SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA

MIDWIVES’ PERCEPTION OF QUALITY ANTEMATNAL CARE: A STUDY IN HEALTH FACILITIES IN THE NEW JUABEN MUNICIPAL AREA IN THE EASTERN REGION OF GHANA

BY
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JULY, 2019
DECLARATION

I, Bernice Yaa Ofosu Ntiamoah, hereby declare that this work is my own as a postgraduate student in School of Public Health, University of Ghana. Any literature and works of other researchers used have been duly acknowledged.

……………………………….  ………………………………
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……………………………….  ………………………………
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(Supervisor)
DEDICATION

This work is dedicated to Almighty Yahweh for sustaining and bringing me this far, my wonderful family, my husband Mr Kingsley Ofosu Ntiamoah and my two sons for their unflinching support throughout my study.
ACKNOWLEDGEMENTS

I am highly indebted to Almighty Yahweh for his guidance and protection throughout this research. My heartfelt gratitude also goes to my tireless well able supervisor Dr. Ernest Tei Maya for his time, patience, guidance, support and for the thorough perusal and review of this work. I am incredibly thankful to my husband and mentor Mr Kingsley Ofosu Ntiamoah for the encouragement and sharing nuggets with me as I march on to greatness. I am equally grateful to my friend and brother Charles Afriyie Agyapong who helped and guide me to put this work together, and to everyone who in one way or the other contributed to this work. I really appreciate.
ABSTRACT

Introduction: Maternal death is one of the greatest burdens in the world, especially in developing countries where 99 per cent of maternal deaths occurs. In 2015, Ghana had a maternal mortality ratio of 319 maternal deaths per 100,000 live births. Some maternal deaths and pregnancy complications can be prevented by the utilization of antenatal care (ANC) services (WHO, 2018). Quality antenatal care improves birth outcomes and promotes the utilization of skilled attendance and health actions. Health service providers yearn to provide quality prenatal care, yet some constraints hinder its delivery.

Aim: This study sought to explore midwives’ perspective on quality antenatal care (ANC) and identified perceived barriers and promoters to providing quality antenatal care (ANC) in the New Juaben Municipality.

Methods: An exploratory study using a qualitative approach was used for this study. A purposive sampling method was used in selecting the participants. Data was collected from eleven midwives who practice antenatal care (ANC) service in the New Juaben Municipal area, using an in-depth interview guide that was administered face-to-face. Thematic analysis was used to analyse the data.

Findings: The midwives perceived quality antenatal care to be the holistic and safe care rendered to pregnant women to meet their needs and demands. The perceived barriers to the implementation of quality antenatal care were limited infrastructure, language barrier, low number of antenatal care providers, and uneasy access to antenatal care facility. However, the facilitators of quality antenatal care included easy access to the antenatal care facility, the availability of infrastructure, good midwife-client relationship and good care practices.
Conclusion: This study explored the midwives in the New Juaben Municipal area’s perception on quality antenatal care and barriers in implementing it. It also explored factors that the midwives perceived to facilitate the delivery of quality ANC. Quality ANC was explored to be dependent on the structure of care such as the infrastructures, staff number and characteristics, and geographical access to the antenatal clinic; clinical care process such as ensuring privacy and confidentiality during the care and seeking the client’s concerns in making decisions concerning their health; and interpersonal care processes such as attitude of the midwives to the pregnant women.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>DHIMS</td>
<td>District Health Information Management System</td>
</tr>
<tr>
<td>FANC</td>
<td>Focused Antenatal Care</td>
</tr>
<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IPT</td>
<td>Intermittent preventive treatment</td>
</tr>
<tr>
<td>MPH</td>
<td>Master of Public Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TD</td>
<td>Tetanus-Diphtheria</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>RCH</td>
<td>Reproductive and Child Health Centre</td>
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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Motherhood is often considered to be a pride and a dream come through experience, by women worldwide and the society at large. An estimated 140 million women give birth every year globally (WHO, 2018). However, life-threatening conditions can accompany pregnancies. In the developing countries, maternal mortality tends to be one of the greatest burden, with 99 per cent of all the maternal mortalities occurring in these countries (Paxton & Wardlaw, 2011). An estimate of 303,000 women died from pregnancy-related causes; an estimate of 2.7 million babies died during the first 28 days of life; and 2.6 million of the babies were stillborn (WHO, 2016). Sub-Saharan Africa reported the highest maternal mortality ratio in 2015 (546 maternal mortalities per 100,000 live births). Ghana had a maternal mortality ratio of 319 per 100,000 live births in the year 2015 (The World Bank, UNICEF, UNFPA, & WHO, 2015). Moreover, an estimate of 830 expectant mothers die from preventable complications of pregnancy and labour every day in the world (WHO, 2018).

