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PERCEPTION OF QUALITY OF MATERNAL HEALTHCARE IN THE WA MUNICIPALITY

LINUS BAATIEMA

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PERCEPTION OF QUALITY OF MATERNAL HEALTHCARE IN THE WA MUNICIPALITY

BY

LINUS BAATIEMA

Thesis submitted to the Department of Population and Health of the Faculty of Social Science, College of Humanities and Legal Studies, University of Cape Coast, in partial fulfilment of the requirements for award of Master of Philosophy degree in Population and Health.

MARCH 2019

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature:……..... Date:…….....

Name: Linus Baatiema

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisors' Signature:..... Date:…….....

Name: Prof. Augustine Tanle

Co-Supervisors' Signature:..... Date:.....

Name: Prof. Eugene K. M. Darteh

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ABSTRACT

Although provision of quality maternal healthcare has proven to be a critical strategy in reducing the high global maternal mortality level, studies on quality maternal healthcare have often been from provider's perspective with limited research on service users, particularly in the context of health facilities. This study therefore assessed the quality of maternal healthcare in the Wa Municipality. The study was qualitative and guided by the Donabedian approach for measuring service quality. Fourteen health facilities were purposively selected and 62 mothers who received post-natal care were interviewed. Six Focus Group Discussion (of 39 members) and 26 In-depth Interviews were conducted in all. The analysis was guided by inductive content analysis approach. The results showed that mothers assigned varied meanings to the concept of quality maternal healthcare, which reinforce the subjective nature of service quality. It was reported that the attitude of healthcare providers towards women during labour was woeful. Again, timeliness, interpersonal care from service providers, limited number of midwives on weekends amongst others were hindrances to the attainment of quality healthcare within the Municipality. It is recommended that the Wa Municipal Health Directorate as well as Nursing and Midwifery Council should deploy more midwives to rural areas in the region to help address referral challenges confronted by expectant mothers. Refresher courses should be given to healthcare providers on quality healthcare, so us to improve their service delivery. It is concluded that quality maternal healthcare received from providers was fair as such users' were less willing to revisit those health facilities.

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KEY WORDS

Quality of Healthcare

Service Users

Healthcare Providers

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DEDICATION

To my late Mother, Mrs Theresa Baatiema as an honour to her motherly care, love and encouragement in my upbringing from childhood.

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
CHPS	Community-based Health Planning and Services
ERC	Ethical Review Committee
FGDs	Focused Group Discussions
GES	Ghana Education Service
GSS	Ghana Statistical Service
IDIs	In-depth Interviews
LICs	Low-income Countries
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NGOs	Non-governmental Organisation
NHI	National Health Insurance
NMC	Nursing and Midwifery Council
OPD	Out-Patients Department
PNC	Postnatal Care
SDGs	Sustainable Development Goals
USAID	United States Agency for International Development
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

Background to the Study

The 2016 World Health Organisation (WHO) report estimated that almost 830 women die from preventable causes related to pregnancy and childbirth every day and about 99 percent of all the maternal deaths occur in developing countries (WHO, 2016). Also, out of the 830 reported cases by the WHO, 550 (66%) occurred in sub-Saharan Africa and 180 (22%) in Southern Asia. The risk of a woman in a developing country dying from maternal-related cause during her lifetime is about 33 times higher compared to a woman living in a developed country (WHO, 2016).

In developed countries, most deaths are due to different direct causes such as complications of anesthesia and caesarean sections (Khan et al., 2006), however, majority of maternal deaths in developing countries occur during labour and in most cases, women die because they deliver without the aid of a skilled birth attendant (Lalonde & Miller, 2016). United Nations suggest that some of the causes of high maternal mortalities in developing countries could be direct including births not attended to by trained personnel, poor access to obstetric services for high-risk pregnancies, and malnutrition of pregnant women (Scorgie, Blaauw, Dooms, Coovadia, Black & Chersich, 2015) while some evidence indicate that women's legal rights, level of economic autonomy, access to education and their overall status in society influence their access to quality maternal health services (Thapa & Niehof, 2013; Gabrysch, McMahon, Siling et al., 2016; Banda, Odimegwu, Ntoimo & Muchiri, 2017; Callister & Edwards, 2017).

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This situation of high maternal deaths in developing countries especially from the African context raises a number of questions in relation to the underlying factors. Whilst the academic literature has identified a number of factors to this (Khan, Wojdyla, Say, Gülmezoglu, & Van Look, 2006; Kassebaum et al , 2014; Maswime & Buchmann, 2016; Koblinsky, Campbell & Harlow, 2018), there is a growing and recurrent consensus among academics (Thompson, 2015, Main, et al, 2015; de Visser, Woiski, Grol, Vandenbussche, Hulscher, Scheepers & Hermens, 2018) and policy makers (Penfold , Harrison, Bell, Fitzmaurice , 2007; Dzakpasu et al, 2012) that the quality of maternal health care plays an indispensable role to the high maternal mortality recorded in such developing countries.

As such, there is an increasing global awareness that in order to attain better maternal health outcome, the quality of healthcare rendered to women particularly during delivery and the immediate hours after delivery must be of paramount concern (Mahiti, Mkoka, Kiwara, Mbekenga et al., 2015; Kruk, Paczkowski, Mbaruku, Pinho & Galea, 2009).

A good healthcare service during delivery is a pivotal element of any health system and is crucial to the achievement of health-related Sustainable Development Goals (Bitton et al., 2017). However, there is lack of consensus on the exact elements for a quality healthcare service. Despite, the elements of comprehensiveness, accessibility, continuity, co-ordination and efficiency have emerged as critical in the measurement of quality healthcare service (Lettieri, Bartoli & Masella, 2013) poor quality of healthcare is still an international public health concern in low-middle income countries.

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Poor quality of healthcare, and for that matter, low client satisfaction result in loss of patients‟ lives, revenue, material resources, time, morale, staff, recognition, trust and respect as well as individuals‟ and communities‟ apathy towards the health services, all of which contribute to lowered effectiveness and efficiency. Literature also posits that high prevalence of poor quality health service at delivery has been linked to failure to attain predictable healthcare indicators in low and middle income countries (Richardson, Berwick, Bisgard, Bristow, Buck & Cassel, 2001; Klazienga, 2010). Studies from India, Malawi and Rwanda have also shown that greater access to institutional deliveries and antenatal care was not accompanied by reductions in maternal and newborn mortality; a finding attributed to poor quality of care (Raven, Tolhurst, Tang & Van Den Broek, 2012; Souza et al, 2013; Godlonton & Okeke, 2016). Also, higher than predicted maternal mortality has been found in hospitals in lower-income countries despite availability of required medicines, suggesting clinical management gaps or treatment delays for women who develop obstetric complications (Souza et al, 2013; Weiser & Gawande, 2015).

The low quality of health services can impact adversely on the achievement of Sustainable Development Goal (SDG) 3 target 3.8, which requires that everyone has access to affordable and quality health services. However, if those services are of poor quality, people are unlikely to utilise or agree to pay higher taxes or insurance premiums for them. Most countries in Latin America according to Dmytraczenko and Almeida (2015) have explicit provisions in their constitutions guaranteeing the right to health care for all citizens, and many nations as well have embarked on universal health

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coverage all in quest for quality healthcare for their citizens most especially the vulnerable in society such as women, children and the aged (Dmytraczenko & Almeida, 2015).

Issues of maternal health as well as quality healthcare have also been a policy concern in sub-Saharan Africa (SSA) since the region disproportionately bear a greater proportion of the global burden of maternal mortality (Prata, Passano, Sreenivas & Gerdts, 2010). Despite major progress made towards reducing maternal mortality over the last decade, many countries in SSA were not able to achieve the MDG of 75% decline in maternal mortality (Lozano et al, 2011; WHO, 2012), partly attributable to the poor quality of maternal health care services rendered in these countries. Meanwhile, delivery in well-resourced health facilities with effective healthcare services reinforces timely management and treatment of complications in order to reduce maternal deaths.

Several studies have examined holistic quality of care in Ghana, for example in trauma (Mock, Nguyen, Quansah, Arreola-Risa, Viradia & Joshipura, 2006), hypertension (Lloyd-Sherlock, Beard, Minicuci, Ebrahim & Chatterji, 2014), maternal and neonatal care (Duysburgh, Williams, Williams, Loukanova & Temmerman, 2014; Nesbitt et al, 2015; Sondaal, et al , 2016) and malaria (Webster et al, 2014). Ineffective functioning of existing administrative structures, lack of adequate equipment, lack of commodities and registries, non-adherence to laboratory examination, counselling and treatment protocols, unprofessional staff attitude and patients not adhering to prescribed treatments are some of the problems found (Escribano-Ferrer, Cluzeau, Cutler, Akufo & Chalkidou, 2016).

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Attaining quality delivery healthcare in Ghana, particularly in rural communities, revolves around a complex interaction of economic, financial, social, and cultural factors that affect access to service and quality. There is also reasonable access to antenatal care, with more than 96% of pregnant women 15-49 years receiving antenatal care from a skilled provider. However, institutional delivery (skilled care at childbirth) is relatively lower (68%), despite the free maternal care policy (Ganle, Obeng, Segbefia, Mwinyuri, Yeboah & Baatiema, 2015). An assessment conducted by the Ghana Statistical Service reported that though the policy led to increases in institutional deliveries, maternal mortality (451/100000) and under-5 mortality rates (82/1000) still remain high (Ghana Statistical Service, 2013). As highlighted by the work of Thaddeus and Maine, the persistent high level of maternal and child mortality revolves around some delays comprising delay in recognizing the problem in order to make a quick decision to seek care; delay in reaching the point of care and delay in receiving appropriate and high-quality care (Thaddeus & Maine, 1994). These findings though not recent, still remain relevant in contemporary times and inform the formulation of current policies and interventions to address the increasing burden of maternal mortalities.

Owing to the high rates of maternal deaths, a number of measures have been instituted to improve maternal healthcare in Ghana. Some of these measures include the free maternal health services implemented in 2000 which became operational in 2008, reproductive and child health as well as the safe motherhood task force system to capacitate midwives through direct midwifery training. The High Impact Rapid Delivery (HIRD) approach is also

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being implemented as a complementary strategy to reduce maternal and child mortality hence addressing issues of quality maternal healthcare. However, Greater Accra, Eastern and Upper West regions present the worse cases of maternal mortality in the country (Ministry of Health (MOH), 2007). This situation therefore attracts policy concerns when it comes to the menace of maternal mortality and quality of ongoing health service delivery at birth in the country. It is within this context that this study is designed to understand the factors leading to the poor maternal health outcomes in the Upper West Region.

Problem Statement

Over the years, Ghana's maternal mortality rate decreased from 634 deaths per 100,000 live births in 1990 through 467 deaths per 100,000 live births in 2013 and finally to 319 in 2015 (WHO & UNICEF, 2015). Despite strives made to improve maternal and child health in Ghana, there are still variations in maternal and child healthcare across the country. Moreover, available community resources and potentials are often inadequately harnessed to support central governments' efforts (Amoakoh-Coleman et al, 2016; Bonenberger, Aikins, Akweongo & Wyss, 2016; Dupas & Miguel, 2017).

Although the provision of quality maternal healthcare has often proven to be critical in reducing the high global maternal mortality rates (Liljestrand & Pathmanathan, 2004; Rush, 2000), there has been little scholarly attention on the delivery of quality healthcare in the country. That is, although some attempts have been made in the country in relation to quality maternal healthcare (Norhayati, Surianti & Hazlina, 2015; Sudhinaraset, Beyeler, Barge & Diamond-Smith, 2016; Kambala, Lohmann, Mazalale, Brenner, Sarker,

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Muula & De Allegri, 2017; Norhayati, Hazlina & Sulaiman, 2017), little research on quality of maternal healthcare focused on service users' perceptive using qualitative approach. Studies on quality maternal healthcare have exclusively been from the provider's perspective without investigating the phenomenon through the lens of service users. Turkson (2009) and Atinga (2012) for instance, investigated quality healthcare in Ghana but did not compare perceptions of service users (mothers seeking maternal healthcare services) and their service satisfaction as well as risk reduction efforts in the context of pertinent health facilities or the International Classification of Diseases (ICD) guide (Ghana Health Service, 2003; Osei, d'Almeida, George, Kiriga, Mensah & Kainyu, 2005; MoH, 2007; Turkson, 2009; Atinga 2012). However, this current study will utilise the qualitative approach in exploring what constitutes quality maternal health care and the problems inhibiting its realisation by users (Creswell, Klassen, Plano Clark & Smith, 2011; Creswell, 2013).

Upper West Region according to the 2016 Holistic Assessment of the Health Sector Programme of Work, is among the top three regions in Ghana with high prevalence of institutional deaths. Since 2014, the Upper West Region has consistently been reported among the leading regions where maternal mortality rates are high in Ghana (MoH, 2016). However, evidence from the region point to the fact that the majority of the cases were reported in the Wa Municipality, raising questions about the nature of maternal healthcare provided in this setting (District Health Information Management System (DHIMS2), 2017). It is worthy to note that the Municipality is leading within the region not necessarily because of referral cases but cases emerging from

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within the Municipality. For instance, cases by district of origin indicated that the Wa Municipality is currently leading in maternal mortality after registering more maternal mortalities than the Nadoli-Kaleo and Wa West districts, which hitherto were leading on maternal mortality in the Region (DHIMS2, 2017).

Statistics from the Upper West Regional Health Directorate further revealed that severe bleeding, anaemia and delivery complication are the leading causes of maternal mortality in the region (Wa Regional Health Directorate Half Year Reports, 2017) and this is consistent with the causes identified by the WHO (2015). Importantly, most of these complications occur during or immediately after delivery. These causes are to a larger extent attributed to healthcare providers, yet very limited attempts have been made to collect empirical data from service users as the causes of such complications and their perspectives about quality maternal health care. An insight from service providers arguably is critical to any policy formulation effort to tackle the high rates of maternal mortality in the Wa Municipality.

Furthermore, the choice of the study setting was informed by the fact that the scholarly literature on quality of maternal health care in the Municipality from service users' perspective on what contributes to maternal mortality are scanty. Indeed, this is an apparent gap which should be addressed for any evidence-based policy efforts to address the situation of high maternal mortality rates. This study therefore sets out to examine quality of maternal healthcare during delivery in the Wa Municipality from the perspectives of service users.

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Research Objectives

The main objective of the study is to assess the quality of maternal healthcare in the Wa Municipality. Specifically, the study strives to:

1. Explore service users' understanding on what constitutes quality maternal healthcare,
2. Investigate service users' perception of the quality of maternal healthcare and
3. Examine the challenges that service users face in seeking quality maternal healthcare during delivery.

Research Questions

1. What do service users consider as quality maternal healthcare?
2. How do service users evaluate the quality of maternal healthcare received from healthcare providers?
3. What challenges do service users face in seeking quality maternal healthcare during delivery?

Significance of the Study

A number of studies have noted that most maternal complications occur in rural settings where access to appropriate health facilities is extremely difficult (Khanum, Quaiyum, Islam & Ahmed, 2000). According to the 2010 Ghana's Population and Housing Census, about 15% of residents in Wa Municipality reside in urban settings and this was far below the national average of 51% (Ghana Statistical Service, 2012). This presupposes that most women in the region are more likely to face difficulty in obtaining efficient, safer, environmentally friendly access to health care, timely arrival at

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appropriate health facilities for safe delivery and other quality indicators making issues of quality healthcare compromised. As a result, a study needs to be conducted to explore the quality of maternal healthcare to help unearth effectiveness of ongoing maternal healthcare services received by mothers and factors that impede quality utilization of maternal healthcare services.

Studies on quality maternal health care in the Wa Municipality from service users' perspective are limited. There is therefore the need to explore mothers understanding of quality maternal healthcare, from service users' perspectives, service users' perception of the quality of maternal healthcare as well as the challenges they encounter in seeking maternal healthcare within the Municipality as such findings from this research has the potential to contribute to the formulation of health policies and interventions aimed at improving maternal healthcare and consequently reducing the current maternal morbidity and mortality in the country. It is also envisaged that the findings will contribute to the existing knowledge on maternal and child health in Ghana. Findings from this study will also serve as reference material for students, scholars and researchers who are interested in issues on quality maternal healthcare

Organisation of the Study

This study is organised into five chapters. Chapter One consists of the background to the study, the problem statement, significance of the study, study objectives, research questions as well as limitation of the study. Chapter Two deals with the review of relevant literature. This covers the following sub-topics: concept of materanl healthcare and quality maternal healthcare as well as dimensions of quality, service user's perception about quality maternal

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healthcare, challenges that service user's encounter in seeking quality delivery healthcare, theoretical issues and conceptual framework. Chapter Three highlights the methodological approaches used. It focuses on the characteristics of the study area, philosophy and research design, data and source, target population, sampling and sampling size, instrument, pre-test, data collection, data management and analysis as well as ethical considerations. Chapter Four consists of the results and discussions while Chapter Five covers summary of major findings, conclusions and recommendations.

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CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

This chapter reviews related literature on quality of services and maternal healthcare services provided to service users. Literature on quality of maternal healthcare were obtained from online data bases (PubMed, JSTOR and Google Scholar). The key words used to search for literature were quality of healthcare, maternal healthcare, perception of service users and challenges. The review is presented under the following themes: maternal health, concept of quality maternal healthcare, dimensions of quality, quality of delivery healthcare rendered in the Wa Municipality from the viewpoint of service users and challenges that impede service users from seeking quality delivery healthcare. The chapter also discusses the theoretical and conceptual framework that guides the study.

Maternal Health

The World Health Organization (WHO, 1946) defined health in its broader sense as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (Official Records of the World Health Organization, no. 2, p. 100).

