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Addressing health system barriers to access to and use of skilled delivery services: perspectives from Ghana

John Kuumuori Ganle[1]*, Raymond Fitzpatrick[2], Easmon Otupiri[3] and Michael Parker[4]

[1]*Population, Health and Gender Studies Group, Department of Geography and Rural Development, Faculty of Social Sciences, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana*
[2]*Nuffield Department of Population Health, University of Oxford, Oxford, UK*
[3]*Department of Community Health, School of Medical Sciences, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana*
[4]*The Ethox Centre, Nuffield Department of Population Health, University of Oxford, Oxford, UK*

ABSTRACT

Poor access to and use of skilled delivery services have been identified as a major contributory factor to poor maternal and newborn health in sub-Saharan African countries, including Ghana. However, many previous studies that examine norms of childbirth and care-seeking behaviours have focused on identifying the norms of non-use of services, rather than factors, that can promote service use. Based on primary qualitative research with a total of 185 expectant and lactating mothers, and 20 healthcare providers in six communities in Ghana, this paper reports on strategies that can be used to overcome health system barriers to the use of skilled delivery services. The strategies identified include expansion and redistribution of existing maternal health resources and infrastructure, training of more skilled maternity caregivers, instituting special programmes to target women most in need, improving the quality of maternity care services provided, improving doctor–patient relationships in maternity wards, promotion of choice, protecting privacy and patient dignity in maternity wards and building partnerships with traditional birth attendants and other non-state actors. The findings suggest the need for structural changes to maternity clinics and routine nursing practices, including an emphasis on those doctor–patient relational practices that positively influence women's healthcare-seeking behaviours. Copyright © 2015 John Wiley & Sons, Ltd.

KEY WORDS: maternal health; skilled delivery; health system barriers; health system responsiveness; Ghana

*Correspondence to: J. K. Ganle, Population, Health and Gender Studies Group, Department of Geography and Rural Development, Faculty of Social Sciences, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana. E-mail: johnganle@yahoo.com

INTRODUCTION

One of the main challenges to achieving the maternal and child health-related Millennium Development Goals is poor access to skilled delivery services (Lewis, 2008; Zere *et al*., 2010). Access to skilled care, especially skilled attendance at birth, can ensure that skilled personnel attend to women and newborns during childbirth and also link women to the referral system in the case of any complications (Parkhurst *et al*., 2006). In many sub-Saharan African countries with high burden of maternal and neonatal deaths however, few women use health facilities for birth. In Ghana for instance, while about 87% of women make at least four antenatal care visits during pregnancy as well as receive the recommended doses of tetanus toxoid immunisation, only 67% of women receive skilled assistance during delivery or postnatal care following delivery (Ghana Statistical Service, 2011; World Health Organization, 2012). In parts of Ghana, more than 45% of births still occur at home without any form of skilled care (Ghana Statistical Service, 2011).

Past studies that examine maternal healthcare-seeking behaviours in low-income settings have identified a number of reasons why women may choose unskilled or home delivery as a preferred option. Some of the most important access barriers include health system factors such as long distance to health facilities, transportation problems, costs of services, including informal charges and opportunity costs from time lost, and poor quality of care (Essendi *et al*., 2010; Abor *et al*., 2011; Shiferaw *et al*., 2013). But socio-cultural barriers such as women's lack of autonomy or decision-making power have also been identified (Griffith and Stephenson, 2001; Stephenson *et al*., 2006; Yanagisawa *et al*., 2006). What is lacking from these studies, however, is a focus on factors that promote access and use of skilled delivery services (Parkhurst *et al*., 2006). A focus on such factors from the perspective of childbearing women and healthcare providers could be particularly useful for learning more about how to overcome health system barriers and promote effective access to, and use of skilled care services. The purpose of this paper is to investigate and identify strategies for overcoming health system barriers to access and use of skilled delivery services in Ghana.

METHODS

Research design

This paper forms part of a larger, original study that was conducted to examine the effects of Ghana's free maternal healthcare policy on women's maternity care seeking experience, equity of access and barriers to accessibility and utilisation of maternal and newborn healthcare services. The design of this larger study was mixed; it involved analysis of a nationally representative retrospective household survey data in combination with qualitative exploration using focus group discussions (FGDs), individual interviews, key informant interviews (KIIs), case studies and structured field observations. The focus of this paper is on reporting findings from the qualitative component of the study, which explored strategies that policymakers and

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maternal healthcare providers in Ghana could pursue to overcome the health system access barriers and promote access to and use of skilled delivery services.