Maternal mortality ratio dropped worldwide by 2.3 per cent per year between the year 1990 and 2015 (The World Bank et al., 2015). However, this was insufficient to attain the 5.5 per cent annual target to reach the three-quarters reduction in maternal mortality targeted for 2015 in the United Nations Millennium Development Goal 5. On January 1, 2016, the United Nations officially accepted the 17 Sustainable Development Goals of the 2030 agenda for Sustainable Development with the third goal targeting the global reduction of maternal mortality ratio to less than 70 per 100,000 live births (UN, 2016).
Fortunately, most maternal mortalities and pregnancy related complications including stillbirths are preventable. These pregnancy related complications and maternal mortalities can be prevented by accessing antenatal services, skilled birth attendant and supportive care during the postnatal period (WHO, 2018). Antenatal care (ANC) is the care, education or counselling given to expectant mothers (GHS, 2017). It involves essential interventions such as the supply of sulphadoxine pyramethamine to protect the pregnant women from malaria, supply of enough folic acid and iron supplements to prevent neural tube defect and anaemia, timely diagnosis and intervention of pregnancy related complications such as pre-eclampsia and eclampsia, administration of tetanus diphtheria immunization, identification and management of infections like syphilis, chlamydia and hepatitis B (GHS, 2017). Antenatal care can also reduce stillbirths and neonatal deaths through the timely diagnosis and management of pregnancy related complication (Lincetto, Mothebesoane-Anoh, Gomez, & Munjanja, 2006).

Quality Antenatal care improves birth outcomes (Afulani, 2016) and improves the utilization of skilled birth attendance, good practices, including exclusive breastfeeding, early postnatal care, and family planning services (GHS, 2017; Wilunda et al., 2015). Antenatal care enhances health promotion, education and support for the pregnant women at the individual and the community level (Sword et al., 2012). Women who fail to seek antenatal care during pregnancy, mostly deliver small for date babies as compared to those with early and continuous antenatal care (Karamzad et al., 2016). Despite these merits for accessing antenatal care, some pregnant women do not attend antenatal clinic. An estimate of 86 per cent of pregnant women in the world receive at least one antenatal care from a skilled provider, with only 62 per cent completing more than four antenatal visits (UNICEF, 2018). Even though, South Asia and sub-Saharan Africa are regions with high maternal mortality, these regions suffer the least antenatal coverage. Only 52
per cent of women in the sub-Saharan African region received at least four antenatal visits between 2010 and 2016 (UNICEF, 2018). Since 2012, Ghana has been reporting declines in its antenatal coverage. In 2017, 98 per cent of pregnant women in Ghana, had at least one contact with a skilled service provider. However, only 89 per cent of the pregnant women in the country, had four or more antenatal visits (Ghana Statistical Service, Ghana Health Service, & ICF, 2018). In the case of Eastern region, 97 per cent of pregnant women in the region received antenatal care from a skilled service provider in the year 2014 (Ghana Statistical Service, Ghana Health Service, & ICF International, 2015). This coverage was not so different from what was recorded in 2017. In 2017 the region recorded 97 per cent of pregnant women who received antenatal care from skilled service providers. Which is not encouraging (Ghana Statistical Service et al., 2018).

There is a rise in skilled and facility-based delivery as a result of increased education of prenatal families (Filby, McConville, & Portela, 2016). It is worth mentioning that, the improvement in skilled and facility-based deliveries is not merely due to an increase in maternal education and wealth, but rather the quality of care associated with it (Kebalepile, 2001). Quality Antenatal care is said to be among the five global strategies used to accelerate the progress in reproductive health (Cummins, Catling, & Homer, 2018).

The significance of quality antenatal care led to the World Health Organization’s emphasis on structural, procedural and outcome evaluation of health services to improve antenatal health (Walker, Batinelli, Rocca-Ihenacho, & McCourt, 2018). The first global strategy on reproductive health, which is made up of five core features, which includes the provision of quality antenatal health care, was embraced by the 57th World Health Assembly to hasten progress in reproductive health goals (Edwards, Jepson, & McInnes, 2018).
Midwives are at the centre of a country’s initiative to decrease maternal and neonatal mortality (Burrowes, Holcombe, Jara, Carter, & Smith, 2017). According to Leinweber, Creedy, Rowe, & Gamble (2017), midwives or service providers yearn to provide quality care for both antenatal and postnatal mothers, yet some constraints and impediment are a hindrance to the delivery of quality antenatal care. This study, therefore, explores the midwives’ perspective on quality antenatal care, to add up to the understanding of the specific dimensions of antenatal care which can ultimately improve delivery of Quality antenatal (ANC), hence better the health outcomes of the pregnant women and their unborn babies.

1.2 Problem statement

In Ghana, just like other developing countries, the high rate of maternal morbidity and mortality, stillbirth and other pregnancy-related complications remain troubling public health issue. There was a decline in maternal mortality rate in Ghana from the year 2013 to 2015 during the implementation of the MDG Acceleration Framework Programme. However, this decline was unfortunately not sustained. Institutional maternal mortality ratio increased from 142 per 100000 live births in 2015 to 163.5 per 100000 live births in 2016 (GHS, 2017). In 2016, the country recorded a stillbirth rate of 16 per cent (GHS, 2017). Eastern Region, Ghana, had 106 of the total 948 maternal deaths that were recorded in Ghana in 2017. New Juaben alone contributed to about 39 per cent (41 maternal deaths) of the 106 maternal deaths that were recorded in the Eastern Region, Ghana (GHS, 2018). This is alarming and needs immediate attention.