Health in general is very essential in the economic development of all nations because it is critical in the human capital formation. However, maternal health in particular is deemed crucial because of its role in the development of a person from conception to death. While motherhood is often a positive and fulfilling experience, for many women, it is associated with

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suffering, ill-health and even death (Liljestrand, & Pathmanathan, 2004). Alden, Lowdermilk, Cashion, & Perry, (2013) also explained maternal health as health of women during pregnancy, childbirth, and the postpartum period. It encompasses the healthcare dimensions of family planning, preconception, prenatal and postnatal care in order to ensure a positive and fulfilling experience in most cases and reduce maternal morbidity and mortality in other cases.

For the purpose of this study, maternal healthcare is defined as any healthcare service given to a woman during pregnancy and delivery for the enhancement of the mother and her child's health. The study, however, exempted postpartum period in the definition as posited by Alden, Lowdermilk, Cashion and Perry, (2013) because, poor care and services rendered within the period of pregnancy and delivery usually predispose mothers to complications, deformation of child, mother being anaemic and sometimes lead to stillbirth. WHO, (2016) also reaffirmed that complications during pregnancy and childbirth are leading causes of deaths and disabilities among women of reproductive age in developing countries.

According to WHO, maternal death refers to 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, 2016). Generally, there is a distinction between a direct maternal death, that is the one emanating from a complication of the pregnancy, delivery, or their management, and an indirect maternal death that is a pregnancy-related death with a pre-existing or newly developed health

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problem. Other fatalities during but unrelated to pregnancy are termed accidental, incidental, or non-obstetrical maternal deaths (Bondas & Eriksson, 2001) meanwhile one of the indicator for measuring maternal health is the proportion of maternal deaths. (Tuo, 2017).

Concept of Quality Health Care

One cannot deny the fact that openness, confidentiality, motivation, and commitment are the foundations of any quality system. However, traditional practices and attitudes toward authority, mutual support, and individual responsibility actively resist improvement. This creates a culture of low expectations and quality (from public and professions), vertical command structures, restricted information, and a negative view of accountability and responsibility (Fountain, 2007; Wang, 2015). This is still a major challenge among most African countries (Milakovich, 2005). Quality care involves providers, clients and managers in a structured process to explicitly identify clients' needs and design service processes with the key feature to meet those needs. In the context of quality design, the features are concrete and reflect practical expressions of clients' needs, desires, and expectations. Quality design is used to develop an entirely new process or redesign an existing process for improved service delivery.

According to Schuster et al. (1998: 518), good healthcare quality means "providing patients with appropriate services in a technically competent manner, with good communication, shared decision making and cultural sensitivity." Also, Mosadeghrad (2012), defines quality healthcare as "Providing the right healthcare services in a right way in the right place at the right time by the right provider to the right individual for the right price to get

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the right results". To him, this definition helps create a common language for quality planning, measurement and improvement throughout the healthcare system. Almost as universal is the view by Ovretveit, (1992), who almost a decade later, recognised the three "stakeholders" components of quality namely; clients, professional, and management quality. Client's quality addresses what the clients' wants from the service. Professional quality indicates whether the service meets the needs as defined by professional providers and referrers and whether it correctly carries out techniques and procedures which are believed to be necessary to meet the client's needs. Lastly, the management quality aspect is concerned with the most efficient and productive use of resources within limits by the directives set by higher authorities and purchasers. According to Ovretveit, (1992) quality health service/system is that empathetic care that gives patients what they want and need at the lowest cost. Kelemen, (2003, p. 7) further views quality from managerial and critical perspective. He defines Managerial perspectives of quality as a self-contained entity or process that can be planned, managed, controlled with the help of technical and managerial knowledge. "Critical perspectives assert that quality is a complex and multifaceted concept which escapes a definitive definition."

Quality Dimensions

Patients' satisfaction is increasingly being recognized as an important measure of outcome and quality of care. Whether patients will seek medical advice or comply with treatment will depend on the level of satisfaction. This quality healthcare concern has led health care organizations to use patient satisfaction data to identify facts about the processes of work and the root

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causes of failures in those processes. This leads to improved standards of work leading to best clinical practices. Various approaches have been used to measure or examine the meaning of quality in medical care. Medical quality consists of a mixture of hard technical elements such as correct diagnosis, appropriate intervention and effective treatment as well as soft elements such as good communication, patients' satisfaction and consideration for the patients' preferences (Newman & Pyne, 1996). It is therefore not sufficient to consider only the technical competence of those providing care, but also care provided more effectively, efficiently and humanely. Ovretveit (1992), stated that "Professional quality has two parts: (1) Whether the service meets professionally assessed needs of its clients and (2) Whether the service correctly selects and carries out the techniques and procedures which professionals believe meet the needs of the clients."

Contributing to the research on quality, Brown (2007), also describes eight quality dimensions of health service delivery: effectiveness, efficiency, technical competence, interpersonal relations, and access to service, safety, continuity, and physical aspect of health care (Brown, 2007). Contrary to the dimension of Brown (2007), Parasuramian et al (1985) dimension of measuring quality has also been widely acknowledged in literature as quality measurement indicator in measuring quality health care in most health centres and hospitals. The Parasuramian's domain suggests that hypothetically, service providers and patients may have the same sensitivities of quality of care on the various dimensions of quality of care, namely; financial access, fairness of care, adequacy of resources and services, effectiveness of care, technical aspects of care, interpersonal aspects of care, and overall care. WHO

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as one of the key frontlines in healthcare planning, development and implementation in 2013 has spelt out six standard domain in measuring quality of healthcare. These key domains include: leadership, information, patient and population engagement, regulation and standards, organizational capability and lastly model of care.

Robinson (1999) purported that service quality constitutes an attitude or global judgment concerning the superiority of a service, even though the exact nature of this attitude is not agreed. Meanwhile Hernon and Whitman (2001) conceived service quality as focusing on the interface between the user and the service provider. Also, Palmer (2005) noted service quality as the standard of service delivery conveyed in terms of the magnitude to which customers' expectations are derived.

However Abdallah (2014), in his quest to understand how vulnerable lower income patients make health care decisions define quality of care based on a survey and a focus group discussion in the United States of America indicates that perception and views of patients on service quality can be categorized into: patient-centred care, timely and efficient care, quality and range of services. Patients' perceptions on patient-centred care noted that treating them in a hospital environment with respect and dignity as well as designing the service delivery to be equitable and fair are the building blocks on quality healthcare. Timely and efficient care was a key perception of patients on service quality: as the study revealed that quality care centred on structural elements of care rather than outcomes. Thus, the study centered on a more service-oriented view of quality: were patients' perceived quality as of services as essential aspects of quality based on the physician's competence,

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which was judged based on thoroughness and a clear intent to help the patient. The physician's ability to communicate with patients was considered to be an essential aspect of quality, particularly the doctor's ability to explain things to the patients.

In the context of Ghana, different parameters have also been initiated as bases to measure or assess quality improvement measures in service delivery especially maternal and child care. For instance, the Structured Quality Healthcare and Quality Assurance (QA) activities within the Ghana Health Service (GHS) were initiated by Bannerman et al. (2006) who developed a quality improvement framework for healthcare facilities based on client-perceived and technical care dimensions. In this framework, client-perceived quality healthcare markers include client satisfaction with affordability of fees, promptness of attention, good staff attitude, respect for patients and their rights, provision of privacy and confidentiality, provision of adequate information, availability of drugs and other logistics, and clean environment. The technical quality healthcare dimensions include availability of standard protocols, adherence to standards and professional ethics, outcome of treatment, human resources development, adequate drugs and logistics. These parameters from 2006 till date have been reference points in measuring quality of healthcare from service and providers.

Service Users' Perceptions on Quality of Maternal Healthcare

Some evidence highlights that service users generally consider quality delivery healthcare as a major contributor toward their health and holistic wellbeing (Behruzi, Hatem, Fraser, Goulet, Ii & Misago, 2010; Dhital, Dhital & Aro, 2015). However, for service users to consider delivery services as

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instrumental implies that the services they receive during delivery meet some expectations they perceive as ideal (Mahiti, Mkoka, Kiwara, Mbekenga et al., 2015). Following this, some research efforts have been directed to women or service users' views or perceptions on what constitutes quality delivery healthcare.

A cohort qualitative inquiry in Nepal indicated that with regard to adequacy of medical equipment, adequacy of health staff and health staff fitted to women's health, care provided by public health facilities are beneath standards (Karkee, Lee & Pokhare, 2014). They again realised that women viewed public hospitals as low rated with regard to adequacy of rooms, water, environmental cleanliness, privacy and information adequacy (Karkee, Lee & Pokhare, 2014). This signifies that women's perception of quality delivery healthcare is hinged on the type of health facility utilised for delivery. Similar investigation in Tanzania indicated that whilst enhancing obstetric services, women's thoughts about quality can be induced by health system factors, such as courteous provider attitude, proficiency, and availability of drugs and medical supplies leading to positive perceptions of services received by users (Kruk, Paczkowski, Mbaruku, Pinho & Galea, 2009).

Nordin and Eklund, (2016) through a qualitative study on women's trust in maternal health care in Ghana revealed that *compliance, building trust* and *nursing strategies* were affecting maternal health care. They further added that hierarchical power imbalance within the nurse-patient interactions, where the patients were perceived and treated as subordinates and passive receivers of the nurses' expertise was identified. They again added that lack of

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critical approach towards nurses' actions might be the source of this underutilization.

Usher-Patel, (2013) using the Life Course Approach tried to access the relationship between nurse and patient advocacy by the International Council of Nurses (ICN) as the core of quality nursing, especially within maternal health care and revealed that positive attitude among health workers and adjustment of provided health services to suit women's individual needs enhance empowering for health promotion. Meanwhile Larson et al. (2015) found interpersonal caring to be the very essence of experienced quality of care for patients within maternity care. Larson et al. (2015) study using 3003 women in Tanzania asked them to prioritize among preferred health care attributes of their delivery facility including medical equipment, medical knowledge, attitudes, organization and cleanliness, access to privacy and costs kind, and respectful treatment from the health providers were ranked as the most important (Larson et al, 2015).

Bohren et al. (2015) also brought to light that disrespect, neglect and abusive treatment of women have been recognised as maternal healthcare problems all over the world. A systematic review of women's experiences of seeking maternal health care in low and middle-income countries (LMIC) indicated that health care providers' attitudes vastly affect women's level of attendance (Mannava, Durrant, Fisher, Chersich & Luchters, 2015). Same study also documented that physical abuse, absenteeism, lack of regard for privacy, unwillingness to accommodate traditional practices and authoritarian attitudes were some of the revelations mothers shared during the study according to Mannava, Durrant, Fisher, Chersich & Luchters, (2015).

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Two rural based studies in Ghana where the attendance rates for maternal health care were the utterly lowest in the country, women who were predisposed to the study highlighted women's experiences on why attendance to maternal healthcare was low. Among some of their views included intimidation they received from providers, physical and verbal abuse, neglect, denial of traditional customs and lack of privacy (Yakong, Rush, Bassett-Smith, Bottorff & Robinson, 2010; Moyer, Adongo, Aborigo, Hodgson & Engmann, 2013).

A study conducted in 2014–2015 by Sereshti, Nahidi, Simbar, Ahmadi, Bakhtiari and Zayeri, (2016) using qualitative content analysis assessed mothers' perception of the quality of services received from health centers after perinatal loss. The finding pointed out to the fact that dissatisfaction with the quality of care received by mothers was the major theme while the main categories included: 1) effective communication, 2) expecting responsiveness, 3) expecting to respect the patient's dignity, 4) expecting better care, 5) tension of medical expenses, and 6) insufficient facilities (Sereshti, Nahidi, Simbar, Ahmadi, Bakhtiari & Zayeri, 2016).

Mothers' perspectives on the quality of postpartum care in Central Shanghai, China also reveal that mothers' perception about quality healthcare was influenced by their concern about child care, an area in which they expressed the need for further improvement. Among some of the areas mothers shared concerns which need serious enhancement includes; (1) health education on childcare; (2) more time allocation for discussion with health workers during their postpartum home visits so their questions and concerns could be addressed effectively; (3) access to health workers in times of need

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rather than during officially prescribed home visits; and (4) provision of continuous training for maternal and child health workers with respect to childcare (Lomoro, Ehiri, Qian & Tang, 2002).

A mixed method study in Thakurgaon and Jamalpur in Bangladesh using two district and 12 sub-district hospitals have their finding reporting that mothers shared a positive satisfaction with cleanliness of the hospital facilities as well as the drugs they received (Islam, Rahman, Halim, Eriksson, Rahman & Dalal, 2015).

An Asia based study according to Aldana, Piechulek and Al-Sabir, (2001) in Bangladesh also posit that the most powerful predictor for service users' satisfaction with government services on maternal and child health was provider behaviour, especially respect and politeness. For service users utilizing maternal health services, provider behaviour, especially respect and politeness were much more important than the technical competence of the provider. They also brought to notice that even in the second and third trimesters, women spend more than 30 minutes at medical standpoint and consultation time just to seek quality healthcare. Waiting time, which was about double at outreach services than at fixed services, was the only element with which users of outreach services were dissatisfied.

A qualitative phenomenological approach in two tertiary hospitals in Kelantan, Malaysia reveals that women's perceptions of quality of their care were influenced by the competency and promptness in the provision of care, interpersonal communication, information-sharing and the quality of physical resources. The predisposition to seek healthcare was influenced by costs, self-

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attitude and beliefs (Norhayati, Hazlina & Sulaiman, 2017). A similar qualitative study in Rwanda using a naturalistic inquiry study design and analysis reported that, woman care-seeking barriers depend on whether the pregnancy was wanted, the gestational age, insurance coverage, and marital status. Poor communication between the women and healthcare providers seemed to result in inadequate or inappropriate treatment, leading some to seek either traditional medicine or care repeatedly at biomedical facilities (Påfs, Musafili, Binder-Finnema, Klingberg-Allvin, Rulisa & Essén, 2016).

Challenges Faced by Service Users in Seeking Quality Healthcare during delivery

Differences in maternal mortality rates demonstrate the disparity in maternal health care between developed and developing countries (AbouZahr, 2003). There are many factors that contribute to the challenges faced in attaining quality maternal healthcare globally.

Ganle, (2015) used a qualitative research on Muslim women in three communities in Northern Ghana to find out why Muslim women in Northern Ghana do not use skilled maternal healthcare services at health facilities. The findings suggest that although Muslim women do want to receive skilled care in health facility, they often experience difficulties in accessing and using such services. These difficulties were often conditioned by a religious obligation to maintain bodily sanctity through modest dressing and the avoidance of unlawful bodily exposure or contact with certain people including male or alien caregivers. Other related access barriers included lack of privacy , healthcare provider's insensitivity and lack of knowledge about Muslim women's religious and cultural practices, and health information that lacked

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the cultural and religious and practice specificity to meet Muslim women's maternal care needs.

Again, a nationwide study in Ghana according to Gething et al. (2012) reveals that one out of three women live two hours (or more) away from a health facility that can provide primary obstetrical emergency care and half of these women live with a similar or longer distance to a health facility that can offer advanced obstetrical emergency care. Gething et al. (2012) also indicated that one-third of women are subject to maternal death due to delivery complications, as a result of living four hours away from a well-equipped health facility.

Using one hundred and sixty articles in a systematic review from sub-Saharan Africa, Kyei-Nimakoh, Carolan-Olah and McCann (2017) realised that obstetric care access is hindered by a number of significant demand and supply-side barriers. The principal demand-side barriers identified were limited household resources/income, non-availability of means of transportation, indirect transport costs, lack of information on health care services/providers, issues related to stigma and women's self-esteem/assertiveness, lack of birth preparation, cultural beliefs/practices and ignorance about required obstetric health services. On the supply-side, the most significant barriers were cost of services, physical distance between health facilities and service users' residence, long waiting times at health facilities, poor staff knowledge and skills, poor referral practices and poor staff interpersonal relationships (Kyei-Nimakoh, Carolan-Olah & McCann, 2017).

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In a qualitative study conducted by Essendi, Johnson, Madise, Matthews, Falkingham, Bahaj & Blunden (2015) in Kitonyoni and Mwania sub-locations of Makueni County in Eastern Kenya on understanding community and provider perceptions of the difficulties faced in providing and accessing maternal and newborn care at health facilities in their localities, the results suggest that mothers within community as well as providers perceive various challenges, most of which are infrastructural, including lack of electricity, water and poor roads that adversely impact the provision and access to essential life-saving maternal and newborn care services in the two sub-locations.

In Sub-Saharan Africa, Gerein, Green and Pearson (2006) and Adam et al. (2005) finding reveals service users' experience of shortages and unequal distribution of midwives, nurses and doctors, facilitating an inadequacy which puts a strain on the few health workers, overburdening and overstressing them and rendering them incapable of offering adequate and quality care was reported as some of the barriers they face in seeking quality maternal health. Dora et al. (2015) empirical findings in Sub-Sahara Africa from demographic and health surveys reveal that poor access to affordable and clean energy and adequate water in health facilities in these areas has also been found to be a major contributor to high maternal and child morbidity and mortality in the region.

One of the confronting challenges faced by service users in attaining quality of maternal healthcare ranges from sociocultural factors, including ethnicity, religion, norms, values, and traditions, and their influence on personal and societal elements, such as wealth, education, and autonomy, act

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as powerful determinants of whether women choose to seek maternal health care during pregnancy or delivery(Lowe, Chen & Huang, 2016; Ganle, Obeng, Segbefia, Mwinyuri, Yeboah & Baatiema, 2015;Nápoles-Springer, Santoyo, Houston,Pérez-Stable & Stewart, 2005). The depth and complexity of these factors and their influence on health care seeking behaviours are further intensified by their potential synergistic and/or independent impact (Ganle et al, 2015). While these factors may encourage the use of health care facilities, they may also be factors contributing to increased risks of obstetric complications or targets for discrimination or exclusion. The interaction of these barriers, and their impact on all of the barriers previously discussed, produce highly complex Phases I and II delays (Thaddeus & Maine, 1994; Gabrysch & Campbell, 2009).