Study context

Empirical research was conducted in Ghana during a total of 6 months between November 2011 and June 2012 in a total of six purposively sampled communities in the Bosomtwe district of the Ashanti region and the Central Gonja district of the Northern region. Ghana was chosen for this research for a number of reasons. Like many countries in Sub-Saharan Africa, Ghana has had a persistently high maternal mortality rate (Witter *et al*., 2007). According to the World Health Organization's (2014) most recent estimates, Ghana's maternal mortality ratio stands at 380 per 100,000 live births. Maternal mortality is the second largest cause of female deaths, accounting for 14% of all female deaths (Abor *et al*., 2011). There are however wide socio-economic and spatial disparities in maternal mortality as well as accessibility to and utilisation of skilled birthing services (Ganle *et al*., 2014). For instance, whereas skilled care providers attended 82% of births in the Bosomtwe district in 2011, skilled birth attendants delivered only 24% of births in the Central Gonja district (Bosomtwe District Health Directorate, 2011; Central Gonja District Health Directorate, 2011). In Ghana, maternal health is therefore seen as a 'national emergency', and this has attracted a lot of policy attention including the implementation of a free maternal healthcare policy since 2003 (Witter *et al*., 2007). Also, Ghana presents an interesting case study because it is one of only a handful of countries in Africa to have actively started implementing both universal maternity care and health insurance policies at the national level. Because of this, Ghana is often touted as 'an example of global good practice' (Saleh, 2013). The economic and political conditions in Ghana also make the country an interesting case study. Ghana is situated within the predominantly economically marginalised and politically unstable region of West Africa, but forms an exception. Ghana is relatively a small fledgling multicultural and multi-party constitutional democracy, characterised by vibrant civil society activism and media pluralism. It is politically stable, and a rebasing of its economy in November 2010 saw the country leap into the category of lower-middle-income countries (Schieber *et al*., 2012). Ghana also recently started producing oil in commercial quantities. Despite all these developments, maternal mortality ratios have remained persistently high, and access to skilled delivery services is still very low.

Research participants

The research participants comprised pregnant women and lactating mothers and healthcare providers. The women consisted of those who were pregnant at the time of this research or had given birth between January 2011 and May 2012. The ages of these women varied between 18 and 45 years. The majority of the women had no formal education. A few of the women were unemployed while most were engaged in diverse occupations such as farming, trading, hairdressing, dressmaking and teaching. Several of the women were also married or living with a male partner. The majority of the women also had between two and five children.

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The healthcare providers' category of respondents included health professionals (doctors, nurses, midwives, healthcare managers and health policymakers or implementers) from health facilities in the study communities, district and regional health directorates and the Ghana Health Service at the national level.

Sampling and recruitment

For all research participants under the 'healthcare providers' category, we used purposive sampling. This was a judgmental selection of participants based on our evaluation of the relevance of their roles to the research topic. In total, we interviewed 20 healthcare providers as key informants.

For the women however, a mix of purposive and convenient sampling techniques was used. This was again a judgmental selection based on a number of pre-set inclusion criteria, including the ease of recruitment, participant's availability and willingness to participate in the study, as well as ability/capacity to consent to participate in the research. Following consultation with community chiefs and elders, and their subsequent approval of the study, the actual recruitment process involved advertising the study at local churches, mosques, water collection points and women group meetings in the six study communities via community and religious leaders, women leaders and Community-Based Surveillance Volunteers (CBSVs). CBSVs are recruits from local communities who have been trained by the District Health Management Team of the Ghana Health Service in various aspects of community health, including but not limited to reporting the outbreak of any disease, and recording births and deaths in their communities. All women who were either pregnant at the time of this research or had given birth between January 2011 and May 2012 were invited to participate in the study. The CBSVs then helped the researchers to recruit interested individual participants for interviewing. Having grown up in the study communities, the CBSVs were very conversant with the local dialect and cultural nuances and were therefore in a good position to advice the researchers on suitable participants as well as arrange interview meetings. In all, 185 women were interviewed.

Data collection

We used focus group discussions, individual interviews and key informant interviews to generate qualitative data. In all, 12 focus group discussions — two in each study community — were completed with women. Women in groups were segmented by age (i.e. 18–30 years and 31–45 years) because initial discussions with CBSVs suggested that there were age hierarchy conflicts among women in the study communities. In other words, younger women (18–30 years) were unlikely to freely express their views in the presence of older women (31–45 years) because of cultural norms, which require young people to listen to their elders. Segmenting discussants by similar age groups ensured that each participant was comfortable expressing their opinions on all the issues as well as share their experiences within the group context without any hindrance. All focus groups were held in the study communities. Groups consisted of 9–12 participants. Discussions in the focus groups lasted 2.30–3 hrs, and ended when a point of saturation was reached, that is, when no new issues seemed to

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arise. All discussions were conducted in the local dialects: *Twi* in Kuntanase, Abono and Piase; *Dagbani* in Sankpala and Tidrope; and *Gonja* in Mpaha. We did this because the literacy [written or spoken English] rates are low among the study participants.