Moreover, it is evident in most literature that those who do not attend antenatal clinics and those with pregnancy complications, contribute to most of the maternal death (Afulani, 2016; Das, 2017; Oyerinde, 2013). Quality ANC delivery highly affects the satisfaction of pregnant women,
hence a major determinant of the utilization of the ANC (Ismail & Essa, 2017). Stillbirths are also reflections of the quality of care given to women during antenatal and delivery. This signifies that when quality antenatal care is delivered to pregnant women, it reduces the rate of maternal morbidity and mortality, stillbirths and other pregnancy complications in the country, hence achieving the SDG 3. Much attention should, therefore, be paid to the quality of antenatal care as it is the major component in delivering optimum health care to the pregnant women from conception to delivery. It links the health outcome with the effectiveness, compliance and continuity of care (Fawole, Okunlola, & Adekunle, 2008).

Poor provision of services by the service providers can lead to maternal mortality (Leinweber et al., 2017; Tuncalp et al., 2015). Midwives are the bedrock for delivering antenatal care in Ghana (Dickson, Darteh, & Kumi-Kyereme, 2017). Quality antenatal care can help in preventing most of these complications, but systemic barriers have hindered such provision. (WHO, 2018). Notwithstanding the significant role of midwifery in quality antenatal care and outcome, facility-based constraints, such as lack or inadequate logistics and infrastructure also hinder the delivery of quality ANC (Calvert, Smythe, & McKenzie-Green, 2017).

Much attention has not been given to the perspective of care providers especially midwives on quality antenatal care (Filby et al., 2016). However, it is evident in several studies that health care workers suggestions help policy makers and planners to identify the root drawbacks in the health system, in other to improve quality of healthcare delivery (Lantis, Green, & Joyce, 2002; Manongi & Merchant, 2006; Songstad, Lindkvist, Moland, Chimhutu, & Blystad, 2012). This study was therefore done to know the midwives’ perception on the barriers and the promoters to the provision quality antenatal care, which will help build up favourable strategies in providing quality antenatal care services.
1.3 Research questions

I. What is the perception of midwives on what quality antenatal care is?
II. What are the midwives’ perceived barriers to providing quality antenatal care?
III. What do midwives perceive to promote the provision of quality antenatal care?

1.4 Objectives of the study

1.4.1 General objectives

To explore the perspectives of midwives on quality antenatal care in Health facilities in the New Juaben Municipal area in the Eastern Region of Ghana.

1.4.2 Specific objectives

I. To explore midwives’ perception of what constitutes quality antenatal care
II. To explore the midwives’ perceived barriers to providing quality antenatal care
III. Explore what midwives’, perceive as factors promoting the provision of quality antenatal care.
1.5 Justification of the study

Mothers and children are very vulnerable and hence maximum attention is needed to be given to them, especially when the mothers are pregnant. Antenatal care is a cost-effective intervention in enhancing maternal health and preventing foetal mortality; hence achieving SDG 3. Seeking midwives’ perception on quality antenatal care in the New Juaben Municipal area is therefore essential in identifying the barriers to the provision of quality antenatal care. This would help obtain the baseline data to inform policy makers and planners in developing optimum strategies in scaling up prenatal care services to achieving SDG 3.

2.6 Conceptual Framework

The Framework used for the current study was adopted from Donabedian’s model on quality health care (1988) to understand midwives’ perception of quality ANC in the New Juaben Municipal area. It is made up of three aspects of care: inputs, processes, and outcome. Donabedian believed that inputs measures have an effect on the process measures, which in turn affect the outcome measures. The three together form the basis of the requirement for an effective group measure.

Inputs refers to the characteristics of facility in which healthcare is delivered and received; the inputs is made up of the physical setting, staff characteristics, and the ability to access antenatal care services. It consists of the qualities of the services provided, such as staff to patient ratio and the operating time of the service provision. It is also known as structure of care.

The Process of care reflects the way the systems and processes work, to deliver the desired outcome. It includes the delivery of services and receiving of care, which is made up of two important modules which are the clinical and the interpersonal care processes. Clinical care
process, apply medical, sciences and technology to attain good healthcare result. Whilst the interpersonal care process explains the social and psychological interactions between healthcare provider and the user of the healthcare system. Examples are: the length of time a client waits for a clinical review, clients receiving the standard of care or not and clients informed of the delays when waiting for an appointment with the service provider. For the purpose of this study, the process is made up of clinical care processes and interpersonal care process. The clinical care process consists of health promotion, illness prevention, screening and assessment, sharing of information, continuity of care, non-medicalization of pregnancy and women-centeredness. The interpersonal care processes consist of respectful attitude, emotional support, approachable interaction style and taking time.

Outcome measures refer to the impact of the care on service receiver, it demonstrates the result of the work done, whether it has achieved the aims. This includes patient satisfaction, reduced mortality, reduced in the length of stay, reduced hospital-acquired infections, improved patient experience etc. Outcome measures are the end results, but are not the components of healthcare and may influence the structure and the processes of care directly or indirectly
Figure 1: Conceptual framework of midwives’ perception of quality antenatal care

(adapted from Donabedian model)
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This section reviews empirical research done to assess the perspective of midwives on quality antenatal care in the New Juaben Municipal area, in the Eastern Region of Ghana. This will focus on the objectives of the study. It provides the general concept of ANC and maternal health, quality of antenatal care and the role of a midwife, healthcare provider’s knowledge on quality ANC, the barriers and promoters of quality ANC.

