her second choice.

I could not sleep yesterday until I called a pastor to pray for me before I could sleep. There are a lot of issues that accompany pregnancy [Linda].

Rosalinda continued to put her trust in God and the prayers of her pastors. She believed utterly in the prayers and advice from her pastors and failed to mention antenatal care, which suggests that she does value antenatal care or may prefer spiritual help over professional help. It also indicates Rosalinda belief in the prophecy that she would die after the delivery. Women seek spiritual stability by fasting for around 12 hours daily for seven to 14 days at a time in such churches. This behaviour make it difficult for pregnant women to seek the help of qualified delivery attendants. Religious declarations are undoubtedly accepted because they are considered sacred and provide a sense of certainty. The prophetic warnings issued by the Spiritual Churches instil the dread of a spiritual attack in pregnant women, causing them to avoid seeking help from professional delivery attendants. The practice of deterring women from using trained birth attendants exposes them to unskilled attendants, increasing their chance of dying during childbirth.

God and the prayers of my parents. During my previous pregnancy, a prophet told my parents that their daughter in Accra was going to die after the delivery. The prophet sent for me, so my parents in the village kept telling me to come to the village so I told my pastor about it and she said any family member could represent me for the prophet to pray for me so there was no need for me to go to the village and he prayed for me and everything went well. I am a trader and sometimes we get agitated by customers and old people who come looking to buy things and all this could have an effect when you are pregnant, so I have to be full of prayers [Rosalinda].

While Mary admits that pregnancy comes from God, she still acknowledges the importance of hospital services. She only knew that she was pregnant because she presented at the hospital.

Laughing! I didn't go for any prayer. Pregnancy is the work of God; I didn't even know I was pregnant until I came to the hospital [Mary].

Rose was already three months pregnant before she found out. During this period, she did not take any actions to protect the pregnancy, despite the challenges she faced at that time. She had a good outcome, which she believed was the work of God.

Oh, OK, God being good, my third child is 9 years-old and I never thought I would conceive again. I realised that I was pregnant for the fourth time in the third month, so I suffered a little. Everyone was saying the third was too old for this baby to come and that was why I suffered. When other pregnant women were having a shot of tetanus, I had two because of the huge gap between this and the third child and, because I did not know about my pregnancy, I did not take a full course of my antenatal [Rose].

Linda appeared to be using two services at the same time. She went to church for advice and at the same time received herbal medicine from them. She also received advice and medicine at the hospital. Her comments showed that she prioritised the services she received from her church and would probably settle for that if the need arose. It seems like this participant wished to reassure me that she had left a gap between taking the herbal and orthodox medicines. Nevertheless, she may have disapproved of using both types of medication. Other women may not have told me they were also doing this for fear of my condemnation. This is probably common among women who wish to ensure that they fulfil the expectations of their relatives and community as well as access the hospital facilities, in case God judges them harshly.

I come for advice and go back to take the herbal medicine from the church, as well as that of the hospital, but there is always a week's interval between the hospital and that of the church [Linda].

Pricilla and Linda believed that it was God who protected them through their pregnancy and birth. They admitted that they did not attend all of their antenatal appointments, possibly due

to their belief that God may intervene. This may have convinced them that hospital care was unnecessary since they can receive help from God:

'I am very grateful to God for protecting me through this pregnancy even though I wasn't consistent about coming to the hospital [Priscilla].

The pastor said that, in my case, in the spirit, my womb has been tied and I came to the hospital and was told there is no sign of the baby coming while I feel that the baby is coming [Linda].

Attending hospital was seen as a way of fulfilling all righteousness. Rita's strong faith convinced her that, when she prayed to God and asked God to forgive her sins, her pregnancy would progress well, without any complications.

Yes, it is your belief that saves you. I believe in Christianity. I ask for forgiveness and pray to God for assistance. That is how a prayer must be said, so I believe this is what helped me to give birth but then I remembered I should have done that before coming. This is the belief of every Christian. After praying, you do the necessary action of coming to the hospital [Rita].

Overall, it was widely acknowledged that these women believe that pregnancy and birth outcomes lie completely in the hands of God. This is a significant issue, which means that they view medical support as secondary to that. Thus, this can cause women and communities to disregard the need to access healthcare and use orthodox medicine. This is one potential reason why women fail to attend for care during pregnancy or only do so at a very late stage. This then seems to result in them being criticised by the midwives (which again is likely to put them off attending) and might annoy maternity health professionals who then react in an abusive, disrespectful way.

Martha described how God saved her and that, for that matter, midwives should be introduced to God:

Oh, it was prayer that saved us and these midwifes have to be taught about God because some accept bribes from the occult to send people with an evil spirit to kill the baby so that, even if

the baby is coming, they recommend CS to you. I was actually scared when I was told I had to deliver by CS because I have given birth before [Martha].

This participant believes that God can do everything for her, since he was the one who created her. She views the challenges or difficulties that people experience during pregnancy or after giving birth as the work of the devil. Based on this belief, Mary appears to believe that there is nothing that she herself can do to protect herself and her unborn baby. She had a strong belief that God can fight the devil to protect her from any danger that might be associated with the pregnancy. This might be an awkward way of thinking or handling pregnancy.

Everything is in the hands of God. He created us. The devil is also working but he can't equal God. If God says you will go and come back, it will happen that way [Mary].

Theresah has a different opinion regarding spirituality. She appears to disregard the power of God, however, and her common sense tells her that following the advice of the health professionals, such as eating a balanced diet, will definitely help both a mother and her baby rather than believing wholly that her pastor's prayers can do everything for her. This could be a healthy way of thinking and handling pregnancy.

Oh! It is about your diet. You should eat a balanced diet to ensure the health of the baby. A pastor can't help you. If you eat well, the baby will be healthy [Theresah].

5.3 Theme 2: Intentional abuse

This theme highlighted disrespect as a huge barrier to accessing antenatal care. There were several reports of disrespect and abuse on the part of both the health institutions and professionals which, in most cases, appeared to be intentional. This disrespect and abuse as expressed by the participants took the form of negative verbal communication, physical abuse, stigma and discrimination, lack -confidentiality care and l privacy, abandonment/neglect and positive care. This appeared to have deterred some of the pregnant mothers from utilising the available maternal care services. The following sub-themes support the alleged intentional abuse.

5.3.1 Negative verbal/nonverbal communication

Different authors have defined non-dignified care as poor verbal or non-verbal communication, such as negative gestures or remarks. This was the most common domain of disrespect and abuse cited by the participants in this study. Examples include the use of an angry tone or furious facial expressions to scold, yell, shout, ridicule, threaten or humiliate the pregnant mothers. In these instances, the client (pregnant, labouring or post-partum woman) was the recipient of the negative communication. The participants noted that their birth companion, such as a family member, also experienced negative communication from maternal health professionals. The majority of the women mentioned negative attitudes and behaviour of the maternity health professionals who shouted at or humiliated them in the health facilities.

Camilla appears to be making excuses for the midwife when she states that the midwife may have been tired, which could have made her behave in the way she did. Strikingly, the participant was able to recognise this unethical behaviour on the part of the midwife and believed that this attitude was not normal. Although this participant appears to be making excuses for the midwife, her attitude was condemnable in the face of their codes of practice. While Camilla may have been able to cope with this abuse, other women may not and may decide to avoid returning to the facility in order to avoid being abused. Camilla spoke of her midwife being exhausted:

'When she is tired, and you are not responding to her questions, then she will shout at you, but that doesn't mean that is what they normally do [Camilla].

Felicity felt that her midwife did not consider her condition when she accidentally soiled her bed, but got extremely angry at her. Although Felicity was not physically abused, the action of the midwife was unethical and may have caused the client to feel embarrassed and disrespected. The midwife could have treated her client more respectfully, being aware that the soiling was beyond her control.

I was due to give birth and was moved to the next bed. I was in pain and told the midwife that I wanted to take a nap but accidentally smeared the bed sheet with poo. The midwife became

agitated and shouted at me but I wasn't physically assaulted and I was also in pain, so I didn't mind [Felicity].

Kasia spoke of the regular verbal abuse of clients and thought that it was getting out of hand, which suggests that she can no longer bear the abuse and may decide to stop attending for antenatal care. She believes that midwives should be proactive in carrying out their assigned duties and stop shouting at them, as it makes them feel stressed while in the hospital.

The verbal abuse is getting out of hand and people should be dedicated to their work. They shouldn't shout at us [Kasia].

Rita described the unfriendly attitudes of the nurses during delivery, as they continuously shouted at them and responded rudely them when they asked for water to quench their thirst. If a client is on nil per oral, it is the responsibility of the nurses or midwives to explain that to the client and make her feel relaxed. The midwives' unprofessional approach towards her made her feel disrespected and abused, and also extended to her relatives, who had been driven out in a rude way:

Ok, during the delivery, the nurses were unfriendly when you shouted for help. They responded rudely without attending to you when you asked for water to quench your thirst. They told you that the drip you are on is not enough. Again, when a relative is around, they drive them away [Rita].

Fear and intimidation precipitated disrespectful, abusive care. The women were threatened by suggestions that they might die during childbirth: the midwives cited the close location of the morgue (adjacent to the maternity ward at Tema General Hospital), commenting that it would not be far to transport them if they did not survive. Rita commented:

Sometimes, they tell me the mortuary is close so, when I die, it will be easy to transport my dead body there. I panic a lot whenever they say that to me [Rita].

This sounds like a transfer of aggression. Some of the health professionals leave home feeling angry and come to the hospital to vent it on the patients. They shout at them at the slightest

provocation, as if they are young children. This does not encourage them to continue working in the field of healthcare.

Some leave home in a very bad mood so they are easily agitated and shout at us as if we were kids [Felicity].

The communication barrier between Jackie and the maternity health professionals was a big issue for her. Jackie is Nigerian and does not understand the local language (Twi) which the midwives usually prefer to use. Although the midwives were aware that some women do not understand the local language, they ignore this or respond angrily when asked to explain what they mean. As well as the language barrier, Jackie indicated that the maternity health professionals prioritise care during antenatal appointments for women from the same country of origin as themselves, who speak the same language as they do. To avoid the negative attitude of the midwives, Jackie chose not to ask them anything further.

They speak Twi so I cannot communicate. When you tell them, because you are Nigerian, the way the people behave I behave as if I am not a Nigerian, but I am a Nigerian. Like I said, I don't have any issue, what they are saying I don't understand, if I ask question they have to explain but because of the way, they do the thing I don't like asking. Instead, I will ask someone close to me. If the person understands, she will tell me…er…that is, it's, just like I said the language [Jackie].

The nurses' reactions did not go down well with Bell. She was spoken to by the nurse in a manner that made her regret coming to the hospital in the first place. As it was her first visit to the antenatal clinic, she was not conversant with the procedures and needed a staff member to guide her. For instance, a urine sample appears to be required from the women attending the antenatal clinic but, unfortunately, Bell was unaware of this. Under normal circumstances, it is the duty of the nurse/midwife calmly to direct and guide her but, instead, she chose to shout at the participant. Bell's experience made her consider not returning, as she felt humiliated and disrespected. Bell illustrated that what might begin as rude or unfriendly communication can develop into outright humiliation and verbal abuse.

I had a personal experience with a young nurse when I first came here. I didn't know I was supposed to bring a urine sample so I entered and the nurse shouted at me and asked if I didn't know I was supposed to bring a urine sample. It took another pregnant woman to show me

where to go with a container to pee. She spoke to me as if I was a kid. Such experience can deter you from coming to the hospital [Bell].

In narrating her experiences, Rita indicated that the midwives' approach often precipitated disrespect and neglect. Ignoring her pain made her feel that the care they gave her was devoid of empathy, respect and encouragement. This clearly demonstrates that the inhumane treatment that the midwives meted out to the participant was so great that it gave her a negative view of the care service.

Sometimes, when you complain about the pain, they respond "Is this your first delivery?" The nurses that give these responses hurt me most when they are much younger. I was in pain and the nurses were supposed to give me some words of encouragement, because my husband would have done that if he had been around. The nurses, who I saw as my sisters and mothers, were instead saying words that increased my pain [Rita].

If it is apparent that the midwives were tired or in a bad mood, the women provide make excuses for them. Hearing the cry of a woman in pain and ignoring her was the height of negligence and inhumanity. The midwives sat back and busied themselves with filling in the patients' folders in preparation for the handover while a patient was in great pain and shouting for help. They wanted the nurse on the next shift to attend to Margaret without considering her current wellbeing. Margaret described how her pain made her shout out:

I was shouting for help when I was in pain, but they were filling in folders and said they were tired and wanted the workers on the next shift to take over [Margaret].

Narrating her own experience of the care, she talked about occasions when she experienced great pain and shouted for help, but nobody listened to her. Even when they ordered her to get off the bed and climb onto a couch, she received no assistanc with this, despite the great pain she was experiencing. Linda believed that the care service was not a good one.

Maybe when you are in serious pain, a staff member may tell you to get down off the bed and walk over unaided to climb a high table. You may be unstable; the maternity staff personnel may not place a stool-step to help you to climb up onto the high table. All of this is not good [Linda].

Edith's experience of the care is similar to that of Linda. She felt she was neglected while in pain and forced to do things that even worsened her condition. She felt that the care service was unsupportive, very humiliating and lacked human sympathy.

When you shout out in pain, they will treat you badly, especially during the evening shift. They can make you walk and climb stairs without assistance; very humiliating [Edith].

Although Rita had had a bad experience with the midwives, she was unwilling to believe that all of them are bad. Rita chose instead to believe that the majority of the midwives are good at their job but that she was unlucky and fell into the hands of bad ones. Rita mentioned how, for her, ideal care in health facilities would include being welcomed kindly and treated as special, with a good relationship with the maternity professionals in the health facility.

Maybe the majority of them are good but maybe I wasn't very lucky, and I got those who are rude. It's bad when you shout at me. If you pamper me, that's good, but when am in pain and you shout at me instead of pampering me, that's very bad [Rita].

In contrast, Theresah felts that the midwives should combine the shouting and pampering for women to comply. While the attitudes of midwives in some respects may have been interpreted differently by other individuals, Theresah rather saw the midwives' strict approach, like shouting or forcing her to push during labour, as a way of helping to save their babies.

They have to put pressure on you to be able to push. They have to force and shout at you or pamper you a little bit. They have to be strict with you so you do not kill the baby [Theresah].

This is a case of different strokes for different folks. While others shared their negative experiences with the health professionals, in Destiny's view, everything that she experienced was positive.

For the antenatal care, I have spoken about it already and, when it comes to relationship with midwives and the post-natal care, it is done here as well. So far, I have not been troubled. Oh, it was good. If I said otherwise, I'd be a big liar [Destiny].

Both Edith and Martha believed that the relationship between themselves and the health professionals was good but could not tell what it was like for other women. The services they received were acceptable.

In my case, I have good relations with the midwives and doctors, that makes the tasks easier for both of us. I don't know what kind of relationship they have with others…so I would say the services are good [Edith].

They took me somewhere and checked my vitals, very good. I liked the way they motivated you and how politely they spoke to me. Oh yes, they have patience [Martha].

Rosalinda also seems to have had a positive care experience or better treatment from the midwives. It is possible that these women had paid the midwives for some aspect of care that the other women could not afford:

'I had a cordial relationship with the midwife at the hospital so I could discuss my concerns with her [Rosalinda].

Some mentioned that the midwives predominantly asserted their power over them through their choice of words when they asked them questions related to their care. The midwives were reported as regularly using abusive language, especially during the process of labour and delivery. This is a typical example of power and control. Furthermore, the midwives tried to control women's bodies while they were pushing and in pain and also control the knowledge, to gain the women's full cooperation or compliance. Consequently, rules, discipline and punishment are applied to achieve this control. Thus, the maternity health professionals had total control and autonomy over the women's knowledge and body. This will be explored further in the discussion chapter.

5.3.2 Physical Abuse

Physical abuse has been reported by other authors as the most serious form of abuse or mistreatment that women experience during labour and delivery care. The women experienced physical abuse in the form of being beaten, slapped, hit, pinched, and punched. An example of physical abuse is when a maternity health professional hit or slapped a woman to 'encourage' her to push. In this study, physical abuse was less common than verbal abuse. If expectant mothers refuse to push, they are likely to suffer abuse for failing to comply.

Bell appears to have misconstrued some of the things that midwives do to encourage women to push harder during labour. While Bell already felt angry at the way her midwife spoke to her or hit her during labour, she had a better understanding of that action and felt better about it after the midwife approached her and explained to her why she did that and at the same time apologised to her.

Bell described her experience with the midwife and her time in the hospital as quite an ordeal:

The senior midwife who assisted me during my delivery hit me but she later apologised and said I wasn't pushing as hard as she expected and that was why she hit me, but we were later OK and she told me what to do [Bell].

Kasia cried and shouted for help when she was taken to an isolated room but nobody could help. The critical analysis of her comments suggests that this action was a form of punishment for arriving at the hospital for delivery before she was due. Regardless of that, it does not justify such inhumane action. When she shouted for help, a nurse threatened to slap her, which displayed the height of disrespect and abuse in a hospital. Kasia described how she was abandoned and neglected:

I was taken to an isolated room and, after five minutes, shouted for help and a nurse passing by almost slapped me because I didn't ask them to take me to the labour ward. I told her they said I should go back home because I wasn't ready [Kasia].

This is an example of abuse that is a violation of a woman's body and likely to be assimilated as trauma, thus having a long-term impact on the women and their families. Ideally, a woman's consent is sought before any kind of procedure is carried out on her body; if not, it will amount

to abuse, as in the case of Camilla. When she tried to complain about the unacceptable manipulation of her body, the midwives shouted at her.

When you complain after they have inserted their hand inside you, they will shut you up by either physically hitting you or shouting at you, and that's wrong [Camilla].

5.3.3 Stigma and Discrimination

Discrimination was another form of mistreatment or disrespectful care reported by the women. According to the interviews, the discrimination was based on the disease, sociocultural and socioeconomic status of the women. Other discrimination stemmed from women having more than six children , tribes and religion. One participant reported that she suffered discrimination at the hands of the maternity health professionals because of her human immunodeficiency virus (HIV/AIDS) status. Generally, women who are HIV/AIDS positive are stigmatised and discriminated against. In this study, HIV positive women were stigmatised as the maternity health professionals communicated loudly about their status, with a disregard for their privacy. There was incident reported whereby a woman infected with HIV was denied water and food after giving birth.

Bell felt embarrassed and uncomfortable when one of the nurses openly announced her diagnosis, which immediately attracted the attention of everyone on the ward. Knowing that HIV is a highly stigmatized disease, the nurse should have tried to protect the dignity of the client by not identifying her by her diagnosis. Bell felt she stigmatised by and discriminated against by everyone on the ward. Moreover, such a public disclosure of one's diagnosis may constitute a breach of confidentiality:

I was asked to push. A nurse who wasn't even assigned to me picked up my folder and said that, this is how they are and 'she's retro'. It meant I was HIV positive and, when she said that, everyone in the room looked at me strangely [Bell].

Margaret complained that they were being discriminated against due to their appearance, diagnosis, perceived poverty, large number of children, giving birth out of wedlock, poor

hygiene and being from a rural community. She also felt that women of higher status in the community were given preferential treatment over others, a practice that is not in line with the principle of equity in health:

If you had a certain kind of disease or you don't look rich or presentable, you could be treated differently. It happened to me and I also observed it happen to others [Margaret].

Similarly, Linda felt discriminated against when she observed the health professionals providing care based on social class. One had to look rich and presentable in order to receive proper attention. This is unprofessional and unethical behaviour in the field of health. Segregation based on class during the rendering of care services could make some people feel disrespected or stigmatised, and discourage them from using the facility.

If the midwives look at your appearance, and you seem like a poor person, they do not treat you very well but, if another woman arrives who looks rich, they will sometimes go into their office to bring out a chair just for her to sit down, whiles others stand up [Linda].

Having experienced the practices in the maternity clinic, Felicity felt that the reason why some of the midwives behave as they do is because they did not receive good training for their job. Nurses should be trained to understand people of different cultures and social classes who come to the hospital for help.

New nurses have replaced the old ones. The new nurses should be trained to understand the diverse backgrounds of people who visit the hospital and how they should be treated and educate us on what to do to avoid conflicts. [Felicity].

For Kasia, disrespect only exists if a pregnant woman visits the clinic without a wedding ring or accompanying husband. The midwives disrespect and mistreat this woman because they feel that she may have become pregnant out of wedlock, and hence is irresponsible and wayward. This is an inadequate way of judging a woman because a pregnant woman who is married can still move around without a ring or her husband. Secondly, there is no justification for denying

a pregnant woman the essential care she needs to protect her wellbeing and that of her unborn baby.

Disrespect existed when you came to the hospital without a ring on your finger. You were treated with disdain because you gave birth out of wedlock and you are irresponsible, but everything goes smoothly when you come with your husband [Kasia].

Kasia's comments raise several interesting points about differences related to wealth, which were an important factor, particularly, the perceived lower status of the midwives contrasted with the status of Kasia. There is the issue of social class – Kasia is a private seamstress, happily married and from a 'solid middle-class' background. Her background contrasted with the midwife's own working-class origins and shaky secondary and diploma midwifery education. On the other hand, it may be considered that Kasia's midwife is showing empathy and being considerate about Kasia's circumstances, which is essential for fulfilling the psychological and emotional needs of Kasia. Considering that Kasia shared her problems and worries with her midwife, who provided her with the needed support and care conveyed a meaningful message: that her midwife was caring for her. However, it is clear that Kasia did this on purpose to receive better care from the midwives because most of the midwives provide preferential treatment to women whom they judge to be wealthy:

I had a motherly relationship with my midwife, so I told her my problems and she assumed I was rich [Kasia].