To complement the focus groups, individual interviews were also conducted with 81 purposively selected women who participated in the focus group discussions. The choice of this data collection technique was informed by previous arguments that people may not necessarily tell the truth in any objective sense when it comes to sensitive issues such as health within a group context (Oppermannt, 2000). For this reason, the focus groups data were triangulated with individual interviews. A major advantage of this method was that it addressed sensitive issues such as personal experiences of childbirth.

Finally, key informant interviews were conducted with 20 healthcare providers. All interviews with individual women were conducted in *Twi*, *Dagbani* and *Gonja* while interviews with healthcare providers were carried out in English. Interviews lasted between 20 and 30 min.

Instruments

Our research instrument consisted of an open-ended thematic topic guide, which we designed to ensure that similar themes were covered in each discussion or interview. However, the instrument had built-in flexibility that allowed us to pick at random and probe more on any pertinent but unexpected issues that arose during the interview process. The instrument focused primarily on exploring women's experiences of seeking or not seeking maternity care services, issues regarding coverage, utilisation and access, women's interaction with maternal and newborn healthcare services, the barriers to and enablers of access and how access could be promoted. To ensure that the instrument was reliable, we pilot-tested the instrument in two of the study communities. During the data collection, we also engaged in a continuous review of the questions and interview process. This helped to reframe questions, clarify and use more appropriate or easily understandable concepts as the research progressed. We audio-recorded all discussions and interviews alongside handwritten field notes.

Ethics

Ethical approval was obtained from the University of Oxford Social Sciences and Humanities Inter-divisional Research Ethics Committee (Ref No.: SSD/CUREC1/11–051), and the Ghana Health Service Ethical Review Committee (Protocol ID NO: GHS-ERC 18/11/11). In addition, informed written and verbal consent was obtained from all research participants.

Analysis

Following the completion of interviews, the data was analysed using the Attride-Stirling's (2001) thematic network analysis framework. The Attride-Stirling thematic network analysis framework is a method for conducting thematic analysis of

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qualitative or textual data, which allows for open and methodical discovery of emergent concepts, themes and relationships through the application of principles of inductive reasoning to generating themes while also employing predetermined (deductive) code types to guide data analysis and interpretation. This involved several steps. The first step involved transcription and reading of transcripts and field notes for overall understanding. During and after qualitative data collection, the first author and three other language specialists — *Twi*, *Dagbani* and *Gonja* — transcribed all audio-recorded interviews. All authors then read and reviewed all transcripts and interview notes for overall understanding and comprehension of meaning. This first step was completed with a separate summary of each transcript outlining the key points participants made. Secondly, the interview transcripts were exported to NVivo 9 qualitative data analysis software, where the data were both deductively and inductively coded. Data coding continued until theoretical saturation was reached (i.e. when no new concepts emerged from successive coding of data). Thirdly, the code structure was applied to develop and report themes. Finally, all the themes identified were collated into a thematic chart to reflect basic themes, organising themes and global themes (Table 1). These constitute the structure of our findings section.

RESULTS

Recent global policies for reducing maternal and newborn mortality emphasise skilled attendants at birth. In focus groups and interviews with women and healthcare providers in parts of Ghana however, it was reported that not only were such potentially life-saving skilled delivery services unequally available to the population, but also that where these services existed and could easily be accessed at no or minimal cost, they could be unfriendly, socially degrading or even abusive to women. These health system factors have combined to discourage many women from using skilled birthing services despite these services being provided free at the point of delivery. During focus groups and interviews, participants' experiences and perspectives on how to overcome these health system barriers were therefore explored in detail. Table 2 summarises a count of statements participants made in relation to how to address health system barriers that discourage women from accessing and using skilled delivery services. These have been grouped under six main headings, namely, (1) improving coverage and quality of services, (2) expanding free ambulatory services, (3) humanising hospitals and doctor–patient relationships, (4) promoting choice in skilled maternity care, (5) training and motivating more midwives and (6) building partnerships with traditional birth attendants (TBAs). Each of these is examined in the succeeding sections.

Improving coverage and quality of services

Throughout the period of our research, women and healthcare providers alike highlighted the importance of safe pregnancy, childbirth and mother–child survival.

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Table 1. Thematic network analysis framework (from codes to global theme)

Codes	Basic themes	Organising theme	Global theme
-Increase maternal health resources -Increase health workforce -Redistribute health resources -Target women in more need	1. Expansion of maternal health infrastructure and resources is needed. 2. Redistribution of existing maternal health resources to target women most in need is key for ensuring equitable coverage and access for all women.	Health system responsiveness	Solutions to health system barriers
-Care quality is key -Train more skilled maternity caregivers -Ensure availability of essential consumables -Motivate caregivers	3. Improving the quality of maternity care services provided is crucial.		
-Caregivers need to respect patients -Warm and friendly caregivers -Patient centred care	4. Improving doctor–patient relationships in maternity wards is important.		
-Women need to be consulted -Give women choice	5. Promoting more birthing choice at health facilities is essential.		
-Ensure confidentiality of patient health information -Maintain privacy -Avoid patient abuse	6. Respect for women's privacy and dignity in maternity wards is important.		
-Maternal health as collective responsibility -Partnership building -Build trust	7. Building partnerships with communities, traditional birth attendants and other non-state actors is needed.		