A multi-site qualitative study in Nigeria according to Ogu, Ntoimo and Okonofua (2017), have majority of the participants submitted that the health providers are burdened with heavy workloads in the provision of maternal health care. Examples of heavy workload cited included complaints from health providers, evidence of stress and strain in care provision by Ogu, Ntoimo and Okonofua providers and the sheer numbers of patients that are left unattended to in health facilities. Poor quality care, insufficient time to carry out necessary investigations on patients, and prolonged waiting time experienced by women in accessing care featured as consequences of heavy workload, with the secondary result that women are reluctant to seek care in the health facilities because of the belief that they would spend a long time in receiving care.

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One main reason why pregnant women face challenges in seeking quality maternal healthcare is the low number of skilled health professionals, which results in long hours of waiting (Kruk et al., 2009). Other studies have suggested that the perceptions of the quality of the local health system influence decisions to deliver in a health facility (Thaddeus and Maine 1994; Kruk et al., 2009). Similarly, other studies have suggested that poor treatment of women by the health care staff may be acting as a significant deterrent to seeking mainstream medical health care (D'Ambruoso, Abbey & Hussein, 2005; Yakong et al., 2010). These barriers and persistent challenges to accessing maternal health have led to some feminist geographers interrogating issues on maternal health and access to health care within feminist perspectives.

Theoretical Perspectives

The theoretical perspectives reviewed are the "Three delays' model developed by Thaddeus and Maine, (1994), Structuration Theory (Anthony Giddens, 1984**),** Symbolic interactionism**,** Social theory of perception (Ichheiser, 1966) and the functionalist theory (Parsons, 1937). The WHO framework for measuring quality healthcare was also reviewed. The choice of the reviewed theories and frameworks is based on the fact that, these theories in their tenet are not entirely mutually exclusive. Secondly, the decision to utilized different theories is to marry and optimizes the various perspectives to explaining mother's perceptions and reasons that prevent services from utilizing quality maternal healthcare. Also, these theories were also concealed just to in a way reduce the shortfalls associated in using of a single theory. Lastly, the reviewed theories also helped in designing of research questions,

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the selection of appropriate conceptual frame for the study and also in the selection of relevant data for study as well as the interpretation of the data. Again,

Three delays Model

The "Three delays" framework proposed by Thaddeus and Maine (1994) states that maternal mortality occurring in developing countries originates from three constraints or delays to accessing quality of healthcare. The model offers a theme of factors prompting appropriate arrival to a facility in obstetric emergencies. The three delays are: delay in acknowledging that a problem is occurring while at home and making timely decision to leave home in order to seek medical assistance; delay in reaching the health facility as a result of poor road network, means of transport or money to pay for transport; and thirdly delay in receiving adequate and quality maternal healthcare within the facility (Thaddeus & Maine, 1994). The "Three delays" model as used by scholars in maternal healthcare also has bearing on issues of quality of maternal healthcare.

The first delay is the delay in decision making which most often happens at home. It embraces deciding whether to seek care or otherwise. The driving forces triggering the decision are sometimes dependent on the low status of women; poor understanding of complications and risk factors in pregnancy and when to seek medical help, the relevance of ANC and PNC; previous bad experience of health care; acceptance of maternal death and financial implications (Thaddeus & Maine, 1994). They further stress that, a person's ability to recognize and take decisions to access quality maternal healthcare services involves some keen socio-cultural influences about the

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conditions or the advice from experiences of mothers before a substantive decision can be made. Again, financial capacity and decision on which specific service to access for a particular health condition is also considered. It is at this stage that a person acknowledges or admits that indeed, there is the need for medical condition that needs treatment or medical support.

The second delay as posit by Thaddeus and Miane (1994) is delay in reaching health facility where the woman or the mother will receive the treatment or the medical support. Many times, this delay is usually a result of insufficient transportation infrastructure with financial constraints emanating as one of the controlling barriers. Again, distance from the health facility to the next referral facility plays a critical role in deciding the kind of care to seek and where. Geographical factors such as mountainous terrain and rivers are also factored by household or family heads and mothers when considering health facility in accessing quality maternal healthcare.

The third delay happens within the health facility upon a mother's arrival from a referral point or from a community. Many factors emerge from the delay preventing mothers from receiving quality maternal health service or being attended to urgently. Some of the factors include; limited staffing; inadequately trained and motivated medical staff; poor facilities and lack of medical supplies; inadequate referral systems; negative attitude demonstrated by some care providers as well as declined quality of available care at the health facility (Thaddeus & Maine, 1994). Studies have reported that reducing the third delay would contribute to immense reduction in maternal mortality thereby enhancing quality of maternal healthcare in less developed countries including Ghana and for that matter, the entire region. (Costello, Osrin &

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Manandhar, 2004; Ellis, Schummer & Rostoker, 2011). Many of these determinants affecting the third delay usually occur when there is an incorrect diagnosis, inappropriate treatment or diagnosis. For instance, women may wait several hours in accessing healthcare until they realise they can no longer cope within their home management practices before they will make a choice in seeking orthodox healthcare.

As pointed out by the model, delay occurs at each stage of seeking healthcare right from the home to the health facility. After conception, during labour and after delivery, women have to decide on the best option to choose when it comes to healthcare. This decision is usually influenced by enabling factors or obstructing ones. The duration of these delays have varied implications on quality of maternal healthcare services to healthcare providers and service users.

Before a mother would decide on the kind of maternal healthcare services to seek at the health facility, so many factors are taken into consideration: cost of the service, husband or mother in-law endorsement, complications arising from previous care, trust, attitude of service provider, socio-cultural norms, waiting time, availability of service provider among others. These factors affect the first "delay" (delay in taking a decision) to the facility. After taking the decision to seek healthcare, insufficient transport infrastructure, distance to the facility also introduces another set of delay. For example , rural areas owing to the distance and scarcity of means to transport mothers during critical health situation means that rural dwellers often have to walk or improvise transport to reach the health facility. During this time, the labour or any of the maternal health conditions that the woman would have

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been going through will deteriorate which can possibly lead to death or elevate the health condition.

The third delay transpires at the health facility. The factors that also set in to compromise quality of healthcare provision include; limited staffing; inadequately trained and motivated medical staff; poor facilities and lack of medical supplies; inadequate referral systems; negative attitude demonstrated by some care providers as well as declined quality of available care at the health facility as well as declined quality of service offered to mothers (Thaddeus & Maine, 1994)

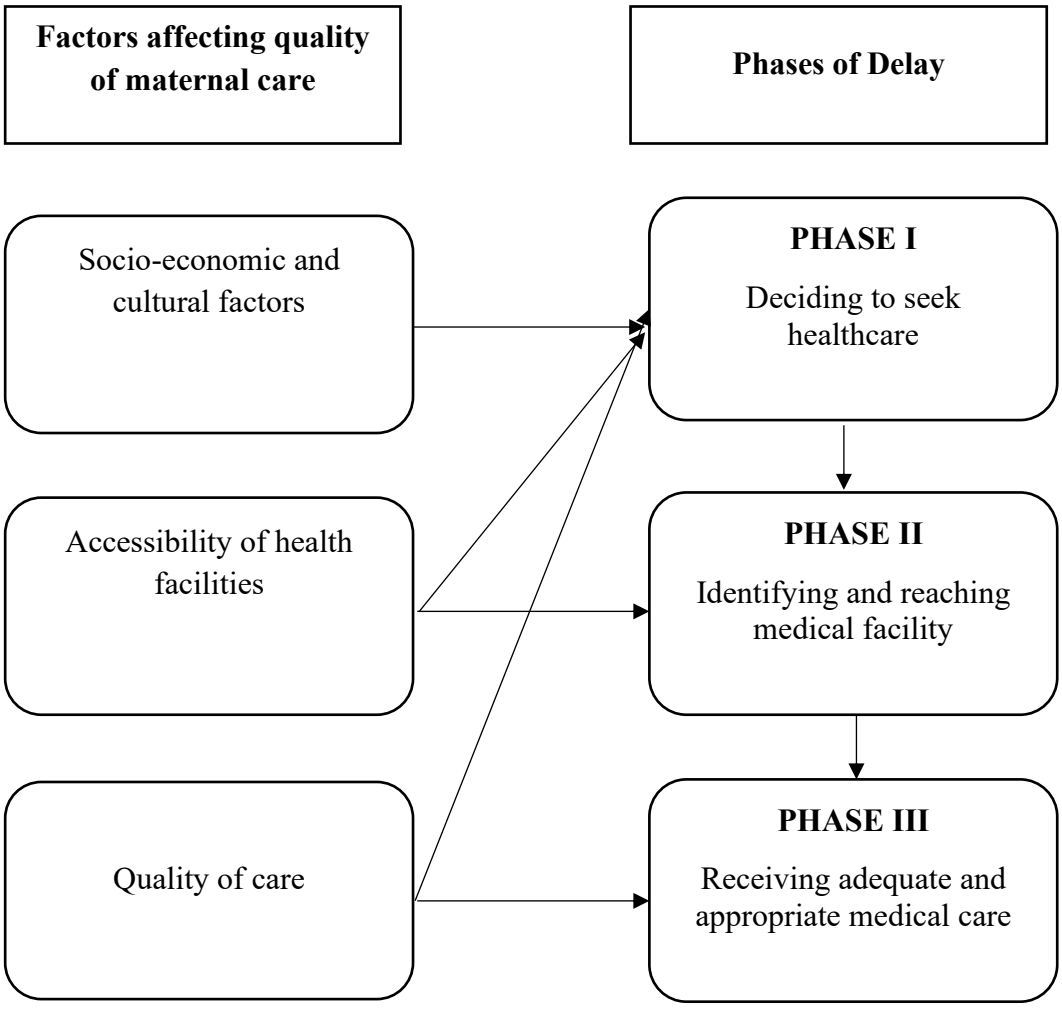

Figure 1: Three delays models
Source: Adapted from Thaddeus & Maine, (1994)

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Structuration Theory

The structuration theory was developed by Anthony Giddens in 1984 as an approach to social theory concerned with free interaction between knowledgeable and capable-social agents and the wider social systems and structures in which they are implicated. The theory consists of six elements namely: agency, structure, duality of structure, institutions, dialectic control and time/space relations.

In this theory, the term "agency" refers to the capacity of an individual to act independently and to make his or her own free choice. It stresses the rational capability of an individual to determine what to do. Again, Giddens regarded the individual as a knowledgeable, well- formed and endowed subject whose actions are mostly intentional and purposive although some actions could be influence by both unintended consequences and acknowledged conditions of the acts. The acknowledged circumstance comprises the unconscious source of motivation as a persistent stream of interference in the world by special agents (Cloke, Philo & Sadler, 1991).

Giddens (1984) conceptualises "structure" as rules and resources utilized by actors in their routine interactions. Structure could also be theorised as recursive rules of society that governs human behaviour. These rules and social forces that limit or influence the opportunities determining the actions of the agent could be social class, religion, gender, ethnicity or customs. The structure has been conceptualised to involve utilization of resources that are the "Material equipment and "organizational capacities" of actors in order to accomplish tasks.

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Duality of structure according to Giddens embraces the relationship between individual (agents) and the rules or norms governing human societies. How individuals operate or interact within the society and the changes that affect the society is the main concern of this element and as a result, it relates to whether individuals recognize rules/regulations in the society or not and how changes occur due to the interaction between the regulations and individuals. Giddens also considers power to be 'an integral element' of all social life 'as are meanings and norms.' All social interaction which takes place involves the use of power. It is possible to analyze power within social systems by considering the relations of autonomy and dependence between actors, and how the actors are able to utilise and reproduce structural properties of domination.

An institution in the structuration theory denotes the various social, economic and political agencies that influence individual behaviour in society. These institutions influence individual's behaviour and their mandate as regulating or providing permission, information and security for health access to occur. These institutions influences individual's behavior in society by ensuring that norms are adhered to and intended to make life easier. The culture and behaviour in societies are created, monitored and sustained by these bodies.

Dialectic control refers to the power of every individual to influence society/community no matter how little the effect may be. Giddens stresses on the power that an individual has to make a difference to the world. He added that, the agent which is the individual is a unique identity that has the power

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and transforms the society /community but not through physical strength but through the reliant knowledge they possess.

Lastly, time/space dimension indicates how social relations vary with time and space. Meaning, some attributes and social changes happen at a particular point in time while others occur within a particular geographical setting. Time dimension could be temporary or permanent while the space dimension donates location where the phenomenon is taking place.

Giddens' Structuration theory has been influential in understanding how actors' routine behavior has influenced the structure of society and introducing ideas of time-space geography. Despite the remarkable contributions the theory brought to bear, it is still noted with some form of shortfalls. For instance, Whittington (1992), noted that complexity and unfriendliness in usage of the theory was one of its shortfalls.

As an agent, the service user behaviour or access to quality maternal healthcare is governed by elements of the structure which basically are the rules, policies, laws, income, sources of information on the use of the facility and the resources within and outside. This relationship known as duality of structure could facilitate or constrain the actions or capability of service users or the caretaker to seeking quality maternal health service at either at the CHPS zone, health centre or the hospital. For example, where service users have access to good ANC services such a comprehensive history-taking, cluster of examination (general , physical , obstetric and vaginal examination, faecal examination, health education delivery by qualified and trained gynaecologist, this could result in positive maternal health outcome while socio-cultural differences, providers unfriendly attitude, longer waiting time ,

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insufficient staffing as well as equipments , restrictive rules and laws on how service users should act and behaviour when seeking care could also result in negative maternal health outcome hence quality of care.

Symbolic Interactionism

Symbolic interactionism was chosen to provide the theoretical guidance for the study. Symbolic interactionism looks at how meanings emerge, are negotiated, stabilised and also transformed through joint actions and social interactions. Interactionists fix their analytical attention on social conventions and norms that shape the feelings that people typically experience and define as 'natural'. This perspective embraces the notion that individuals are capable of internally developing meanings associated with external influences. Central to symbolic interactionism is the concept of meaning proposed by Mead (1962). Mead (1962) explains that meaning is the relation between the gesture of a given individual and the subsequent behaviour of this individual as portrayed to other people. He further explains that meaning is associated with social processes. Therefore, suggesting that as people meet others, they form opinions based on this interaction.

Symbolic interactionism is based on the premises that (a) "human beings act toward things on the basis of the meanings that the things have for them"; (b) "the meanings such things are derived from, or arises out of the social interactions that one has with one's fellows," and (c) "these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters" (Blumer, 1969: p. 2). Therefore, symbolic interactionism attempts to describe how people interpret and describe their life experiences.

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On the other vein, a mother will react positively to healthcare service at a health post regularly depending on the kind of meaning and interaction she derives from the facility. For example, if a mother perceives healthcare providers as rude, or the delivery environment in which she finds herself not satisfactory, she will not utilise any of the healthcare services at that facility.

Social Theory of Perception

The social theory of perception, according to Ichheiser (1966), is concerned with the interpretation of quality care of behaviour in social setting and generally refers to how people perceive others whether favourably or unfavourably. Of particular interest to psychologists are the processes by which individuals form opinions of other people or group of people and how these affect the quality of relationship with them. These factors include the means by which initial impressions are formed, the reasons for prejudice and discrimination and also the development of liking and relationship with specific individuals through interpersonal attraction (Ichheiser, 1966).

Lieberman (2010), also posits that, social perception (or person perception) is the study of how people form impressions of and make inferences about other people. People learn about others' feelings and emotions by picking up information they gather from physical appearances, verbal, and nonverbal communication. Again, Fiske and Taylor (2013), and Kelley and Michela (1980), conceptualized social perception as deals with how people think about and make sense of other people; how they form impressions, draw conclusions and try to explain other people's behaviour. Sometimes called social cognitive or the study of "naitive psychology", social perception focuses on factors that influence the ways in which people

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understand other people and on how people process, organize and recall information about others

The theory in its contracted form argues that an expectant mothers' first impression to how a provider delivers services at the facility tends to influence their perception to service utilization either drawing service users unto or force mothers to withdraw from. They further added that, mothers may tend to always make sharp judgements about service providers and categorize them according to characteristics such as physical appearance, dress, accent, and so on. Indeed, initially these features are usually all we have to go on and as such can serve as a basic for future interactions (Ichheiser, 1966).

A provider's character for example, hardworking, friendly, warm, cold, reserved or stubborn, cleanliness, how providers sterilize their equipment can positively or negatively influence a pregnant mother's perception whether to accept or reject a service provider or choose a facility to deliver. Thus, the initial or later impression formed by a mother towards a service provider may go a long way to influence their perception. The theory also implies that initial or later impression formed by an expectant mother, (service providers) may influence clients' perception positively or negatively to accept or not to accept the service (Ichheiser, 1966).

Koeng, Hossain and Whittaker (1997) reported that the attitudes and skills exhibited by service providers can easily influence clients in a positive or negative way and may, thus , influence one's perception to accept a rendered service or not. However, it is useful to note that even though impression formation has been found to be effective in influencing peoples'

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perception, it may not always be the case as impression may become distorted if assumptions are made from limited data (Wishner, 1960). Another related factor, which influences peoples' perception, is the prejudice and discrimination. Prejudice and discrimination in their restricted sense happen when clients begin to prejudice and have unfavorable negative attitude towards a particular group of people. This normally takes place when people have negative attitudes or assumptions about people they are dealing with. Nevertheless, prejudice and discrimination could also be from positive point of view. The focus of the client (whether positive or negative) may finally determine whether the client should cooperate with the service providers or discriminate against them. The weakness of prejudice and discrimination, which forms part of the social theory of perception, is that an individual may form a prejudiced viewpoint against others for many reasons and once formed, this prejudice may be highly resistant to change. At best, these unfavourable attitudes to others could only be reduced under certain circumstances, even though their perception may not have any basis for prejudice and discrimination against others. Consequently, these stereotypes or generalizations influence peoples' perceptions towards accepting or rejecting people and the kind of services that they provide (Ichheiser, 1966).