2.2 Concept of ANC and Maternal health

Quality maternal health care plays a vital role in reducing maternal and neonatal mortality. Globally, maternal mortality reduction has been a priority for more than two decades; one of the aims of goal three (3) of the sustainable development goals is to reduce maternal mortality ratio to less than 70 deaths per 100,000 live births (WHO, 2018). Even though progress has been made to reduce the number of maternal deaths, developing countries continue to bear the larger portion. Every day, an estimate of 830 females die from preventable causes associated with maternity and accouchement in the world of which majority of these deaths occur in the developing countries (99 per cent). In the year 2015, developing countries recorded maternal mortality ratio of 239 deaths per 100000 live births as compared to the developed countries which recorded 12 deaths per 100000 live births (Alkema et al., 2016).

A number of interventions have been put in place to reduce the high incidence of maternal mortality in Ghana. Some of these interventions are the Safe-Motherhood Initiative; which is a National Reproductive Health Service program, delivered through the Primary Health Care. The
main constituent of the Safe-Motherhood Initiative is pre-conception care, antenatal care, supervised delivery, postnatal care, family planning services, prevention and management of unsafe abortions, and health education.

Antenatal care (ANC), also called prenatal care, is a general term used to depict the medical procedures and care that is carried out during pregnancy. It is the care given to a pregnant woman throughout her pregnancy and is important in guaranteeing a healthy pregnancy and safe delivery (GHS 2017). Early and regular antenatal care services rendered by a trained health provider is important to the health of both the pregnant woman and the unborn baby. Furthermore, antenatal care is a form of preventive care with the aim of providing regular check-ups that enable health workers to detect early variants from the norm and complications in the pregnancy or potential medical issues that may emerge in an amid pregnancy and treat (WHO 2005). In the year 2002, the World Health Organization’s focused antenatal care (FANC) was adopted by the Government of Ghana, to address the high maternal mortality rate and to enhance access, quality and coherence antenatal care services to pregnant women (Baffour-Awuah, Mwini-Nyaledzigbor, & Richter, 2015).

Pregnancy is a critical time to promote healthy behaviours, avert stillbirths and maintain a strategic distance from some significant reasons for ailment among infants. Essential services rendered during the pregnancy are provided through antenatal clinics. Some of the services include tetanus-diphtheria (TD) immunization, testing and management of sexually transmitted infection (STIs; malaria prevention by the intake of sulphadoxine pyramethamine by the pregnant women under direct observed therapy, and sharing of treated bed nets to the pregnant women to sleep in; treatment of infections, counselling and educating pregnant women on birth
preparedness and complication readiness; and diagnosing and managing pregnancy related complications, like anaemia, pregnancy induced hypertension and pre-eclampsia (GHS, 2017).

2.3 Quality of ANC and the role of a midwife

Quality antenatal care plays a role in reducing the incidence of maternal and neonatal mortality. Quality care amid ANC in health facilities mirrors the accessible physical infrastructure, management, supply and human resources with the ability and the knowledge to address pregnancy and childbirth. Quality of care is a multi-dimensional concept which is not easy to measure (Tuncalp, 2015). It is generally recognized that it grasps different dimensions, from patient to health system and health policies, and various measurements, including security and in addition proficiency (Duysburgh et al., 2013). World Health Organisation (2006) has provided a six-factor working definition of quality of care and proposes that health systems should try to make enhancements in the six dimensions of quality care. These dimensions focus on efficiency, effectiveness, safety, amenities, technical competence, and continuity of services, interpersonal relationships, and accessibility. Ghana Health Service (2004) defined quality health care as the right overall execution of interventions which are known to be safe and reasonable to the general public being referred to and affect positively on morbidity, incapacity, and mortality. It can also be defined as the extent to which health services meet the expectations of an individual or group and that the expectation of a client is to be satisfied with services rendered and to get well (GHS, 2004).

Quality assessment frameworks underline that quality incorporates the quality of care given and additionally the clients’ understanding of care received and that when assessing the quality of care, contracts between viability of interpersonal care (alluding to patient-centeredness of care)
and adequacy of clinical or specialized care (including specialized care, accessibility of assets and counselling practice) are imperative (Duysburgh et al., 2013).

Quality antenatal care should be timely, effective, safe, woman-centred, and equitable (WHO 2006). It ought to be proof based and conveyed as close as conceivable to the communities where women live or work. It should keep on being free and open to everybody at the point of need. Quality antenatal care from the midwives’ perspective for the purposes of this study is defined as antenatal care that has good interpersonal relationships between provider and patient and promptness of attention in terms of adequate waiting time and time spent by the midwife or doctor with patient, is safe and has health education at the facility (GHS, 2005). The absence of these characteristics indicates that, there is substandard antenatal care.