The women's accounts demonstrated this authoritative control of power over choosing who receives preferable treatment. According to Bell, undue favouritism appears to influence the midwives' conduct in the clinic. This act is a form of corruption and may have a drastic effect on the wellbeing of some clients. Favouring certain classes of women at the expense of others could lead to the neglect of clients who need immediate attention.

Sometimes, when you are in a queue, which is a normal thing, some of the nurses favour some people by helping them to jump the queue [Bell].

5.3.4 Lack of confidentiality and privacy

A lack of confidentiality and privacy are interrelated but distinct. A lack of privacy means being seen by others, while a lack of confidentiality relates to the inappropriate sharing of information. Women reported that the maternity health professionals failed to respect their privacy, which resulted in distrust and humiliation. The violation of physical privacy was associated with an insufficient infrastructure, such as a lack of beds, ward space, and theatres. Mothers who shared beds suffered due to non-confidential care, and also risked exposure to infection and cross- contamination, which was dehumanising, humiliating and uncomfortable for mothers and their infants. The following quotes explain what they regard as non-confidentiality/a lack of privacy.

Ursula and Linda stated that "privacy" can mean that the clinic failed to provide privacy for the client due to the lack of space. This resulted in some people being kept and treated in communal or open places, with no regard for their privacy.

This is general. There is no privacy for anyone here [Ursula].

We sleep on the floor because there are no beds, and no privacy [Linda].

Linked to privacy issues, some of the participants stated that sensitive information was shared with others, who had no reason to access their medical records. Women's disease status was shared with other maternity health and non-professionals. Confidentiality is crucial, since women were exposed when their sensitive information related to their HIV/AIDS status was shared with others (including other patients and non-maternity health professionals). When this information was passed on to others, it caused distress for the female patients. Therefore, stigma and the fear that their personal information would be shared deterred access to facility-based childbirth. Bell provided an emotive account:

The saddest thing of all was that she wasn't even assigned to me and nurses should be discrete regarding the personal information of their patients. After giving birth, I wanted to confront her, but my husband asked me not to. One day, she is going to meet her match [Bell].

Confidentiality and privacy issues are very important, especially in HIV/AIDS settings, due to fear, stigma and discrimination. Although not mentioned specifically by our sample, facility-based delivery requires women to be in a state of undress or exposed to men or strangers. In contrast, it is evident that home care does not require this, so the health care systems have failed to protect the patient's right in this regard by failing to impose privacy laws. Thus, patients' medical information should only be shared with others with the patient's consent. This will be discussed further in chapter six.

5.3.5 Abandonment/Neglect

Women reported incidents of abandonment/neglect during every stage of their labour and delivery. The literature reports that it is common for women to feel dehumanised and abandoned at some point during their labour. Abandonment was individually and differently construed. Some of the participants recounted occasions when the maternity health professionals ignored/neglected them for several hours despite them calling for help and pain management. Abandonment of care was described as the maternity care providers failing to respond to the female patients' needs, especially when they were in pain and needed pain relief. In general, Ghanaian hospitals are not equipped with buzzers for patients to call for assistance. Thus, the only way to attract attention is to walk to the midwives' station MHP. Although some of the women attempted to reach the midwives' station, the midwives did not give them the needed attention and they had to wait long hours, regardless of the urgency of their needs. This made the women feel neglected and abandoned. The implication was that both the mother and new-born were potentially at risk of life-threatening conditions since no one was monitoring them. The respondents interviewed highlighted the stark contrast between home birth, when the women are never left alone, and facility-based birth, when women may be left alone for many hours. Rosalinda, in comparing her experience at home and in the hospital, appeared to blame herself for going to the hospital to give birth, as she regarded facility-based care as lacking compassion and emotional support, as the midwives only attended to clients when they deemed it necessary rather than on request. Rosalinda spoke of her second birth with remorse, when she felt unsupported by the maternity health professionals:

I gave birth to my first baby at home and, even with the second, I didn't know that I could deliver at home or I wouldn't have gone to the hospital [Rosalinda].

The poor response that Rita received from the maternity health professionals when she complained to them about her excruciating pain made her feel worse. Asking her whether this was her first baby looks as if the midwives are telling the woman that, once she has gone through her first labour, she will not feel any pain in the subsequent ones. This cannot be true, as no two pregnancies are the same. Each pregnancy is unique and should be treated like a new case. Rita found it strange that she was asked whether this was her first baby:

When a relative is around, they dismiss them. Sometimes, when you complain about pain, they respond by asking "Is this your first time of giving birth?" [Rita].

When you are in labour and calling for help, the midwife will yell at you, saying that the baby isn't coming and sometimes they only realize when it is too late, and you can't scream for help [Margaret].

It is apparent that the midwives/nurses ignore the women's calls for help, seeing them sitting in front of the maternity ward or doing something else. The midwives may be taking a break or being lazy but also may be because they cannot physically attend to the women due to other demands on their time that they described earlier, such as their heavy workload coupled with staff shortages. However, this leads to the women feeling unsafe and uncared for, which will create great anxiety and fear and probably lead them to seek care elsewhere next time, if they have a choice.

Sometimes, they don't attend to you. I was initially told I would go for a *caesarean section but, less than five minutes later, I shouted out that the child was coming but they thought it was a joke so I wasn't given immediate attention and, by the time they arrived, I had given birth. This happened with my second child. They fell below my expectations in this respect [Perpetual].*

Having to deliver a baby unattended is the height of negligence and poses a huge risk to both the mother and baby. This happened after the client had for the midwives who, as usual,

ignored her. The client felt unsupported and indicated that the health professionals were failing in this respect.

Godly believed that the unprofessionalism of the health professionals was the cause of her collapse during her previous pregnancy. What constituted unprofessionalism in this regard was the negligence on the part of the health professionals, which almost cost her her life. The participant said tgat she received the best treatment immediately she woke up from the coma, which means that the professionals know how to provide optimum care but deliberately fail in their role.

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I believe they should be very professional, because I bled here once and collapsed but immediately came round so, after that, I was treated carefully [Godly].

Dela took the view that the medical negligence of some health professionals may have been responsible for the death of one of her relatives during childbirth. Whether this claim is true or not, negligence on the part of the professionals is widely reported. This could be a wake-up call for maternity health professionals to be more proactive in rendering care to mothers and their babies.

Last week, we buried one of our relatives because she wasn't given immediate attention at a hospital [Dela].

Perpetual had witnessed informal complaints being made by women concerning the attitudes of the maternity health professionals in the delivery room. However, nothing is done about these complaint so, clearly, there is a weak mechanism in place, if any, to allow women to seek redress for disrespect and abuse, which perpetuates the problem.

They should always be with the pregnant women so they can attend to them in case anything arises. They shouldn't leave us alone and go and sit outside, but people normally complain about their attitude in the delivery room [Perpetual].

Rosina concluded that her midwife behaved badly, based on the unpleasant experience that she had with her. Drawing on her wealth of experiences from her previous pregnancies, she was able to monitor the progress of her own labour. Rosina knew when the baby was coming and alerted the midwife but she ignored her, believing that the client was not serious, and went away. Neglecting a woman's statements regarding the progress of her labour could mean that the midwives do not involve their clients in their own health care. Secondly, the midwife demonstrated a high level of medical negligence, which can threaten the lives of a mother and/or her baby. Rosina thought it was 'a shame' that her midwife ignored her comments on the progress of her labour:

She didn't behave well. I have given birth before so I knew it was time for the delivery but the midwife insisted I wasn't due for labour and went outside to eat something so, when I went into labour, I kept calling her but she didn't heed my calls until a passing junior nurse saw that the baby was coming and the midwife finally came to help. I am not the type to make noise during labour but there was someone crying. When I called for the midwife, she didn't attend to me because she believed it wasn't time for me to deliver. After I had given birth, I told the midwife to make some tea for me. I had everything in my bag. She said that she would get someone to do that, but she did not [Rosina].

After giving birth, I asked the junior nurse to tell my sister outside to bring me some water to drink because I was thirsty, but she didn't [Bell].

Similarly, Bell also judged the post-delivery care to be very poor. Ignoring a thirsty client who had asked for help when they needed it was unprofessional:

5.3.6 Positive care

Good quality care has been defined as the extent to which health services for individuals or populations achieve the desired health outcomes. The health systems should effectively and efficiently provide services whereby mothers can access high quality care, and the provision and experience of care are part of the process that determines the quality of the care. According to the WHO, high quality maternity care is a human right, with the goal of ensuring

equity and providing a positive maternal experience based on effective communication, respectful, dignified care and emotional support.

In this study, some of the mothers' comments indicated their positive experiences and their perception of being well-cared for by the maternity health professionals, who helped them/advised them what to do, or showed acts of love and kindness, such as collecting money to buy food for the women after the delivery. Linda stated that a friendly approach by the maternity health staff sets the tone for the labour and delivery experience, that general human kindness can have a dramatic effect on the outcome, and that negative words or sentiments are detrimental, just as positive ones can uplift and empower women while they are in a vulnerable state. Although some of the other participants previously narrated their unpleasant experiences with the service providers and the services themselves, Linda countered this and aptly explained what positive care should be like. Notably, Linda did not dispute the claim of those who had had the opposite experiences, as it is possible that not all of them were treated the same. Also, Linda's experience of the service might depend on the specific midwife who cared for her. Above all, however, the participant's perceptions of positive care were derived from her personal encounter with the maternity health professionals, which encouraged Linda to use the service again in future:

I don't know what it's like for other people, so I would say the services are good. Yes, of course, to the extent of even buying food for you at their own will and sometimes not taking money from us. Whenever I come in, they have a friendly way of approaching me with greetings, ask me about my health and even go on to ask if I have eaten, and are ready to assist me getting something to eat. Being in the house most times reminds me of the good times I have had with the doctors and midwives, so I am motivated to come have good times with them as well as be treated [Linda].

Felicity described how she had a cordial relationship and effective interactions with the maternity health professionals. Receiving the attention of the midwife and their advice was very helpful. Although she noted that they might not be perfect, their friendly approach led to her positive remarks about the service itself and the health professionals. For this participant, the service was by all definitions a standard service, but she did not feel disrespected, as she believed that she got what she deserved.

My pregnancies normally begin with vomiting and a loss of appetite so, during my antenatal visits, I explain my symptoms to the midwife. I also follow the advice she gives. The one I saw was very good. She was very friendly. I don't think they are perfect, but they are good. I wasn't disrespected, and I got what I deserved [Felicity].

Perpetual felt that her relationship with professionals at the hospital was a cordial one, because the midwife was always there to respond to her questions, address her worries and also assist her when necessary. Her comments reflected her positive experience with the professionals and the service itself.

Our relationship is cordial, oh yes it was cordial. I have never asked my midwife a question. If you ask, they will assist you [Perpetual].

Rosalinda enjoyed a cordial relationship with the health professionals because she was always able to access the health professionals to discuss her worries. For Rosalinda, such an attitude was a positive one, which encouraged her to keep returning to use the service:

I had a cordial relationship with the midwife at the hospital so I could discuss any issues that were worrying me with her [Rosalinda].

Similarly, Edith believed that she had a cordial relationship with the midwives. Although she was not specific about this, she believed that her relationship with the midwives made things far easier for both herself and the midwives, although she did not dispute other participants' claims to have been maltreated and disrespected by the health professionals:

For me, I have good relations with the midwives and doctors, that makes the tasks easier for both of us. I don't know what kind of relationship they have with the others [Edith].

Theresah pictured the health professionals in a positive way. She saw them as people who are always ready to listen to her complains and assist her when needed. Such feelings may have encouraged her to continue to use the service or seek the professionals' help.

It is cordial, they are ready to help anytime you call them [Theresah].

Positive care may mean different things for different women. For Bertha, having the opportunity to talk with her midwife and resolve any concerns at anytime was heart-warming and a relief. Such a positive experience may have encouraged her to utilise the maternity services:

I was on good terms with them. We talked and, if something troubled me, I asked them about it [Bertha].

Camilla's experience of the service itself and the health professionals informed her conclusion that her midwife was very good. This is a positive recommendation about the staff which could mean a lot to the participant.

My midwife was very good [Camila].

5.4 Conclusion

This chapter has demonstrated the diverse, complex responses of the women who participated in this study, highlighting their positive and negative perceptions of care quality and reports of the clients' negative experiences as important barriers to care-seeking. Although a few of the women reported positive experiences, several reported disrespectful communication, stigma/discriminatory behaviour, non-confidentiality and abandonment/neglect. The focus of this study has enabled these women's individual stories to highlight the enduring harm caused by negative experiences, which has created a public perception that health facilities provide low quality care. The findings for the above main themes and sub-themes were identified. These two main themes have been discussed within the context of the eight subthemes detailed in section 5.2.

The subthemes identified that some women are failing to present themselves at the facilities due to a fear of breaches of confidentiality, informal fees requests, neglect and abandonment, verbal abuse, discrimination, physical abuse, and undignified care, among other examples of

disrespect and abuse. The women revealed that a lack of privacy and confidentiality are barriers to them seeking to access the facility-based delivery services. The women generally wanted the maternal healthcare in their communities to improve and felt that the low care quality results in delays and the avoidance of using the facilities in the future. The disrespect and abuse experienced by the female patients may result in delays to accessing and the underutilisation of the facility-based services.

This chapter was the second of the two empirical chapters. The next chapter (chapter six) draws together the discussion of the findings from the interviews with the midwives (chapter 4) and the interviews with the new mothers from this chapter into an overall discussion.

CHAPTER 6: DISCUSSION OF THE FINDINGS

6.1 Introduction

This research study aimed to gain an in-depth understanding of the experiences of maternity care from the women and providers' perspectives. The interviews yielded a large amount of data which have been analysed and organised into important themes which addressed the following objectives of the study:

1. To explore women's barriers to accessing maternity care.

2. To explore women's maternity care experiences.

3. To explore the views of women on how maternity care could be improved.

4. To explore the MHPs/midwives' experiences of delivering maternity care.

5. To explore the MHPs/midwives' views on how maternity care could be improved to increase access.

This chapter begins by discussing the extent to which the study has met its objectives. Secondly, it provides an overview of the findings, highlighting the experiences of MHPs and the women of reproductive age in the study communities of the Tema district. This discussion considers the findings of this study in relation to the existing literature, identifying how this research illuminates and challenges the findings of other studies (Lythgoe, 2015). Some of the themes drawn from the literature review (Chapter 2) resonate strongly with the findings of the present study and will be incorporated into this discussion where appropriate, whilst areas of divergence or contrast will also be highlighted. The discussion includes the main themes emerging from the data analysis, which are the financial and transport costs, maternal health knowledge, spirituality, health systems, informal fees requests, disrespect and abuse, social support, health education and training, in the order in which they were presented earlier for the MHPs (chapter four), and mothers interviewed (chapter five). In this study, an original approach was adopted, following a qualitative methodology and drawing on an iterative methodology – constructivism The discussion concludes by outlining the original contribution of this study to the subject area.

6.2 Meeting the Study Objectives

A variety of approaches may be used in qualitative studies to explore the social world subjectively in its natural form. The use of a semi-structured approach and generation of data through participants' in-depth interviews proved useful in exploring the research objectives of this study. The qualitative approach provided an in-depth understanding of the experiences of MHPs and women of reproductive age who have to cope with their reproductive health issues within the communities. Furthermore, this research approach revealed how pregnancy and childbirth are intimately linked to the broader respectful maternity care and religious factors that influence various aspects of women's lives. In addition, the discourse highlights the significant role played by MHPs in maternal health practices within the communities even though they are, to some extent, disempowered themselves.

6.3 Overview of the Findings

Although both of the frameworks employed in this research (WHO, 2018; Freedman et al., 2014) emphasised the need for quality care for mother and newborns, this is not reflected in the current maternity care practices in Ghana. Emerging evidence from this study showed that Ghanaian women do access professional healthcare services. However, many issues have also been uncovered in this study which deter such women from accessing the services. Issues like the financial and transportation costs, poor infrastructure, inadequate manpower, disrespectful care, spirituality, ignorance, healthcare professionals' unethical behaviour and many others are the reasons why many women are unwilling to continue to access the services. Meanwhile, universal access to safe, acceptable, high quality sexual and reproductive health care, particularly contraceptive access and maternal health care is considered key to reducing the global burden of maternal morbidity and mortality (Bohren et al., 2015). To accomplish this, (WHO, 2018) in its framework, pointed out that health services must be safe, effective, efficient, fair, timely and people centred. In light of this, one of the recent interventions to reduce maternal morbidity and mortality has been to increase the rates of skilled birth attendance and facility-based childbirth in Ghana (Ganle et al., 2014). Increasing the rates of skilled birth attendance is in line with the framework of (WHO, 2018), in which the availability of skilled workers is key to achieving quality care in facility-based childbirths. Nevertheless, the global skilled birth attendance rates only rose by 12% in developing regions over the past

two decades, so almost one-third of the women in these regions still deliver without the assistance of a skilled birth attendant (Bohren et al., 2015; Campbell et al., 2016). In many countries of sub-Saharan Africa including Ghana, the proportion of women giving birth in a PHF remains low, as it requires the authorities to make comprehensive efforts to overcome sociocultural, economic, geographical, and infrastructural obstacles to provide facility-based care (Bohren et al., 2015; Campbell et al., 2016). Additionally, it requires efforts to improve both the geographical coverage and good quality care for all women at the PHFs, including providing respectful care (Bohren et al., 2015; Campbell et al., 2016). In a study based in Ghana, there were strong indications that home births remained prevalent among community dwellers, that such deliveries took place outside health facilities and that they were not conducted by trained professionals (Anafi et al., 2018; Ghana Statistical Service, 2018). The present research study reports the view of MHPs that the poor working environment in the health facilities is impacting negatively the quality of care currently being provided. This also impacts on the workforce, who report feeling disempowered and disenfranchised as a result. Culture, religion, patriarchy, poverty and infrastructure all contribute to this complex picture, creating a challenge for the Ghanaian government when seeking to find ways to reduce maternal and neonatal mortality and morbidity.

In this study, the belief that pregnancy and childbirth outcomes are predestined by God was shared by many. It is noteworthy that both the midwives and women sometimes shared the same mindset and attitudes, which appeared to affect how they view everything. This study therefore highlighted how much religion impacts on their decisions and the protective measures that they take for their pregnancy and childbirth. Almost all the MHPs interviewed in this study mentioned health systems constraints, claiming that the disrespect and abuse were unintentional and largely due to staff shortages and the limited resources. According to WHO (2018), providing quality care in facility-based childbirth requires adequate supplies, a sound physical infrastructure, and sufficient manpower. The absence of these things can greatly affect the provision quality care services. Such constraints (including a lack of resources, inadequate infrastructure, understaffing, burn out and moral distress, motivation, negatives attitudes, governance, and leadership) were uncovered in this study. These factors jointly affected how the Ghanaian women experienced the care service and how the healthcare professionals perceived the conditions of the care service. The women understood these health system constraints, with some of them perceiving the disrespect and abuse as unintentional, while

others viewing them as deliberate and intentional. Further, the lack of maternal education is a barrier that was identified by the midwives in this study. For the mothers, the MHPs offered them little or no guidance or explanations when providing them with care. In contrast, the MHPs did not have any access to education or ongoing training to allow them to support the women more effectively. It was also apparent that the women and their families, including their husbands, lacked an understanding of the reasons for seeking medical care, especially during emergencies. The women were also ignorant of their maternal health and relied on their husbands and mothers to make the decision regarding when to access care. All of these emerging themes will be discussed in detail below.

6.4 Financial cost

As mentioned in chapter five, financial constraints were noted to be a major barrier to receiving the needed maternity care. Although the maternity care service has been declared to be free for women of child-bearing age in Ghana, certain services, such as laboratory investigations, scans, medication and transport costs were not covered by the policy. This constituted a considerable cost for the participants. Most of the participants (the women and MHPs) in this study individually explained how the financial cost either hindered their ability to access maternity care or affected the kind and quality of care provided in the maternity clinics. This finding concurred with those of previous studies (Dzakpasu et al. 2012; Ganle et al. 2014; Ghana Statistical Service, 2018). This suggests that social inequality appears to have taken centre stage in the Ghanaian health system, despite the fact that the (WHO, 2018) framework clearly states that every individual should have the right to non-discriminatory, accessible, quality, acceptable, universal care. The effects of social inequality have previously been reported, with (Bowser & Hill, 2010) explaining that financial cost was a major hindrance to women seeking maternity care. However, in this study, two sides to the financial difficulties experienced were identified. While some participants revealed that poverty is strongly associated with their inability to meet the financial cost of maternity care, others attributed their problem to the unofficial demanding of and collection of fees by MHPs. Regarding poverty, Ghana is a low-income country (Ganle, 2014), which explains the poverty level among the people. In this study, the participants were accessing the public facility and, as such, tended to be from a poorer background, as wealthier or more educated women generally access private maternity care. The issue is further complicated by the fact that the gender inequality existing in Ghanaian

society makes it difficult for women to find gainful employment. A lack of job opportunities to enable women to generate an income promotes an over-reliance on their husbands, who may be unable to meet all of the bills. Most of the women were earning money as casual traders, selling oranges, second-hand clothing, fish, bananas and confectionary. In this present study, none of the women mentioned childcare costs as an expense, although childcare was given as a reason for not attending hospital. Is it possible that, in this culture, it does not occur to women that they could pay someone to look after their child(ren). This led most of the women to be poor and over-reliant on their husband/partner to pay for maternity care services. In a patriarchal society in this context, where men dominate women, there is an impact on maternal health care. Thus, women do not have control over their own body and healthcare. It is acknowledged that, in societies where women have greater autonomy, the birth-rate tends to fall and so does maternal mortality and morbidity. The acceptance of male authority over women is a core element of the traditional hierarchy, whilst gender inequity related to access to education and employment persists, and the gendered expectations of women's role are socially disempowering (Bradley, 2016). Women tend to lack the capacity to pay for transport and other expenses, such as purchasing drugs, scans and supplies. This low financial power of women prevents them from seeking maternity care at an early stage.