Interpersonal attraction, one of the factors of social theory of perception and which explains peoples' perception, posits that often, people are attracted to others based on the quality of interaction. Several actors have been identified as major determinants for good interpersonal attraction. They include physical attractiveness, familiarity, mutual liking, similarity, complementarity and perceived competence (Ichheiser, 1966).

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Physical attractiveness has been shown to be a major determinant in influencing people to others. Attractiveness may be important for a number of reasons, one of which suggests that being in the presence of an attractive person gives prestige and status to the individual concerned. For example, attractive appearance by the use of clothing, cosmetics (good looks) may influence peoples' perception (client) towards the service provider.

Perceived competence also has it that people tend to be attracted to those who appear capable, knowledgeable and intelligent as opposed to those who are not. In addition, we may gain some satisfaction from being with people who demonstrate competence in what they do. Thus, a competent person may become more endearing in our eyes if he or she occasionally show signs of imperfection (Ichheiser, 1966; Aronson, 1988). Bruce (1990), Manchester et al. (2014) uphold the above viewpoint. They are of the view that perceived competence of providers attracts the service providers. It must be noted, however, that continued exhibition of competence does not always attract people.

Functionalist theory

The functionalist theory is one of the cornerstone theories in sociology. It is premised on the works of Herbert Spencer, Emile Durkheim, Talcott Parsons, and Robert Merton (Parsons, 1937; Parsons, 1951; Merton, 1968). According to the functionalist theory, society is a system of interconnected parts that work together in harmony to maintain a state of balance and social equilibrium for the whole. That is, each social institution contributes important functions for society such that the family offers a context for reproducing, nurturing, and socializing children whilst education institutions transmit

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society's skills, knowledge, and culture to its youth. In the same vein, politics provides a means of governing members of society; economics provides for the production, distribution, and consumption of goods and services; and religion provides moral guidance and an outlet for worship of a higher power.

The functionalist perspective stresses the interconnectedness of society by concentrating on how each part influences each other and being influenced by other parts. Functionalists make use of the terms *functional* and *dysfunctional* to describe the effects of social elements on society. Elements of society are functional if they contribute to social stability and dysfunctional if they disrupt social stability. Some aspects of society can be both functional and or dysfunctional. For instance, maternal and child mortality signifies a dysfunction health service delivery because such outcome is not expected if the health systems function optimally.

Sociologists have also identified two types of functions namely; manifest and latent (Merton, 1968). Manifest functions constitute the consequences that are intended and commonly recognized. Latent functions, on the other hand, are consequences that are unintended and often hidden. For example, the manifest function of education is to transmit knowledge and skills to youths in the society. But public elementary schools also serve as babysitters for employed parents, and colleges offer a place for young adults to meet potential mates. The baby-sitting and mate-selection functions are not the intended or commonly recognized functions of education; hence they are latent functions. As such, all aspects of society can develop substantially when all service providers and institutions function as expected.

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In spite of the insightful content of the theory, the functionalist theory is not free from critique. For instance, in the 1960s, functionalism was criticized for being unable to account for social change, or for structural contradictions and conflict. Again, it ignores inequalities including race, class and gender tensions. Another major critique emerges from the epistemological argument that functionalism is autologous; it attempts to account for the development of social institutions only through recourse to the effects that are attributed to them and therefore explains the two circularly. Despite these critiques, the focus of this study rightfully fits the tenets of the functionalist theory and as such is suitable for the study.

Within the scope of this study, the functionalist theory can serve a crucial role in realizing the focus of the study. Through the lens of the functionalist theory, the study can determine whether maternal healthcare services rendered to mothers by the service providers are of quality, whether systems within the facilities are functional or dysfunctional to provide quality care. Guided by the functionalist theory, the study will explore whether quality of maternal healthcare in the Wa Municipality are effectively and efficiently rendering the services for which they were instituted. In order for health facilities to be functional, essential resources and support required from stakeholders such as government and the society in which they operate is key. Although possible challenges might confront the quest for quality, safe and risk free delivery of mothers striving to serve the purpose for its existence, some positive outcomes are to result (such as safe delivery of babies by midwives and doctors, declined maternal mortality, improved maternal and

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child health) in order for it to be considered as functional within the scope of the Functionalist Theory.

Also, service users have a function to play in order to achieve the desired outcome of improving maternal healthcare manifesting in reduced maternal mortality, risk free delivery either normal delivery or surgery and absence of maternal mortality and improved child health. Consequently, women are also to comply with the care providers and access the services in a timely fashion in order for all their health concerns to be addressed effectively and timely to avert potential maternal health complications such as hemorrhage, obstructed labor or maternal deaths. Consequently, the functionalist theory is apt for this study.

WHO Framework for Measuring Quality of Healthcare (2006b)

The WHO (2006b) model for measuring quality healthcare is one of the guiding frameworks for this study. The model has six key domains, namely: leadership; information; model of care; regulation and standards of care; organization capacity and lastly, patients and population engagement.

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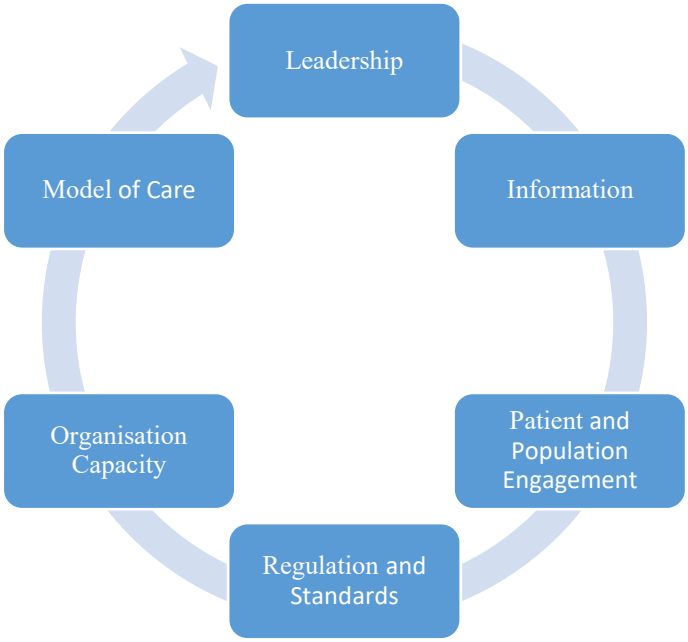

Figure 2: Framework for measuring quality of healthcare

Source: Adopted from (WHO, 2006b)

Leadership

As illustrated in Figure 2, the first component is leadership. Leadership is a fundamental indicator for the delivery of quality health service to achieve desirable health outcomes, a strong leadership and support for quality needs to come from national and community leaders as well as leaders of health-service delivery organization. Regarding the role of a healthcare manager, Mintzberg (1973) classified them in three major categories with specific sub roles and tasks. These three major categories are as follows;

1. *Information:* This includes monitoring (seek and acquire work-related information), dissemination (communicate/disseminate information to/with others within the organization) and public relation (transmitting information to the external environment).

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2. *Interpersonal*: This includes representation (performing social and legal duties and acting as symbolic leader), being a leader (direct, motivate, train subordinates) and creating the liaison (establishing and managing contacts within and outside the organization).
3. *Decisional*: The third role includes entrepreneurship (identifying new ideas and initiating improvement projects), conflict manager (solving disputes or problems and overcoming crisis situations), and allocating resources (setting and distributing resources according to priorities). This implies that if quality maternal health services can be delivered, there is the need for proactive leadership whereby clear directions, codes of conduct and existence of all factors necessary for effective maternal health services will be well instituted and coordinated to ensure that the right services are delivered to women in a timely fashion.

Information

The second domain for measuring quality of care is information. Information is fundamental to improvement of maternal and neonatal care services because any quality improvement measures which gear towards improvement of service delivery. Maternal healthcare especially seriously depends on the capacity to measure change in processes and outcomes, and on mothers, caretakers, stakeholders having access to the information can change what they do or adhere to. To attain the full quality of maternal healthcare across the whole systems for easy and subsequently comparison in outcomes and progress within health facilities, those systems also need to be visible enough, accessible, and user friendly so that mothers, caretakers as well as

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shareholders can easily apply them or explain this information to colleague mothers. Information system which strives to improving quality of maternal healthcare within healthcare facilities can be complex and resource intensive. One commitment needed from leadership is to ensure that a proper capacity in a form of information or knowledge update is needed by healthcare providers as well as service users. The scope of information such as availability of information about best practice; the way in which information is given to service users by those providing care; the access by communities and individual to information which will help them manage their own health.

Patient and Population Engagement

Patient and population engagement is a critical quality maternal healthcare indicator, since individuals including mothers seeking ANC, delivery and PNC services and the community at large play so many roles within the health systems either directly or indirectly. Since they are key actors to quality improvement process, they should be involved in decision-making, and have clear information and tools to help them take care of themselves at home. Evidence has shown that patients who seek healthcare demonstrate improvements in their ability to self-manage their care, obtain better outcomes and experiences in hospitals, and usually have lower costs of care. The major constraint faced by service users that inhibit their fullest participation in health systems is the fact that their commitments in health systems are not translated into meaningful action, their opinions are not taken into consideration when designing health reforms. Healthcare providers and management consider the fact that patient engagement is paramount to layers of healthcare design and as such some strategies are developed to end these

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misconceptions held by these service users. They include: targeting health literacy, self-care and patient experience with health system. When involving community members and service users in the governance arrangement of health system, their views should be heard in decision making. All these will go a long way to improve the mutual co-existence between service providers and service users.

Regulation and Standards

Regulation and standards are essential in the quest to improve health systems and they offer considerable scope for policy interventions at country level. Inspection and accreditations at varying levels can be provided as appropriate to the resources available in the country. Setting standards and monitoring adherence to them may be one of the more efficient means of facilitating higher compliance with evidence. That scope is not limited by the fundamental characteristics of the health system (e.g. by the system of funding for health care, or by the level of government involvement in the delivery of health services), because of the power to legislate and regulate which is held by all governments. It is, however, a domain in which professional bodies and regulatory agencies for health workers will often play a major part either independently or in partnership with governments. The use of regulation and standards seek to change performance through the application of externally developed measures. Their use by health-service providers is often subject to external inspection or accreditation, and contrasts with other approaches to quality improvement which are more internally driven. The challenge to policy-makers is to find the right balance between internal and external drivers for improvement, and reflect that balance in their strategy for quality.

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Organizational Capacity

The fifth domain involves organizational capacity. The issues for quality in this domain apply throughout the health system. At the national level, there should be the capacity to lead the development of policy, to drive implementation, and to keep performance under review. Within communities, there should be the capacity to identify needs and preferences and to articulate them within the health system. Issues of capacity are, however, particularly relevant for those organizations which are delivering health services to individuals and communities as this is the interface at which users directly experience the quality of care available to them. Whether a health-service-provider organization is under government sector, the private sector, or is part of a non-governmental organization, the capacity issues on which they need to focus in order to deliver quality to service users remain the same. Organisation capacity in maternal health service delivery is concerned with whether staff are professional enough and offering standard maternal health services that can really lead to improvement in maternal health outcomes.

Models of Care

The final domain reflects currently understood best practices for the delivery of health care generically and to particular population groups, such as groups defined by a common need (e.g. people with chronic conditions) or common characteristics (e.g. children or the elderly). The development of new models of care will normally aim at addressing all the dimensions of quality described earlier (i.e. effective, efficient, accessible, acceptable/patient-centred, equitable, and safe) and will seek to improve outcomes by organizing integrated responses. It is important for decision-makers to consider that the

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reorganization of health care across settings, and seeking integrated and continuous care may provide the largest leverage in quality improvement. The development of new models of care usually involves high levels of stakeholder involvement (including service users and communities), an appraisal of evidence, the development of protocols and guidelines, and a process to redesign the delivery of care. The challenge to policy- makers is to know when this approach is needed, and for which population groups. Likewise, in maternal health care delivery, stakeholders such as the women themselves, partners/husbands and immediate family members must be actively involved in order to achieve high service utilisation rate and positive maternal health outcomes.

Conceptual Framework

Premised on the set objectives of the study, the Donabedian (1985) Model for Measuring Quality Healthcare was adapted as the conceptual framework to guide the study. The model has three main constructs namely: structure, process and outcome. The model defines structure as the characteristics of the setting in which care takes place. Measures of the setting used might include characteristics of physicians and hospitals (e.g., a physician's specialty or the ownership of a hospital); personnel; and/or policies related to care delivery, population participation, model of care (attitude exhibited by service providers, waiting time for services, referral issues, accessibility and affordability as well as access to information on maternal healthcare issues) (Figure 3). Structure is viewed as not just the way clinics and hospitals are organized and operated but by the policies they have in place that affect quality of care.

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For example, processes for monitoring and promoting quality, incentives for high quality care among others can have an influence on how well care is delivered. A motivation for focusing on the structure is the premise that the setting can be a strong determinant of care quality and given the proper system, good care will follow. For example, one would expect maternal healthcare service, which is delivery, to be of higher quality when all staff are clear about their roles and responsibilities, when healthcare facilities are kept clean and free from nosocomial infections, and also when community and shareholders who are the frontliners to implementing maternal healthcare services placed at every stage of healthcare activities. Again, taking a keen look at strategies for monitoring adherence to recommended procedures, there are systematic approaches to continuously improving maternal healthcare quality.

Process assesses whether a patient received what is known to be good care. They can be referred to anything that is done as part of the encounter between a physician, another healthcare professional and a patient, including interpersonal processes, such as providing information and emotional support, as well as involving patients' decisions in a way that is consistent with their preferences.

Lastly, Donabedian (1985) defined outcomes as patient's health status or change in health status (such as improvement in symptoms or mobility). This outcome is the result of the medical care received and includes intended outcomes, such as relief of pain and unintended outcomes like complications. Although the term "outcomes" is sometimes used loosely to refer to results such as mammography rates, such measures are actually process measures in

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the Donabedian sense. There is also a category of measurement called intermediate outcomes. This includes measures like Hemoglobin levels for people with diabetes and blood pressure measurements. These intermediate outcomes are often closely related to other health outcomes. Some literatures on quality of maternal healthcare have also posited that, for outcomes to be used as quality of care measures, they must reflect, or be responsive to, variations in the care being assessed (Deyo, Diehr, & Patrick, 1991; Terwee, Dekker, Wiersinga, Prummel, & Bossuyt, 2003). For example, it is known that taking blood pressures is necessary for monitoring how well blood pressure is controlled and that controlling blood pressure reduces the probability of heart attacks, strokes and other bad outcomes. It is also known that certain outcomes, such as death after being treated in a hospital for a heart attack is related to the quality of care provided.

These antecedents are deemed indispensable because the adapted conceptual framework (Figure 3) also links the objectives of the study by focusing on maternal health service users as the unit of analysis. It conceptualises what service users perceive as quality maternal healthcare, their perceptions about services received from healthcare providers and the various factors that either facilitate or prevent service users from attaining quality maternal healthcare. These predictors are conceptualized as the structural variables. These variables includes: availability of care and equipment, human resource, environment, manner of care (attitude exhibited by provider, communication, timelines of care and safety). These structural predictors are linked to process of quality care which comprises series of questions that needs to be answered to achieve the desired outcome (what service users

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consider as quality maternal healthcare? how service users evaluate quality maternal healthcare received from healthcare providers? and what challenges service users face in seeking quality maternal healthcare?). Subsequently, getting responses to the process questions leads to the expected outcome (services users understanding of quality maternal healthcare, quality maternal health rendered to service users and challenges services users face in seeking quality maternal healthcare at delivery). The prevailing structure (including the availability of care and equipment, human resource, environment, manner of care (attitude exhibited by provider, communication, timelines of care and safety)) affect the realization of the process predictors and hence the outcome. Below is a diagrammatical illustration of the conceptual framework.

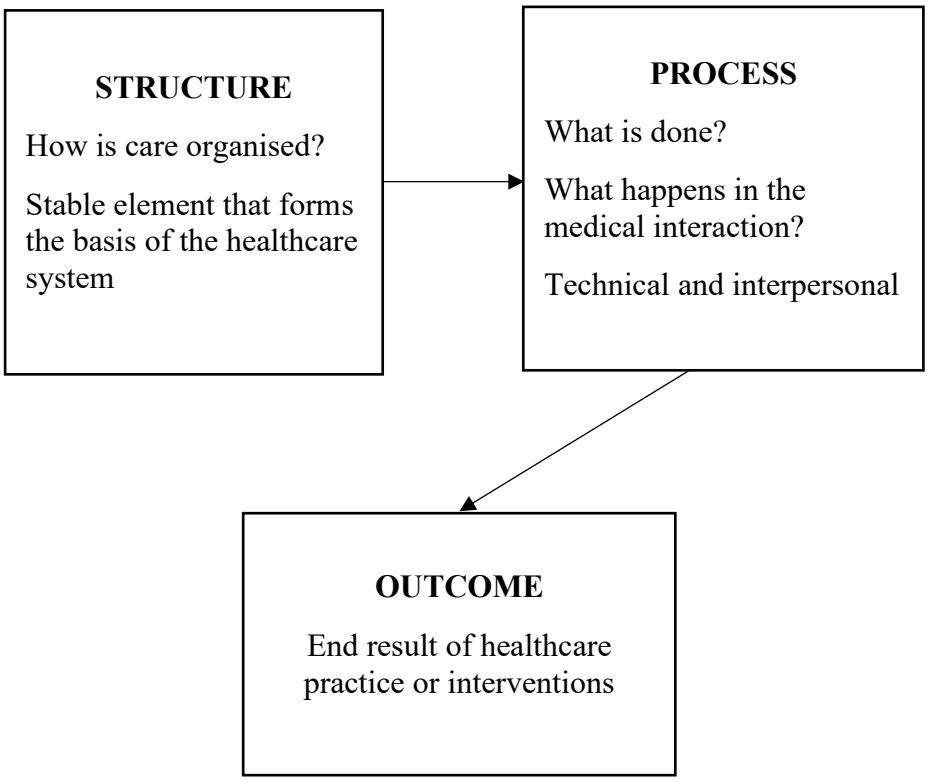

Figure 3: Framework for Assessing the Quality of Medical Care

Source: Donabedian (1985).