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Table 2. Stakeholders proposed solutions to health system barriers

Stakeholders proposed solutions to health system barriers	Frequency of statement (women)	Percentage (%)	Frequency of statement (healthcare providers)	Percentage (%)
1. Improve coverage and quality of skilled maternity services	53	17.4	10	25.6
2. Expand free ambulatory services	50	16.4	7	18
3. Humanise hospitals and doctor–patient relationship	126	41.3	6	15.4
4. Promote choice in skilled maternity care	64	21	0	0
5. Train and motivate more midwives	8	2.6	13	33.3
6. Build partnerships with traditional birth attendants, community leaders, and other non-state actors	4	1.3	3	7.7
Total	**305**	**100**	**39**	**100**

However, it was reported that Ghana is one country in which for the majority of women, the experience of pregnancy and childbirth can still in fact be equivalent to a death sentence, characterised by fear, anxiety, anguish and pain. This situation arises from the limited and unbalanced distribution of skilled delivery services and personnel (between and within regions, districts and communities), and poor quality of care. In Tidrope and Abono, for example, there are no health facilities, and the distance from any of these communities to the nearest health facility is approximately 12 km. In these communities, the majority of research participants, especially young women, reported that the lack of skilled delivery services within reasonable distance has resulted in some women lacking complete access or experiencing grave difficulty accessing and using skilled birthing services. To remedy the situation, several participants recommended the expansion of coverage of skilled maternity care services to improve access.

> *The solution to me is for the government to build more clinics. That way, women will have no problems travelling to obtain care* (Lactating Mother, KII, Abono).

But in addition to improving coverage of services, several women also argued for more attention to be paid to improving the quality of care at existing health facilities.

> *For me the solution is that the health workers must make sure that they take good care of pregnant women. Sometimes, pregnant women will struggle to go to the hospital only to be told that there is no medicine. This is not good…it makes us very reluctant to go to hospital* (Pregnant Woman, FGD, Kuntanase).

Many of the healthcare providers interviewed within the top hierarchy of the Ghana Health Service supported the view that coverage and quality of services should be improved. Indeed, a few believe it was wrong in the first place to start a

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free maternal healthcare policy in 2003 when service coverage was already limited and quality of care sub-standard.

> *I can tell you that we still have the old problems… we're still faced with limited services coverage, mal-distribution of services, and poor care quality. We should have extended service coverage to every part of the country and also invest more resources into improving the standards of care before embarking on the free maternal health policy. That is what we need to do now* (Male Healthcare Provider, KII, Accra).

Another participant said:

> *I think the problem we have in the health sector is how we distribute health facilities and personnel. Most resource allocation decisions are based on how many hospitals you have in an area and not about whether the people there are in more need. So if we want to make progress, we must be able to redistribute resources. We need to target more resources to deprived communities to ensure that there is equity* (Male Healthcare Provider, KII, Tamale).

Expanding emergency ambulatory services

One strategy that both pregnant women and lactating mothers and healthcare providers proposed is the expansion of ambulatory services to all parts of the country. Under the current regime of maternity care in Ghana, ambulatory services are not covered by the fee-exemption policy. Ambulatory services are also very limited, often ineffective, and usually restricted to urban centres. In communities such as Abono and Tidrope where there are no healthcare facilities, and where appropriate transportation is difficult and expensive to arrange in the event of obstetric emergency, women reported that providing responsive ambulance services would make it possible for more births to take place in hospitals.

> *Right now, the government says it is free if you go to hospital to deliver, but it is not easy to get to the hospital…hiring a car is always a problem because the cost is very high. If you can't reach the hospital, how can you benefit from this free thing? So if the government is serious, then it should also provide transportation or even if it can pay for that, it will encourage more women to go to hospital when they are pregnant* (Lactating Mother, KII, Abono).

One woman also said:

> *What they [government] can do? I think the government should do something about transportation. The government should help us with a car [referring to ambulance] that can come and help when there is problem. If the government doesn't do that, the whole free maternity care thing will not work well, because if people can't get to the hospital in good time, then it is only free for those who have the means to get to the hospital* (Pregnant Woman, KII, Tidrope).

Although many community health nurses and midwives acknowledged the constraints imposed by resource scarcity, there was still consensus that providing responsive ambulance services is one effective way to increase hospital delivery by facilitating prompt referrals and transfer of patients to health facilities.