The MHPs were equally aware that the financial and transport costs were a barrier to women accessing maternity care. The MHPs emphasised the severity of the financial and transportation costs for the women, including the need to pay for drugs, scans, and other supplies. These findings support earlier findings by (Heaman et al., 2015; Ghana Statistical Service, 2018) about the financial- and transportation-related problems faced by a considerable number of women, who were asked to pay for laboratory tests, drugs, and supplies. This study was based on information gathered through conducting surveys, questionnaires and face to face interviews. However, in the current study, during the in-depth interviews, both the women and the midwives stated how the financial and transportation costs affect their decisions, especially the mothers when deciding whether or not to access care, which in most cases resulted in either of them missing their appointments or being unwilling to seek any care at all. Other studies have also stressed that some women presented to the hospital late or did not present at all due to the cost involved (Ishola et al., 2017; Warren et al., 2017). Despite issues related to the heterogeneity within the available evidence, childcare problems, and financial and transport costs are all reported to be barriers to women accessing maternity care. The women who

participated in this study indicated that the financial and transportation costs were to barrier to presenting themselves to the maternity hospital for care. Their personal experience was that, because of the financial and transportation costs involved, they only attend the health facility when they can afford to pay for the transport and other expenses. These findings concur with those of (Heaman et al. 2015; Ghana Statistical Service, 2018), that women fail to attend the health facilities because of transportation issues and miss hospital appointments (Heaman et al., 2015). However, the findings from the MHPs and mothers indicate that some women were not presenting themselves because of financial and transportation difficulties. The Ghanaian National Health Insurance Scheme (NHIS) introduced a free maternal care health care intervention policy in 2008, exempting all pregnant women from antenatal, delivery and postnatal fees. Under this policy, women are allowed six free antenatal visits, free delivery in the health facilities, two postnatal visits within six weeks and care for the new-born for up to three months, comprising several vaccinations (Anafi et al., 2018; Dzakpasu et al., 2012; Ganle et al., 2014). However few studies have focused on the impact of the hidden costs associated with this 'free' delivery care (Anafi et al., 2018; Ganle, 2014). It is apparent that some key services and essential drugs are excluded from the free care package, making it difficult for women from lower socioeconomic backgrounds to access the facility-based delivery (Moyer et al., 2014; Warren et al., 2017). The concept of a free maternal care service appears to make it more difficult for most mothers to receive any support from their husband and significant others. This could be because, in addition to the high level of poverty in Ghanaian society, most families rely on the concept of free care without realising that there exist other hidden costs, including bribes.

The majority of the women reported that 'bribes', which are informal or unofficial requests/demands for and collection of money by the MHPs, had affected the kind of care they received and how they felt about it. This finding is similar to previous findings. For instance, women who participated in studies in Uganda (Ackers et al., 2017), Roma (Janevic et al., 2011) and Tanzania (McMahon et al., 2014) reported that the MHPs asked them to pay certain unofficial fees before they could access the needed maternity care services. Unofficial requests or demands for money from women using maternity services have become rampant in most counties, making it more difficult for the women to access the needed care (Dzakpasu et al., 2012). A study by Bohren et al. (2019) recently found that women were asked by the healthcare providers to pay bribes and informal payments in Ghana, Nigeria, Myanmar and Guinea.

Similarly, in this study, most of the women recounted how the MHPs on several occasions asked them for informal fees and bribes. This is unprofessional and has a huge negative effect on the help-seeking behaviour of the affected women, as this extra financial cost was seen as a barrier. Even worse, this ugly practice in the maternity clinic affected key aspects of care, such as access to a bed and transfer from the labour ward to the post-delivery ward, making life very difficult for the service users. The implication of this is that those who are unable to pay these informal fees are cut-off from the service. This finding is consistent with other studies (Anafi et al., 2018; Ganle, 2013; Hsiao et al., 2019), in which financial costs, including informal fees, were reported to be a major barrier to the access and use of maternity care services.

The financial burden suffered by most of the women was also attributed to hidden legal charges levied by the health facility, such as payments for things like medicines, tests, and scans. While there has been widespread publicity regarding the free maternal care services provided by the Ghanaian government, certain aspects of these services are not included which, unfortunately, most of women did not realise beforehand. For the women, such payments were seen and interpreted as unclear, unstructured fees. While some of the women were able to afford to pay these fees, others were not and therefore were unable to access those aspects of the maternity care services. In Tanzania, women reported that an unclear fee structure for services and supplies rendered during childbirth led to frustration, confusion, and a fear of detainment in the facility if they were unable to pay these hidden charges (McMahon et al., 2014). This deterred some women from using the maternity services. Similarly, in another study, Schaaf and Topp (2019) identified hidden costs, corruption, and unofficial requests for money as potential barriers to women accessing and utilizing maternity care services. In Ghana, Apenkro (2020) highlighted that bribery and other type of unethical behaviour that hinder the provision of medical care are examples of the informal fees existing within the Ghanaian healthcare system. Bribes in the health sector in Ghana are due to the lack of effective policies, transparency and trust, which culminate in ineffective public service rules and a lack of accountability mechanisms (Agbenorku, 2012). From this present study, the presence of bribes/corruption in the healthcare system appears to be on the increase. MPHs' indiscriminate demands for unofficial payments from women were frequently reported by the participants. This was a problem to accessing maternal care services, given that the MHPs always had to place it as a condition for the type of care that a client receives. Such a practice had serious negative implications for how the maternal health care services were being delivered or received. Those

who could not meet such financial demands were always denied the needed care, resulting in some deciding to avoid seeking professional help. Interestingly, social class was seen as a significant factor that aided corruption among the health care professionals. Women who were financially buoyant considered the unofficial demand for money as normal and were happy to pay. This lead to discrimination against women who could not meet this financial demand. Although corruption was widely condemned, some women had to accept the situation in order to receive proper care and respectful treatment. Previous studies (Bohren et al., 2015; McMahon et al., 2014), also reported that women believed that paying bribes positively influenced the quality of the services that they received in the health facilities and that bribery could ensure that they received timely care, adequate attention from the healthcare providers, and all necessary drugs or medications. However, allowing this to become the norm in the health care system could systematically disenfranchise poor individuals, who are unable to afford such payments. In a study by (Janevic et al., 2011) based in the Balkans, women were reported to have avoided accessing facility-based delivery due to their awareness that they must pay bribes in order to receive sufficient care. Yet, (WHO, 2018) has proposed that every woman should have an equal right to use high quality, accessible healthcare services. This finding exposes the loopholes in the existing health care policies of the Ghanaian health care system. Allowing this level of corruption to thrive unabated indicates the absence of a functional policy in Ghana's health care system. The unofficial demand for money from women by health care professionals made it difficult for the women to know when they were supposed to pay for certain services. When the women were asked to pay for certain services such as urine pots, blood tests, scans, X-rays, laboratory investigations and tubal ligation, the majority of them had a problem with this. They believed that those services were covered by the free maternal care services declared by the Ghanaian government, so asking them to pay for them was considered another form of extortion. This finding suggests a lack of information on the side of the women. They did not know when they were supposed to pay and when not. Therefore, the exploitation of the women was inevitable for services that are supposed to be free and the situation does not appear to be safe and fair, as proposed in the framework of (WHO, 2018). Such requests for informal fees have been shown to have negative effects on the current and future use of maternal health services seeking behaviour and choice of facility-based childbirth (Hsiao et al., 2019).

The women who participated in this present study faced financial and transportation costs, informal fees and an unclear fee structure for services and supplies rendered during childbirth, which led to frustration, confusion, and fear. This is an important issue that may be inversely related to the level of desperation that these women were experiencing, an issue that is rarely explored in the available literature but which warrants further investigation to increase our understanding of why the MHPs collect these informal fees. The impact this issue has on how the women feel seems to be underestimated, as it seems to lead to feelings of shame, humiliation, being judged as foolish and thus feeling unworthy of the care and treatment to which they are entitled. This, in turn, affects them, creating a fear of neglect and even the death of themself or their baby. This potentially has a very powerful effect on the women's willingness to attend the health facility again in future. This calls for policy makers to review the free delivery of care and make explicit the components of care which should be exempt from cost, to reflect the recommendations of (WHO, 2018; Freedman et al. 2014) that aim to promote quality care for mothers and their babies. In addition, the government should assist with transportation costs and offer tangible rewards to motivate women to attend for care. This will ensure safe, fair and timely access to health facilities, as recommended by (WHO, 2018). Furthermore, more community-based clinics should be established, and these should be located closer to the communities. To address this, an intervention by the health officials to explain to the women in the communities about the coverage of free maternity care would help to reduce the friction between the women and the healthcare providers. The concerned authorities should introduce effective health policies that could restrict corrupt healthcare professionals and punish them when necessary, to deter others from engaging in such corruption.

6.5 Maternal health knowledge

Another barrier that hinders the access to and utilisation of maternal healthcare services by pregnant women is ignorance about the relevance of their health issues, including maternal healthcare education, due to a lack of formal education. This is a key finding, that was common among both the mothers and MHPs. However, while both the women and the midwives acknowledged the issue, their perspectives differed: the mother's lack of education caused them to fail to attend the hospital on time/be unaware that they are pregnant. In other words, a lack of education and awareness about their own maternal health is a notable factor among women accessing care. Thus, they may not present themselves because they have no way of confirming

that they are pregnant, and so fail to attend for care or do so only late in their pregnancy. The women confirmed that they lack knowledge about their health and pregnancy because the midwives did not educate them about these matters. On the other hand, the midwives attributed the women's perceived knowledge deficit about their own health and body to their lack of formal education. The perception of the midwives about the women is consistent with the findings of the report by (Ghana Statistical Service, 2018), in which over half of Ghanaian women aged 15-49 are confirmed as being illiterate. Given the high rate of illiteracy among women in Ghana, pregnant women may have limited knowledge about their health and maternal health issues. In effect, women may not attend the clinic because they have no way of confirming whether they are pregnant nor at what stage of pregnancy they are in. Previous studies (Bradley et al., 2019; Shimoda et al., 2018) had similar findings and believed that women do not attend or seek professional help during pregnancy due to a deficit in knowledge. These previous findings were generated using systematic reviews, observations, questionnaires, and exit surveys, in other Sub Sahara African countries. However, the more in-depth interviews with the midwives in the current study revealed more about the impact of their lack of formal education on the women with regards to their maternal healthcare. Be that as it may, any mother and her baby must be able to access healthcare services. The current World Health Organization framework makes it clear that every woman is entitled to quality care, irrespective of her culture, religion and social class (WHO, 2018). Therefore, to achieve this, it is the responsibility of the MHPs to engage in effective communication with the women and their family members about their health and the available healthcare services.

Women blame the midwives but the stretched services mean that the midwives cannot spend time educating the mothers. Thus women are being put off when the midwives get frustrated with them. It was found in this study that the mothers felt that midwives did not give them information about their pregnancy and the available healthcare services that they needed. In addition, the women reported that the staff offered them little or no guidance or explanation when providing care. This is a major cause of distress and a sense of lack of control, especially as the women expected the midwives to provide them with health information and advice. Unfortunately, the women were left to deal with their problems on their own. The women, in turn, described the MHPs as having little or no compassion for their situation. This is in direct contradiction of the recommendation of the Maternal and Newborn Quality Framework proposed by Freedman et al. (2014), which asserts that the care should meet the women's

emotional and social support needs. In this study, the MHPs explained that they need to explain everything, which takes time and so they are able to do this. This was mentioned by MHPs who had experience of both private and public care in the community. Conversely, the MHPs reported that they did not need to explain everything to more educated women, who might be encountered in a better care environment, who would probably have done some reading in advance. In the current study, the in-depth interviews with the midwives revealed that the women in the public hospital did not know what to do, unlike their peers who attended the private hospital. This is because most of the women who attend a public hospital are uneducated and know little about their condition; hence, they tend to rely greatly on their husband for advice and decision-making. However, there is a notion that the private facilities are better in terms of staffing, the provision of patient-centred care and other resources. This is not always the case, as the public facilities may have the required staff and the resources to operate but the huge number of patients using the facility due to its low cost has been identified as a challenge to delivering the needed, high quality maternal healthcare. To address the overuse of these facilities, the government need to expand and improve the infrastructure to enable MHPs to work in an conducive environment and so be able to provide person-centred care, as proposed by the WHO framework.

The training needs of midwives and lack of infrastructure and support for midwives. Indeed, the midwives also appeared to lack the required skills and knowledge, as they did not have access to education or ongoing training to supporting the women with maternal healthcare. In addition, the time that the midwives had available to support the women to cope was severely constrained by staff shortages, a lack of motivation, and resource deficits that leave support and care in extremely limited supply. The midwives felt that the women did not know what to do; they then controlled where the women could go and how they behaved, and overrode the women's embodied knowledge to dictate how the women should give birth (Bradley et al., 2016; Bradley et al., 2019).

The MHPs exerted control over their clients and the childbirth process, which led to the clients feeling mistreated. The mistreatment of women attending the maternity facility by MHPs has been widely reported in many studies (McMahon et al. 2014; Moyer et al. 2014; Bohren et al. 2015). It is apparent that this problem may be due to the low socio-economic status of the women and their lack of health education. Thus, the signs and symptoms of obstetric dangers

are difficult to detect by uneducated women. Hence, women have little control over their own maternal healthcare.

Women's lack of education is related to their lack of financial independence, as detailed in section (5.2.1) but also to a reliance on their husband/wider family for knowledge about their pregnancy. Socioeconomic and genders disparities related to health status have manifested as a significant factor. Women living in remote parts of the Tema communities, as well as those from poorer households or with less education, face more constraints with regard to accessing maternity care services. These are compounded by the degree of the women's control over family income and the locus of the decision-making about their health care. This appears to be an issue for non-educated women, who tend to be unaware that they are pregnant and, even when they are, may be unaware of their best course of action and traditionally rely on their husband or mother for directives. The negative impacts of gender inequalities related to resource control and decision-making have been reported by (Sialubanje et al., 2015). The over-reliance of the women on their husband to provide for them and make all of the decisions about the matters affecting them and their babies was reported to be a contributing factor to the lack of/low utilisation of maternal health care services (Sialubanie et al., 2015). In this arrangement, the husband must pay for all tests, medicines and other supplies, and even approve the use of the services before a woman can attend the clinic, irrespective of her condition. In this regard, involving men in the provision of maternity care is crucial to achieve the positive maternity care envisaged by the WHO.

This situation also seems to result in them being criticised by the midwives (which again is likely to deter the women from attending hospital). Possibly might annoy the MHPs, who then react in an abusive, disrespectful way. Some women lack the education to know what a pregnancy is and so rely on the midwife for information. Interestingly, this issue may be inversely related to the level of distraction that these women were experiencing, an issue that has not really been explored within the available literature and is worthy of further investigation to increase our understanding of the uptake of maternity care.

To address the deficits in knowledge, trained public health and community nurses or midwives should visit these communities to teach and educate the inhabitants about pregnancy and childbirth. In addition, the Ministry of Health should increase the public's awareness about the need to use contraception and access maternity care. As detailed in (section 4.6.1), the

midwives sometimes collaborate with the religious leaders, such as pastors and Imans, to educate women about accessing maternity care. Effective communication, as recommended by the WHO (2018), on positive intrapartum care must be embraced by the maternity providers to support women on the labour ward. This will enable the women in these communities to gain a better understanding of their health, and especially the need for maternal healthcare.

6.6 Spirituality

Spirituality is another important factor that emerged from this study. The discussions with both the women and MPHs showed that religious beliefs affect maternal and new-born healthcare services' access and use via the concepts of faith healing, prayer, and asking pastors for advice. These factors influence the women's help-seeking behaviour, although accepting doctrine and identifying with religious groupings is believed to be another way of staying healthy, as faith provides social support networks (Ganle et al., 2014; Mukabana & Mukaka, 2019). Conversely, the belief that birth outcomes depend completely in the will of God is a significant issue, causing the women to view medical support as secondary to that. Anafi et al. (2018) and Ganle (2014) found that their religious belief affects how mothers view everything, as it has a huge impact on their decisions and affects their ability to protect their pregnancy. Similarly, in the current study, religion was found to exert a powerful influence on the women and affected how they sought and utilised the maternity care services. As revealed by the MHPs, some women refused to accept medication, a blood transfusion and/or hospital admission because their pastor had advised them to rely more on their faith and religion. One consequence of their attachment to their religion is that the women may present to the facility late, and in some cases with serious medical complications. Their faith is a potential reason why they do not attend for care or do so only at a late stage in their pregnancy. This then seems to result in them being criticised by the midwives (which again is likely to deter them from attending). Being too attached to her religion or faith may give a woman a different orientation, even to the point of believing that only God can grant her a safe delivery, thereby leading her to disregard the MHPs' directives/advice. However, it was not only the mothers who held these fatalistic beliefs, as the midwives themselves also referred to God in terms of whether things go well. Thus, the women and midwives shared a belief that God decides what will happen in the end. Sometimes, when things went wrong, they attributed this to God's will. Anafi et al. (2018) and Ganle et al. (2014) found that faith-based healing practices and a belief in God's protection during pregnancy

affected women's decisions about accessing maternity care, based on focus groups, interviews and observations. In the current study, similar findings also emerged. The in-depth interviews with the women revealed that their decision about whether or not to attend the clinic was hugely impacted by their faith and loyalty to their pastors and the prophets of their religion. The women had to consult their pastors or prophets to decide whether it was appropriate to go to hospital, even when they were in labour. Arguably, religion was a key factor in the women's decision to access maternity care services. In addition to the involvement of the religious leaders in the women's decision-making regarding their maternal health and wellbeing, it is also important to acknowledge the relevance of the same religious leaders in reaching the women. Although, , some of the women in this current study does not recognised religion as significant on their maternal healthcare journey.

Unfortunately, the framework and guidance in (WHO, 2018) does not appear to recognise the significant impact of religion on the women or their family's decision-making when seeking to improve the maternity care services. The World Health Organisation document on intrapartum care, a framework about positive birth experiences of women published in 2018, failed to mention religion or spiritual care, which appears to be a significant omission. This comprises the concept of faith healing, prayer, asking pastors or prophets for advice, the religious doctrine, and keeping healthy, as the social support network provided by religious groupings (Anafi et al., 2018; Ganle et al., 2014). Spiritual care should be incorporated into a positive intrapartum care framework and guidelines, designed to support women throughout their maternal journey. Religion is said to be the opium of the masses (Rogers & Konieczny, 2018). This implies that religion is an illusion, that provides reasons and excuses to keep society functioning just as it is. In this study, the participants believed that spirituality is the faith healing process that improves their pregnancy outcomes. In an attempt to address this, much emphasis should be placed on the omission of faith from the WHO framework, as this is a significant flaw when discussing countries that are dominated by beliefs and religion. Thus, failing to engage with faith as a potential way to improve maternity care seems illogical, and further research on this area would be useful. The midwives perceived that that the women did not know what to do, and displayed limited compassion for their situation (Bradley et al., 2019; Oluoch-Aridi et al., 2018). The MHPs, therefore, used the women's lack of education and low literacy levels as an excuse to show disrespect, as also reported by (Bradley et al. 2016). This contrasts with the women's perceptions of their lack of knowledge and the fact that they were

offered little or no guidance or explanations when receiving care. This is a major cause of distress and sense of a lack of control among them, especially since they expected the midwives to offer them health information and advice. Although challenges were articulated related to the relationships between the women and the midwives, there were also pockets of good practice that demonstrated how the midwives wanted to work and the efforts that many made to keep the woman the focus of their care. MHPs, particularly midwives, who respect women and act professionally while providing maternity care are indispensable. Therefore, a midwifery educational system must have effective programmes that raise awareness about disrespect and abuse and teach respectful childbirth care. Health facility level factors that promote disrespectful behaviour must be identified and addressed. Jewkes and Penn-Kekana (2015) stated that it is necessary to support institutions through resource allocation, training and supervision, and enforcement, without blaming individual healthcare providers.