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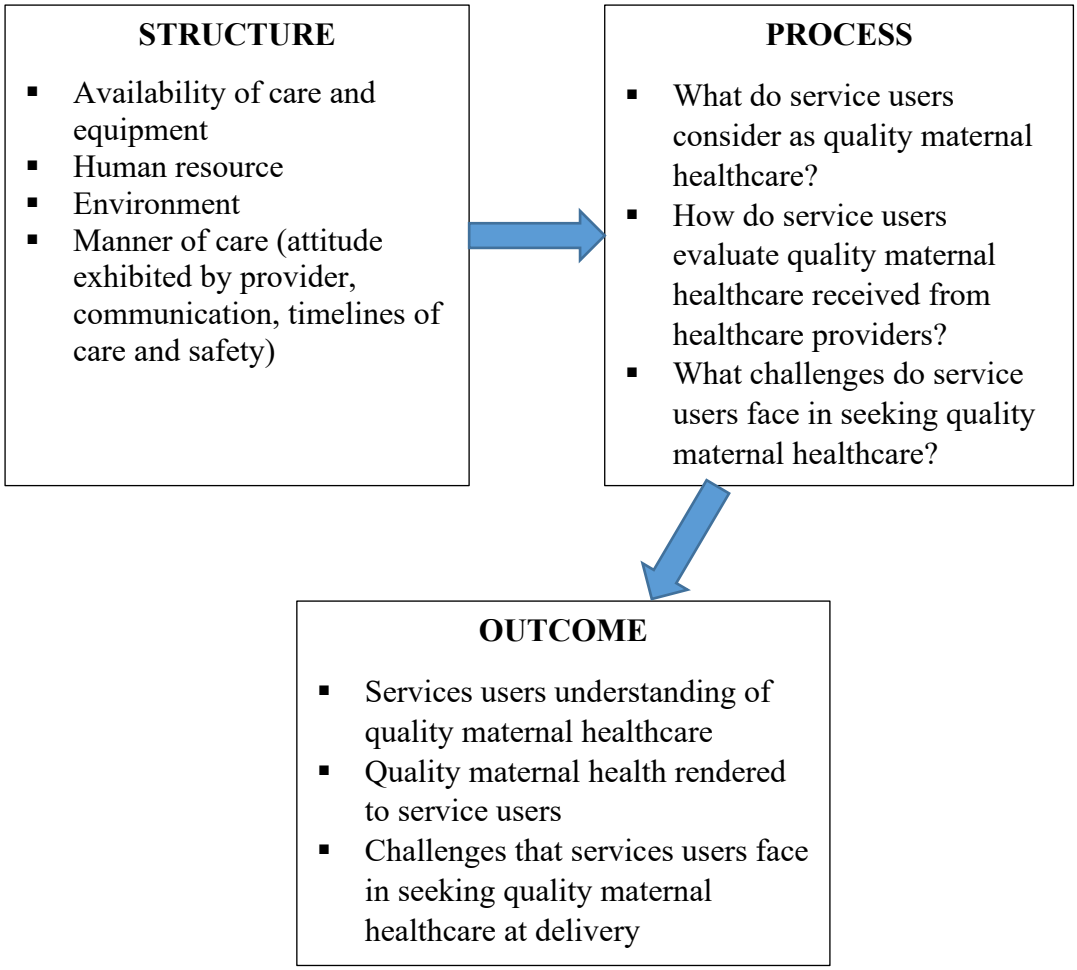

Figure 4: Adapted Framework for Accessing the Quality of Care

Source: Adapted from Donabedian (1985).

Chapter Summary

This chapter dealt with early researches people explored and found in the area of quality maternal healthcare in Ghana as well as from other settings. The review touched on three board headings namely; empirical review, theoretical perspectives and conceptual issues. The first part reviewed empirical findings of the study. Themes like the concept of maternal health and quality maternal healthcare as well as dimensions of quality were reviewed, Appraisal of quality of maternal healthcare rendered to service users

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and the challenges that impede service users from seeking quality maternal healthcare were also reviewed.

The second section of the review also systematically reviewed theories guiding the study. The theoretical perspectives reviewed were the "Three delays' model developed by Thaddeus and Maine, (1994), Structuration Theory (Anthony Giddens, 1984**),** Symbolic interactionism**,** Social theory of perception (Ichheiser, 1966) and the functionalist theory (Parsons, 1937). The WHO framework for measuring quality healthcare was also reviewed.

Premised on the set objectives of the study, the Donabedian (1985) Model for Measuring Quality Healthcare was adapted and reviewed as the conceptual framework to guide the study.

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CHAPTER THREE

METHODOLOGY

Introduction

This chapter deals with the processes involved in collecting and analysing the data. The chapter comprises the description of study area, research philosophy, study design, sources of data, target population, sampling and sample size and the instrument used. Other issues covered in this chapter are pre-test of the instrument, data collection, data management, data analysis and ethical consideration.

Study Area

The Wa Municipality which is the study area shares administrative boundaries with Nadowli District to the North, the Wa East District to the East and the South to the Northern Region (Figure 1). Wa Municipality has a land mass of approximately 234.74 square kilometres, which is about 6.4% of the Region (Wa Municipal Assembly, 2014).

The Wa Municipality has a total population of 107,214 compromising 54,218 females representing 50.6% as against 52,996 males representing 49.4% males (Ghana Statistical Service-GSS, 2013). The demographic structure of the Municipality shows that the active working population represents 47% compared to a dependent population of 53%.

Again, the Municipality has a household population of 102,264 with a total of 9,592 houses. The average household size in the district is 5 persons per household. Children constitute the largest proportion of the household structure

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accounting for 42.0 percent of the household population whilst spouses form about 9.7 percent. Nuclear households (head, spouse(s) and children) constitute only 9.5 percent (Ghana Statistical Service, 2013).

In terms of educational infrastructure, the study area has 78 Early Childhood Care Development Centres, 76 Primary Schools, 59 Junior High Schools, seven Senior High Schools, four Technical/Vocational Schools, one Training College, one Polytechnic, one University Campus, one College of Education, one Nursing Training College and two Special Schools (Wa Municipal Education Directorate, 2014).

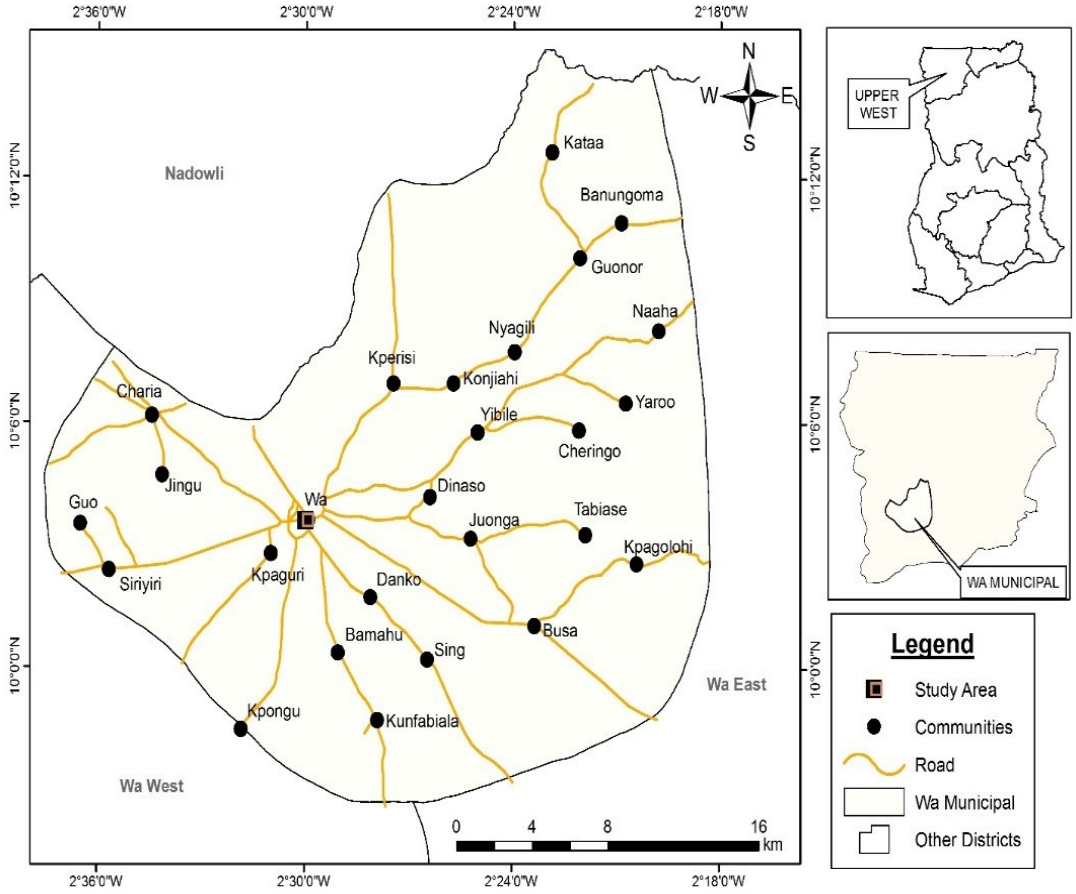

Figure 5: Map of Wa Municipality

Source: Department of Geography and Regional Planning, UCC (2017)

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The Wa Municipality has 38 health facilities comprising one Regional Hospital, six Health Centres, six Clinics, 25 Community-Based Health Planning and Services (CHPS) Compounds (Table1). The Municipality has six Sub-Districts namely; Bamahu, Busa, Charia, Charingu, Kambali and Wa Central. The Municipality has 49 midwives all of them found at the various sub-District and CHPS Zones (Table 2) (Wa Municipal Health Directorate, 2016).

Table 1: Health Care Facilities in the Wa Municipality

	Government				Government
Sub District	CHPS	Clinic	Health Centre	Regional Hospital	Total
Bamahu	4	-	1	-	5
Busa	2	-	1	-	3
Charia	3	-	1	-	4
Charingu	4	-	1	-	5
Kambali	5	1	1	-	7
Wa Central	7	5	1	1	14
Grand Total	25	6	6	1	38

Source: Regional Human Resource Report, 2016

The main economic activity of the Wa Municipality is agriculture employing over 70% of the population (GSS, 2012). This is followed by commerce and industry. Other key sectors of the economy are transport, tourism, communication and energy. The Municipality has about 15 financial institutions which include both banking and non-banking institutions. However, due to poor

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financial record keeping, lack of collateral and high interest rate, it is difficult for businesses to secure loans from these financial institutions.

Research Philosophy

This study utilises the interpretivist school of thought to help understand and evaluate the quality of maternal healthcare in the Wa Municipality. Again, the interpretivist philosophy was also adopted on the premises that, the study believes that reality constitutes people's subjective experiences of the external world; thus, they adopt an inter-subjective epistemology and ontological belief that reality is socially constructed. The interpretivist researcher relies on the varied and multiple meaning of the research participant in order to look for complexity of views rather than narrowing meanings into categories or ideas (as in positivist philosophy). Thus, interpretive research philosophy employs qualitative research methods in data collection and analysis. To the interpretivist, social science is a rather subjective than objective enterprise and therefore does not generate knowledge of any kind. It attempts to understand phenomena through the meanings that people assign to them (Blaikie, 2007). The interpretivist paradigm does not predefine dependent and independent variables, but focuses on the full complexity of human sense making as the situation emerges (Blaikie, 2007).

According to Edwards (2012), interpretivist is not a single paradigm; it is in fact a large family of diverse paradigms including hermeneutics and phenomenology. Despite the strengths attributed to interpretivist paradigm, the paradigm is noted with difficulties in analysis and interpretation (O'donoghue, 2006; Creswell, 2013).

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Literature indicates clearly that perceived service quality assessment by users is best measured from a quality perceptive, which is from an individual constructivist point of view (Abuosi, 2015 & Atinga, 2013; Raven, Van den Broek, Tao, Kun & Tolhurst, 2015; Fisseha, Berhane, Worku & Terefe, 2017). On that score, the current study found it useful to have employed this philosophy in conceptualisation, data collection (IDIs and FGDs) and analysis (inductive) and interpretation. By this thinking, the philosophy was deemed to provide an individual-centred in-depth assessment of the health care services offered in the Wa Municipality of Ghana as well as the challenges service users face in their quest to seeking quality maternal healthcare.

Research Design

Based on the research philosophy, a cross sectional study design was chosen as the research design for the study. The cross sectional design was chosen for the research mainly because it possesses distinct attributes which supports the use of different methods to collect data from respondents (Creswell, 2013). Cross-sectional design was deemed appropriate for this study because data is collected from the study population once within a specific period (from May to June, 2018). Also, cross sectional studies give a picture of a situation as it occurs in its natural setting without any manipulation (Olsen & George, 2004). The design is also concern of conditions that exist, opinion that are held, processes that are going on, effects that are evident or trends that are developing. However, it is worthy to note that a cross-sectional design is limited in terms of making causal inference (Frankfort-Nachmias & Nachmias, 2007).

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Data and Sources

Data for the study was derived from primary source. The primary data for the study was obtained from mothers within the reproductive age group (15-49) seeking maternal health services.

Study Population

The study targeted women within the reproductive age group (15-49) who have delivered at the various health facilities in the Wa Municipality to evaluate the quality of health services they received from the healthcare providers. The inclusion criteria was that the women should be residents of the Municipality, and should also access skilled delivery at any of the health facility within the Municipality within the last three years. The choice of mothers who have delivered within the last three years preceding the study is that they are the people who have had delivery experience within health facilities in a relatively recent period and as such are more likely to recall and share their assessment of the services they received. The study excluded service users seeking ANC services. Also, view of caregivers or husbands who accompanied their wives to deliver was not considered. Again, mothers outside the reproductive age range (15-49) were not considered for the study. For service users less than 18 years, permission was sought from their husbands, parents or caregivers after which the service user herself consented to be part of the study.

Sampling procedure and Sample Size

The study employed non-probability sampling (purposive and convenience sampling) technique in selecting the health facilities and respondents

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for the study. There are 38 Health Facilities within the Municipality. Out of the 38 health facilities, 14 health facilities were purposively considered. The selection of the 14 Health Facilities was based on the fact that, the selected facilities have midwives as well as Community Health Officers (CHOs) providing maternal healthcare services.

The study utilised convenience sampling technique to recruit respondents in order to attain their assessment of quality of maternal healthcare they received from healthcare providers. These mothers were sampled when they attended postnatal care (PNC) service in the various sub-districts. With this, mothers who attended PNC and were about leaving the health facility were approached and after giving consent, were interviewed. The whole process was repeated until the study got to saturation with a total of 62 mothers seeking PNC services were interviewed through focus group discussion (FGD) and In-depth-interviews (IDIs).

Research Instrument

This study used both focus group discussion and in-depth interview guides. Both the FGD and the IDI consisted of four sections. The first section looked at the socio-demographic background of mothers: service users' age, highest level of education, marital status, occupation, income level and place of residence. The second section focused on service users' perceptions about what constitute quality maternal healthcare. The section three appraised quality of maternal healthcare rendered in the Wa Municipality from the viewpoint of

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service users. The last section examined the challenges that service users faced in seeking quality healthcare during delivery.

Table 2: Summary of Sampling Techniques and Research Instruments

Unit of analysis	Information sought	Sampling technique	Research Instruments
Women who have delivered within five years preceding the study.	- Service users' perception about what constitutes delivery service quality. -Quality of delivery healthcare rendered in the Wa Municipality from the viewpoint of service users -Challenges impeding service users from seeking quality delivery healthcare	Purposive Convenience	In-depth Interview Guide and FGDs

Pre-Test

The FGD and in-depth interview guide was pre-tested at the Wa West District. The District was selected because it exhibits similar characteristics like the study area. Six CHPS zones within the District were selected for the pre-testing with one mother each who had delivered in a health facility within the Municipality. Again, three FGDs were randomly conducted at the district too. The rationale of the pre-test was to identify lapses which were likely to show up during the actually data collection. The feedback from the pre-test was used to restructure some of the questions. Misplaced questions were re-arranged and

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clarifications were also made on some of the questions that seemed confusing to respondents.

Data Collection Procedure

The data collection lasted for 28 days (four weeks). The data collection comprised recruiting and training of field assistants, community entry process and fieldwork. Three field assistants were trained to help in the fieldwork. The selection of the field assistants was based on experience in qualitative data gathering and one's ability to speak any one of the three main languages in the study area which are Dagaare, Waale and Brefo. The objectives of the study were explained to the field assistants to enable them be abreast with what the work intended to achieve. The training of field assistants lasted for a day. They were trained on how to identify respondents, recording and management of data and the translation of the contents of the instruments into the most common languages spoken by the service users. The field assistants were also trained on how to handle ethical issues on the field. Lastly, they were made to engage in mock interviews on the administration of the instrument.