It is the responsibility of the midwife to provide quality antenatal care. The main goal of quality antenatal care is to obtain a healthy mother and baby. Quality care incorporates midwifery-led care leading to good pregnancy outcome, birth and throughout the postnatal period. Every pregnant woman needs midwifery care at each stage. The midwife empowers and encourage pregnant women to make informed decisions based on their clinical need, qualities and inclinations, based on the facts and the context of care. The midwife has an indispensable part to play not just in guaranteeing the wellbeing of the pregnant women and their unborn babies, however in future health and well-being that of society as a whole. When midwives are educated, trained and licensed by a regulatory body with regular in-service training, it enhances the quality of care, and the incidence of maternal and neonatal mortality is reduced.
2.4 Healthcare provider’s knowledge of quality ANC

The knowledge, attitude and the perception of health care providers plays a crucial role in the care of women in the focused antenatal care model (FANC). Communication plays a vital role in the care of pregnant women in the focused antenatal care (FANC) model; it builds trust between the pregnant women and the service providers which leads to good pregnancy outcomes.

A qualitative study conducted by Baffour-Awuah et al. (2015) to explore the perception of practising midwives on focused antenatal care in Ghana showed that midwives had knowledge in FANC. Focused antenatal care contributes to the improvement of the health of the pregnant women. This cannot be achieved without a multi professional and client centred approach, due to this there should be regular in-service training for midwives and policy formulation, to support effective implementation of FANC.

Another qualitative study conducted on health care providers’ knowledge and practice of focused antenatal care in a rural community hospital in Enugu state in Nigeria also showed that healthcare providers have poor knowledge on the concepts, component and timing of visits in focused antenatal care (FANC) model. The findings also showed a major discrepancy between current ANC practice and the requirement of FANC WHO guidelines (Ojong, Nwonu, & Akpan, 2016).

Ojong, Uga and Chiotu, (2015) in a cross-sectional descriptive study done on the knowledge and attitude of women towards Focused Antenatal Care in South-East Nigeria found out that 42 per cent of the respondents had good knowledge on timing of visit. 52 per cent of respondents identified ignorance as a factor affecting FANC services implementation, and 66 per cent accepted that FANC is not enforced by their care facility as a result of policy concerning the
practice of FANC. Only 6 per cent of the respondents disagree that early detection of diseases is a major component of FANC.

However, none of the literature could provide the in-depth perception of the midwives on what quality antenatal care is. In fact, to date, there has not been any study on the perspective of midwives on quality antenatal care (Filby et al., 2016). This study will therefore try to explore the in-depth perception of the midwives on what constitute quality antenatal care.

2.5 Barriers to and motivators of the provision of quality ANC

Increasing access to quality of care given to pregnant women is generally seen as the key strategy for counteracting maternal deaths. Different barriers impede this access: health systems constraints, economic barriers and cultural barriers, among others (Ha, Chankova, & Sulzbach, 2009).

Literature review on Ghana's healthcare system performance, conveyance in rural setting proposed that the problem with poor maternal healthcare may be connected to generalize problem with the health care system (Turkson, 2009). For example, a recent study by the World Bank on the analysis of the health sector of the Republic of Ghana also established that the country’s health system does not meet the required standard of care: most healthcare facilities, including maternity homes did not have the recommended principles and protocols during emergency obstetric and new-born care (Salah, 2013).

A qualitative study conducted among 28 midwives using focused group discussion in the regional referral hospital in Dar es Salaam, Tanzania, to access their challenges in discharging their duties as midwives revealed that lack of assistance from the hospital management and in appreciation on the part of the clients makes them feel demoralised. Limited human resources
and material resources specifically, was featured to prompt an over the top remaining task at hand bringing about difficulties with giving satisfactory care. These challenges were intensified by lack of equipment, facilities and non-optimal organization of the healthcare system (Bremnes, Wiig, Abeid, & Darj, 2018). Bremnes et al. (2018) also explored the barriers to the provision of midwifery services including antenatal care to be associated with the poor health system (that is limited resources) rather than the clients.

Graner, Mogren, Duong, Krantz and Klingberg-Allvin (2010) in their study also second that poor health system hinders the provision of antenatal care. They stated that structural constraints within the healthcare system including inadequate financing of the primary health care, resulting in a lack of human resources, lack of regular professional in-service training and inadequate equipment possess challenge to the provision of quality antenatal care. However, Graner et al. (2010) believed that the hindrances to the provision to antenatal is not only associated with the health care system but also with the clients. It was reported in their study that women’s use of maternal health care was influenced by economic constraints and cultural norms.

A systematic study conducted by Filby et al. (2016) in Australia on what prevents quality midwifery care in low and middle-income countries from the provider’s perspective highlighted these barriers into social barriers, economic barriers and professional barriers. It was found that the low socio-economic status of the midwife due to low wages, informal payments and lack of government financial commitment, portray midwifery to be an unvalued profession, which thus alludes back to the low social status. The major professional barriers found in the study were; lack of investment in quality midwifery education, weak or absent regulation, inadequate number of staffs, and lack of affordable transport, weak facility management and poor working conditions. Most community midwives are struggling to survive in the rural areas, they are
inadequately trained as maternal care providers, hence also need help for integration into the
district health system (Sarfraz, & Hamid, 2014).