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It is true that the maternal health services we offer are free, but at times how to get women to the health facilities is not easy…sometimes, we can't blame these women. Maybe the resources are not enough, but the government must do something about this…like provide ambulances for all clinics and health centres so that it will be easy to respond to emergencies at the community level (Female healthcare Provider, KII, Mpaha).

Even in urban settings where public and private transport services are mostly available, it was reported that urban public transport in Ghana presents its own challenges when it comes to its use for maternal healthcare purposes. It was reported that sometimes a pregnant woman still has to walk or be hand carried from home to bus terminus or from bus terminus to the healthcare facility when public transport is used. In other cases, pregnant women may even stand in the vehicle when it is full. Delays associated with the operations of these transport services often cause further delays in reaching a health facility too. Also, it was reported that expectant mothers often endure traffic jams on the way, and this resulted in delays in getting to healthcare centres. There was therefore widespread support in both rural and urban Ghana for the provision of free ambulatory services, or at least a system that will reimburse women with transport costs.

Training and motivating midwives

About a quarter of the statements the healthcare providers made diagnosed the problem of poor maternal health in Ghana as twofold: limited numbers of trained midwives and poor remuneration. As a remedy, participants proposed that more midwives be trained and motivated to deliver quality service to patients.

As you can see, I am the only midwife, so any time I am not available there is nobody around to attend to the women. I believe if we want to improve care, we have to train more midwives and give them incentive packages like good accommodation so that they can stay in the communities to provide care (Female Healthcare Provider, KII, Sankpala).

One participant also said:

Here in the Northern region, we lack midwives and doctors. How can we provide quality care if we don't have trained personnel? We need to put priority on training more midwives to be able to improve access to care (Male Healthcare Provider, KII, Tamale).

In all the above-mentioned recommendations, there were emotive accounts of how inadequate staffing of health facilities, coupled with poor working conditions, often led to stress, overwork and lack of enthusiasm among the few healthcare providers in the system. For example, there were reports of public midwives, doctors and medical assistants working 80, 110, and 127 h per week, respectively.

Humanising hospitals and doctor–patient relationships

The word 'hospital' derives its original meaning from the Latin *hospitalis*, which generally connotes 'hospites', 'guest' and 'hospitality' (Turner, 1987). Despite this, for the majority of the women interviewed, the hospitals or health facilities in Ghana come with a sense of fear. This sense of apprehension originates not only

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from the unfamiliarity and anxieties women often face from mammoth structures of exotic buildings (buildings that usually do not bear resemblance to the small houses in their own communities) to teaming crowds of patients, but also from the austerity of maternity ward surroundings and the poor quality of relationships that often characterise the encounter between patients and caregivers. This has resulted in many women opting out of the formal healthcare system where services are provided free.

To reverse this, many women proposed the promotion of a regime of care that is patient-centred and 'humanised'.

> *One problem is that the health facilities and the workers are supposed to serve our needs. Unfortunately, you will go to the hospital and the workers will treat you like 'a boar bi' [some animal]…I mean they are not friendly. I believe if they really want us [women] to come regularly to check our pregnancy or even give birth in the hospital, then they have to change the way they treat us…they should be more friendly, compassionate and treat us like human beings* (Pregnant Woman, FGD, Kuntanase).

Another discussant agrees:

> *I totally agree…at Kuntanase hospital, there used to be one midwife…she was very nice to all the women who go to her…she will chat with you nicely when examining you and she will take her time to advise you very well. Even when you make a mistake, she will not shout at you; she will take her time to talk to you. So a time came that all the pregnant women wanted only that midwife to attend to them. But now, she has been sent to a different place, and most of the new people are not friendly at all. That is why many people are not going there these days* (Lactating Mother, FGD, Kuntanase).

Among the healthcare providers interviewed, there was recognition that improving the doctor–patient relationship at healthcare facilities is an important approach to attracting more women into the formal healthcare system. One of the regional directors of public health spoke of the need to pursue a 'labour-ward-friendly-concept' of care:

> *To move forward, I believe we the healthcare providers need to focus on how we treat the women who come to us. We must focus on making all our facilities and especially labour wards patient-friendly…We have started piloting this at the major hospitals, but I think we need to do more* (Male Healthcare Provider, KII, Kumasi).

One healthcare provider also recommends:

> *I think we need to focus on improving the relationship between pregnant women and caregivers. I mean, more patient-centred care that is able to address the needs of women, accord them respect and assure dignity anytime they visit a health facility* (Female Healthcare Provider, KII, Tamale).

Promoting choice

Within reproductive medicine, 'choice' or 'right to choose' is a term very explicitly associated with the need for women to exercise control over their reproductive health decisions. For several of the women interviewed however, there are limited birthing

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choices offered by the modern Ghanaian maternity healthcare system, and this has acted to exclude several women who desire some choice and freedom during pregnancy or labour. For this reason, some women reported that ensuring increased access to, and use of skilled delivery services would require offering them some choice and the right to choose how, where and with whom to give birth.