A few initiatives had been introduced in response to the challenges described here. At the hospital level, a campaign about the need to access maternity and health education was underway and there were clear ideas about the changes that needed to be made. Examples of this were conveying health awareness to women through the radio, churches and mosques, and involving the men of God and imams. The midwives who participated in this study reported the interactions they had with both the men of God and the communities. The midwives felt strongly that education is the way forward. In this study, the participants proposed that the MHPs should receive training in order to improve the quality of maternal health care. However, the MHPs who participated in this study considered the women to be illiterate and proposed that they should be given a basic level of education. Indeed, the MHPs' strongest and most frequently voiced recommendations for improving maternal care quality focused on educating communities about the value of midwifery services in preventing maternal mortality; for instance, training and educating the wider community would be beneficial in addressing the poor care or disrespect and abuse. Education is key for both the women and MHPs, particularly midwives, in order to promote the provision of respectful care. In addition, the MHPs could improve the quality of care provided if they had received training on counselling and were more skilled at building a good rapport with the mothers during their initial encounters, as well as at explaining the procedures more clearly.

6.7 Health system constraints

The lack and unavailability of health workers especially doctors, midwives and nurses' results in longer waiting times, neglect and sub-standard maternity care. Moreover, the healthcare workers also lack the skills, knowledge and experience to provide good maternity care. Poor conditions of physical structure. For example, only one delivery theatre serving the entire hospital affects the care provided for women. Further, the poor-quality service due to the excessive number of patients leads to a lack of privacy at the hospital. There were also acute shortages of basic supplies, such as gloves and surgical equipment, as well as beds and waiting rooms. A lack of funds, workload, poor supervision of MHPs, health policies, and a lack of continuity of care were all noted among the healthcare professionals.

Health system constraints is another important finding in this study which covers many factors including disrespect, as mentioned by almost all of the women attending the maternity clinic. Although disrespect was generally mentioned as a constraint, the majority of the MHPs claimed that the disrespect and abuse cited by the women were unintentional and largely due to the staff shortages and lack of resources. This is in line with previous studies (Bradley, 2018; Brown et al. 2011). What constituted constraints for the participants included the lack of resources, inadequate infrastructure, under staffing, burn out and moral distress. Other constraints include a lack of motivation, lack of privacy, overcrowding, the negative attitudes of some staff members, poor governance, and leadership. These have previously been identified in Ghana as disrespect and abuse (Ganle & Krampa, 2018; Maya et al., 2018; Moyer et al., 2014). Similar studies in Kenya and other Sub-Saharan African countries have identified these factors as the drivers of disrespect and abuse (Oluoch-Aridi et al., 2018; Warren et al., 2017; Bradley et al., 2019). However, from this study, some women seemed to understand these health system constraints, and thus perceived the disrespect and abuse as unintentional, while others claimed that this treatment was deliberate and intentional. These varied perspectives of the participants simply show the uniqueness of their experiences as well as individual differences. These findings corroborate those of a study set in Kenya, where almost all of the healthcare professionals reported that any disrespect and abuse were unintentional, associated with staff shortages and a lack of resources (Oluoch-Aridi et al., 2018). Similarly, other authors have noted that the disrespect and abuse was intentional and unintentional, and due to health system constraints (Warren et al., 2017). Freedman et al. (2014) explained that the disrespect and abuse was due to the situation in the maternity facility and that the interactions were perceived as

humiliating and undignified during childbirth. The kind of disrespect and abuse mentioned by the women who participated in this study match the structural level of disrespect and abuse described by Freedman et al. (2014). The excessive number of patients in maternity hospitals and poor management of health facilities are among the concerns mentioned by the women. A lack of funds, shortage of healthcare employees, heavy workload, poor supervision of MHPs, health policies, and a lack of continuity of care were all noted by the healthcare professionals. The perceived disrespect and abuse is in line with Freedman et al.'s definition of disrespect and abuse, which encompasses elements that impact care at the individual, structural, and policy levels (Freedman et al., 2014).

The in-depth interviews with the women revealed more details about these negative impacts, and the identified health system constraints contributed to their present and future use of the health facility. This is consistent with the findings of previous studies conducted in Kenya (Warren et al., 2017), in which the findings from the focus group discussions, in-depth interviews and client-provider observations suggested that health system constraints affected the women's utilisation of maternity clinics. This indicates that health system constraints is a key factor in women accessing care. In the current study, this issue is clearly related to the reason why the women feel reluctant about seeking professional interventions, an issue that has rarely been explored within the available literature, and hence further investigation is warranted to increase our understanding of the impact of health system constraints on the women's decisions about accessing care. The health system constraints were one of the most immediate barriers to respectful maternity care, particularly with regard to women's right to access the highest attainable level of health care (Bradley, 2018). Being forced to work in these conditions could also be constituted as disrespect and abuse of the midwife and doctors. A significant body of evidence demonstrates the detrimental effects of the current working conditions in many sub-Saharan African countries (Bradley, 2018; Warren et al., 2017). This could arguably mean that women and midwives are both victims of the poorly equipped health facilities, although it is the women, who are the service users, who seem to suffer the most negative effect.

One of the most serious challenges voiced by the participants was the chronic, ongoing human resource shortages. In many instances, this was seen as sub-standard care and articulated by most of the participants as a driver of disrespect. A cause of controversy was the inability of the MHPs to pay sufficient attention to the women, as they were caring for many others at the

same time. The implication of this is that many of the women felt unwelcome, abandoned, snubbed and disrespected, while the midwives, on the other hand, felt frustrated because the system was not supportive enough. These findings are similar to those of other studies, including (Bradley et al., 2019; Filby et al., 2016; Oluoch-Aridi et al., 2018). A major problem in the human resource discourse has been the use of the provider: population ratios as a way of estimating the staffing level of establishments (Bradley, 2018). However, these ratios rarely consider context-specific factors, such as poverty, the fertility rate or the burden of disease. Also, as discussed earlier, one of the reasons for the inadequate number of skilled healthcare professionals in Africa (and probably other low- and middle-income countries such as Ghana) is the brain drain (Prytherch et al., 2013). For example, the estimated rate of expatriation in 2000 for medical doctors born in Ghana but working in the OECD countries was 31%, with 25% for nurses (OECD, 2007). Nurses emigrate from Ghana at a rate that is 18% more than that of Tanzania and 25% more than that of Burkina Faso (OECD, 2007). Where there is a shortage of staff, the facility managers default to using generalist nurse-midwife cadres, who lack the midwifery-specific interpersonal and clinical skills required to administer proper care to women in the culturally and emotionally sensitive arena of childbirth (Fauveau, Sherratt, & De Bernis, 2008). Task shifting and sharing may increase the access to and availability of maternal and reproductive health (MRH) services without compromising performance or patient outcomes and may be cost effective. Despite the support for task shifting/sharing, a number of barriers were reported, including poor staff co-ordination and preparation, low skills, provider absence and resistance, and a lack of equipment and drugs (Dawson et al., 2013).

In the case of the shortage of staff as uncovered in this study, there were instances where the midwives had to adopt the role of doctors, for example by prescribing, but must carry out their other tasks at the same time, such as general nursing, changing beds, providing water, etc. This could amount to work overload, leading to burnout, which other studies (McAuliffe et al., 2010) have reported are a huge challenge within the delivery of health care services. Apart from the burnout that may result from work overload, patients might be at the risk of receiving the wrong prescriptions since the midwives may not have been trained to prescribe (Tariq et al. 2022). To address these issues and better support the staff, there needs to be efficient co-ordination to ensure an appropriate skill mix and teamwork, in-service training, supervision, career progression and incentive packages to better support the MHPs' practice, job aids and

tools, supervisory mechanisms, career opportunities, adequate remuneration and access to facilities with equipment and drugs (Dawson et al., 2013).

Human resource problems are common in many countries. Among the factors exacerbating these problems is the non-uniform distribution and low workforce productivity coupled with an acute shortage of skilled workers in the government health sector (Rolfe, Leshabari, Rutta, & Murray, 2008). As uncovered in this study, it is clear that not all of the MHPs were qualified for the roles they were undertaking, thus making it challenging for them to discharge their duties and responsibilities. This leads to the deployment skill mix of unqualified professionals, which endangers both women and their health. One study showed that some MHPs felt uncomfortable about allowing women to decide their preferred birth position because they had not received any training on how to assist women to give birth in positions other than lying down, which lead to them insisting that the women should deliver in a supine position (Garcia-Jorda et al., 2012). Further effort needs to be made to match the staffing of establishments with the local need, rather than the existing policy of allocating staff according to facility type (Bradley, 2018).

An interesting new element was the midwives' perceptions that women were intentionally being 'naughty' and uncooperative, with limited empathy demonstrated for their pain or situation (Bradley et al., 2019; Oluoch-Aridi et al., 2018). This contrasts with the women's perceptions of pain as a major cause of their distress and lack of control, which they expected the midwives to assist with and advise upon. However, the time available for the midwives to help the women to cope was severely constrained by the staff shortages and exacerbated by resource deficits that left pain relief in extremely limited supply (Bradly, 2018). Studies by Freedman and Kruk argue that, although disrespect and abuse are perceived differently by women and healthcare workers in the context of health system constraints, there are certain practices that are unambiguously disrespectful (Freedman & Kruk, 2014). The midwives' inability to provide pain relief and the impact of this on their sense of professionalism may well drive a dynamic of disrespectful care and bears further investigation.

A lack of staff, overcrowding, lack of adequate resources and inadequate referrals combine to disempower midwives (Bradley, 2018; Mselle et al., 2013). A study carried out in Malawi shows that a shortage of staff causes an increased workload and generates a range of negative consequences, including burnout, absenteeism, and reduced morale (McAuliffe et al., 2010).

High levels of burnout, particularly emotional exhaustion and reduced personal accomplishment, have been reported among Malawian maternity care providers (Bradley, 2018).

An organisational culture of blame coupled with ongoing staff shortages and the challenges existing within the health systems (including the infrastructure, space and resources) impede the midwives' ability to work professionally and have a significant impact on the human interactions on the labour ward. Some of the midwives interviewed struggle to refer to themselves in this respect, feeling uncomfortable about the behaviour of the staff. Whilst, presumably they included themselves when describing this poor behaviour, they preferred to refer to the poor practice of other MHPs. This is also seen in the literature (Bradley et al., 2019; Oluoch-Aridi et al., 2018; Warren et al., 2017). However, these studies were carried out in other countries in Sub Sahara Africa, and clearly there exist differences between various the geographic settings. In this present study, the midwives reported having to work in more than one health facility to earn enough money, which compromised the quality of the service. They might have been struggling to be honest in the interviews, as they possibly felt ashamed about taking days off work or being very late for work because they were working elsewhere in a private facility or simply felt so burnt out that they decided to take time off. Echoing previous findings from a study in Malawi, there were reports of nurse-midwives being pressured to work extra shifts, even on their days off (Bradley et al., 2019). This might leave their colleagues in a difficult position but, as they too have suffered the same situation, they may no longer feel guilty. These findings remain relatively unexplored in the literature on midwifery in low-income contexts but have a significant impact regarding the dynamics at play in the maternity ward. Some authors (Bradley et al., 2019; Warren et al., 2017; Yakubu et al., 2014) have suggested that one solution to this disrespect and abuse would be to train midwives how to deal more effectively with the current constraints. This has the potential to push the responsibility to cope back onto the midwife (Bradley et al., 2019).

A large proportion of the findings reported in this thesis centred on disrespect and abuse within the health facility. This includes physical abuse, stigma and discrimination, non-confidential care /lack of privacy, and abandonment/neglect. This study found that displays of disrespect and abuse towards women during childbirth occur in Ghana and can take the many forms described in the literature in reference to other settings (Abuya et al., 2015; Bohren et al., 2019; Ishola et al., 2017). The type of abuse most repeatedly reported was negative verbal

communication, stigma and discrimination, non-confidential care/lack of privacy, and abandonment/neglect. The least commonly reported was physical abuse, which might be unsurprising as this is an extreme form of abuse. Nevertheless, these issues may be being under-reported as this behavior may be accepted as normal and not considered as abuse or disrespect by some women (Abuya et al., 2015; Ishola et al., 2017; Warren et al., 2017). In this current study, while some women explicitly expressed their anger over what they described as disrespect, others did not express an opinion, probably because they thought this was the normal way to treat women in the hospital or are afraid to expose the healthcare professionals. The women who reported disrespect revealed that it took different forms, such as verbal abuse in the form of shouting, yelling, insults and derogatory remarks, which had a negative impact on their self-confidence and wellbeing. This particular form of abuse seems to be a recurrent issue in the literature. Bohren et al. (2015), Ganle et al. (2014), and Moyer et al. (2014) reported similar findings, noting that such unprofessional attitudes among MHPs affected the health and wellbeing of both the mothers and their babies. Also, similar to the findings of the current study, previous studies (Bohren et al., 2015; Ganle et al., 2014) established that verbal abuse, as reported by the women, is mostly committed by nurses and midwives. This could be the case, because nurses and midwives have more interactions with the women during maternity care and birthing than other healthcare professionals. Hence, this suggests that healthcare professionals, especially nurses and midwives, should receive more training and the Ministry of Health Ghana should provide a conducive environment with an adequate infrastructure to enable them to understand their job and deliver the needed quality health care services.

Other forms of disrespect and abuse, as expressed by the participants in this study, included abandonment, a lack of support, withholding treatment and neglecting women's needs. Abandonment and withholding treatment could arguably be attributed to the fact that some of the women who participated in this study reported that healthcare professionals on several occasions demanded informal fees (bribes) from them. A failure to pay these resulted in some women being denied key aspects of the care services or even being completely abandoned by the healthcare professionals.

This study has also shown that a lack of professional standards during delivery was seen as a major challenge, resulting in disrespect and abuse, which can in turn deter women from accessing facility-based delivery again in the future. It was apparent that multiparous women and women who failed to attend antenatal care and other appointments were the most

frequently mistreated group. The findings of this study reflect those of several previous studies conducted in Ghana (D'Ambruoso et al., 2005; Maya et al., 2018; Moyer et al., 2014; Rominski et al., 2017), which reported that women experiencing physical, emotional and verbal abuse, such as spanking, beating, scolding, shouting and abandonment during childbirth, as well as health facilities that are unresponsive to their needs or unable to provide the necessary emotional and physical support during childbirth, had issues with maintaining regular attendance at the clinic. Indeed, the MHPs participated in and reinforced the culture of blame, by not only blaming the women for getting pregnant, but also increasing the level and form of abuse (through reducing their privacy or shouting at them about their lack of knowledge about their bodies).

Verbal abuse was very prevalent in this setting; indeed, contempt and the use of derogatory terms was commonplace. This was the most common domain of disrespect and abuse cited by the participants in this study. Examples include the use of an angry tone of voice to scold, yell, shout, ridicule, threaten or humiliate someone. In these instances, the client (pregnant, labouring or post-partum woman) was the recipient of the verbal/negative communication. This study found that birth companions, such as a family member, also experienced verbal/negative communication from the MHPs.

Client-provider interaction has the potential to improve or worsen every other domain of disrespect and abuse (Peca, 2016). Some of the women who participated in this study described the MHPs as rude, unfriendly, and hostile, while the midwives described the women as uncooperative during this period. Some of the professionals justified using physical and verbal abuse as punishment for non-cooperation and to ensure a good outcome for the baby, as also shown elsewhere (Bradley et al., 2016; Bradley et al., 2019).

This present study found that maternity professionals used their domineering demeanour to impose power and control over the women. Many of the midwives felt driven to maintain control over the women in order to avoid bad outcomes for which they would be blamed, in line with the findings of Bradley et al. (2016) and Bradley et al. (2019). This is consistent with the women's perceptions of being blamed, as the MHPs blame them for the negative outcomes (of their pregnancy), and reprimand them for calling for help, indicating the manifestation of the power relations between certain MHPs and women in maternity settings, that constitute hegemonic dominance, and parallel the dominance of men within society. Further, creating fear

and panic via threats is a way of getting immediate attention rather than having to explain the need to do something, as in combat situations. The midwives seem to use this as a way of getting women to cooperate quickly to save time when in pressured situations. This is clearly unacceptable but is a known method of gaining compliance without argument. In my study, I found that some of the women reported that the midwives apologised after the birth for hitting or shouting at them. This indicates a level of awareness of the abuse, that they regret or perhaps felt was necessary to prevent a bad outcome. I argue that this is due to inadequate training and MHPs being placed in situations for which they felt ill prepared and which they lacked the confidence to handle. Addressing these structural issues around provider workload would complement the training on disrespect and abuse.

One of the worst problems in the Ghanaian context was the prevalent rhetoric of "the uncooperative woman," which allowed the midwives to exert power and control over women and their bodies by punishing disobedience. This echoes some of the recent findings on midwives' perspectives of disrespectful care (Bradley, 2016; Bradley et al., 2019), where women were seen as purposefully challenging and actively disobeying the midwives' authority, thereby justifying the control and discipline that was applied to them. The midwives acknowledged that they made conscious decisions to ignore or refuse to provide care for women who were judged to be "uncooperative." By exercising their discretion in this way, the midwives serve as street-level bureaucrats, juggling the requirements of the women with those of the institution and their own voluminous workload (Lipsky, 1980). Though concerns about the baby's wellbeing might provide a partial explanation during this period, such abusive behaviour is likely to exacerbate women's feelings of anxiety, distress, fear, intimidation, and disempowerment (Bohren et al., 2019). Some of the mothers in this study also believed that women are uncooperative and pardon the midwives, based on the justification that their behaviour leads to a good outcome for both baby and mother. However, fear and intimidation were used by the MHPs to make the women comply with their rules. The MHPs were using their power to create extreme fear and anxiety in order to control the women, causing them to follow their instructions and avoid asking for help. This study found that the women were threatened by suggestions that they might die during childbirth: one woman reported that the midwives mentioned the close proximity of the morgue (with is adjacent to the maternity ward at Tema General Hospital), commenting that it would not be far to transport her if she did not survive. These findings corroborate the limited research literature on disrespect and abuse

during delivery. However, the health system constraints caused this behaviour in the MHPs (as detailed in section 6.7).

Verbal abuse in Ghana has been reported previously by Moyer et al. (2013), as has abusive treatment in Nigeria (Okafor et al. (2015) and Kenya (Abuya et al. (2015). Negative and unfriendly staff attitudes as a barrier to seeking facility delivery have been reported throughout sub-Saharan Africa (Bohren et al., 2015; Ishola et al., 2017 (Nigeria); Kruk et al. (2014) (Tanzania). Effective communication as recommended by the WHO (2018) on positive intrapartum care must be embraced by maternity providers to support women on the labour ward.

As detailed in section 5.3.3, the women mentioned significant stigma or discriminatory behaviour based on their race, age, disease, religion, class, and socioeconomic status, with less educated and younger women being at highest risk. This dynamic formed a smaller component of the interviews with the midwives. However, synthesising the midwives' perceptions added to my understanding as it revealed that many felt driven to maintain control over the women in order to avoid bad outcomes for which they would be blamed (Bradley et al., 2019; Oluoch-Aridi et al., 2018). The interpretation of the women's experiences concluded that a significant driver of the behaviour that the midwives exhibited was an attempt to increase the social distance and maintain status (Bradley et al., 2018; Bradley et al., 2019; Yakubu et al., 2014). This emerged less strongly when hearing from the midwives directly, although some were more open than others about discussing the differential treatment of women with varying socioeconomic, ethnic or disease statuses. This could, however, be interpreted as social inequalities regarding how women are treated during childbirth. A study set in Ghana by Yakubu et al. (2014) suggested that social distance was not an issue, describing instead a 'mother-daughter' relationship. This could, however, be argued to be a way of increasing the midwives' status by infantilising women and rendering them powerless (Bradley et al., 2018; Bradley et al., 2019). Indeed, the MHPs in the study likened the physical abuse of the women to mothers disciplining a naughty child.

In addition to this study, feelings of abandonment and neglect related to facility-based delivery services have been documented in other settings (Bohren et al., 2015; Moyer et al., 2014). The need to contextualise the different experiences and reports of the women and the healthcare providers is also illustrated by the additional categories of abandonment described, when the

healthcare providers fail to respond to women's needs, especially when they are about to give birth or suffering postoperative pain (Burrows et al., 2017). The women may sometimes perceive this system failure as an inadequacy on the provider's part in terms of the long waiting times, lack of promptness of care, neglect or abandonment of care, lack of privacy, overcrowded rooms and occasions when providers lack the patience to indulge in pleasantries due to their heavy work load, fatigue, burnout and stress. The issue of confidentiality/a lack of privacy are well discussed (section 5.3.4). In this study, the MHPs did not perceive these violations to the women's confidentiality and autonomy as disrespect and abuse. It is apparent that many women felt that the skills of the healthcare providers were also lacking, coupled with the fact that some women reported a lack of confidentiality, whereby their medical information was shared. This disempowered the women and reduced them to a passive state, in which they were unable to be active participants in their own birth experience (Burrow et al., 2017). This study found that non-confidentiality/a lack of privacy deter women from presenting for facility-based delivery. These findings are in line with those of Bohren et al. (2015), Bohren et al. (2019), Burrows et al. (2017) and Warren et al. (2017), who describe manifestations of the mistreatment of women, as female patients expressed frustration at the lack of confidentiality during delivery, their lack of autonomy, abandonment by the providers, and unsanitary maternity settings. Addressing the drivers of this structural disrespect and abuse requires substantial investment to improve the structural features, such as the absence of curtains or screens, that contribute to the lack of confidentiality or privacy. Equipment shortages, especially a lack of beds, also contributes to this limited confidentiality and privacy, as women sharing a bed overheard each other's interactions with the healthcare providers. Further, the lack of privacy means that the women witness other women suffering abuse/disrespectful care or in desperate need, so the issue of the disrespect and abuse of women accessing facility-based delivery requires serious consideration in terms of future research and regulatory strategies. In addition, the Ministry of Health and other stakeholders should implement policies to promote the respectful care of women during delivery in facilities. Further, it is vital to provide education and training for MHPs about the provision of high-quality care and eliminate or minimise the disrespectful care of women accessing maternal healthcare in Ghana.