Five days were used for the community entry processes. The research team visited Regional Health Directorate as well as the Municipal Health Directorate to seek permission. At the health facilities, the team briefed the healthcare providers on the purpose of the study. Subsequently, the team was introduced to the service users who were seeking PNC services to be briefed on the study. The sampled mothers were asked to propose a time they would be

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available for the interview to be conducted. Based on their proposed time, data collection plan was developed indicating date and venues for each interview.

Twenty-three days were used for the actual data gathering. Based on the data collection plan, the data collection started at Bamahu and ended at Charia Health Centre. The respondents consented to participate freely. Each of them either signed or thumbprinted a written consent form to indicate that they had freely decided to participate in the study. With respect to those who could not read, the field assistants read the informed consent form to them in the language they best understood.

In all, six focus group discussion (FGDs) were conducted; one FGD per each sub-district. The group consisted 6-8 participants. The six FGDs were conducted on separate days, usually on Wednesdays, a day set aside for PNC. And mothers seeking PNC and fall within the inclusive as stated in the target population were invited for the FGDs. Each group constituted based on the number of participants available. Once the groups at the various sub-districts were constituted, the participants were prepared for the discussion by introducing them to the study. The discussion were guided by a moderator (or group facilitator) who introduces the topics for discussion and helps the group to participate in a lively and natural discussion among themselves. the moderator played a key role in the FGDs as to help to facilitate the discussion by ensuring that the discussion did not deviate much from the substantive topics and also asking the right questions in clear manner to enhance the validity of the data. All focus groups were held in the study communities, at venues chosen in consultation with

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participants. Each FGD lasted 30 minutes to 45 minutes. On the other hand, 26 IDIs were conducted alongside with the FGDs.

In relation to the study, FGDs was applied because of its notable strengths including the following. The FGD allowed the participants to agree or disagree with each other and by so doing provided an insight into how the group (service users) thinks about issues about the range of opinion and ideas, and the inconsistencies and variation that exist in a particular community in terms of quality maternal healthcare issues, experiences and constraints.

A face-to-face in-depth interview with the participants using an interview guide was conducted. The questioning approach was unstructured, whilst prompts and follow up questions were frequently used to gain greater insights into the responses and to clarify responses from the interviewees. Throughout the data collection process, the interview guide was revised where necessary based on the outcomes and the interview process as it progressed from one interviewee to the next, a strategy which supported the elicitation of new insights from the subsequent interviews. Prior to all interviews, written consent were obtained from participants for their participation and the overall interview process was audio-recorded. With participants' consent, all interviews were audio-recorded and transcribed verbatim. All the IDIs were conducted at the facility, at venues chosen with the mother. Each IDIs lasted 25-35minutes. All discussions and interviews were conducted in the local dialects; Dagaare, Waale and Brefo. Audio were transcribed verbatim in English for further analysis.

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Data Management

The qualitative data obtained from mothers seeking PHC services and falls within the reproductive age group (15-49) and meets the inclusive criteria was recorded using two audio tapes. The two tape recorded data was backed up on the field. At the end of each field trip, the collected data was safely stored to prevent access to any third. The recorded interviews and the soft-copy version of the transcription after the study were stored from a third party access using 'my locked box', while the field notebooks were kept out of sight.

Data Processing and Analysis

The data were analysed manually, guided by an inductive content analysis approach. The approach, which involves thorough reading of data before analyses (Thomas, 2006), helped the study to identify the major themes as well as sub-themes that emerged.

First, all qualitative in-depth interviews from the field data collection were audio-recorded and transcribed verbatim. All non-English transcripts were translated into English. Secondly, data from the interview transcripts were familiarised through constant line-by-line reading and re-reading. This was carried out by the researcher and three independent bilingual specialists each checked the quality of translations from Waale, Brefo and Dagaare to English. As encouraged by qualitative researchers Allen, (2010) re-listening of audio recordings and reading of field notes was further undertaken during this stage to enhance familiarity with the data. Third, coding and taking of notes to categorise emergent key concepts and patterns was then conducted.

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Both similar and different views and experiences on the subject were identified under sub-themes to aid comparison. Finally, quotations were used to support the views raised by the respondents

Limitation of the study

Even though this study offers insight into quality of maternal healthcare in the Wa Municipality, the study used qualitative techniques and thus the findings cannot be generalized. Furthermore, the findings as reported pertain to only service users who have had delivery supervised by a doctor or a midwife in the study area. Health facilities and service users were purposively recruited constituting a small sample size, as such views expressed by mothers are unique to their own observation and knowledge and may not represent those of other mothers in the same communities.

Ethical Issues

Ethical clearance was first sought from the Institutional Review Board (IRB) of the University of Cape Coast. Afterwards, permission was obtained from the Wa Regional Health Directorate, Municipal Health Directorate, and the Traditional Councils of the respective sub districts before the field work was embarked on. During the interviews, the field assistants identified themselves to the respondents to avoid impersonation. The purpose of the study and the nature of the instruments were made known to the respondents as well. Participants were informed that the interviews as well as the FGDs would be tape recorded and their identity would remain strictly confidential. Their names were not shared with other participants or individuals outside the study.

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The anonymity of the individuals was protected by assigning participants' identification numbers for the interview. Participants were informed and assured of their right to refuse to answer any questions during the interviews. Those who chose not to participate were respected and thanked for their choice without any form of penalty. Beneficiary, justice, needs, and values of the participants were ensured. All data (copy version of the transcription) were stored from a third party access using 'my locked box', while the field notebooks were kept out of sight.

Chapter Summary

This chapter discussed the methodology used in conducting the study. Thematic issues discussed included the study area description, research philosophy, and the study design and data source. The target population, sample size and sampling techniques as well as research instrument were also discussed. Lastly, the chapter described the data collection procedure, pre-testing, data management, data processing and analysis as well as some ethical issues considered.

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CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents the results and discussion of the study. It starts with a description of the demographic background of the respondents. This is followed by the situation of quality of maternal healthcare services provided in the study area. Mothers' understanding of quality of maternal healthcare, appraisal of maternal healthcare services and challenges involved in seeking quality maternal healthcare are presented.

Socio-demographic Characteristics of Respondents

Socio-demographic profile of any given population is essential for understanding the dynamics of that population (Grix, 2004). Age, marital status, and level of education, place of residence, occupation, and number of children born as well as those still alive constituted the demographic characteristics of the respondents (Table 3).

Sixty-two mothers were interviewed for the study. The results from the qualitative study indicated that 27 mothers were within the age group of 25-29 years (Table 3). Fifty-one of the service users were married. Twenty-six of the participants had attained no formal education while 23 of the users had born three children prior to the study. Twenty of the mothers had their children born and they were alive. Twenty-six of the mothers were into Artisan (hairdresser, craftwoman, waiver etc). With regards to residence, 12 of the mothers were from Wa Urban health Centre (Regional hospital).

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Table 3: Socio-demographic background of the Respondents

Demographic Characteristics	Frequency *f*
Age	
20-24	8
25-29	27
30-34	20
35-39	7
Marital Status	
Never Married	11
Married	51
Level of Education	
No Education	26
Primary	13
JHS	11
SHS	3
Tertiary	9
Number Of Children Born	
1	10
2	12
3	23
4	9
5 And Above	8
Number Of Children Alive	
1	11
2	14
3	21
4	9
5 and Above	7
Occupation	
Farmer	17
Trader	11
Artisan	26
Public Servant	5
Unemployed	3

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Table 3 continued

Place Of Residence	
Busa	9
Charia	11
Charigu	10
Kambali	10
Wa Urban Health Centre (Regional Hospital)	12
Bamahu	10
Total	62

Source: Field Work (2018).

Mothers' perceptions of Quality MHC

The study revealed that varied meanings are attached to the concept of quality maternal healthcare. These meanings reinforce the subjective nature of the concept of quality as noted in the literature. A number of the respondents had some knowledge of what constitutes quality of care and could meaningfully express their understanding. Five main unique but interrelated dimensions emerged from the interviews. These are, timeliness, interpersonal care from service providers (compassion and support, being polite and respectful), satisfaction to service delivery, physical appearance of facility and discrimination in service delivery

Timeliness

Service users revealed timeliness as the key determinant of service quality in their quest to seeking healthcare delivery services at the various facilities and centers. Thus, they were of the view that, time is an indispensable resource facilitating healthcare delivery and therefore indicated that a mother will freely deliver safely if service providers attend to her on time. Specifically, research participants from Kperisi and Busa indicated that quality health service delivery

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can be compromised if healthcare providers take their timing for granted especially with regards to the time of reporting to work, time in accessing other essential care such as laboratory tests, X-ray and the long waiting time at the O.P.D to take history. All these in one way or the other can compromise the quality of delivery. Some of the patients shared these views as follows:

> *…….As you can see inside their facility, there is nobody there yet and we have been waiting for some time now. How can service quality change much less to talk of deliveries? The same attitude they exhibit here is the same they transfer to the delivery process* (33 year old; Artisan at Busa).

> *Sometimes, you will get there to meet a lot of people but only one or two people will be serving while the rest are just sitting down. We sometimes end up spending the whole day at the hospital just to screen or collect lab results* (29 year old; Artisan at Kperisi).

Interpersonal care from service providers (compassion and support, being polite and respectful;

Interpersonal care from a service provider constitutes an important component of service quality (Parasuramian's, 1985; Brown, 2007; WHO, 2006). Acts such as compassion and support, politeness and respect have very significant influence on the patient's overall understanding of quality of maternal healthcare delivery (WHO, 2013; Abdallah, 2014). It was established that service users' understanding of the quality of MHC was enhanced when communication between them and the providers was such that they had access to information relating to their conditions and treatment. Research participants added that

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interpersonal care from the service provider to service users, per their understanding of quality healthcare, is attained when healthcare providers exhibit good manners and gestures. This they said creates a friendly environment within the facilities for service users to feel free to seek clarification from providers regarding treatment. Behaviours such as arrogance and disrespect demonstrated by service providers to a large extent have impact on level of utilization of a service at a facility. Participants in the FGD had these to share

> *…..excuse my words, but some of these nurses, especially the younger ones, are ill-mannered. All they know to do is pressing their phones while a woman is seriously suffering on the bed. They only rash to come and help when they realize the baby is coming out…. Is this quality healthcare? (35 years old; Unemployed from Kpongu)*

A 36 year old teacher in an angry mood added:

> *….most of them [nurses] aren't respectful enough especially the younger ones. Is it the kind of training that they got from the Nursing Training Schools? Is this training the proper training that should be given to people that deal with the lives of people? (36 years old; Public Servant from Dondoli).*

While some service users grieve over the attitude exhibited by some nurses, some mothers were very comfortable with the kind of treatment and relationship that existed between themselves and the nurses. Here are some testimonies shared by mothers:

> *Some of the nurses are good while others are not. Today, I met this young man at the facility who assisted me to*

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> *change my babies pampers and went ahead to discard the used one (*34 year old; Artisan at Kambali*)*

One of the PNC mothers added that:

> *The way nurses attend to us here is remarkable especially when a woman is in labour. Once we call the nurse and by the time we reach the facility here, arrangements are made. What is more than this my brother? I really think if such attitude and behaviour continue to exist, deaths of all kinds within this our communities will end* (31 year old; Trader from Charia).

To reaffirm this, a mother from Charigu had this to share:

> *Our doctors here are good, they take good care of us, and they don't worry us. If you are expected to bring some items during the delivery, they normally inform us before the delivery period. They don't insult us, they take care of us as we expect. For me, when I delivered, they gave me tea to drink and another time, they gave me key soap for the washing of clothes (*34 years old; Farmer, from Charingu*)*

Another mother also added

> *The nurses are taking good care of us, when you go to the facility, they will first ask you what is wrong with you and depending on the situation, they prescribe drugs for you to go home and take. They normally advise us to come back to the facility when we are not feeling Ok after taking the drugs* (35 year old; Farmer from Charia).

Satisfaction to service delivery

Service satisfaction is the sole interest of every customer in accessing services of any kind. Thus, patients are of the view that, the hospital should

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provide service based on the patient's charter, where the needs of the patients are catered for in healthcare delivery. They further note that service provision should be satisfactory to patients. However, it was revealed that patients were satisfied with the services that staff provided at the O.P.D. Also, a significant proportion of the mothers believe that, satisfactory delivery service which they view as quality should have some level of trust, confidentiality and privacy in the service and the degree to which the risks of injury, infections or other harmful side effects are minimized.

Physical appearance of facility

The setting of health facility partly determines quality and users satisfaction. This can create a sustainable competitive niche for the healthcare facilities. A key informant from Busa posited that a clean, safe and pleasing environment can significantly improve the patient's mood, satisfaction and perceived quality of the healthcare experience. In the fFocus group discussion at Buli, participants explained their understanding of quality as the physical appearance of the facility and the level of cleanliness, comfort and amenities offered to them during delivery. While a proportion of the mothers lamented about cleanliness of the facilities and hospitals, some others refuted such claims. These are some claims made by mothers:

> *...The environment at our facility here is always clean and neat. Our doctors here take their time to clean the floor and used some liquid to sprinkles the floor which gives it good smell. I have witness that twice at the facility. With this, I*

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> *think am free from contaminations when seeking QMHC (35 years old; Public Servant,* Wa Urban Health Centre*).*

Similarly, a mother from Kperisi also expressed that

> *...My brother, are you a health worker? If yes, please help us communicate to the management of the regional hospital. The environment at the hospital is not conductive for delivery. The floor is sandy and there are blood all over which we believe is from previous deliveries. hmmmmmm, what more can we see ... (Respondent 4, FGD* from Kperisi*).*

Discrimination in Service Delivery

Another dimension of providers' attitude that caused displeasure among service users is preferential treatment. The informants lamented the issue of "*whom you know.*" While some mothers have to join the queue, others show up and get immediate preferential treatment. The informants were assertive that they have never come across situations in which card bearing members of the NHIS are discriminated against.

Appraisal of Quality of Maternal Healthcare

Appraisal of quality of maternal healthcare in the Wa Municipality was one of the core objectives of the study. Thematic areas that emerged in appraising the quality of maternal health services were logistics and equipment, referral service, empathic service delivery by providers, inadequate care providers, affordability of service, satisfaction with service received as well as experience and service delivery. .

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Logistics and Equipment

Most of the participants considered health care related logistics and equipment in the hospitals they visited as being inadequate, especially beddings. They noted that deliveries are stuck due to limited number of beds. Some women have to wait for the care providers to attend to one before the next person could have access to a bed. These are some assertions made by mothers

> *We don't have enough beds here. We have just two beds; one for other sick people and the other for delivery of women. A week ago, a woman came around to the health center and ended up giving birth in the washroom. One woman was also referred back to her room at home to go and wait where she ended up giving birth without the supervision of the health workers* (28 years old; Trader from Busa).

> *The rooms are not spacious enough. The day I went to deliver, four of us gave birth that day. We were sitting down waiting for one to finish before the other because the bed is only one. When one delivers then they start to supervise the next person* (30 years old; Unemployed from Sombo).

Referral Service

Due to limited resources at most health facilities rendering maternal services, referral to higher facilities with the required expertise and resources is a common phenomenon in maternal healthcare delivery. As such, some key informants and mothers shared their thoughts and experiences by way of

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appraising the ongoing referral services they experience in their communities. In a focus group discussion, discussant indicated that

> *Usually when we are referred to the Wa Municipal hospital from the Kpongu clinic, the midwives sometimes tell us that the babies are not positioned well so we need to go to the bigger facility. However, from our experiences there was really not much difference in the experience between the Clinic here and there* (Respondent 1, FGD at Kpongu).

Other women described the entire referral process as being a problem due to the transportation arrangement, poor roads and the financial commitment involved. The women expressed themselves as follows:

> *The major difficulty we encounter is the referral, when we are given referral to Wa it becomes difficult for us to get there. We have to hire a car. I was pregnant and water was running out of my genital, I thought I was due to give birth, so I went to the health center. They examined me and realized that the child was not closer, yet the water was flowing, so they had to refer me to the Regional Hospital* (33 years old; Farmer from Boli).

> *I could also die in the process of going to the Regional Hospital to deliver because the road from Charia connecting Wa is rough and full of pot holes .....the kind of balancing this Motor King ridder had to take me through could have killed me ... hmmmmmm but do I really have a choice?* (34 years; Public Servant from Wa Urban Health Centre).

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Empathic Service Delivery

The research participants appraised how diligent and empathic some healthcare providers are toward the services they deliver to them anytime they access care at the facility. It was realized that, a number of the participants were touched by the diligence and empathy healthcare providers attached to the maternal health services they rendered to them. These are some of the thoughts shared by the participants:

> *The nurses are reliable, anytime you call her she comes around to attend to you. They don't sleep here but they are responsive. For the midwife when she even close and goes home and you call her to come and perform deliveries she comes back* (30 years old; Unemployed from Kpongu).

> *The midwives are very timely to call because when a nurse is responsible to deliver you, she sits by you throughout especially at night to constantly check and take care of you. Even when the nurses go to sit at their table and you call them they are quick to come to your aid* (Respondent 1, FGD at Kpongu).

Still on this, one woman commented "*the nurses are very empathetic to clients because they do not shout or treat clients badly. They try to share your pain with you, they are patience with you in the pain you go through till you deliver"* (29 years old; Trader from Sombo).