> *Another thing that can be done to encourage more women to give birth at hospitals is to permit pregnant women to choose the nurse or midwife they want to go to or the position they want to be in to deliver. This is because if you go to the hospital to give birth, they normally put you on a small straight bed…you can't even turn. In the house you can move around, lean against the wall, squat, sit down or even lie down while you are in labour. But in the hospital, it is only one way …you have to lie down on their bed. For me this makes things difficult* (Lactating Mother, FGD, Kuntanase).

One participant also said:

> *The free maternal healthcare policy is good, but the problem is that if you want to enjoy the benefits, then you have to go to the hospital even if you don't like it. But in the hospital too, not all the nurses and doctors are correct, and yet you can't choose the one you want to care for you. Even sometimes, if you prefer a woman nurse, midwife or doctor to examine your stomach or deliver your baby, you will not be given that chance. And you know as Muslim women, it is bad for a man who is not our husband or boyfriend to unlawfully touch us. So I think that the hospital workers should listen to us more to understand our problems so that they can best give us the help we need* (Lactating Mother, FGD, Sankpala).

While a significant number of women believed that giving more opportunities to women within the formal healthcare system to decide how, where and with whom skilled maternity care services is accessed and used was vital for encouraging access; the concept of choice appears removed from Ghana's maternal healthcare system. Throughout the period of this research, little was heard either among nurses, midwives and senior healthcare managers like district and regional health directors about the need for women to be offered choice in relation to how, where and with whom skilled care may be obtained.

Building partnerships

One other strategy that a few research participants proposed was the need for Ghana's Ministry of Health and Health Service to actively engage TBAs in the delivery of skilled delivery services. In the rural community of Piase in the Bosomtwe district of the Ashanti region, one midwife suggested that improving access to skilled delivery services in Ghana would require the formal healthcare system forcefully engaging with multiple stakeholders at different levels, especially TBAs at the community level.

> *My own experience over the years as a woman who has experienced childbirth as well as worked at urban and rural settings providing maternity care services has shown that if we want to make progress with maternal health, then we must begin to foster more collaboration between nurses, midwives, TBAs, and community and religious leaders* (Female Healthcare Provider, KII, Piase).

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For this midwife, this recommendation is born out of very positive results she has had from implementing a community-based participatory maternity care approach. Although this participant admitted that her approach was unconventional and may be unfeasible in some contexts because of unwillingness on the part of both healthcare providers and community members to engage, she believed Ghana health service needed to do more to build partnerships with TBAs, traditional and religious leaders and community members on the issues of maternal health.

> *I will admit that the approach I have used in the past to engage TBAs, community leaders and women in this community, is alien to the health system in Ghana. It might therefore not be accepted in some contexts. But you see since I started engaging community members in 2005, most TBAs, pastors and husbands who hitherto were discouraging pregnant women from coming to the health centre, have all started to encourage pregnant women to come for ANC and give birth in the health facility. Because of this, no maternal or neonatal death has occurred in the community since 2005. What this means is that Ghana Health Service must do more to engage or build partnerships with local communities, especially men, on the issues of maternal health* (Female Healthcare Provider, KII, Piase).

For her, partnerships means shared responsibility between healthcare providers and individual women and communities, and that such an approach offers opportunities for changing women's and communities' beliefs and attitudes towards hospital-based maternity care services.

DISCUSSION

It is often claimed that 'we know what works' to reduce maternal and newborn mortality in both developed and developing countries (Campbell and Graham, 2006). While this is undoubtedly true in terms of clinical interventions, how to effectively deliver these interventions to ensure they reach all women is one of the key challenges facing many low-income countries (Liljestrand, 2000). This study is one of the few studies to have focused explicitly on identifying and describing strategies, which if properly implemented, could enable more women to access and use skilled delivery services.

Qualitative analysis of the experiences and accounts of women and healthcare providers in parts of Ghana revealed that most women do want professional assistance in a health facility setting during childbirth. However, the maternal healthcare system in Ghana lacks many of the attributes of a responsive health system, and this has discouraged many women from using skilled delivery services. To remedy the situation, the women and healthcare providers interviewed in this study identified a number of strategies for improving access to and use of skilled delivery services. These include expanding the coverage of skilled care services; training and motivating midwives; improving doctor–patient relationships; and promotion of choice, privacy and patient dignity in maternity wards. Although most of these recommendations are not entirely new, together, they highlight the urgent need to ensure health system responsiveness in Ghana.