Furthermore, a qualitative study conducted in Ghana on health system barriers to accessibility
and utilization of maternal and new-born healthcare services in Ghana, after the user-fee
abolition revealed unequable delivery of skilled maternity care services, pregnant women
experiences with the healthcare providers, social cold heartedness, long waiting time at various
healthcare facilities, restricted birthing choices, low quality healthcare service, the absence of
privacy in the healthcare settings, and difficulties in arranging suitable transportation during
referrals, were significant healthcare system barriers to access and utilization of healthcare in
Ghana (Ganle, Parker, Fitzpatrick, & Otupiri, 2014). The poor quality as a barrier to service
mentioned in this study was not able to follow the beginning of unsatisfactory care within the
maternal healthcare services, obviously due to the free maternal care; maternal health care
services rendered to pregnant women have been of low standard.

However, Miltenburg et al. (2017) stated the provision of quality antenatal care require the
increased attention for the overall process of the care beyond the coverage of the care, but
including attention for the antenatal response-based services. The use of functioning logistics in
providing antenatal care also improve the provision of quality antenatal care (Mansur, Rezaul, &
Mahmudul, 2014).

At the same time, it has long been appreciated that women’s perceptions on how they would be
treated by the midwives, at health care facilities strongly influence their choice about where to
deliver, and the fear of abuse and disrespect are significant factors in keeping pregnant women
away from health facilities (Díaz-jiménez, Rodríguez-villalón, & Moreno-Dueñas, 2018). Peprah
et al. (2018) mentioned that most of these cases do not end well, thus pushing the blame on the
service provider as incompetent. Evidence suggests, that quality antenatal care and outcome do not only depend on the skills, knowledge and availability of logistics for service providers but also the knowledge level of the mothers on what constitutes quality antenatal care and how to go about it (Sibiya, Ngxongo, & Bhengu, 2018). It has also been widely reported that abuse and disrespect of patients, particularly during childbirth affects mothers’ decisions to opt for antenatal care at the right time (Rifat, Qureshi, & Khan, 2017).

It is reported that the availability of resources such as money, building facility, logistics and medicines and capacity building of health providers are the key factors to enhance knowledge and skills for ensuring quality of care and outcome (Kusuma, Kaushal, Garg, & Babu, 2018). The main constraints in antenatal care are inadequately skilled human resources and their management: training and mentoring, supervision, monitoring and accountability, on one hand, and poor quality of care, supplies and support on the other (Prosen & Krainc, 2018). The intervention to improve access to quality antenatal care can lead to a significant reduction in maternal and neonatal mortality (Chedid, Terrell, & Phillips, 2018). However, both access and quality antenatal and neonatal care especially at primary health care settings are yet to be optimized (Lawford, Giles, & Bourgeault, 2018). Therefore, it is essential to assess the practicing midwives critically to ensure good pregnancy outcome (Bai, Jawo, Steven, Wardle, & Steel, 2018).
CHAPTER THREE

3.0 MATERIALS AND METHODS

3.1 Study design

An exploratory study employing a qualitative approach was used to explore the in-depth perception of the midwives on quality antenatal care. This type of study design can provide a complex textual description of how the respondents perceive the research issue (Mack, Woodsong, Macqueen, Guest, & Namey, 2005). It allows researchers to have much richer answers to questions that are being asked the participants and give valuable insights which may be difficult to capture by any other method. Sandelowski (2000), noted that qualitative study, is helps in gaining conventional imaginative answers to questions that are relevant to the researcher and policymakers.

3.2 Study site

This study was done in New Juaben Municipality in Eastern Region of Ghana. It is the smallest among the 26 districts in the region with an estimated population of 227573. The municipality houses the regional capital, Koforidua. The Municipality shares boundaries with the East Akim District in the north, south with the Akuapim North District, east Yilo Krobo and west with the Suhum Municipality. It covers an area of 159 square kilometres which is approximately 0.6 per cent of the total surface area of the Eastern Region; and has 52 major communities.

The Municipality is heterogeneous in terms of ethnicity with a high dominance of Akans and Ga-Adangbes.

New Juaben Municipality possesses the Eastern Regional Hospital and two other mission hospitals (Seventh Day Adventist Hospital and St. Joseph Hospital). These hospitals are
supported by eleven private clinics, four public health centres, five Reproductive and Child Health centres, and fifty-four CHPS centres. There are one hundred and fifty-two midwives in the municipality out of which only forty-six provide antenatal care services.

3.3 Study population

The population for the study included all midwives in the various health facilities in New Juaben Municipal area who had provided antenatal care services for more than a month.

3.4 Inclusion and Exclusion criteria

3.4.1 Inclusion criteria

Midwives used included those who

- had provided antenatal care services for more than a month
- were available at the time of the study
- consented to participate in the study

3.4.2 Exclusion criteria

- An individual was excluded from the study if they had
- provided antenatal care services for less than a month
- not consent to participate in the study

3.5 Sample size

Qualitative researches involve much time in collecting data and analysing hence usually requires smaller sample size study (Collumbien, Busza, Cleland, Campbell, & WHO, 2012). However,
there is no precise mathematical formula or rules for obtaining the samples size. The data was collected from the study participants until saturation was reached.

Moreover, Morse (2000) suggested the use of six to ten participants for phenomenological qualitative studies like this one. However, eleven midwives were interviewed for the study since data saturation was reached after interviewing the eleventh midwife. Two midwives were purposively selected from each of the three hospitals, including the Regional hospital and one from each of the RCH facilities.