6.8 Social Support

Social support was another important finding that emerged from the study. One of the issues highlighted under social support was the lack of a birth companion. The most common strategy for navigating maternity healthcare was for women to be accompanied by a birth companion (usually a family member). The companion's role was to care for the woman in ways that the health system could not; for example, providing for their needs, fulfilling requests to bring forgotten patient folders, and buying baby clothes and nappies (Peca, 2016). Given that the hospital does not provide food or bedsheets, during hospitalization, women always need a companion with them. Unfortunately, despite the importance of a birth companion, most of the participants reported that the MHPs denied them the right to have a birth companion with them on the labour ward.

On the question of whether or not the MHPs allow the supporter/family to be present during the labour, some of the women also reported that they had been denied the opportunity to be accompanied by a spouse or family member while giving birth, although few identified this as disrespect and abusive care. In contrast, the MHPs insisted that it was their duty to involve significant others in women's maternity care. However, while the MPHs appeared to recognise the benefits of this for a woman during birth, they preferred only to involve relatives in the first stage of labour in the ward area, to provide food, drinks and other items, and did not allow them to enter the birthing environment. There is confusion here, as the women and MHPs' perceptions conflict somewhat. There is no reason to assume that the women's accounts were inaccurate; therefore, it seems that the midwives correctly identified that their policy was to encourage women to have a supporter present and stated that they followed this policy. They did not admit to occasions where this policy may not have been implemented.

The companion cared for the new-born baby while the immobile mother was connected to blood infusion apparatus. Apart from providing this care, some of the participants stated how the presence of a companion alleviated their sense of abandonment/neglect, and also eased their feeling of physical and/or emotional loneliness. Providing social and emotional support to women during the birthing process has been associated with increasing mothers' satisfaction (Peca, 2016). Bohren et al. (2019) and Maya et al. (2018) found that women lack supportive care, including a perception that the care provided by the health workers was mechanical or lacked comfort or courtesy. These studies were conducted in eastern Ghana (Maya et al., 2018),

and Guinea, Nigeria, Myanmar and Ghana (Bohren et al., 2019) and used observation, surveys, focus group discussions and large sample size. The use of in-depth interviews in the current study encouraged the participants to discuss freely their lived experiences without any fear of being reprimanded or victimised by the MHPs, particularly the midwives. In this study, the women revealed that they suffered psychological distress during their antenatal care, labour and childbirth resulting from instances of neglect, lack of support, and MHPs' unresponsiveness to their needs. Although the women acknowledged that the number of skilled attendants was understaffed to meet the demands of women, they felt that the attendants focused on other activities rather than showing an interest in their care. Indeed, the women who participated in this study reported that the MHPs disrespected and abused both the women and their family members (companions). This conflicts with the midwives' claims, during the interviews, that the significant others of the women are involved in their maternity care to support the provision of respectful maternity care. It was apparent that aspects of the companions (who they are, the healthcare providers' opinion of them and their role in the process) influenced whether the companion facilitated or unintentionally hindered the provision of respectful care. It is acknowledged that the women often desired the presence of a birth companion, such as a family member, husband, or friend, but many were prohibited from having their companion of choice with them during the delivery (Bohren et al., 2015; Chadwick et al., 2014). This lack of a companion left the women feeling disempowered, frightened, and/or alone during the delivery (Bohren et al., 2015; Peca, 2016).

The WHO quality of care framework for mothers and new-borns makes explicit the need for more evidence and action regarding good communication, respect, dignity, and emotional and social support in an effort to improve the quality of care (Tuncalp et al., 2015; WHO, 2018). This approach could empower women, promote positive childbirth experiences, and increase their satisfaction, but could also increase their demand for and utilisation of maternal health services (Bohren et al., 2015; Bohren et al., 2019; WHO, 2018). Addressing this area (e.g., companionship, and emotional support) might require structural changes; for example the presence of a birth companion, such as a family member, husband, or friend, should be encouraged and women should have their companion of choice with them during delivery at a facility. In addition, the labour wards should be designed to facilitate companions, such as providing separate cubicles. Further research is needed to explore the effect of labour companionship on positive birthing experiences, but the presence of a companion, another

recommendation by WHO, has a positive effect on outcomes including women's birth experiences and person-centred care.

6.9 Chapter Conclusion

This study contributes to the literature on the experiences of MHPs and women, which may be related to the maternal mortality rate in the Tema metropolitan area of the Greater Accra region of Ghana. This study is the first to be conducted in southern Ghana. This qualitative study sought to provide insights into MHPs, particularly midwives, and women's perceptions and experiences of quality maternity care by exploring midwives' perceptions of its impact and identifying the challenges they face in providing care. A significant divergence was seen between the themes arising from the midwives and women's respective perceptions of facility-based delivery. This was most apparent when the midwives rationalised their exertion of power and control over the women and their bodies as necessary due to the latter's ignorance and lack of cooperation. It also shows, albeit to a lesser extent, that social inequality affected the care that some of the women received, particularly those with a low socio-economic status, which might even prevent them from accessing care (Bradley et al., 2019). This study has also shown that both positive and negative experiences of women during facility-based delivery are rife in peri-urban settings, as illustrated by the vivid descriptive accounts of both the women and MHPs, particularly midwives. It also explains how religious faith influences the fatalistic behaviour of both the MHPs and women in these communities.

In the next chapter, I will discuss the implications of the findings for practice, policy and research. This will be followed by the conclusion.

6.10 Strengths and limitations

A strength of this research was the use of qualitative methods, that harnessed two different perspectives across the study. These ranged from midwives on the labour ward, who were at the sharp end of service delivery, to the women who used the service. In addition, the four/five-long month data collection period allowed ample time not only to collect a great deal of data, but also to purposively target the key participants in response to the emerging themes. The interview transcripts were checked by three supervisors and a meeting was held to agree on the themes. Another strength was the fact that the translation from Twi to English was checked by

an independent translator, and my translations were compared with those of another native speaker. Further, a registered qualified midwife with experience of a similar Ghanaian hospital setting, independent of the project, reviewed the data analysis for both the mothers and midwives. This improved the quality of the data collected and also provided sufficient leeway for me to delve more deeply into previously unfamiliar issues, thus strengthening the quality and breadth of my interpretations.

Despite its strengths, there are several limitations to this study. First, although the aim was to explore women's experiences of maternity care, disrespect and abuse emerged as a very strong theme within the data. Second, it is possible that selection bias may have influenced the responses, given that this study relied upon purposive sampling and the identification of the respondents was based upon women who agreed to participate who had accessed care in a hospital (and thus had already made that choice). This is a limitation, as women who chose not to attend hospital to give birth were not represented (Bradley, 2018; Goffman, 1959), bringing into sharp focus the dissonance between what I was told in interviews and what I observed as someone from this culture (Bradley, 2018). It was apparent that some of the MHPs presented themselves as the professional they wanted me to see, or perhaps the professional whom they aspired to be (Bradley et al., 2019), rather than describing their actual practices and behaviour.

This was illuminating, as it indicated an awareness of how a professional should behave, even if that was not always achieved in practice, and informed elements of the ideal model for positive birth experiences described in Chapter 2. Further insights offered by the participants were also used to refine my understanding of the gap between what I heard and what I observed. However, it was clear that much of the behaviour that I witnessed has become so normalised for both mothers and midwives that it did not register as disrespect and abuse (Bradley, 2018; Freedman et al., 2014).

A further limitation is the potential problems related to translating to and from English, acknowledging that the context and subtext can be lost in translation. As a native Twi speaker, I have been trained in health services management in Ghana and was therefore familiar with the linguistic and cultural nuances within the research context. Every attempt was made to confirm the reliability of the translations to and from English, to ensure that they reflected the actual meaning intended by all parties. In addition, an independent translator was employed who translated several of the scripts, after which myself and the supervisory team compared

them and discussed the differences. It was found that the independent translator had made the translations more literal than I had. It was agreed that this was better, so I then modified the translations to make them more literal.

Another limitation is that the aim of the study was to explore the experiences of women attending a public hospital. It is acknowledged that a percentage of women choose to give birth with support from TBAs (herbalists, spiritualists, etc.) as they are unwilling or unable to attend a health facility. However, for this study, I did not interview any women who fell into this category. I believe that this provides valuable insights into the reasons why hospitals may be off-putting.

Another limitation was that 20 of the interviews conducted with the women proved to be of little value for the analysis. In these cases, the women gave monosyllabic answers, and all appeared to endorse the care that they had received by, for example, simply responding 'It was fine' to every question. It is difficult to determine the reason for this. Despite probing with questions from the interview schedule, they seemed reluctant to expand on their answer. They may have been embarrassed to discuss their birth stories with a man or may have feared that they might be denied the needed services if they criticised the MHPs in any way. Although they were reassured that this would not be the case on the participant information sheets, their refusal to comment on the questions posed during the interviews might suggest the need for continuous reassurance during the interview that their information would be treated with the utmost confidentiality. Another way to overcome this limitation would be to train local women as co-researchers to ask the questions.

Another limitation was the possibility of researcher bias. The analysis of the qualitative interview data required interpretation that may have entailed the researcher making value judgments. When organising the material, every effort was made to allow the respondents to speak for themselves. Mitigation attempts included a member of the supervisor team checking that that the analyses were accurate and consistent with the intent of the respondents. As the researcher and a health service administrator, I assured the women and MHPs that this study was for academic purposes only and would help their voice to be heard, with the aim of limiting the bias created by the women and MHPs feeling obliged to offer positive feedback, to please the interviewer (Lythgoe, 2015).

The aim was to recruit participants who were unaware of my professional or health management background, in order to reduce the bias. Most of the participants clearly did not know that I was a health service administrator. However, two MHP participants did recognise this, and made several references to it (e.g., saying ‘Sir, do you know what I mean?’). As the interviews evolved, some of the other MHP participants may also have guessed my background regarding the study. As a researcher, I offered them an opportunity to talk to someone who was obviously an outsider, whom they might perceive as having the power to make changes, which they might see as helpful, so my powerful positionality can be positive as well as negative. My position as a health service manager, and a male, may have given me a certain status that may have made it difficult for the MHPs and women, who may have seen themselves as being in a subordinate position, and so been less open in their discussions with me. At times, this might have meant that they tried to give the 'right' answer rather than the honest answer. I acknowledged that this could affect how the women and midwives talked to me during the data collection. However, I tried my best to mitigate this effect, and tried to reduce the power imbalance by reassuring the MHP participants that I was not acting on behalf of the hospital managers. I also ensured that I interviewed them in a comfortable, safe place, away from their work environment. Again, I reassured them that the interviews were confidential and that I would not share the information with their manager so it is to be hoped that they felt safe about sharing information with me. This issue could have affected the MHP participants’ responses during the interviews, and so the credibility of the study. To mitigate this possible bias, I used reflexivity and my positionality within the analysis of the interviews, and tried to create credible truth while presenting the research. Further explanation of this reflexivity and positionality can be seen in Chapter 3, section 3.8 of this thesis.

6.10.1 An Exploration for Discovery – My PhD Journey

Looking back at my PhD journey, I gained a surfeit of learning experiences that were shaped by a combination of my work experience at Tema General Hospital and my academic life which, together, led to my development as a person and also as a novice researcher. Reflecting on the commencement of my PhD in January 2017, I remember how I imagined the process of undertaking a PhD to be illuminating and straightforward. Instead, undertaking this PhD proved to be a journey of discovery. I started by making an exploratory visit to Ghana, with no

fixed methodology in mind other than to enter the field and explore the experiences of MHPs and women.

I recollect vividly my PhD supervisors advising me to immerse myself in the context so that I might understand the Ghanaian public health system better with regards to maternal healthcare. I also remember how the unavailability and inaccuracy of secondary data made it challenging to embark on quantitative or mixed method reserach. However, this journey has enabled me to develop my skills as a researcher substantially. It has provided me with an opportunity to develop in-depth knowledge regarding research methodologies, particularly semi-structured interviews and the application of the framework analytical process. From conducting mostly structured interviews in the scoping phase to in-depth semi-structured interviews in the follow-up phase of the study, I gained a clearer understanding of the deeper meanings of the MHPs and women's experiences.

Throughout my PhD programme, I have attended a variety of seminars and conferences that are related to my research methodology and method; this developmental activity helped to inform this thesis. In many ways, this PhD journey experience has been a source of frustration for both myself and my supervisors, particularly during my first year. In respect of all of the experiences, therefore, I conclude that the process of undertaking a PhD is not a direct process but somewhat spherical in nature, that demands frequent supervision and research direction. Having excellent support and guidance from my academic supervisors has enabled me to apply this research knowledge to the project and complete this thesis. Throughout this process, I have gained confidence and courage about both writing and presenting. Reflecting now, it seems to me that my initial view that a PhD is a straightforward matter proved to be unrealistic. In fact, it has been a chaotic experience, which required my total involvement, grit and unceasing reflection. My PhD programme has ended in the completion of this study, making an original contribution to the evidence base. The dissemination of its findings will help to inform practice and enable me to take a leading role in the promotion and development of high quality, respectful care within maternity services. I hope that it will also enable me to inform professional development for all health professions regarding the appropriate care for women by promoting person-centred care, to reduce the suffering and improve the outcomes of women and their families.

CHAPTER 7: CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

The conclusions are outlined in terms of their relevance to the idiographic and overall experiences of the women and maternity health professionals (MHPs) related to the quality of respectful maternity care. It then discusses the contribution of the study to existing knowledge and the implications for future research. Following this, the chapter discusses the strengths and weaknesses of the study, and outlines a set of recommendations, before drawing the final conclusion.

7.2 Contribution to Knowledge

The findings offered some new insights into the MHPs and women's experiences of maternity care. This thesis supports the existing literature from sub-Saharan Africa, especially Ghana, that has explored experiences of maternity care of women and midwives during facility-based childbirth. This echoes many of the factors identified by other authors which were outlined in the analyses of the women and midwives' perceptions described in Chapters 4 and 5, respectively. There was significant convergence in this study with previous data that demonstrated midwives' understanding of birth as a medical event, facilitated by their exertion of power and control over women and their bodies, and rationalised as necessary due to women's ignorance and lack of cooperation. It also shows, to some extent, that social inequality affected the care that some of the women received, particularly in the Tema peri-urban community.

Some critical gaps in the existing literature were identified and addressed in this research. The first was the paucity of evidence on midwives' perceptions of good midwifery in this context, and their practice of maternity care. This study's findings make significant contribution to the rapidly expanding literature on women and MHPs experiences on maternity care. The study also explored the midwives' perceptions of the barriers to quality maternity care, which have received limited attention in the literature to date.

Another gap was that some of the midwives apologised after the birth for hitting or shouting at the women. This indicates a level of awareness of abuse that they regret or perhaps felt was

necessary to prevent a bad outcome but unfortunately was not in line with the code of practice. The midwives were aware of the fear and unhappiness of the women when the care was disrespectful but felt powerless to change the dynamic. However, the impacts of high quality, respectful maternity care and its benefits, particularly for the women, were less clearly articulated, indicating that professional training on respectful maternity care warrants further attention.

Furthermore, a notable gap was the use of psychological scare tactics by the midwives to encourage the women to cooperate. The midwives used the threat of death, informing the women that if they refused to push and died, the morgue was just around the corner. The researcher therefore argues that midwives should be given education in order to empower them to use professional skills to encourage women during labour or when attending the maternity clinic to comply with what is expected of them. These threatening words sometimes terrified the women, so this fear might harm them and their babies.

Another critical new finding of this study relates to religion/culture. Faith/religion and spirituality were noted as important influences on the uptake and utilization of maternity care services. Religion impacted the women's ability to take decisions about their health. They believed and trusted their pastors and prophets far more than the midwives and would always consult their religious leaders when deciding whether or not it was appropriate to go to attend hospital, even when in labour. This indicates that religion is a key factor in women accessing maternity care services. While this may sound problematic, it presents a new opportunity which, if well harnessed, could enhance maternal and child health in Ghana. Given that women appear to trust and listen to their pastors and prophets more than their midwives, therefore, these religious leaders could serve as gatekeepers in order to influence women. To achieve this, the Ghanaian maternity care system may consider engaging these religious leaders and using them in some cases to educate women about their health and encourage them to attend maternity care. Further, it is striking that even the midwives shared the same attitudes of being fatalistic. Sometimes, when things went wrong, they attributed this to God's will rather than human action. More research on this area would be useful. The researcher, therefore, argues that, to improve the maternal healthcare services, far more emphasis should be placed on the religion/cultural aspect in the WHO framework, as it is a significant issue when discussing countries that are dominated by belief and religion. The failure to engage with this phenomenon

means that improvements/initiatives designed to promote positive maternity care are likely to fail.

Further, another gap identified was the influence of the husband and family on the women's accessing of healthcare in general, which indicates that the husband and family are a factor in women's decision-making about accessing maternity care services also. It is possible that women are choosing to go to TBAs to give birth rather than the fearful environment of the hospital, which might be considered a reasonable choice, given that the lack of staff and resources means they will not receive the one-to-one care and support that they need at the hospital, despite the wealth of evidence that one-to-one care during labour improves birth outcomes.

Moreover, there were gaps in the literature around the payment of informal fees. This research found that bribes were requested in return for key aspects of care, such as a bed or urine pot. The views of the mothers and MHPs differed, whereby the latter did not mention any informal requests for payments, which they recognised as corruption. In addition, unexpected payments were requested for things such as medicine, which are not part of the government package. However, the impacts of informal fees on the quality of respectful maternity care, particularly for the women, were less clearly articulated, indicating an area of professional ethics and training on respectful maternity care that warrants further attention.

Further, another key issue was that the women were unaware of how far advanced their pregnancy was and relied on discussions with their husband and mother to decide if they needed to attend hospital. This indicated that the women's unawareness of maternal healthcare is a notable factor in them accessing care. This lack of awareness of their own bodies seems unusual and is not described in the maternity care literature from similar countries. Thus, the women may not present themselves because they have no way of confirming that they are indeed pregnant. This is one potential reason why they do not attend for care or only do so late in their pregnancy. This then seems to result in them being criticised by the midwives, which is likely to put them off attending again in future. Health education and outreach programmes for women in the communities would help to educate them about the early signs and symptoms of pregnancy. This also suggests a need to provide and make available pregnancy tests and track and trace for expectant women. This area is relatively unexplored in the maternal healthcare literature to date.

Moreover, another knowledge gap is the culture of blame that the MHPs participated in and reinforced, by blaming the women not only for any poor outcomes but also for their lack of knowledge about their body. Conversely, the women blame the midwives for not assisting them. The midwives are disempowered themselves because of the untenable situation they find themselves in with regards to the severe shortage of staff and equipment and a lack of recognition of their value by their seniors.

7.2.1 Contribution to Theory

In the literature, the attempts to understand high-quality respectful maternity care and the factors that enable it have tended to be descriptive in nature. Where qualitative methods have been used, these are mostly focus group discussions. I used in-depth interviews and the WHO 2018 theoretical framework of positive birthing experiences of intrapartum care to illuminate the broader context in which the prevailing dynamics and behaviour articulated by respondents were embedded. To my knowledge, no other studies have followed this route. Rominski et al. (2017) addressed the reasons why midwifery students disrespected and abused labouring women in Ghana, using focus group discussions and the WHO 2015 document theoretical frame which emphasises the availability, accessibility, acceptability and quality of services. There are some disparities between their analysis and mine in terms of the methodology and theoretical frame. My use of this specific methodology and the WHO 2018 theoretical frame of positive birthing experiences was intended to provide insights that could have resonance across sub-Saharan Africa, and that explored the broader context in terms of respectful maternity care, labour companionship, and effective communication. This perspective allowed me to use the participants' insights to describe the torrent of the negative experiences of the women and the dynamics that directly impacted on the practice and performance of care on the labour ward, which would otherwise be missing from this discourse.

7.3 Implication of the Findings

In chapters 4 and 5, several issues of concern arose from the research findings, such as the confusion produced by the unclear, unstructured system for collecting fees at the health facilities, the women's lack of knowledge about their own reproductive health, pregnancy and childbirth as well the influence of the 'men of God', i.e., the pastors and imams. All of these factors have implications for practice, policy and research, as outlined in the following sections.

7.3.1 Implications for Practice

It is noted that many of the women who participated in this study had serious issues related to the payment of unclear, unstructured fees which dominated the maternity care services. The impact of this issue on how the women felt seems to be underestimated, as it seems to have lead to feelings of shame, humiliation and being judged as foolish and thus feeling unworthy of the care and treatment they should receive. This, in turn, creates a fear in the women of neglect and even the death of themselves or their baby, especially when they are unable to pay such fees. This has a potentially very powerful effect on the women's desire to attend the health facility again.