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But inevitably, the various proposals for addressing the health system barriers themselves present unique opportunities and challenges. Aside the fact that many of these proposals neither considered the question of feasibility, the existence of an evidence base, nor the cost and the broader implications of implementing any of the proposed solutions, women's priorities and proposed solutions diverged and converged with those of healthcare providers in significantly interesting ways. With regard to convergence, most women and healthcare providers agreed on the need to expand coverage of services as well as improve the quality of skilled delivery services. Similarly, there is convergence of opinion on the need to train more skilled birth attendants as well as provide effective and efficient ambulatory services, especially in remote communities such as Tidrope and Abono where there are no health facilities. There is also strong convergence of opinion about the fact that improving doctor–patient relationship at healthcare facilities is an important approach to attracting more women into the formal healthcare system.

Convergence in terms of women's and healthcare providers' priorities on the above-mentioned strategies for redressing the health system barriers to skilled care clearly provides opportunities for instituting the necessary remedial and promotive policy actions to bring about improvement in skilled delivery in Ghana. Indeed, the strategies on which the ideas of both women and healthcare providers strongly converged should be the starting point of real solutions to the problems of health system barriers to access and use of skilled delivery care in Ghana. For instance, in contexts where the unavailability of health facilities and skilled birth attendants prevents women from accessing and using skilled delivery services, and where there is convergence of opinion on the need to improve both coverage and quality of care, the health service in Ghana could take concrete steps to first change the practice of concentrating health facilities and resources in urban areas to ensure equity in services distribution. In this regard, it might be useful for policymakers and healthcare practitioners in Ghana to take steps to develop comprehensive need-based targeting and resource allocation formula that can gradually redistribute more services and resources towards communities such as rural areas and populations such as young women and adolescent girls who have the greatest needs. In particular, the building of more primary level healthcare facilities such as the Community Health Planning and Services compounds in remote communities — a development currently being undertaken in Ghana — can mitigate the distance barrier for rural women.

Of course, the mere availability or equal distribution of health infrastructure and personnel might not guarantee automatic access and use of skilled delivery services by all women. Before improvement in access to and use of skilled birthing services occurs, it is imperative that capacity levels of health facilities and staff are improved so that additional resources that will be gained from any redistribution are not wasted through facility and staff limitations. Health centres and Community Health Planning and Services compounds should be adequately stocked with essential medical consumables and other logistics like motor bicycles and tricycles so that healthcare providers in remote locations can safely respond to emergency labour situations or quickly refer or transport patients to the nearest health facility where the needed care can be provided. In addition to improving the midwifery skills and competencies of healthcare providers, the development of simple,

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replicable assessment tools and techniques that could be used to evaluate the quality of care provided at health facilities will also be important. The development and use of such tools could enable maternity care providers and healthcare managers to easily identify maternity care facilities that deliver sub-standard or sub-optimal care. This could be important for both making and monitoring the desired levels of improvements. Also, there will be the need for better planning and the institutionalisation of a booking or appointment regime — something currently absent in most health facilities in Ghana — so as to reduce overcrowding in health facilities and long waiting times before care is received. This of course could be problematic to implement in the short term especially in remote areas where communication and transportation services might be lacking. However, in the long term, healthcare facilities can establish systems in local communities that could be used to facilitate booking before attendance. For instance, community health workers could be trained and equipped with mobile communication devices. These community health workers could then be tasked with the responsibility of receiving booking requests from women in the community and then communicating such requests to the appropriate healthcare facilities.

One other area in which there is convergence of strategy, and for which action could be taken, is the need for partnership between the health system and TBAs. TBAs, who are often illiterate elderly women and who usually learn their midwifery craft from personal experience and from older women in their community, have historically operated throughout Africa and Asia (Sibley *et al*., 2004; Darmstadt *et al*., 2009). In Ghana, it is estimated that more than 30% of births still occur at home with TBAs (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro, 2008). Despite the significant role TBAs continue to play in maternity care, the Ghana Health Service has largely failed to engage TBAs in the provision of maternal health services as illustrated by one of the midwives in this study. Given the significant role TBAs continue to play and the shortage of skilled birth attendants (SBAs) in Ghana and across Sub-Saharan Africa as indicated by the World Health Organization report on the 'state of the world's midwifery' (World Health Organization, 2011), a case can be made for the training and incorporation of TBAs into the maternal healthcare system. Indeed, various evaluations of programmes, which promoted trained TBAs, have indicated that TBAs' services could increase women's use of skilled delivery services through early detection of signs of complications and timely referral to healthcare facilities (Sibley *et al*., 2004; Titaley *et al*., 2010). Oxfam's work and research with 150 TBAs in six communities in Bolgatanga, Kassena Nankana and Bawku West districts of the Upper East Region of Ghana have particularly demonstrated remarkable success (Oxfam, 2012). According to the organisation's research report, every month, in each of the six communities, double the number of women is now being referred by TBAs to clinics and hospitals for potentially life-saving care and support. Maternal mortality has also reduced by 7% (Oxfam, 2012).