### 3.6 Sampling Method

The midwives in the Municipality were selected purposively for the study. Purposive sampling technique allows to identify and select participants who are especially knowledgeable and experienced with the phenomenon of interest, hence could best answer the research question (Creswell & Plano, 2011). Maximal variation sampling method was employed to select the midwives from the various ranks. This type of purposive sampling was the most efficient in exploring the perceptions of the midwives in all the different ranks on quality antenatal care (Creswell, 2012). The various ranks of the midwives identified for the study were staff midwife, senior staff midwife, midwifery officer, and senior midwifery officer.

### 3.7 Data collection method and instruments

The midwives were contacted at their clinics about the studies, they gave me date and time for the interview. A face-to-face in-depth interview was done in their office, with the aid of an interview guide. The interview guide was pretested among three midwives who practice antenatal care services at Suhum Government Hospital to check for unclear wording in the interview guide and familiarize the moderator and the notes taker with it. The interviews were
audio recorded with an audio recorder, notes were taken with a field note book, with the permission of the participants. Follow-up questions were asked when relevant. All questions were read in English without translation since all the midwives understood English. Only one moderator asked the questions throughout the study. The moderator was assisted by one notes taker who took the field notes and audio recorded the interview. The interview lasted for a maximum of 45 minutes.

3.8 Data processing and analysis

Thematic content analysis was employed to analyse the collected data. This approach helped the identify themes within the qualitative data which was then used to interpret and make sense of it to address the research question (Maguire & Delahunt, 2017).

The notes were compared to the audio recorded for completeness. The audio recordings were transcribed verbatim into a textual form. These transcripts were then read and re-read extensively to familiarise the researcher with the data.

The transcripts were coded. The coded data were perused extensively and recoded. These generated codes were categorized into themes based on their similarities or relationship. The themes and the connections between them were interpreted in relation to the objectives of the study. The notes were incorporated into the analysis.

3.9.0 Ethical consideration

Ethical approval was sought from the GHS Ethics Review Committee (GHS-ERC 023/03/19), and further approval obtained from the Eastern Regional Health Directorate. All the participants were asked to consent to the study before they were recruited into the study and permission was asked before recording the interview.
There was no direct benefit in participating in the study. The risk that emerged from taking part in the study was the time spent in answering the questions (maximum of 45 minutes).

Privacy was ensured during the interview of a participant. Information relating to the participants were kept confidential and was not revealed to anyone.

Information given was entered with the participants’ ID number, not the name, and was used only for research purposes. The information taken including the audio were stored in a well-secured cabinet accessible to only the investigators and would be destroyed after five years.

The participants were made aware that participating in the study was voluntary, they had the right to refuse to participate or withdraw from the study. They could freely opt out at any stage of the study without any intimidation, punishment, losing any benefit or whatsoever.

3.9.1 Quality control

To ensure the quality of the research, the research notes taker were trained before the data collection. She was taken through the interview guide and the various ethical issues involved in this study. The interview guide was piloted at Suhum Government Hospital in the Suhum Municipality, a border municipality to New Juaben Municipal. The pilot study enabled the research team to determine the validity and reliability of the interview guide. It also helped identify potential challenges in the survey and revised the methods before starting the actual fieldwork. The voice recorder was checked prior to and after each of the interviews for efficacy and efficiency. The audio recorded during the interview were transcribed verbatim and perused multiple times to ensure accuracy.

Any issues, clarity or concerns of the midwives about the research were addressed appropriately.
CHAPTER FOUR

4.0 FINDINGS

4.1 Introduction

This chapter presents results on the midwives’ perception on quality antenatal care, a study in health facilities in the New Juaben Municipal area. The chapter is portioned into background characteristics of the midwives, their perception on what quality ANC is, their perceived barriers to providing quality ANC and promoters to providing quality ANC.

4.2 Background characteristics of the midwives

A total of eleven midwives were interviewed in the study with only one of them aged within fifty-one to sixty years, four of them were between the ages of forty-one and fifty, with two between the ages of thirty one and forty and four between the ages of twenty one and thirty. Six of the midwives has been practicing as a midwife from six to ten years, with four between two and five years and one person between eleven and fifteen years.

Most (six) of the midwives had been providing ANC for between two and five years, with four midwives providing antenatal between six and ten years. Detailed demographic data of the midwives are shown in the table one below.
Table 1: Background characteristics of midwives

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>4</td>
</tr>
<tr>
<td>31-40</td>
<td>2</td>
</tr>
<tr>
<td>41-50</td>
<td>4</td>
</tr>
<tr>
<td>51-60</td>
<td>1</td>
</tr>
<tr>
<td><strong>Number of years as a midwife</strong></td>
<td></td>
</tr>
<tr>
<td>2-5</td>
<td>4</td>
</tr>
<tr>
<td>6-10</td>
<td>6</td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
</tr>
<tr>
<td><strong>Number of years provided ANC</strong></td>
<td></td>
</tr>
<tr>
<td>2-5</td>
<td>6</td>
</tr>
<tr>
<td>6-10</td>
<td>4</td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
</tr>
<tr>
<td><strong>Rank</strong></td>
<td></td>
</tr>
<tr>
<td>Staff midwife</td>
<td>1</td>
</tr>
<tr>
<td>Senior staff midwife</td>
<td>6</td>
</tr>
<tr>
<td>Midwifery officer</td>
<td>3</td>
</tr>
<tr>
<td>Senior midwifery officer</td>
<td>1</td>
</tr>
</tbody>
</table>
4.3 Perception on quality antenatal care

The midwives had varying perception on what quality antenatal care is. Some of the midwives perceived quality ANC as the care that is safe whereas others perceived it based on the availability of logistics and the serenity of the health facility. Other midwives also perceived that quality antenatal care is the care that meets the needs and demands of the client, hence the one that the client is satisfied with.