In spite of these, some of the participants had a contrary perspective to the diligence and empathic conduct of the care providers, particularly the nurses. On this, some women expressed their views as:

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> *Not all of the nurses are reliable and responsive to client because when I went to deliver, I had a cut and when one of the young nurses who conducted the delivery saw that the cut was beyond her, she when out to call one of the elderly nurses who was sitting at the table (a senior nurse) to come and assist her, all she replied was "she is not ready to stitch anything today". I had to lay down and wait for her before she came at her own convenient time to stitch (Respondent 2, FGD at Dondoli).*

> *The nurses are very empathetic but there are times that the attitudes of "we" the women in labour forces the nurses to shout at you to enable you to be serious to push. Because when at a point during labour the woman tries to complicate things that could lead to death of the baby, they lose the empathy and discipline you (Respondent 6, FGD at Kpongu).*

One of the mothers also commented:

> *At the Regional Hospital, nurses harass people. I saw women who were being harassed when we went first. Some of my colleagues who got pregnant whilst in school, they were insulting them and even refused to use the Dettol they bought and brought to the health facility. They told them that the Dettol was very old*. (32 old years; Farmer from Kpongu).

Inadequate Care Providers

One other essential indicator used by the research participants in appraising quality of maternal healthcare they received was adequacy of care providers. It was noted from the conversations with the participants that some of

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the health facilities have limited staff which sometimes compromises the quality of the services they received as mothers described in the following words:

> *The personnel are not really much they are about five (5) but they are doing well, they try all their best to take care of us…there is only one midwife here and she does deliveries with the help of a Community Health Nurse here.* (33 years old; Public Servant from Charia).

Meanwhile, one participant had a contrary view and commented as follows: "…*and there are always a good number of nurses and midwives in the ward to take care of us".* (Respondent 1 FGD at Kpongu). Additionally, a mother similarly noted that there are adequate healthcare providers to cater for maternal health services:

> *There are enough personnel here and also the tools and equipment for delivery are enough and functioning well. There are two (2) midwives here who conduct delivery and they are very reliable and responsive to clients because immediately you get here, they come to you and begin to interact with you till you deliver*. (29 years old; Trader from Sombo)

Affordability of Service

Affordability of health service is another critical issue as far as quality of maternal healthcare is concerned. Quite a number of the participants claimed that the care they received from the care providers was affordable:

> *Yes, it is affordable to me because I paid Ghc 6. I was even lucky because most of the things I could not buy and the*

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> *nurses told me to pay for and later dashed to me. I did not pay before I was discharged* (Respondent 4, FGD at Dondoli).
>
> *We only pay Ghc 2.00 for light bill anytime we deliver at the facility. Everyone needs good and quality health care services after delivery. So if someone asks me to choose a health center for delivery, I will recommend this CHIPS compound to the person* (31 years old; Artisan, Sombo).

Another key informant also noted that the maternal care services offered to the women was affordable in his opinion due to the National Health Insurance "*It is very affordable because health insurance covers all. The only difference is the few things that you buy"*. (29 years old; Public Servant from Charia),

Satisfaction with Services Received

As to whether the service users were satisfied with the various services received from the care providers, it was realized that whilst some were satisfied with the service, others were not. Some of the reasons advanced for satisfaction with services received from care providers were as follows:

> *Yes am very satisfied with the overall maternal healthcare services received here because the nurses care and are very patient with clients and also do their best to help you deliver safely and take your child in good health. The processes involved when I went to deliver were that they took my card and maternity book, checked my BP and items I brought (Dettol, parazone, rags and others). I was given a drip and asked to walk around until I felt like going to toilet and when the nurses checked me at that time they said I*

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> *was due, I was then delivered, the placenta was also taken out and they clean me and my baby* (30 years old; Public Servant from Kperisi).

> *I am very satisfied with the maternal healthcare services in the facility. When you are due delivery, they ask you to bring Dettol parasol, soap, rubber and pads. During the delivery, they normally ask you to lie on the bed and they will put hand gloves in their hands and insert their fingers into your vagina to find out whether the child is closer or not. When you cannot push by yourself, they normally provide a machine to help you push out the child.* (30 years old; Farmer, Charigu).

> *Well to me am very satisfied with the conduct of nurses I met when I went to the facility to delivery. But because there are always changing am not sure if all of them are good but those "dea" I met when I went to deliver were very good. Right from the receiving point to me delivering, there were good. They really assisted me left right (*29 years old; Trader from Dondoli)

However, some indicated that they were not satisfied with the maternal healthcare services rendered by the healthcare providers. Some of their complaints included the following:

> *No, for me am not satisfied with the overall maternal services of the Regional Hospital because they delay and waste our time a lot during the health talk when we are pregnant and go for the monthly checkups and even send our babies to weighing. So I think they should always try to summarize whatever they want to talk about because am a teacher in one of the villages and anytime I have to seek*

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> *permission from the headmaster and they end up delaying me all times which gets the headmaster mad at me*. (Respondent 4, FGD from Dondoli).

> *Am not very satisfied with the delivery process. A case where you go the hospital to deliver and these "small small", will sit and expect you who is in labour to spread the cloth and rubbers and be waiting for the baby to come. All they do is sit with their phone kiki! kiri! kiri... while you are suffering…. sometimes when they prescribe a drug for you to buy, they will ask you who is in labour to get to the pharmacy to get the drugs especially if you don't have a guardian* (31 years old; Farmer from Wa Urban Health Centre).

Experience and service delivery

Quality of maternal healthcare was also appraised in light of one's experience. To a greater extent, they were of the view that the more experienced providers offered high quality services than the novices in the service. This was summarized by one participant who further proposed that the experienced nurses ought to educate the younger ones;

> *I also think the experienced nurses should educate the younger ones because the last time I went for one of the monthly checkups, one of the young nurses wrote that I should go and take a scan and that was around my seventh month on pregnancy but when I got to the table one of the elderly and experienced nurses told me that scan is only done during the ninth month so I had to go and come back for them to rewrite the scan for the ninth month. So I think the young nurses are not very experienced because they*

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> *calculate wrongly for clients which am not very happy about* (Respondent 5, FGD at Dondoli).

Challenges service users face in seeking quality MHC

This section presents the major challenges encountered by women in seeking quality maternal healthcare services in the Wa Municipality. The challenges observed varied from one CHPS compound to another and between CHPS within the Wa Township and those at the outskirt of the Wa Township. Overall, the observed challenges ranged from insufficient beds, lack of access to screening and lab services, and to limited number of midwives.

Insufficient beds

Access to a bed is fundamental to quality maternal healthcare particularly for women seeking delivery services. Access to bed constituted one of the major barriers to quality maternal healthcare in all the studied CHPS compounds. This challenge does not only limit women access to full-time attention from the midwives conducting the deliveries but also delay delivery particularly when two or more expectant mothers report to the facility at the same time. In *Sombo, Dondonli* and *Kperisi,* expectants are referred to the Regional Hospital as an alternative when two or more expectant mothers report to the facility at the same time. In *Kpongu, Charia* and the *Regional Hospital,* for instance, women with envisage complication lie on the bed whilst the other is allowed to lie on cloths on the floor to go through delivery. In *Busa* and *Charigu, mothers have this to share:*

> *My brother, we as mothers in this community are running out of patience, why because, management are not making any effort to make life better for us. This facility is*

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> *seriously challenged with delivery beds. Sometime kuraaa if two mothers happen to come to the facility with labour case, the midwife have to pack her documents , table and seat at one corner of the room so that there can use the space to detain a mother for delivery. (Respondent 3, FGD from Busa)*

In the IDI, one of the mothers added that:

> *...you can enter there and see for yourself, the examination bed and the same as the bed they use to delivery women. These beds are not enough so when they delivery you a woman, the child and the mother have to lie on the floor for other mothers to be cared for…* **(**27 years old**,** Artisan from Charia***)***

Accessing screening and lab services

The lack of screening equipment was another challenge bemoaned by the respondents. The challenge cuts across all health centers but difficulties/ challenges vary from community to community. In the case of *Bulli,* a sub-district under *Bamahu*, discussants lamented over the times they spend to access screening services. In many instances pregnant women have to travel to the Wa hospital for screening services. In *Charigu*, women shared their experiences of travelling longer distances to access screening services. The situation is more compounded when patients have to hire a vehicle or motor king or "Mahama Can do" to the Wa Municipality. In such instances, some pregnant women end up abandoning the test prescribed by their health care providers at their respective communities. Participants revealed this as follows;

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> *Sometimes we come very early in the morning, hoping to have early care but the nurses take a long time to set up the OPD section and taking of history too. More so, they bring their relatives and friends out of the queues and serve them first, keeping us here for a very long time, it is too bad (36 year old; Public Servant from Charingu).*

Patients at the outskirts of the township also shared their challenges as follows;

> *We normally have to travel all the way to the Wa Township to do lap test or through Piisie to Bamahu. It is not really easy, our husbands are not always able to give us money to take car to the health facility. Even when he manages to get you the money another thing is what to eat and where to sleep whilst waiting for the results. It sometimes take us days to get the result and to return to the health facility for further diagnosis. (Respondent 3, FGD from Charingu, Busa, Kperisi and Kpongo).*

As indicated above, challenges of screening and lab services was observed to vary between CHPS compounds closer to the Wa hospital and those at outskirts of the township. Whilst patients within the Wa township expressed challenges with longer queues and delay in getting their laboratory results, the challenges of patients at the outskirts are much compounded; they are challenged financially to access means of transport for laboratory screening, longer queues as they travel all the way from their communities, and further delays in accessing the screening results even when the screening is conducted.

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Inadequate Midwives

Participants expressed satisfaction with the number of nurses at the various CHPS compounds but less satisfaction with the expertise of the nurses. In the studied CHPS compounds, one out of four nurses is a midwife including the one in-charge. This does not only place pressure on the midwife, but also denies clients the opportunity to have a full time care during delivery. This is particularly common when two or more women visit the facility for deliveries. In such instances, deliveries with complications get more attention from the midwife than the latter with less or no complications. This challenge has however compelled midwives to frequently give referral when they envisage that the pregnant woman is a para-zero mother.

Despitev the limited number of nurses at the various CHPS compound, the discussants indicated that they are less reliable towards the provision of quality health care services. This is because health personnel providing services during the week days neglect weekends. A participant shared her frustrations as follows;

> *…….Actually when we went to the facility that faithful Saturday, the facility was locked. My mother-in-law and I had to rash to the hospital (Wa Regional hospital). If we relented at the point and decided to go home and been attended by a TBA, I would have lost my son because what they brought out of my sons toe after I gave birth was not something small, I was just imagining how all these things would have happened delivering after the nurses at the facility failed us* (29 years old; Farmer from Charia).

In *Charigu* for instance, the limited number of female midwives has given room for male midwives to provide services to delivering mothers. Though this

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has filled the vacuum of the female-midwife, the discussants expressed less satisfaction with male midwifery asserting that it breeds shyness and it is against their cultural beliefs. This has in many cases resulted in some expectant mothers delivering at homes while others travelled to the Wa Township to access delivery services. A 28 year old female-discussant expressed in the course of the focus group discussion as follows;

> *...We fill shy of the mid-husband who assist us in the deliveries here, we would have been very comfortable if he was a female. Because of that, we are not always comfortable anytime we are due delivery, as it is also against our culture for a male to see our nakedness besides our husbands. It was really tough when I want first to deliver my first born, my husband and I could not imagine being assisted to be delivered by a mid-husband. It was when my husband realized that I was in severe pain that he gave up for the mid-husband to conduct the delivery (Respondent 3; FGD from Charigu)*

However, this observation varied from one woman to another and community alike. For some group of women, male midwives are in better positions to handle pregnant women better than the midwives during delivery. This observation varies from community to community. Whilst women in *Charigu* expressed displeasure with male midwives conducting deliveries, women in *Kperisi* expressed their contentment with their services. A 30 year old woman expressed her satisfaction with male midwive services as follows;

> *I witnessed a situation at the regional hospital where a pregnant woman said she does not want to be assisted by a*

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> *mid-husband to deliver, so they didn't say anything but just ignored and attended to me. For me the males are even better than the females' midwives, they are able to handle pregnant women better than that of the females during deliveries. I actually enjoyed the way the mid-husband spoke with me and handled me in the process of the delivery. I also enjoyed how he massaged me till the baby came out (Respondent 4, FGD from Kperisi).*

These two experiences are disjointed and could be shaped by the life experiences of the women, their level of cultural accordance, length of marriage and perception about health care.

Discussion

Issues of maternal health have been a topical national concern whilst the provision of quality maternal healthcare has often proven to be critical in reducing the high global maternal mortality rates. The discussion is presented under the following themes: Mothers' perceptions of quality maternal healthcare, appraisal of quality of maternal healthcare and challenges facing service users in seeking quality MHC.

Mothers' perception of Quality Maternal Healthcare

Diverse meanings were offered about the meaning of quality maternal healthcare among the women who participated in the study. In spite of the varied thoughts expressed by the participants, five key issues that emerged as indicators of quality maternal healthcare were timeliness, interpersonal care by service providers, desired outcome of service delivery, accommodating setting or the appearance of the physical facility as well as service discrimination. These

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findings stress that health care providers must be fair in addition to maintaining a good interpersonal relationship with care receivers all throughout the discharge of their duties.

On timeliness, the respondents indicated that getting a healthcare provider to attend to you in a timely manner is a key indicator of quality maternal healthcare. Timely maternal care is of essence because in the absence of a midwife/physician or delay on the part of the care provider during delivery can lead to the death of both the mother and the unborn child (Godlonton & Okeke, 2016). As such, it is possible that some of the respondents have ever witnessed or heard of the implications of delay in service delivery on the life of a woman seeking maternal healthcare. Conceptualisation of timely service as key indicator for quality healthcare by the respondents is consistent with Schuster et al (1998: 518) view about what constitutes quality healthcare. He similarly acknowledged that service can be adjudged to be quality if it is rendered in a timely manner. That is, getting timely service at the health facility can offset the third delay purported by the Three Delays Model (Thaddeus & Maine, 1994) and thereby enhance maternal and child health. The same findings reconfirmed the conceptual framework on manner of care of which timely is one of the variables. However, in the view of Ovretveit (1992), timeliness of service is not an indicator for determining quality healthcare.

Interpersonal care by service providers was noted as a major indicator of quality maternal healthcare. Receiving good interpersonal care from one's care provider can be a source of psychological relief and have the potency of calming

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down anxieties and igniting hope that one can receive the best of services. The essence of good interpersonal care in healthcare delivery is a core dimension of quality healthcare as stressed by Parasuramian et al, (1985). In the same vein, Abdallah (2014) noted that establishing and maintaining good interpersonal care is key in the conceptualisation of quality healthcare.

The respondents noted that attaining the desired outcome of service delivery is an indicator for determining quality healthcare. They stressed on attaining satisfactory service from their care providers. As women visit the health facility for healthcare, their ultimate desire is to attain comprehensive healthcare for themselves and their children. Outcome as an indicator is echoed by the Donabedian (1985) framework for accessing quality care that attainment of satisfactory service marked by desired outcome is core as far as quality healthcare is concerned. As posited by Giddens (1984), healthcare as a structure can be termed as effective if women seeking maternal healthcare achieve the outcome or objective for which they sought the service.

A comfortable environment or the appearance of the physical facility as noted by the women is a critical element in all human settings. This is because the atmosphere of a health facility alone ought to bring about encouragement and should be able to convince the woman that she will not return with the problem she came to the facility with; be it related to prenatal, delivery or postnatal health care.

Service discrimination as noted by the respondents as a key indicator is of extreme essence in all human settings. Fairness on the part of care providers can

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build trust and bring about psychological relief on the part of women seeking maternal healthcare. This finding is consistent with the conclusion drawn by Abdallah (2014) upon investing how vulnerable lower income patients make health care decisions and conceptualise quality care. Abdallah (2014) highlighted that fairness in service delivery cannot be relegated to the background in the conceptualisation of quality healthcare.

Creating a suitable environment for maternal healthcare is essential because in spite of the fact that motherhood is usually a positive and fulfilling experience, for many women it is associated with suffering, ill-health and even death (Liljestrand & Pathmanathan, 2004). As noted by Alden, Lowdermilk, Cashion and Perry (2013), maternal healthcare is to encompass the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to ensure a positive and fulfilling experience and reduce maternal morbidity and mortality in other cases.

This presupposes that every maternal healthcare must aim at ensuring a more positive and fulfilling experience which will finally lead to reduction in maternal morbidity and mortality. In consonance with the findings of the study, Ovretveit (1992), expressed quality healthcare as care that addresses what the clients want from the service. This implies that, the discourse on quality is incomplete without comparing the practice against the expectation of the care receivers. Ovretveit (1992), similarly holds the view that quality health service/system is to offer empathetic care that gives patients what they want and need at the lowest cost. Schuster et al. (1998: 518) also added that good healthcare

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quality means "providing patients with appropriate services in a technically competent manner, with good communication, shared decision making and cultural sensitivity". Whereas Mosadeghrad (2012) study conceptualised quality healthcare as: "Providing the right healthcare services in a right way in the right place at the right time by the right provider to the right individual for the right price to get the right results". On the contrary to the position of Ovretveit, (1992), the element of cost was not a determiner in the view of the research participants of the current study in their conceptualization of quality healthcare. This could imply that the women who participated in the current study obtained maternal services free of charge or at relatively lower price as compared to the research participants Ovretveit interacted with.

Appraisal of Quality of Maternal Healthcare

The research participants appraised the quality of maternal healthcare obtained from the various locations they obtained maternal healthcare from. Upon their appraisal, the issues that they are not pleased with and therefore expect improvement included limited logistics and equipment. Limited logistics and equipment can compromise the quality of service in diverse ways considering the fact that the number of women who might be in need of any of the maternal services at any given time cannot be estimated.