While encouraging all women to seek delivery care from skilled health personnel is the optimum action to take, it is clear that such an ideal is not feasible or achievable in the short term in countries such as Ghana where there is acute shortage of healthcare staff. Of course, there can be real challenges in attempting to recognise,

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train, supervise and incorporate TBAs into the maternal healthcare delivery system. For instance, reaching all TBAs and integrating them into an already bureaucratic health service could be a major challenge. Similarly, the issue of the receptiveness of TBAs to training and modernisation could also pose a challenge. However, research suggests that most TBAs are actually very receptive to training in modern ways of maternity care (Oxfam, 2012). The Ghana Health Services could therefore train more TBAs and use innovative incentive mechanisms such as cash reward to encourage TBAs to promptly refer mothers to healthcare facilities especially during labour. Partnerships between TBAs and SBAs would also be critical for helping healthcare workers to learn from TBAs how best to address the cultural needs and concerns of childbearing women. As some studies have shown, some women prefer the services of TBAs because of the cultural sensitivity embedded in the services TBAs provide (Titaley *et al*., 2010; Warren, 2010; Shiferaw *et al*., 2013). Because TBAs already have an advantage with regards to providing culturally competent birthing services to women, they [TBAs] can be engaged to train the formal healthcare workers to be more engaged in, and to take account of, the cultural and local practices of childbearing women. Before all this can happen, there will first be the need for the health system and TBAs to reposition themselves to be more welcoming to each other. This is because the lack of an underlying positive sentiment towards TBAs has been the main cause of mistrust between TBAs and the healthcare system. Changing the attitude of healthcare workers towards TBAs may be difficult, and may not happen any time soon. But the success that past TBA training programmes have had, and the fact that SBAs are woefully inadequate in Ghana suggest the need to keep on training both TBAs and SBAs and encouraging them to be more tolerant of each other.

In terms of divergence, many women believed that giving more opportunities to them within the formal healthcare system to make choice or decide on how, where and with whom skilled care services is accessed and used was vital for encouraging more women to use skilled birthing services. Fewer healthcare providers however supported this idea. Similarly, whereas the health centre or hospital is a place where women felt apprehensive and therefore argued for health centres and doctor–patient relationships to be made more friendly and hospitable, many healthcare providers appeared to underestimate the importance of this. The seeming disjunction in the above-mentioned areas of strategy clearly points to the potential for conflict and policy failure. It is therefore important that steps are taken to address these potential conflicts and build consensus on strategy. For example, part of the reasons why some women do not use skilled delivery services is the fear that they will be treated poorly by healthcare providers. Several of the women in this study expressed discontent with many of the procedures healthcare providers carry out during childbirth, which rarely promote women's dignity and greater involvement and control over the process of childbirth. Like women all over the world, the women in this study wanted to be treated with respect, sensitivity and dignity. This suggests that the relationship between caregivers and women in healthcare facilities need to be taken seriously. This directly calls for changes in both consumer behaviour and existing nursing, midwifery and obstetrical/gynaecological practices, including an emphasis on basic relational practices in maternity care;

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training and retraining of health facility managers, nurses, midwives and doctors in patient-centred care; enforcement of good and ethical codes of practice in labour wards and improvements in provider–client communication. As other researchers have found, a focus on training of health personnel on 'public relations' could build trust and restore confidence in the healthcare system (Essendi *et al*., 2010). In addition, we recommend the strengthening and/or institutionalisation of an effective reward and sanctions regime whereby caregivers whose practices promote women's access are rewarded, while those who contravene good practice and ethical standard of care, thereby obstructing women's healthcare seeking choices, are penalised. The recommendations here further suggest the need for training and education in healthcare ethics and in communication skills for health professionals. This is the kind of thing that motivated the formation of the Ethox Centre in the UK, and there may be a need for leadership in ethics and communications skills training and support in Ghana too.

CONCLUSION

Overall, our study not only improves understanding of what the barriers to skilled care accessibility and utilisation are in Ghana, but also the actionable points our study elicited from different stakeholders adds new insights and evidence about how these health system barriers to maternity care use could be addressed, hence giving our research the potential to inform policy and practice. As access to and use of, skilled maternal and newborn healthcare interventions continue to be an essential ingredient to the reduction of maternal and newborn mortality, efforts must be made to ensure skilled attendance at all deliveries. This requires expanding and redistributing health infrastructure and resources, properly equipping delivery facilities to enhance quality of care, as well as training more midwives. Skilled delivery services will also have to be organised and delivered in a way that is medically appropriate, socially sensitive and culturally responsive, including respect as reflected by the degree to which the health system is sensitive to women's needs, dignity, confidentiality, choice and autonomy as well as the level of attention given to clients in terms of promptness, and quality of environment and interpersonal relationships between caregivers and women. In sum, the healthcare system in Ghana needs to become more responsive to the care needs of childbearing women.

COMPETING INTERESTS

The authors have no competing interests.

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