Furthermore, both the women and MHPs had limited exposure to information, resulting in ignorance about good maternal health practices during pregnancy and childbirth. In addition, the women perceived their own lack of knowledge and reported that the staff offered them little or no guidance or explanations when providing care. This is a major cause of distress and sense of a lack of control, as the women had expected the midwives to assist them by providing them with health information and advice. However, the midwives lacked access to education and ongoing training about how best to support women during maternal healthcare. Controlling women was a powerful dynamic within in the labour ward, reinforcing the message that birth is a medical event, mediated by experts. The midwives felt that the women did not know what to do, so controlled where they could go and how they behaved, overriding the women's embodied knowledge to dictate how they should birth (Bradley et al., 2016; Bradley et al., 2019).

The MHPs wanted to exert control over the women and the childbirth process, which led to the women feeling mistreated and disrespected. This is one of the factors that deter women from accessing care. The underlying cause of this problem may be the low socio-economic status of the women and their lack of health education. Moreover, the hospital's environment and practices may be considered unsafe so not attending hospital may be a reasonable choice for them, despite the potential risks associated with this. Thus, signs and symptoms of obstetric dangers are difficult to detect by uneducated women, and women have little control over their own maternal healthcare. The MHPs' experience was that they need to explain everything to the women, which takes time, and the staff reported being unable to this. In addition, the time that the midwives had available in which to support the women to cope was severely

constrained by the staff shortages, lack of motivation, and lack of training, exacerbated by resource deficits, that leave support and care in minimal supply. Based on these findings, it is recommended that effective maternal health education is key for both the midwives and women. However, this needs to be accompanied by a better infrastructure and respect for MHPs, so that they are motivated to provide better support.

It also became clear in the study that the women believed strongly in the prayers offered through faith healing and churches. The core of these prayers was to ask God for protection during pregnancy and childbirth against the wicked people within the communities (Mboho, 2009). Further, even the midwives shared this attitude, often expressing fatalism. This belief that births outcomes lie completely in the hands of God, with medical support viewed as being of secondary important, is a significant issue. The findings of this study and others on maternal health care in the faith-healing churches (Anafi et al., 2018; Ganle et al., 2014) show that there exists a clear need for the government of Ghana to set minimum standards of practice for churches operating maternity care services, in consultation with or incorporated into the World Health Organization's operating guidelines regarding positive birth experiences. The women revealed that they would consult their pastor to decide whether or not it was appropriate to attend hospital, even when they were in labour. This indicates that religion may be far more of a key factor in women's accessing of maternity care services than has been previously thought, and WHO does not appear to have recognised the significant impact of this on women's/family decision-making when seeking to improve access to maternity care services.

Based on these findings, it appears that ignoring belief and religion, which have a strong influence in the communities, means that the maternal death rate will continue to rise, since the practice of the faith-healing is likely continue for a long time in the communities. I recommend that emphasis should be placed on this omission from the WHO framework, as it a significant flaw when discussing countries that are dominated by belief and religion. A failure to incorporate this factor means that any improvements /initiatives designed to promote positive maternity care are likely to fail.

This study also found that the women's negative experiences and perceptions of the MHPs' attitudes contributed to their mistrust and reluctance to present themselves at health facilities. Seeking maternal health care should not be a dehumanising, disrespectful experience. Pregnant mothers should be treated with respect, dignity and compassion. One of the key implications

for practice that emerged from this study relates to the education and reorientation of the practices of the midwives in the health facilities. For example, it was observed in the study that the MHPs (midwives) often apologised after the birth for hitting or shouting at the women, which indicates a level of awareness of abuse that they later regret or perhaps felt was necessary to prevent a bad outcome. The midwives were aware of the fear and unhappiness of the women when the care was disrespectful but felt powerless to change the dynamic. However, the impact of quality respectful maternity care and its benefits, particularly for the women, was less clearly articulated. I recommend that professional training on how to deliver high-quality, respectful maternity care is urgently required. This must incorporate into the midwifery pre-registration curriculum, combined with follow-up workshops and seminars, where evidence-based practices may be discussed.

7.3.2 Implications for Policy

During the course of this study of experiences of maternal health practices, the role of religion and beliefs in the utilisation of maternal healthcare facilities and the poor state of such facilities, with a scarcity of MHPs coupled with poor working conditions, suggest that the intervention strategies designed to promote maternal health care in Ghana need to be modified. This positive action would exert a significant impact on the experience of facility-based birth. The recommendations outlined below were largely synthesised from the input of the midwives and women, and centre around community involvement in maternal health education, development and training for the providers, government assistance, the WHO guidelines, labour companions and improved working conditions.

1. The many issues identified in this study clearly indicate the need for active, functional policies to protect the interests of women. Most of the participants in this study felt unprotected when seeking healthcare services. This was reflected in the way in which they were extorted, neglected, abused, disrespected, maltreated and denied access to vital aspects of the care services because they were unable to meet the demands of the MHPs. Such practices are, by all definitions, below the standard set by WHO (2018) and Freedman et al. (2014). Policies that meet the standard of the WHO should be developed by the Ghanaian government, who should ensure their implementation by the healthcare professionals to protect the interests of women.

2. With regard to community involvement in maternal health care in the area, the MHPs' frustration is often triggered by women not knowing what to do and lacking knowledge about their own body. Educating the wider community on the role of midwifery services in curtailing maternal mortality will promote trust in the MHPs, and also equip the women in these communities with more knowledge about their health, especially the need to attend for antenatal care and childbirth.

3. Development, education and ongoing training are required in order to provide high quality, respectful maternity care and eliminate or minimise the disrespectful care of women accessing maternal healthcare in Ghana.

4. The government and Ministry of Health of Ghana should assist with transportation and other financial costs, such as those for caesarean sections and laboratory tests, and offer tangible rewards to motivate the women to attend for care. Further, more community-based clinics (peripheral clinics) should be established to ensure the closer proximity of these clinics to the communities.

5. To support the WHO guidelines on positive birth experiences, emphasis should be placed on the role of religion. This is omitted from the current WHO framework, which is a significant flaw with regard to countries that are dominated by belief and religion. A failure to incorporate this factor means that improvements and initiatives designed to promote positive maternity care are likely to fail.

6. The concepts of labour companionship and emotional support require structural changes to be made; for example, the presence of a birth companion, such as a family member, husband, or friend, should be encouraged, and women should have their companion of choice beside them during delivery at a facility. In addition, the labour wards should be designed to facilitate companions, such as offering separate cubicles.

7. To improve the working conditions, it is necessary to streamline the health systems, pay structure regulations, health policies, and budget allocations through close cooperation and collaboration among researchers, key health programme planners, the Ministry of Health and the Ghanaian Government.

7.3.3 Implications for research

This thesis addressed some of the knowledge gaps identified by the literature review. The power dynamics and inequalities between the mothers and midwives in the maternity ward in the Ghanaian context warrant closer examination. There is a small body of literature on this phenomenon in South Africa (Kruger & Schoombee, 2010), but it has received limited attention elsewhere in sub-Saharan Africa. It was an important theme in this study, making significant impacts on the provision of care.

Further qualitative studies exploring, traditional birth attendants, husbands and pregnant women's experiences of respectful maternity care during pregnancy and birth in differing contexts, including the treatment delivered by midwives and gynaecologists, would be of value. Research on the impact of spirituality/religion on midwives, pregnant women and their families on the accessing of maternity care would help to inform the development of guidelines on the issue. In particular, the views of those giving birth outside the hospital system (e.g., using traditional birth attendants) were not included in this study, so this area would benefit from further research.

There should be further qualitative studies on the levels and impact of anxiety and stress during pregnancy, to enable the development of effective strategies and treatment to address the needs of the women, their babies and their families.

7.4 Conclusion

This study provides a unique insight into the experiences of MHPs and women regarding maternity care. The paucity of qualitative literature regarding the experiences of maternity care of MHPs and woman has been addressed, making a significant contribution to the evidence base. The main themes of this study have been discussed in line with the available evidence, highlighting the significant findings and considering their relevance in relation to the aims of this study. This qualitative study sought to provide insights into the MHPs, particularly midwives and women's experiences of maternity care. It illuminated how the women were treated during their pregnancy and labour and explored the MHPs' perceptions of the challenges that they face when providing care. Significantly a convergence was seen between the themes arising from the MHPs' perceptions and those derived from the women's

experiences. This was most apparent when the midwives described their exertion of power and control over the women and their bodies, which they rationalised as necessary due to the women's ignorance and lack of cooperation. The findings of this study provide valuable new experiential insights into women and MHPs' voices and make an analytical contribution to the existing body of knowledge, with both academic and policy implications. Further, the study identified a range of avenues for potential future research. Finally, the study provided a set of recommendations that can be applied to address some of the complexities that exist within the maternal healthcare services.

This study has also shown that poor experiences of facility-based delivery are rife among women in peri-urban settings, as reflected by the vivid descriptive accounts of both the women and MHPs, particularly midwives. These poor experiences are largely driven by an unbalanced relationship between the MHPs and the women whom they serve, due to the women's socioeconomic status and institutional barriers.

The Ministry of Health Ghana should be involved in addressing the need for high quality, respectful maternity care through conducting further research and creating accountability procedures.

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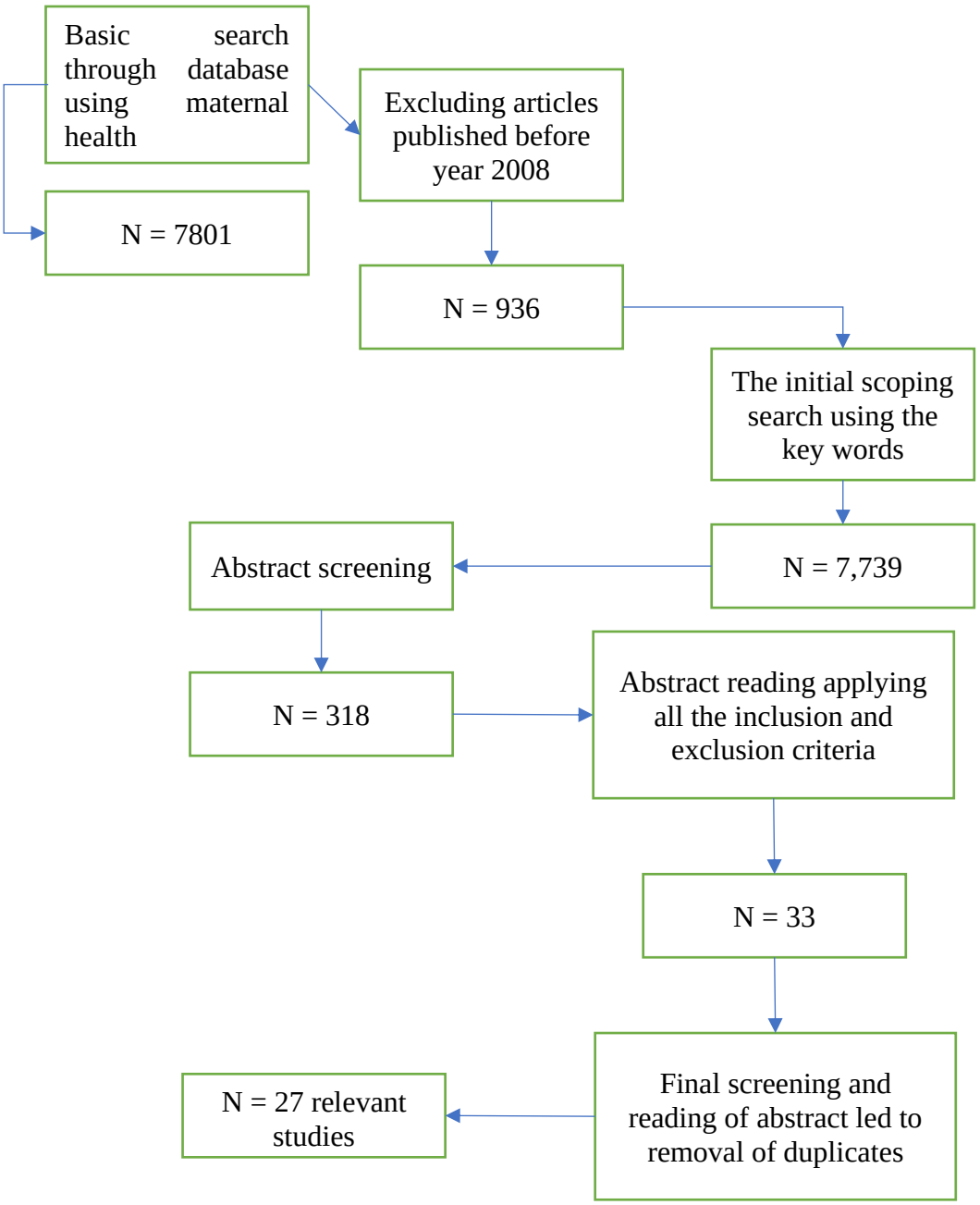
APPENDICES

Appendix 1 Flow dagram of literature search and study inclusion and exclusion process



AUTHORS AND YEAR	COUNTRY	AIM	DESIGN	SAMPLES	FINDINGS	LIMITATION/RECOMMENDATION/FUTURE RESEARCH
Abuya et al. (2015)	Kenya	To identify contextually the different sorts of disrespect and abuse and to quantify their prevalence	An analysis of cross-sectional data from a quasi-experimental study	641 postpartum mothers	Women experienced humiliation during labour and delivery. Women without a partner during childbirth were less likely to be requested for improper payment; women with three or more children were more likely to be held if they were unable to pay and were asked for a bribe.	The study examined the prevalence of Bowser and Hill's Disrespect scale. While this gave a comprehensive overview and solid foundation, the framework itself has not yet been tested or confirmed.
Amroussia et al., 2017,	Tunisia	To examine single mothers'	Semi-structured interviews	11 single mothers who had given birth a	Gender role in constructing experiences while intersecting with other social structures.	The sample was small in size. The study was limited to births to lone mothers

		experiences and perceptions of		public healthcare facility.		
Asamoah et al. (2011).	Ghana	Assessingand analysing the causes of maternal mortality in Ghana based on socio-demographic parameters.	Questionnaires	The data from Ghana Maternal Health Survey 2007, which was acquired from the . 240,000 households were selected from the 10 administrative regions of Ghana across urban and rural areas , out of which 226 209 completed the	Haemorrhage occurred most in women between 35 and 39, at 27.5%, with 22.5% of cases in women between 30 and 34, 20.3% between 25 and 29, and 14.5% between ages 20 and 24. Maternal mortality was inversely related with greater education levels. For example,	Lack of paperwork prevented the verification of certain reasons of death.

				household questionnaires. Verbal autopsy questionnaires were used in phase II to enquire into female maternal deaths.	women with only a basic education accounted for 54.9% of maternal mortality, while only 2.1% of deaths were of women with a higher or tertiary education	
Asefa & Bekele, (2015).	Ethiopia	To determine level and types of abuse faced by women during childbirth at	Cross-sectional study with exit survey	173 women recently had vaginal delivery	89.4% of women reported Violation of the right to information, informed consent, and choice/preference of	The study's limitations include the following: exhaustively addressing all types of disrespect and abuse that may have been practised but were not captured; delineating urban–rural differences, as the setup may differ in these different contexts; and non-random selection of mothers, as interviews were conducted in a sequential order.

		four health centres in Ethiopia			position during childbirth	
Boafor et al. (2021).	Ghana	To describe the trends and contributory factors to maternal mortality at the Korle Bu Teaching Hospital Accra, Ghana.	Retrospective	All maternal deaths at KBTH from 2015 to 2019.	hypertension at 37.3%, haemorrhage at 20.6%, Sickle cell disease and sepsis at 8.3% each, and pulmonary embolism at 8.0%. Three significant factors linked to maternal mortality in Korle-Bu teaching hospital in Accra included:	Inadequate documenting of events or missing folders or case notes with partial information from the existing folders. Due to the monthly audit of these instances, which is documented in the departmental mortality audit file, it was possible to acquire the necessary information. Future overcoming of this difficulty will be substantially aided by the ongoing transition to an electronic data collecting method. In cases where an autopsy was not performed, the exact reasons of death were discovered by a clinical audit. Formal education and improvements to prenatal care may aid in the prevention of these deaths.

					lack of a formal education [AOR 3.23 (CI: 1.73-7.61)],attending fewer than 4 antenatal appointments [AOR 1.93(CI: 1.23-3.03)], and undergoing emergency caesarean section	
AUTHORS and YEAR	**COUNTRY**	**AIM**	**DESIGN**	**SAMPLES**	**FINDINGS**	**LIMITATION/RECOMMENDATION/FUTURE RESEARCH**
Bohren et al. 2015	Global	mixed-methods systematic	Systematic Review	65 total studies included	Physical abuse, verbal abuse, sexual abuse,	Lack clarity on the proposed typology be adopted to the phenomenon and be used to develop

		review aims to synthesize qualitative and quantitative evidence on the mistreatment of women during childbirth in health facilities to inform the development of an evidence-based typology of the		from 34 countries	stigma and discrimination, poor relationship between women and HPs, inability to satisfy quality of care, and constraints in health system and facilities failure	measurement tools and inform future research, programs, and interventions

		phenomenon.				
Bowser & Hill (2010)	Global	To examine reports on the contributors, scope, possible interventions, and impact of disrespect and abuse in order to initiate discussion and conduct research on disrespect and abuse	Review	Not Stated	Seven categories of disrespect and abuse have been identified: physical abuse, non-confidential care, imprisonment in institutions, discrimination, non-dignified care, non-consented care, and abandonment. Individual, community, and national policy, Human Rights, service delivery,	

					and Health care workers were the topics addressed by disrespect and abuse contributions. Disrespect and abuse discourages utilisation of maternity services	
Bradley et al.,2016	Sub-Saharan Africa	To investigate how women perceive interpersonal components of maternity care	Systematic Review	25 original Studies were included	Power and control Social inequality between mothers and midwives Found model of maternity care was institution-centred, medicalised and hierarchical	Future research should investigate the opinions of midwives regarding the value and practise of interpersonal components of maternity care, as well as the impact of disrespectful treatment on their sense of professionalism and personal ethics.

Burrowes et al., 2017	Ethiopia	Examine the nature of disrespect and abuse in midwifery care during delivery.	Surveys	A convenience sample of 23 women over the age of 20 who had given birth attended by a midwife within the past year and	Health care providers and patients reported frequent physical and verbal abuse as well as non-consented care during labour and delivery	The sample size is small and restricted to a single geographic region, making it impossible to extrapolate the results to other Ethiopian or African settings. The interviewed patients had an unusually high degree of education.
Der et al. (2013).	Ghana	To evaluate the causes of maternal death in southern Ghana using autopsy results	Retrospective	Autopsy log books of the Department of Pathology,	81 percent of pregnancy-related deaths happened in the communities or within a day of admission to an established health facility, and just 18.5 percent happened after day of	Inadequate clinical history, a drawback inherent to retrospective investigations. It is suggested that efforts be implemented to combat these preventable causes of maternal mortality. These should include improved education on the necessity of antenatal care and an increase in the number of properly educated maternal health staff capable of addressing these major causes of maternal death in the community.

					admission to a health facility.	
AUTHORS and YEAR	**COUNTRY**	**AIM**	**DESIGN**	**SAMPLES**	**FINDINGS**	**LIMITATION/RECOMMENDATION/FUTURE RESEARCH**
Ganle et al. (2014).	Ghana	To explore health system factors that inhibit women's access to and use of skilled maternal and new-born healthcare services in Ghana.	Qualitative study using FGD and key informant interviews	185 expectant and lactating mothers and 20 healthcare providers in six communities in Ghana.	Women's experiences, intimidation, unfriendly healthcare providers, long waiting time, limited birthing choices, poor care quality, lack of privacy and difficulties arranging transportation	Additional investigation into the non-monetary reasons that may be impeding access to and utilisation of services.

Ganle et al. (2019).	Ghana	Estimate the incidence of monitored delivery and identify the factors that influence the utilisation of supervised delivery services in a Ghanaian district.	Retrospective cross-sectional survey using structured questionnaires	322 randomly sampled postpartum women	High (90.4%) ANC attendance but low as 68% supervised birth More than a quarter (32%) of the postpartum women delivered their babies at home without skilled birth attendants. Religion, distance to health facility, 4 ANC visits, need partner's approval before delivering in health facility, woman's feel religious beliefs	The study lacks generalization to the UK context

					prohibits health facility use.	
Gumanga et al. (2011).	Ghana	To determine the annual maternal mortality ratio from 2006 to 2010 and trends in the causes of 139 audited maternity fatalities in Northern Gana.	Retrospective descriptive review of maternal deaths	Data obtained from patient folders, and labour ward records.	There were 280 maternal deaths within 4year. The main causes of 139 audited maternal deaths from 2006 to 2010 were sepsis, hypertensive disorders, haemorrhage, unsafe abortion, obstructed labour, anaemia, sickle cell disease and malaria. The ages of the 139 audited maternal deaths	The study can not be generalized in different context.

					ranged from 14-48 years. The (13%) of the maternal deaths were from towns over 150km from Tamale.	
Janevic et al., 2011,	Serbia and Macedonia	To develop a conceptual framework showing how different levels of racism occurs in maternal health	Community-based participatory research study with focus groups and semi-structured interviews	71 Romani women who had given birth within the past year recruited through purposive sampling, 8 gynaecologists, 11	Twenty-two emergent themes identified barriers that reflected how racism affects access to maternal health care.	The study lacks clarity on its methods

		settings and affect access to maternal health care among Romani women		key informant interviews from NGOs & state institutions recruited through snowball sampling.		
AUTHORS and YEAR	**COUNTRY**	**AIM**	**DESIGN**	**SAMPLES**	**FINDINGS**	**LIMITATION/RECOMMENDATION/FUTURE RESEARCH**
Kruger et al., 2010,	South Africa	To explore experiences of nurse in labour ward birth.	Qualitative	93 low-income, Afrikaans speaking women	Abuse reported by both patients and nurses were related to issues of power and control, hierarchy and order.	The study included only nurses in the labour ward thus the study can not be a representative of the study population.