As such, when women present a condition necessitating a particular logistic or equipment, those who report later are more likely to suffer and the implications of such situations are obvious. The limited equipment and logistics therefore stands a greater likelihood of causing a third delay, that is, delay in

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receiving health care even after reaching the facility as acknowledged by the Three Delays Model of Thaddeus and Maine (1994). It also defines the capacity of the facility as identified by the WHO (2006b) framework for measuring quality of healthcare as one of the cardinal domains for measuring quality of healthcare.

The issue of limited logistics and equipment is not only an issue in Ghana but in other places such as Nepal where Karkee, Lee and Pokhare (2014) noted that women viewed public hospitals as low rated with regard to adequacy of rooms, water, environmental cleanliness, privacy and access to information (Karkee, Lee & Pokhare, 2014). Also, in Tanzania, Kruk, Paczkowski, Mbaruku, Pinho and Galea (2009) realized that women's thoughts about quality bothered on health system factors, such as politeness of providers' attitude, proficiency as well as availability of drugs and medical supplies thereby leading to positive perceptions of services received by users. Unlike the findings of Nordin and Eklund (2016), the issue of power imbalance between care providers and care receivers was not a concern among the participants of the current study.

When women access maternal healthcare from a particular facility and consistently experience shortage in the logistics and equipment required, they could develop a perception toward the facility as highlighted by the Social Theory of Perception (Ichheiser, 1966). The theory explains the possible perceptions to be developed when people are satisfied with a service. For instance, as a greater proportion of the participants of the current study indicated that most care providers were empathic and diligent in discharging their duties, positive perceptions are likely to be developed. With this, the Social Theory of Perception

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argues that an expectant mother's first impression to how a provider delivers service at the facility tends to influence her perception to service utilization. This happens by either drawing service users unto the facility or forcing mothers to withdraw from the facility (Ichheiser, 1966).

The research participants noted that experience of care providers reflected in their service delivery to the extent that one of the participants claimed that the more experienced staff should educate the newly recruits. Indeed experience is essential in any field of work and considering the fact that maternal health needs are mostly related to issues of life and death, there is the need for more experienced staff to tackle more critical issues which have the potency of leading to the death of either the woman or her child.

In line with this, Donabedian (1985) conceived that "process measures" explain whether a patient received what is known to be good care. However, if the inexperience of some care providers are too obvious such that care receivers can identify, it might affect the care receivers' interpretation of whether the service they received was good or not. The functionality of the inexperienced staff can be said to be below the expectation of the care receivers which represents an imbalance in the view of the Functionalist Theory (Merton, 1968; Parsons, 1951; Parsons, 1937). This is because, healthcare providers are expected to render their services to meet the standard of care of a service user before a system can be considered as balanced. Again, in the conceptualization of Merton (1968); Parsons (1951) and Parsons (1937), each social institution contributes important functions in order for society to thrive. As such, in this context all healthcare

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providers offering services should have the required experience and skills to deliver services to the expectation of the care receivers.

Challenges facing service users in seeking quality MHC

It is worthy of note that some challenges were enumerated by the research participants. These challenges were insufficient beds, difficulty in accessing screening and lab services due to lack of screening equipment as well as limited midwives and nurses. The insufficient beds and lack of screening equipment might be as a result of limited or no resource devoted to capital investment expenditure of the health facilities. This finding feeds into the structure domain of the underlying conceptual framework by Donabedian (1985). With the structure domain, Donabedian (1985) espoused that multiple issues including personnel are key factors in accessing how quality a health service is.

Contrary to the observation made in the present study, Kyei-Nimakoh, Carolan-Olah and McCann (2017) realized that maternal healthcare access, specifically obstetric care access, is hindered by a number of significant demand and supply-side barriers namely: limited household resources/income, non-availability of means of transportation, indirect transport costs, lack of information on health care services/providers, issues related to stigma and women's self-esteem/assertiveness, lack of birth preparation, cultural beliefs/practices and ignorance about required obstetric health services. These issues noted by Kyei-Nimakoh, Carolan-Olah and McCann (2017) were not key issues as far as this study is concerned.

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The women complained that some facilities were not providing services on weekends and as such recommended that the providers ought to extend their services to the weekends. The absence of service on weekends can have enormous adverse implications on the holistic wellbeing of women because one cannot predict when exactly delivery will occur as well as other maternal health related issues that will necessitate the attention of care providers. Such occurrence in the view of Donabedians (1985) mitigates the efficacy structure component of the Framework for Assessing the Quality of Medical Care as it relates with the geographical accessibility of healthcare. This can be linked to the processes for monitoring and promoting quality, incentives for high quality care among others which influence how well care is delivered (Donabedians, 1985). This is because care providers are more probable to be at work on weekends if weekends are added to their working days and they are monitored closely by the leadership.

As noted by the WHO (2006b), framework for measuring quality of healthcare, information flow is essential if the quality of healthcare can be improved. This is because healthcare receivers are not likely to complain if they are well informed that services are not provided during weekends. When it is communicated to them, they will not spend their time to go to such places during weekends which will save them time and reduce the delay in reaching a suitable health facility as noted by the three delays model (Thaddeus & Maine, 1994). Similarly, the WHO (2006b) framework acknowledges that information is fundamental to improvement of maternal and neonatal care services. This is because any quality improvement measures which is geared towards improving

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service delivery, especially maternal healthcare, seriously depends on the capacity to measure change in processes and outcomes which is also much reliant on flow of information between care providers and receivers.

Chapter Summary

In conclusion, this chapter presented the findings obtained from the research participants, discussed the findings in relation to both theoretical and empirical literature and what academics have already found and reported as far as quality of maternal healthcare services.

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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter presents the summary, conclusions and recommendations of the study. It first summarizes the entire work and then presents the key findings of the study. The chapter also captures conclusions and recommendations of the study.

Summary

The study investigated quality of maternal healthcare in the Wa Municipality. Specifically, the study explored service users' perceptions about what constitutes quality maternal healthcare, appraised quality of maternal healthcare in the Wa Municipality from the viewpoint of service users and lastly examined the challenges that service users face in seeking quality maternal healthcare during delivery. The study was qualitative guided by the Donabedian, (1985) perspective for measuring quality of maternal healthcare services.

The Municipality has six sub-districts. Out of the six sub-districts, 14 health facilities with midwives conducting deliveries were purposively selected for the study. FGD comprising six to eight mothers in a group was conducted in each sub-district. Twenty-six in-depth interviews with service users/mothers were conducted at the health centres. In all, there were 26 IDIs and Six FGDs in the six sub districts.

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Summary of Main Findings

Findings from the study revealed that most of the respondents had some knowledge about quality delivery and could meaningfully express their understanding. Mothers revealed varied meanings to the concept of quality of maternal healthcare. These meanings however reinforce the subjective nature of the concept of quality as contained in the literature.

Secondly, an appreciable number of the respondents had some knowledge of what constitutes quality of care and could meaningfully express their understanding. The study has also highlighted five unique but interrelated dimensions emerging from the transcripts. These are timeliness, interpersonal care from service providers (compassion and support, being polite and respectful), satisfactory service delivery, physical appearance of the health facility and discrimination in service delivery.

Based on respondents' conceptualization of quality healthcare, the study proposed a definition of quality maternal healthcare as "any timely service rendered to an expectant mother driven by strong interpersonal care from a service provider through compassion and support, politeness and respect which yields a satisfactory delivery in a safe environment."

However, in analysing service users' perception of quality service within the Wa Municipality, it was realized that quality of maternal health services is conceptualized within the scope of logistics and equipment, referral service, diligent and empathic service delivery by providers, inadequate care providers, affordability of service, satisfaction with service received as well as experience in

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service delivery. Respondents indicated that addressing the differences could better place these hospitals in the position of providing services that are patient-centered.

It was also observed that challenges associated with seeking maternal healthcare ranged from insufficient beds, lack of access to screening and laboratory services, and inadequate number of midwives most especially weekends amongst others. These were revealed by the respondents as hindrances to the attainment of quality healthcare within the Municipality.

Conclusions

Based on the key findings, a number of conclusions were made.

Mothers revealed that logistics and equipment inefficiency were some of the parameters they based their assessment on. A key indicator that came up in their assessment of quality maternal healthcare services was referral service. Diligent and empathic service delivery by providers, inadequate care providers, affordability of service, satisfaction with service received as well as experience and service delivery were the revelation that they unearthed as bases for evaluating quality of maternal healthcare.

It is worthy of note that respondents' perceptions about their satisfaction of services they received from the care providers were mixed. A number of these women were satisfied with services they received from the care providers especially those CHPS zones found within the rural settings as compared to CHPS zones found within urban setting including the regional hospital where most of their referral cases are directed to. These satisfactions erred manifested in warm

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reception and empathy that some care providers exhibited towards them. On the contrary, some of them lamented that they were dissatisfied with services received due to some attitude of care providers which manifested in some young nurses sitting idle without attending to them while in labour among other behaviours.

The study further concludes that mothers encounter some challenges in seeking quality maternal healthcare in the Wa Municipality. Key among the challenges mentioned was insufficient bed to host mother during labour for delivery. This canker usually results in the situation whereby mothers lie on the floor immediately after delivery in order for other pregnant women to be placed on beds to be delivered of their babies. Lack of access to screening and lab services count among the challenges mothers face in seeking quality maternal healthcare services. Also, limited numbers of midwives on weekends amongst others were revealed by the respondents as hindrance obstructing their attainment of quality healthcare within the Municipality.

Recommendations

Based on the major findings and conclusions, the following recommendations are made;

1. Owing to the negative attitude of some of the health care providers, the Wa Regional and Municipal Health Directorate as well as Nursing and Midwifery Council (NMC) should intensify refresher courses targeting new nurses to shape their communication and interpersonal skills.
2. The Wa Regional Health Directorate should assign at least two midwives to Community-based Health Planning and Services (CHPS) compounds to

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ensure midwives and other healthcare providers are available at the facility on weekends.

3. In order to bridge challenges as associated with referrals, especially from rural to urban areas, the government through the ministry of road and housing as well as Ghana Highways Authority must endeavour to improve roads linking rural communities to health facility in order to avert delays that might be triggered by poor roads.
4. In spite of the limited resources of the Ghana Health Service, some basic resources and equipment such as beds for expectant mothers during delivery must be prioritized in the Wa Municipality as this can contribute significantly towards quality maternal healthcare.
5. Nurses should be advice not to use their cell phone during working hours.

Suggestions for Further Studies

1. This study was limited to only maternal healthcare services during pregnancy and delivery service and as such future studies can consider assessment of maternal healthcare in the context of prenatal and postnatal healthcare.
2. Further studies need to be done on the challenges service providers face in delivering quality maternal healthcare to service users. This is because it is possible that they also have some peculiar challenges.

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APPENDICE

A- Consent Form

COLLEGE OF HUMANITIES AND LEGAL STUDIES

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF POPULATION AND HEALTH

CONSENT FORM FOR STUDY ON THE PERCEPTION OF QUALITY OF MATERNAL HEALTHCARE IN THE WA MUNICIPALITY

General Information about Research

The main objective of the study is to assess the quality of maternal healthcare in the Wa Municipality. Specifically, the study strives to answer the following questions: What is the meaning of quality maternal healthcare from the perspective of service users? What is the assessment of service users about the quality of maternal healthcare they receive? And what challenges do service users face in seeking quality healthcare during delivery?

Upper West Region is rated third among the 10 regions in Ghana with a high prevalence of maternal mortality. These increasing prevalence according to literature suggest that, quality of care rendered to the mothers during and after delivery has been compromised by certain indicators. Therefore, this study would want to assess the quality of maternal healthcare within the Wa Municipality. The study will be guided by the Donabedian, (1985) perspective for measuring service quality. An in-depth interview guide shall be used to gather data for the study. It is expected that each interview section shall last for about 20-40 minutes. Mothers would be expected to answer questions relating to delivery services rendered to

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them during labour. Informed consent would be sought from the participants before they would be included in the study.

Procedures

To find answers to the questions this study seeks to address, we invite you to take part in this research project. If you accept, you will be required to: participate in an interview that would be conducted by Field Assistants. You are being invited to take part in this study because we feel that your experience as a mother before and during delivery can contribute much to this discussion. The type of questions that are likely to be asked touches on aspects such as your understanding quality of healthcare, your assessment of the services you received from the providers and lastly, the challenges faced in seeking quality healthcare during delivery?

If you do not wish to answer any of the questions posed during the interview, you may say so and the interviewer will move on to the next question. The interview will take place at the health facility, and no one else but the interviewer will be present. The interview will be recorded for recall sake. The information recorded is considered confidential, and no third party will be privy is this conversation except with your express consent. The expected duration of the interview is between 30 and 60 minutes.

Possible Risks and Discomforts

There would be no realistic predictable risks or discomforts to the participants.

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Possible Benefits

Findings from this research have the potential to contribute to the formulation of health policies and interventions aimed at improving maternal and neonatal healthcare and consequently reducing the current maternal morbidity and mortality in the country. It is also envisaged that the findings will contribute to the existing knowledge on maternal and child health in Ghana and the world as a whole. Findings from this study will again serve as reference material for students, scholars and researchers who are interested in issues of quality maternal healthcare. Again, **the** findings from this study will point out areas for future research. The study would be of benefit to the Upper West Regional as well as Municipal Health Directorates, Non-Governmental Organisations, Policy Makers and Health Planners for best policy and planning practices.

Confidentiality

The information you give in this interview will be kept safe and used later in the study analysis but you are assured that, we will protect information about you to the best of our ability. The recorded interview, as well as the transcription, would be kept safe with the aid of '*mylockbox app'* to prevent unauthorised people from having access to the data and only the researcher would have access to it. You will not be named in any reports.

Compensation

There is no compensation package either in cash or kind offered for participation.

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Voluntary Participation and Right to Leave the Research

Your participation is solely voluntary and you can choose to exit from participation at any point in time when you feel uncomfortable with the questions being asked without any penalty.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ _____

Date Name and signature or mark of volunteer

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B- In-depth Interview Guide/FGD Guide

UNIVERSITY OF CAPE COAST

COLLEGE OF HUMANITIES AND LEGAL STUDIES

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF POPULATION AND HEALTH

PERCEPTION OF QUALITY OF MATERNAL HEALTHCARE IN THE WA MUNICIPALITY

IN-DEPTH INTERVIEW GUIDE FOR SERVICE USERS

Introduction

The main objective of the study is to assess the quality of maternal healthcare in the Wa Municipality. You are assured that all responses provided would be strictly confidential and used only for academic purposes. Please, your anonymity is guaranteed and your participation in the study is voluntary; however, your decision to participate will be very much appreciated. The discussion will take about 20 minutes of your time. Thank you for agreeing to participate in the study. For further enquiries please contact Mr. Linus Baatiema on +233(0)240468122 or +233(0)209502794.

Time of interview [Begins]..... [Ended].....

Date.....

Number of Visit.....

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Section I: Background characteristics of respondents

- ✓ To begin our discussion, can you please tell me a little about yourself? **Probe** [age, highest level of education, marital status, number of children born and number still alive, main occupation, residence, etc.]

Section II: Service users' perception about what constitutes quality maternal healthcare

At this section, I want you to share your views about what constitutes quality of maternal healthcare

- ✓ In your opinion, what is meant by quality of maternal healthcare? **Probe** [what else do you know about quality of maternal healthcare]

Section III: Appraisal of quality of maternal healthcare provided in the Wa Municipality

Now let's talk about your views concerning maternal healthcare provided in the Wa Municipality.

- ✓ Since you have ever received maternal healthcare service before at the Wa Municipal hospital, what is your general evaluation of the service(s) rendered to you?
- ✓ What can you say about maternal healthcare services received in this health facility? **Probe** [Does the facility have spacious ward; delivery beds; enough personnel; tools or equipment which are used to offer delivery services]. **Probe** [Are the equipment or tools for delivery at the healthcare functional]. **Probe** [Does the facility have midwives; do they conduct deliveries; they reliable and responsive to clients, why/how? Are

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the staff empathetic to clients and why/how; are they timely to duty call and why/how? Do the staff communicate with you during delivery session why/how?]

- ✓ Have you ever been referred to seek delivery service from other healthcare facilities? **Probe** [From which health facility to which facility and reasons for the referral]. **Probe** [Experiences at each of the facilities]
- ✓ Are you satisfied with the overall maternal healthcare received in this facility? **Probe** [What are the processes that you go through when you go to the hospital to deliver; are you comfortable with the processes and why]. **Probe** [Is the delivery service (s) affordable to you and why].**Probe** [Is the delivery service you require/need accessible to you and how]. **Probe** [How will you rate the overall quality of delivery service of this facility; what are the reasons for the rating].

Section IV: Challenges service users face in seeking quality healthcare during delivery

I would want us to discuss challenges mothers encounter when seeking delivery services.

- ✓ What are some of the challenges mothers encounter when seeking maternal healthcare in the Wa Municipality?
- ✓ The last time you visited this facility, what were the main challenges you faced?
- ✓ Can you make any recommendations to improve quality delivery healthcare in this health facility?

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Section VI: **Closing key comments**

- ✓ Before we end our discussion, is there any other thing you would want to add to our discussion or know?

THANK YOU FOR PARTICIPATING IN THIS STUDY.

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C-Ethical Approval

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

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OUR REF: UCC/IRB/A/2016/247
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

30TH APRIL, 2018

Mr. Linus Baatiema
Department of Population and Health
University of Cape Coast

Dear Mr. Baatiema,

ETHICAL CLEARANCE –ID: (UCCIRB/CHLS/2018/05)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol titled ***Quality of Maternal Healthcare in the WA Municipality.*** This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research.

The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

for: Samuel Asiedu Owusu (PhD)
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST
Date: 30/04/2018

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