Kujawski et al.,2015	Tanzania	To assess the association between perceived experiences of mistreatment and delivery satisfaction perceived quality of care and intervention to deliver at same facility in future	Cross-sectional study with survey	1388 postpartum women discharge from 2 hospitals	Abuse during childbirth was associated with lower satisfaction with delivery and reduced likelihood of rating perceived quality of care as good	Future research, especially qualitative research, is required to investigate the causative pathways and evaluate the efficacy of interventions. Solutions and approaches will undoubtedly necessitate a health systems focus that analyses both the context and delivery of care.
Lee et al. (2011).	Ghana	Examine the top causes of maternal mortality in	Retrospective	Three hundred and twenty-two	Hypertension as the leading cause of maternal deaths	Inadequate clinical history, a drawback inherent to retrospective investigations.

		Ghana, categorise the leading causes of maternal fatalities, and provide ways to enhance mother care.		maternal deaths with 30 269 live births in 2year period.	(26.4%) alongside with haemorrhage, genital tract sepsis and early pregnancy deaths, which represents 62.2% of all-causes of maternal deaths and 87.3% of direct deaths. Interestingly, infection and sickle cell disease represented 13.7% of all-cause maternal deaths and 61.1% of indirect deaths.	
Maya et al. (2018).	Ghana	To investigate women's perceptions of mistreatment	Qualitative study	110 women recently delivered in a health facility.	Mistreatment identified were verbal abuse (shouting, insults, and derogatory remarks), physical	It's possible that the nurses who recruited participants for the study swayed their responses to favour providers. There was no stratification of socioeconomic characteristics, such as educational level and marital status, that could influence women's delivery experiences. Due to the qualitative approaches employed in this study, it is possible that the findings cannot be

		during facility-based treatment.			abuse (pinching, slapping) and abandonment and lack of support. Women may avoid giving birth in health facilities in the future because of their own experiences of mistreatment, or	generalised to populations beyond the study settings. Due to varying perceptions among women, agreed definitions, validated indicators, and techniques for evaluating abuse are required to determine prevalence, identify potential entry sites to reduce the issue, and enhance respectful care during childbirth.
McMahon et al. (2014)	Tanzania	To investigate how women and their male partners describe and react to	Qualitative study	49 females, 27 male partners, 20 community health professionals, 11 religious leaders, and 5	Verbal abuse, feeling ignored or mistreated, monetary demands, physical violence, and prejudice were identified as	Future research is needed on characteristics of women that could have informed analysis, such as age, parity, socioeconomic position, relationship and gender of facility escort, and how a woman would describe her (or her family's) relationship with or prior experience within a facility. 2.The study did not include interviews with clinicians, who could have provided insight into whether,

		disrespect and abusive experiences.		community leaders.	abusive events. Women responded to violence using non-aggressive measures, such as returning home. Male spouses replied with assertive ways like requesting better care.	how, and why they engaged in disrespectful care or abuse.
AUTHORS and YEAR	**COUNTRY**	**AIM**	**DESIGN**	**SAMPLES**	**FINDINGS**	**LIMITATION/RECOMMENDATION/FUTURE RESEARCH**
Moyer et al., 2014	Ghana	To examine if participants mention	Qualitative study	Herbalists, women, TBAs, community	Physical and verbal abuse, denial of traditional	Future research must collect specific social, cultural, and demographic data on individual responses to facilitate a more in-depth examination of which women are most susceptible to abuse.

		abuse without prompting, to identify types of maltreatment, and to compare these to existing categories.		leaders, Health care workers, grandmothers, and household heads.	behaviours, neglect, and prejudice are kinds of maltreatment that have been identified.	
	Ghana	To explore providers' perspectives and behaviour regarding respectful maternity care,	Mixed-methods cross-sectional study combining quantitative survey data, qualitative	43 front-line maternity care providers completed a survey of practice patterns before a		

		including knowledge, attitudes, and practices.	interviews, and observations of labour and delivery across four health facilities in rural northern Ghana	quality of care training. Then purposive and convenience sampling was used to recruit a sub-sample for in-depth interviews (N=17), and convenience sampling and self-selection to observe approximately half (N=8)		

				providing clinical care.		
Mselle et al.,2013	Tanzania	To identify potential weaknesses in acceptable and quality care for women who suffer obstetric fistula	Qualitative	25 women affected by obstetric fistula and 5 nurse-midwives at maternity wards and Focus Group Discussions with husbands and community members	lack or poor provision of birth care causes women to lose trust in health care facilities.	The study was limited to women with a previous history of obstetric fistula as a result of childbirth. In tracking shortcomings in health care delivery, the accounts of women who had normal births could have served as a useful contrast.
AUTHORS	**COUNTRY**	**AIM**	**DESIGN**	**SAMPLES**	**FINDINGS**	**LIMITATION/RECOMMENDATION/FUTURE RESEARCH**

and YEAR						
Okafor et al. (2015).	Nigeria	Determine the frequency and pattern of disrespectful and abusive care during childbirth in health care facilities.	Cross-sectional study	437 postpartum women	98.0% of the women reported at least one form of disrespectful and abusive care in their last childbirth. Physical abuse and non-consented care were the most frequently reported types of disrespectful and abusive care	Additional research, particularly involving a focus group discussion with all stakeholders, including patients, is required. The study was hospital-based, which restricts generalizability to the entire population.
Ratcliffe et al., 2016,	Tanzania	To report the effects of a set of	Exit surveys, direct observations,	sampled 64 women four to six weeks		Lack of clear methodologies to address the phenomena.

		interventions to reduce abusive care during childbirth and measure levels of mistreatment before and after the interventions.	follow up interviews, provider surveys, and in-depth interviews	post-delivery and 197 direct observations of the labour, delivery and postpartum.		
Rominski et al. (2017).	Ghana	To explore the perspectives and experiences of midwifery students regarding the	Focus group discussion	83 Midwifery students at 15 public midwifery training school in 10	During their training, student midwives observed an abundance of disrespect and abuse. They believed that RMC	Participants in a focus group may have been influenced by cultural norms when describing instances of disrespect and abuse.

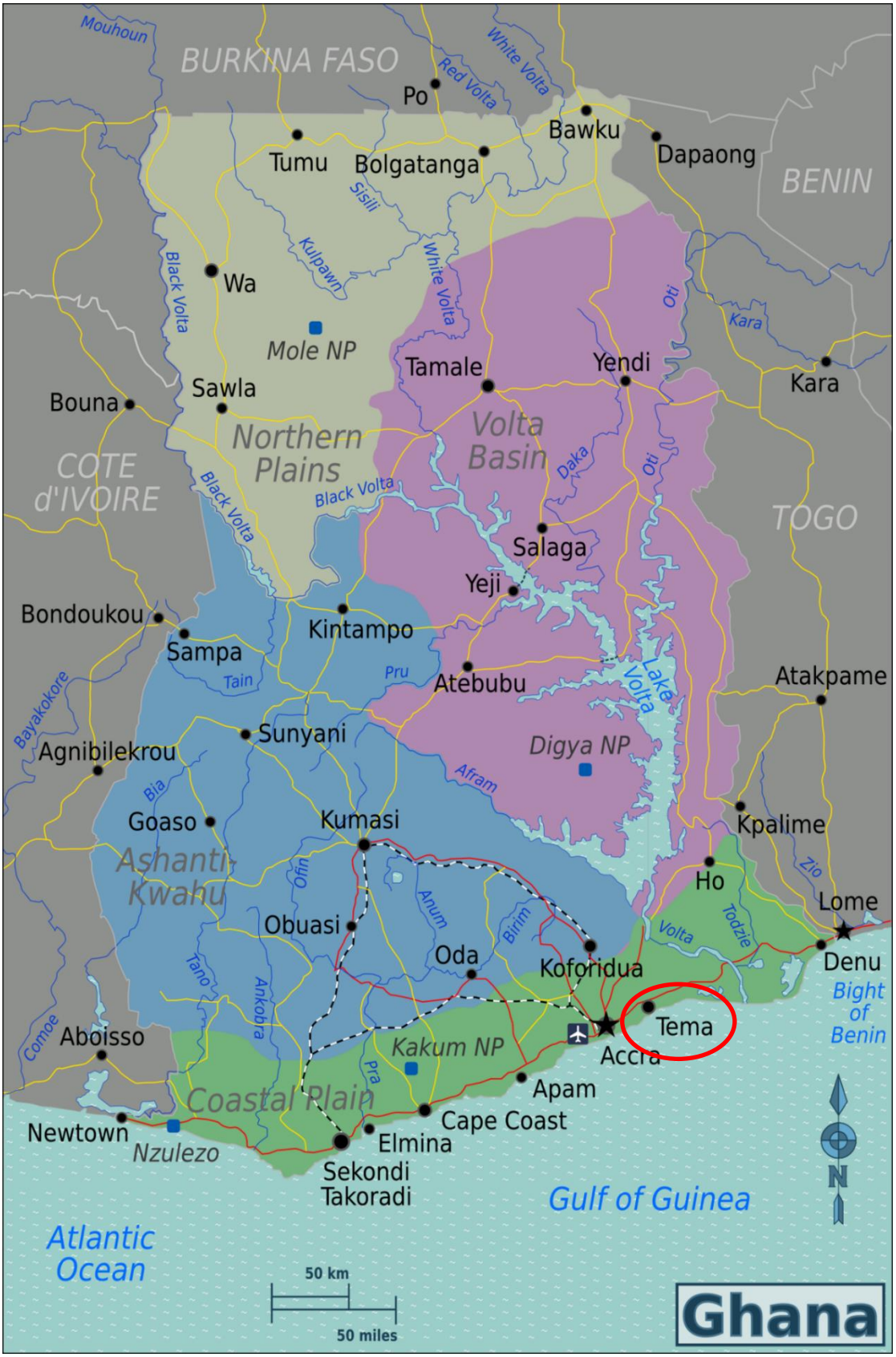
		care of women during labour and childbirth.		regions of Ghana.	treated each patient with dignity regardless of her ability to pay or background. Disrespect and abuse was deemed required to preserve the lives of mother and infant during childbirth.	
Sheferaw et al., 2016,	Ethiopia	To validate a scale that measures women's perceptions of respectful care.	in-depth interviews, survey tool	509 women seeking postnatal care for infants in hospital	defined as courteous care, abuse-free care, timely care, and care without discrimination	Additional study on exploratory and confirmatory factor analysis in various regions.

AUTHORS and YEAR	COUNTRY	AIM	DESIGN	SAMPLES	FINDINGS	LIMITATION/RECOMMENDATION/FUTURE RESEARCH
Vogel et al., 2015,	Ghana, Guinea, Myanmar, Nigeria	To explain a study protocol for assessing mistreatment against women in childbirth in four countries.	with in-depth interviews focus group discussions, systematic review, exit surveys, direct observation	Medical personnel in maternity centres, facility administrators, and women (15–49) using those facilities recruited through purposive sampling.		Further evaluation and implementation of successful treatments to prevent maltreatment and enhance respectful care worldwide

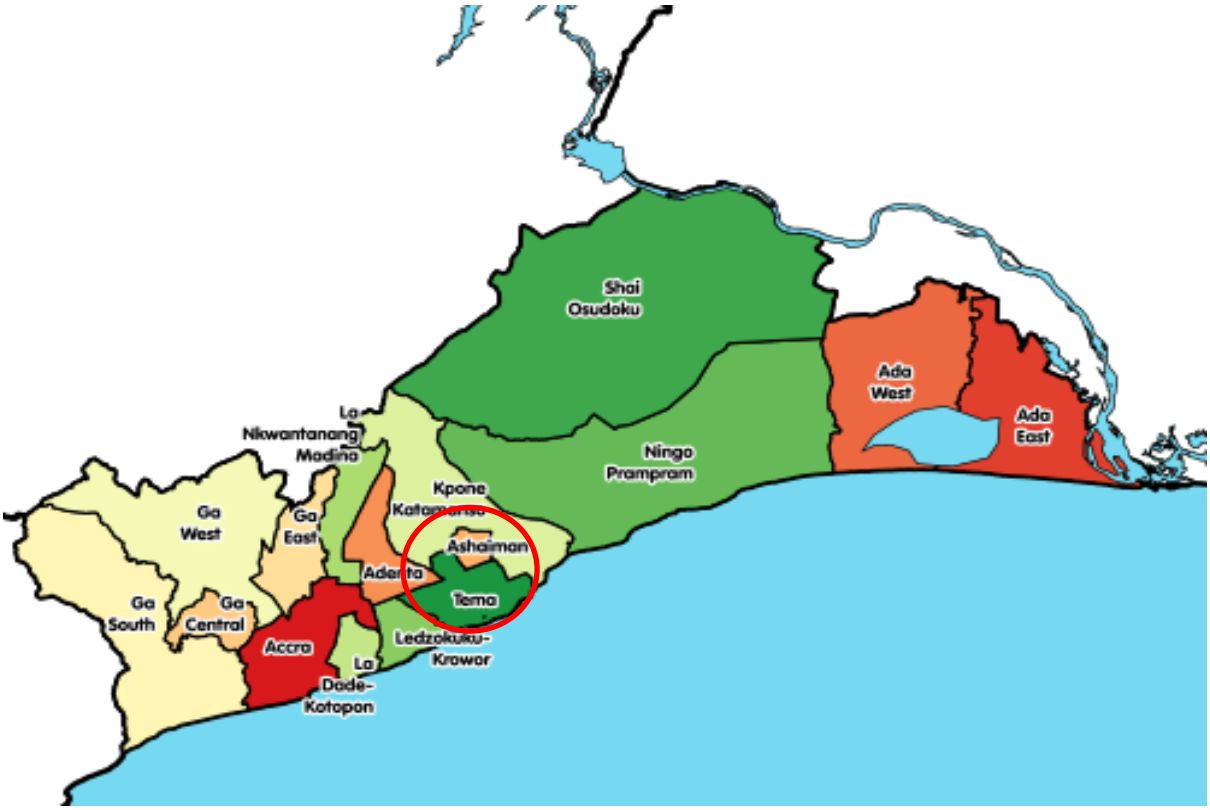
Warren et al. (2017).	Mali	To investigate the opinions of auxiliary midwives on mistreatment during childbirth in rural Mali.	Survey	Survey 53 & 33semi-structured interviews.	Reported abusive and disrespectful behaviour toward women, particularly yelling, insulting, and displaying a hostile or aggressive attitude.	The participants of the study were recruited from a convenience sample of auxiliary midwives participating in an instructional session. Again, the results cannot be generalised due to biases such as selection and reporting bias.
Yarney (2019).	Ghana	Determine if maternal health decisions in rural Ghana are influenced by understanding of socio-cultural factors connected to maternal mortality.	Cross sectional study	233 participants from 3 rural districts in the Greater Accra Region. .	Significant relationship exists between all the socio-cultural factors studied (Traditional Birth Attendants (TBAs), religious beliefs and practices, herbal concoctions, and pregnancy and	The sample was restricted to only three regions in Ghana (out of 10).

					childbirth-related taboos) and maternal health decisions.	

Appendix 3: Map of Ghana



Appendix 3: Map of Greater Accra region of Ghana



Appendix 4: Participant Information Sheet

Participant information sheet for recently delivered women

Title of study: A qualitative study into birthing experiences of Ghanaian women in Tema Ghana

Name of Researcher:

[Anonymise for initial approval]

Invitation paragraph

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please find below some information which you may want to know about this research. Please take time to read the following information carefully. Ask questions if anything you read is not clear or would like more information. If you require additional information, please feel free to contact me or my supervisors on the contact details at the end of this information sheet. Take time to decide whether or not to take part. If you decide to participate in the study you will need to sign a written consent form.

What is the purpose of the study?

To gain an in-depth understanding of the experiences of maternity care from women's and providers 'perspectives.

Why have I been invited to take part?

We are inviting you to participate in this research study because you have recently had a baby and you may have insight and experiences to share about the care you received while you were pregnant and when you had your baby. The information you provide will help in better understanding safe and unsafe maternity care in the antenatal, delivery and postnatal periods. This information should assist in the development of strategies for future maternity care programmes and activities.

Do I have to take part?

Your participation in the research is entirely voluntary. It is therefore up to you to decide whether to take part in the study or not. You will be interviewed by the researcher and one research assistant. We will describe the study and go through the information sheet and address all your concerns. If you agree to participate in the study, we will ask you to sign a consent form to show you agreed to take part in the study. You are free to withdraw from the interview at any time, without giving a reason. However, if you decide to withdraw and wish the information you have given not to be used in the study you need to let us know within 30 days of being interviewed.

Each individual interview should take about 30-60minutes. The interviews will take place at convenient location suitable for you, and no one else but you, I and a female research assistance will be present during this discussion. During the interview, you will be asked questions related to your views, perceptions and experiences with maternity care including antenatal, delivery and postnatal care at health facilities. Also, I will ask you about reasons you think women like you may or may not want to get help from health professionals (eg., midwives, etc) and or health facilities (eg., clinics, etc). With your kind permission, the individual interview will be audio recorded, which will be used solely for the study.

Expenses and payments?

What are the possible disadvantages and risks of taking part?

There are minimal risks and discomfort associated with participating in this study. You will be asked to share some very personal and confidential information (example economic situation) and you may feel uncomfortable talking about them. Also, some of the questions will ask you about your beliefs about seeking maternity care which may make you uneasy. But as I said, you can decide not to answer the question without providing any reason. We will nevertheless minimise such risks and discomforts and act promptly to assist you, if you experience any psychological distress during the process of your participation in this study. Where necessary, you may be referred to various support services for assistance.

What are the possible benefits of taking part?

We cannot promise the study will help you personally but the information you provide will help to increase the understanding of barriers affecting quality maternity care which should enable the implementation of intervention to improve it.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researcher or my primary supervisor-Penny Cook,P.A.Cook@salford.ac.uk. However, if you remain dissatisfied please contact:

The Chair: Dr. Sue McAndrew,

Research Ethics Panel

Health-ResearchEthics@salford.ac.uk

Will my taking part in the study be kept confidential?

Yes your confidentiality will be safeguarded during and after the study. All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the health facility will never have your name and address so that you cannot be recognised. To protect your confidentiality, your real name will not be used during the individual interview or on any documents related to the research instead you will be given a research code which will be known by only the researcher and the research team. A master list identifying participants to the research code data will be held on a password protected computer accessed only by the researcher and the research team. With your kind permission, the individual interview will be audio recorded which will be stored on a computer with a password. Data files both hard and soft copies will be kept within locked office under lock and key in a cabinet and only I and research team will have access to them. Electronic data will be stored on a password protected computer; the password will be known only by researcher and research team. If a report or article about this study is produced, your identity will be protected to the maximum extent possible. You need to be aware that if you reveal anything related to serious criminal activity and/or something that is harmful to self or other, the researcher may have to share that information with the appropriate authorities. Information you provide will be retained for a minimum of three years after which the data will be disposed of securely.

What will happen if I don't carry on with the study?

If you withdraw from the study all the information and data collected from you through interviews will be destroyed and your name will be removed from all the study files. You can withdraw any time up to 30 days after the interview. Please phone the researcher at the contact below.

What will happen to the results of the research study?

The findings and recommendations of this study will be disseminated to participants and the Management of the Greater Accra Regional Health Directorate and the participating District Health Directorate (that is., Tema Metropolitan District Health Directorate) under the Ghana Health Service using durbars. In addition, the findings will be published in peer reviewed journals. Participants will not be identified in any report, publication and PhD Thesis.

The research is sponsored by the University of Salford. It has been reviewed by the ethics committees of University of Salford and the Ethical Review Committee and funded by the Ghana Education Trust Fund (GETFund).

Further information and contact details:

Principal Investigator:
John Yaw Obeng
Tel: XXXXXXXXXXXXXXX | Email: xxxxxx @edu.salford.ac.uk
Office: xxxxxxxxx
Tel: xxxxxxxxx | Email:xxxxxxxx@gmail.com

Appendix 5 Participant information sheet for health professionals (doctors, midwives, community health nurses and health care managers)

Title of study: A qualitative study into birthing experiences of Ghanaian women in Tema Ghana

Name of Researcher:

[Anonymise for initial approval]

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please find below some information which you may want to know about this research. Please take time to read the following information carefully. Ask questions if anything you read is not clear or would like more information. If you require additional information, please feel free to contact me or my supervisors on the contact details at the end of this information sheet. Take time to decide whether or not to take part. If you decide to participate in the study you will need to sign a written consent form.

What is the purpose of the study?

To gain an in-depth understanding of the experiences of maternity care from women's and providers 'perspectives.

Why have I been invited to take part?

We are inviting you to participate in this research study because you are a health professional who may have insight and experiences to share on quality maternity care. The information you provide will help in better understanding quality maternity care incidents in the antenatal, delivery and postnatal periods. This information should assist in the development of strategies for future maternity care programmes and activities. Your participation will be through interviews.

Do I have to take part?

Your participation in the research is entirely voluntary. It is therefore up to you to decide whether to take part in the study or not. You will be interviewed by the researcher. We will describe the study and go through the information sheet and address all your concerns. If you agree to participate in the study, we will ask you to sign a consent form to show you agreed to take part in the study. You are free to withdraw from the interview at any time, without giving a reason. However, if you decide to withdraw and wish the information you have given not to be used in the study you need to let us know within 30 days of being interviewed.

What will happen to me if I take part?

Each individual interview should take about 30-60minutes. The interviews will take place at a convenient location suitable to you, and no one else but you and I will be present during this discussion. During the interview, you will be asked questions related to your views, perceptions and experiences with maternity care including antenatal, delivery and postnatal care at health facilities. With your kind permission, the individual interview will be audio recorded which will be used solely for the study.

Expenses and payments?

We cannot pay you for taking part in this research, but after the end of the interview, you will be provided with refreshment as a small token of appreciation.

What are the possible disadvantages and risks of taking part?

There are minimal risks and discomfort associated with participating in this study. I will be asking you to share some confidential information such as barriers hindering access to quality maternity care and you may feel uncomfortable talking about them. Also, some of the questions will ask you to provide your experiences about any incidents where a woman died in childbirth or a 'near miss' occurred which may make you uneasy. But as I said, you can decide not to answer the question without providing any reason. We will nevertheless minimise such risks and discomforts and act promptly to assist you, if you experience any psychological distress during the process of your participation in this study. Where necessary, you may be referred to various support services for assistance.

What are the possible benefits of taking part?

We cannot promise the study will help you personally but the information you provide will help to increase the understanding of barriers affecting quality maternity care which should enable the implementation of intervention to improve it.

What if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researcher or my primary supervisor-Penny Cook,P.A.Cook@salford.ac.uk. However, if you remain dissatisfied please contact:

The Chair: Dr. Sue McAndrew,

Research Ethics Panel

Health-ResearchEthics@salford.ac.uk

Tel: 0161 295 2280

Will my taking part in the study be kept confidential?

Yes your confidentiality will be safeguarded during and after the study. All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the health facility will never have your name and address so that you cannot be recognised. To protect your confidentiality, your real name will not be used during the individual interview or on any documents related to the research instead each participant will be given a research code which will be known by only the researcher and the research team. A master list identifying participants to the research codes data will be held on a password protected computer accessed only by the researcher and the research team. With your kind permission, the individual interview will be audio recorded which will be stored on a computer with a password. Data files both hard and soft copies will be kept within locked office under lock and key in a cabinet and only I and research team will have access to them. Electronic data will be stored on a password protected computer; the password will be known only by researcher and research team. If a report or article about this study is produced, your identity will be protected to the maximum extent possible. You need to be aware that if you reveal anything related to serious criminal activity (e.g. theft or bribery) and/or something that is harmful to self or other (e.g. maltreatment of staff or patients), the researcher may have to share that information with the appropriate authorities. Information you provide will be retained for three years after which the data will be disposed of securely.

What will happen if I don't carry on with the study?

What will happen to the results of the research study?

If you withdraw from the study all the information and data collected from you through interviews will be destroyed and your name will be removed from all the study files. You can withdraw any time up to 30 days after the interview please email/phone the researcher at the contact below.

The findings and recommendations of this study will be disseminated to participants and the Management of the Greater Accra Regional Health Directorate and the participating District Health Directorate (that is., Tema Metropolitan District Health Directorate) under the Ghana Health Service using durbars. In addition, the findings will be published in peer reviewed journals. Participants will not be identified in any report, publication and or PhD Thesis.

Who is organising or sponsoring the research?

The research is sponsored by the University of Salford. It has been reviewed by the ethics committees of University of Salford and the Ethical Review Committee and funded by the Ghana Education Trust Fund (GETFund).

Principal Investigator:
John Yaw Obeng
Tel: XXXXXXXXXXXXXXX xxxxxxxx@salford.ac.uk
xxxxxxxxxxxxxxx
Office: xxxxxxxxx
Tel:xxxxxxxxxxxx xxxxxxx@gmail.com

Appendix6: Consent Form

Title of study: A qualitative study into birthing experiences of Ghanaian women in Tema Ghana

Name of Researcher:

[Anonymise for initial approval]

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and yes or no, as applicable in the box on the right hand side.

1.	I confirm that I have read and understand the study information sheet version 2, dated 14/09/2017, for the above study. I have had opportunity to consider the information and ask questions which have been answered satisfactorily.	Yes/No
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected.	Yes/No
3.	If I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, may be used in the research. However, if I wish the information I have given to be removed from the research I must let the researcher know within 30 days of being interviewed.	Yes/No
4.	I agree to participate by being interviewed- audio taped	
5.	I understand that my personal details will be kept confidential and not revealed to people outside the research team. - However,	Yes/No

I am aware that if I reveal anything related to criminal activity and/or something that is harmful to self or other, the researcher will have to share that information with the appropriate authorities.

Yes/No

6. I understand that my anonymised data will be used in my thesis and other academic publications and conferences presentations.

Yes/No

7. I agree to take part in the study:

_____	_____	_____
Name of participant	**Date**	**Signature**
_____	_____	_____
Name of person taking consent	**Date**	**Signature**

Appendix 7: Interview Guides

Interview Guide for recently delivered women

Title of study: A qualitative study into birthing experiences of Ghanaian women in Tema Ghana

Name of Researcher:

[Anonymise for initial approval]

1.1. Introduction & Debriefing

Good morning/ afternoon and welcome to our session. Thank you for agreeing and for taking the time to be part of this interview. We appreciate your willingness to participate. I am conducting this study as a requirement for the award of a Doctor of Philosophy (PhD) in Public Health at the University of Salford, Manchester, United Kingdom. We are going to have a discussion about your perception, views and experiences with quality maternity care services and the social factors influencing access to quality maternity care for women. We need your **input** and want you to **share your honest** and open thoughts with us. It is important that we discuss this topic as honestly as we can so that the appropriate strategies and interventions can be planned to improve the quality of and access to maternity care in the antenatal, delivery and postnatal periods. We are having same discussions like this with several other women who recently delivered and health professionals in this District/ community/ health facility. Before we start, let us introduce ourselves. My name is John Obeng, the Conductor; and the Interpreter is Madam …….. Please mention your name. Just the first name is okay.

Ground rules

) Confidentiality:

Your confidentiality will be safeguarded during and after the study. All information which is collected about you during the course of the research will be kept strictly confidential, and any

information about you which leaves the health facility will never have your name and address so you can never be recognized. Everything we discuss should be kept in the room and that no one will be able to link statements to individuals.

a) Reporting of hazards/ illegal act:

In the course of our discussion, if we uncover information regarding an illegal act or criminal activity and/or something that is harmful to you and or others we will have to share that information with the appropriate authorities (e.g., security agencies).

b) We will be tape recording the interview:

You have probably noticed the recorder. With your kind permission we will be tape recording the session because we do not want to miss any of your comments. People often say very helpful things in these discussions and we cannot write fast enough to get them all down. We would not use any names in our reports. You may be assured of complete confidentiality. We want to capture everything you have to say. We would not identify anyone by name in our report. You will remain anonymous.

c) We want you to do the talking:

We would like you to participate. My role as moderator will be to guide the discussion.

d) There are no right or wrong answers:

All your experiences and opinions are important. We want to hear a wide range of opinions, views and experiences. Please feel free to share your point of view. Keep in mind that we are just as interested in negative comments as positive comments, and at times the negative comments are the most helpful.

e) Cell phones on vibration/ silent/ off:

I would be grateful if you could please turn off/ put your phone on vibration or silence so you can focus on the topic.

1.2 Demographic information of women

a. Age of mother

b. Level of education

c. Occupation

d. Religion

e. Marital status

f. Number of pregnancies

g. Number of children

1.3 Access and barriers to maternity care

Antenatal care, delivery and post-natal care

1. Tell me about your pregnancy and birth of your baby - what did you do to look after yourself? Who helped you?

Prompts

a. How easy was it to get the one you needed to feel safe?

b. Who is the main person you go to for advice about your pregnancy?

c. Do you get health advice from a health professional i.e.: midwife, nurse, doctor, or another person such as a local birth attendant or both?

d. How do you decide where to get your pregnancy health advice? Why or why not?

2. How easy or difficult is it for you and other new mothers to access maternity care (antenatal care, delivery and post-natal care services) in this community? Did you have any problem accessing antenatal care? If yes or no, kindly explain it in details?

Prompts

a. Do you have to travel to access maternity care services? If yes, how long (in terms of minutes/hours/days etc.) does it take?

b. How easy is it for you to pay for transportation to these services (availability and means of transport)?

c. Do you have to pay for maternity care?

d. Were you able to attend all appointments? If no, why not?

e. What other barriers do you encounter in accessing the service?

3. Tell me more about your maternity care experiences (antenatal care, delivery and post-natal care services) you received from community health nurses, doctors and midwives?

Prompts

a. Was the care satisfactory and helpful? Kindly explain it in details?

b. Did you find the staff i.e. community Nurses midwives and doctors kind and understanding?

c. Were staff able to meet you and your baby's needs?

4. Do you access maternity care (antenatal care) and received advice to have a safe experience of pregnancy, childbirth and the postnatal period? Kindly explain your answer(s) in details?

5. Do you access maternity care (birthing) and received care to have a safe experience of pregnancy, childbirth and the postnatal period? Kindly explain your answer(s) in details?

6. Do you access maternity care (postnatal) and received care to have a safe experience of pregnancy, childbirth and the postnatal period? Kindly explain your answer(s) in details?

1.4 Factors that promote access and uptake of maternity care

7. What are the factors that promote access and quality of maternity care? Kindly explain your answer(s) in details?

Prompts

. Is there effective interpersonal relationship between women and health care providers? Explain

a. Do you receive supportive care? Explain

b. How do these facilitators influence the uptake of maternity care by recently delivered women?

1.5 Barriers affecting access and uptake of maternity care

8. What are the barriers that hinder access and quality of maternity care? Kindly explain your answer(s) in details?

Prompts

a. How is your relationship with the health professionals?

c. Are women attended to in a timely manner?

d. How do these barriers influence the uptake of maternity care by recently delivered women?

9. Are there any factors that you think might need to be changed to improve the access and safety of maternity care (antenatal care services) in your community? Kindly explain your answer(s) in details?

10. Are there any factors that you think might need to be changed to improve the access and quality of maternity care (birthing care services) in your community? Kindly explain your answer(s) in details?

11. Are there any factors that you think might need to be changed to improve the access and safety of maternity care (postnatal care services) in your community? Kindly explain your answer(s) in details?

1.6 Social factors associated with both safe and unsafe maternity care

12. Are there any special things that you do that might bring you luck for a safe delivery and a healthy baby—e.g. special prayer or ritual?

Prompts

a. How does it influence your access and uptake of maternity care?

Appendix 8 Interview guide for midwives and doctors

Title of study: A qualitative study into quality of maternity care in Ghana

Name of Researcher:

[Anonymise for initial approval]

1.1. Introduction & Debriefing

Good morning/ afternoon and welcome to our session. Thank you for agreeing and for taking the time to be part of this interview. We appreciate your willingness to participate. I am conducting this study as a requirement for the award of a Doctor of Philosophy (PhD) in Public Health at the University of Salford, Manchester, United Kingdom. We are going to have a discussion about your perception, views and experiences with quality maternity care services and the social factors influencing access to quality maternity care for women. We need your input and want you to share your honest and open thoughts with us. It is important that we discuss this topic as honestly as we can so that the appropriate strategies and interventions can be planned to improve the quality of and access to maternity care in the antenatal, delivery and postnatal periods. We are having same discussions like this with several other women and health professionals in this District/ community/ health facility. Before we start, let us introduce ourselves. My name is John Obeng, the Conductor. Please, mention your name. Just the first name is okay.

Ground rules

a) Confidentiality:

Your confidentiality will be safeguarded during and after the study. All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the health facility will never have your name and

address so you can never be recognized. Everything we discuss should be kept in the room and that no one will be able to link statements to individuals.

b) Reporting of hazards/ illegal act:

In the course of our discussion, if we uncover information regarding an illegal act or criminal activity and/or something that is harmful to you and or others we will have to share that information with the appropriate authorities (e.g., security agencies). .

c) We will be tape recording the interview:

You have probably noticed the recorder. With your kind permission we will be tape recording the session because we do not want to miss any of your comments. People often say very helpful things in these discussions and we cannot write fast enough to get them all down. We would not use any names in our reports. You may be assured of complete confidentiality. We want to capture everything you have to say. We would not identify anyone by name in our report. You will remain anonymous.

d) We want you to do the talking:

We would like you to participate. My role as moderator will be to guide the discussion.

e) There are no right or wrong answers:

All your experiences and opinions are important. Speak up whether you agree or disagree. We want to hear a wide range of opinions, views and experiences. Please feel free to share

your point of view. Keep in mind that we are just as interested in negative comments as positive comments, and at times the negative comments are the most helpful.

f) Cell phones on vibration/ silent/ off:

I would be grateful if you could please turn off/ put your phone on vibration or silence so you can focus on the topic.

1.2 Demographic information of health care professionals

a. Age range

b. Rank of staff

c. Qualification

d. Years of working experience

e. Role

1.3 Provision of maternity care services

1. What is your role as a midwife/ doctor in ensuring good quality maternity care? Please provide details?

2. Tell me about the provision of maternity care in this community?

Prompts

a. Do you provide ante natal care services?

b. Do you provide delivery care services?

c. Do you provide postnatal care services?

d. Do women in this district access/ use these services? If yes, how often? Why and why

e. Do you feel that you provide women with safe maternity care?

3. Can you give me some examples of incidents where you felt you were able to provide good care to women in a way that improved their chances of a safe pregnancy, safe delivery and good recovery in the postnatal period?

1.4 Factors that promote access and uptake of maternity care

4. What are the factors that promote access and quality of maternity care? Kindly explain your answer(s) in details?

Prompts

a. Do you feel there is any relationship between women and health care providers? Explain

b. How do these facilitators influence the uptake of maternity care by women?

1.5 Barriers affecting access and uptake of maternity care

5. What are the barriers if any that hinder access and quality of maternity care? Kindly explain your answer(s) in details?

Prompts

a. Are equipment and infrastructure available and adequate?
b. Are the numbers, skills and knowledge of Doctors adequate?

c. Remuneration and terms of condition (salary, promotion, motivation, allowance.

d. How do these barriers affect uptake of maternity care by women?

1.6 The challenge of safe maternity care

6. Can you tell me about any incident where a woman had good experience care?

Prompts

a. How did you do it?

b. What was the best practice?

7. Can you give me some examples of incidents where a woman's care could have been improved or serious problems averted?

Prompts

a. Why did this happen?

b. How could it have been prevented?

c. What was learned from this that has changed practice?

8. In what ways do you feel care could be changed in order to make childbirth safer for women in this this community?

Prompts

Kindly explain your answer(s) in details?

Do you have any control over these factors (why or why not)?

How could women be encouraged to access antenatal care?

Appendix 9: Ethical Approval

Health Research Ethical Approval Panel

Amendment Notification Form

Please complete this form and submit it to the Health Research Ethics Panel that reviewed the

original proposal: Health-ResearchEthics@Salford.ac.uk

Title of Project: **A quality study into quality of maternity care in Ghana**

Name of Lead Applicant: John Yaw Obeng *School:* Health Sciences

Date when original approval was obtained:17/10/2017 *Reference No: HSR1617-174*

Please outline the proposed changes to the project. NB. If the changes require any amendments to the PIS, Consent Form(s) or recruitment material, then please submit these with this form highlighting where the changes have been made:

These changes have been made based on recommendations from my examiners at the Interim Assessment Panel Report.

1.The title of the project was changed from 'Exploring the perceptions, views and experiences of health professionals and recently delivered women about safe maternity care' to 'A qualitative study into perceived quality of maternity care in Ghana'. The reason was that, safety is more of quantitative concept (i.e. could be measured using quantitative methodology) than is 'perceived quality'. Additionally, I aim to find out about women's experience more broadly, whereas safety is only one aspect of quality maternity care.

2. As per the reorientation of the study towards women's and health care professionals' perceptions, the aim of this study was changed from 'Explore the perceptions, views and experiences of health professionals and recently delivered women about safe maternity care' to 'gain an indepth understanding the experiences of maternity care from women's and providers perspectives', the reason was to gain an indepth understanding of mothers' maternity care experiences and health professionals perceptions.

3.The objectives were changed to align with the revised aim and title of the project.

4.The rationale was changed to align with the revised aims and objectives, to have less of a focus on safety.

Version 1.0 – 19 June 2017

Health Research Ethical Approval Panel

5.With regards to research method, 'Mothers who will be recruited with help of community nurse' was changed to 'Mothers will be recruited for this study in the Tema community by approaching them with the help of the community head who are gate keepers through churches and women's groups'. This was due to the potential bias and influence of the community nurses on the recruitment process of the study. In addition, the length of the interview was changed from one hour, forty-five minutes to thirty to sixty minutes based on methodological literature. One of the local languages, Ga, was omitted due to small fraction of the Ga population in the study, Twi and English language will be used in the study.

6.The were amendments on the interview guides as well. These were to embrace the new aims of an exploratory, indepth, qualitative study looking at the experience of maternity services.

7. Also, mothers who either used the maternity care services in the Tema General Hospital or elsewhere in the Tema Metropolitan District, or have not used maternity services. This is because I wanted women with a variety of experiences.

Please say whether the proposed changes present any new ethical issues or changes to ethical issues that were identified in the original ethics review, and provide details of how these will be addressed:

The proposed changes do not present any new ethical issues.

Chair's Signature:

Approved: 06-04-2018

Version 1.0 – 19 June 2017

Research, Innovation and Academic

Engagement Ethical Approval Panel

Research Centres Support Team

G0.3 Joule House University of Salford

M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk/

17 October 2017

Dear John,

RE: ETHICS APPLICATION–HSR1617-174 – 'Exploring the perceptions, views and experiences of health professionals and recently delivered women about safe maternity care.'

Based on the information you provided I am pleased to inform you that application HSR1617-174 has been approved.

If there are any changes to the project and/or its methodology, then please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Sue McAndrew

Chair of the Research Ethics Panel

Appendix 10: Letter of approach

University of Salford MANCHESTER

Appendix [I]

LETTER OF APPROACH/ORGANISATIONAL AGREEMENT

The Regional Director of Health Services
Greater Accra Regional Health Directorate
Greater Accra

School of Public Health
University of Salford
Manchester, United Kingdom

4th September, 2017

Dear Madam,

REQUEST FOR APPROVAL TO CONDUCT A RESEARCH STUDY TITLED 'A QUALITATIVE STUDY INTO QUALITY OF MATERNITY CARE IN GHANA

I am a PhD student in Public Health and Behavioural Medicine at the University of Salford. As part of my studies, I am undertaking a research study titled: **A qualitative study into quality of maternity care in Ghana.**

The proposed study will seek to find the views from health professionals and recently delivered mothers about maternity care.

Prior to undertaking the study, I need approval from your Regional Health Directorate before I can approach health professionals and recently delivered women within the organisation to take part in the study. I will recruit people to the study using invitation letters. I hope to recruit 25 participants to take part in the study.

I can assure you that I will make every effort to ensure the study does not disrupt the working environment of health professionals and that of recently delivered women in any way and any data collected will remain confidential, and be kept for three years after the graduate award is made. I am applying for ethical approval for the study from the University of Salford, Post-Graduate Research Ethics Panel for the Schools of Health and Society and Health Sciences.

My research is supervised by Professor Penny Cook (p.a. cook@salford.ac.uk), Dr. Jeanne Lythgoe (J.Lythgoe@salford.ac.uk) and Dr. Fiona MacVane Phipps (f.e.macvanephipps@salford.ac.uk) should you require any further information.

Thank you.

John Yaw Obeng
(PhD Student)

Version [4] Date [15/03/2018]

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Appendix 11: Institutional permission

TEMA GENERAL HOSPITAL

P. O. Box 14, Tema Tel: 0303 - 302696 - 7 Fax: 0303 - 302336 E-mail: te,ageneralhospital@ymail.com

Our Ref: GHS/TGH/GF. 106 Date: 13TH APRIL 2018

Your Ref:

THE UNIVERSITY OF SALFORD
SALFORD MANCHESTER
UNITED KINGDOM

LETTER OF APPROVAL
MR. JOHN YAW OBENG

Reference to your application letter to conduct the study on Qualitative study into quality maternity care in Ghana.

Approval has been given to you to conduct the study at the Tema General Hospital.

Warmest Regards.

DR. KWABENA OPOKU-ADUSEI
MEDICAL DIRECTOR

Appendix 12: Confidentiality Agreement

University of Salford MANCHESTER

Appendix [I]

CONFIDENTIALITY AGREEMENT FOR RESEARCH ASSISTANT/CHAPERONE

Project title: **A qualitative study into quality of maternity care in Ghana**

I Geeta agree to keep what is discussed in the interviews confidential.

Research Assistant's signature: _____

Research Assistant's name: Geeta Owusu

Date: 05-05-2018

Signature of Principal Investigator: _____

Name of Principal Investigator: John Obeng

Version [4] Date [15/03/2018]

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