This is what a senior midwifery officer who had been delivering antenatal care for fourteen years perceived quality ANC to be:

“quality antenatal care is the care that you give to a pregnant woman and the woman herself appreciates it” (Senior midwifery officer, who has provided ANC for fourteen years).

These are what other midwives also said about quality ANC;

“errmm, when we say quality antenatal care, it means the care that you give to the client should be such that the client will be able to deliver safely, will be able to walk through the pregnancy safely and have a baby boy or girl. It is that counselling you give, the scans, the lab investigations you request for, the revisit schedules that she will come for, everything that will help the woman attain her 9months journey successfully” (Midwifery officer, who has provided ANC for seven years).

“Quality ANC is giving the client all the necessary care for her to gain a good health, as in getting a healthy mother and getting a healthy baby” (Senior staff midwife, who has provided ANC for four years).
“Okay, errr, good counselling to the client; when you have all the logistics, like the lab, the scan, at your end and it will all make to provide the quality care. Giving the clients privacy, giving health education, providing them good customer care, good attitude of the midwife and timeliness, tracing defaulters and reminding them of their next ANC visit” (Senior staff midwife, who has provided ANC for three years).

4.4 Perceived barriers to quality ANC delivery

The midwives perceived the unavailability of some physical settings which falls under the structure of care, such as laboratories and also poverty on the side of the pregnant woman to be a major hindrance to the provision of quality antenatal care.

These are what some of the midwives said:

“we not having the lab affect us negatively because sometimes the client would come instead of having access to everything, we will have to refer her. Most of our women here are not working and hence depend solely on their husbands for money. So, if their husband refuses to give them money, the person may come for the next visit without doing the labs for you to know the baseline to start providing the antenatal services” (Midwifery officer, who has provided ANC for six years).

“that one too is another issue that hinder the provision of quality antenatal care. When you request some laboratory investigation, the distance from the antenatal unit to the laboratory is enough to stress the pregnant woman. The pregnant women therefore find it difficult to access the laboratory which sometimes delay the antenatal care” (Senior staff midwife, who has provided antenatal for two years).
Furthermore, interpersonal care process and clinical processes, such as poor attitude of midwives was mentioned to be a major challenged to the provision of quality ANC. Most of the midwives reported that poor attitude of some health staffs impedes the provision of quality ANC to the clients. Poor attitude of the midwives like shouting on the client, the use of abusive words on the client and coming to work late, can prevent the clients from continuing to seek antenatal care. Sometimes the client would not feel comfortable sharing their problems with the health provider, which will directly or indirectly make it difficult providing quality services to them.

Some of the midwives said:

*Midwives’ attitude can really affect the provision of quality ANC. Depending on the way you talk, your tonation. So, for staff attitude, if you are not in good relationship with the community members they wouldn’t come to the facility for services. Because after all if they come and you will insult them or you don’t talk to them in the nice way, you talk to them rudely. And if she wants to access health care she needs you to receive her warmly so she will be opened to you. But if that does not happen, then it means you are not good and people will not be coming to access services”* (Midwifery officer, who has provided ANC for seven years).

Another one said:

“Yes, staff attitude really affects the quality of antenatal care and sometimes even the patronage of the service. Because most of the mothers are adolescents and when they don’t receive the kind of care and attention that they need, usually it causes a lot of problems. It means they would not even come to the health facility and when that happens the quality care that we are supposed to give is affected. The quality of ANC is affected because the adolescent or the pregnant woman
refuses to visit your facility. Supposing she is to visit at least eight times and she doesn’t come, it means that interventions you must give to her during that period, like tetanol diphtheria immunization, serving of sulphadoxine pyramethamine which protects the mother against malaria cannot be given on schedule so the quality of care would be affected. So, it comes back to affecting the quality of ANC that we provide” (Senior staff midwife, who has provided ANC for two years).

In addition, small staff strength was identified as a barrier to quality ANC delivery. The midwives were of the view that, when the midwives are not enough in the facility, they do not get enough time for a client since she had to rush her through and move to another client. This they said results in the midwife not being able to efficiently provide all the necessary care to the client.

This is what some of the midwives said about the staff strength which is the human resource and falls under the structure of care:

“Yes, low staff number affects us, because we don’t have much staff at the facility. So maybe if you need to refer a case and you need to accompany the client to the referral point, it means you need to leave those there and accompany only one person to that place” (Midwifery officer, who has provided ANC for ten years).

Another midwife said:

“When the staff number is low that’s when you don’t have enough staff, then it means you are going to take longer time taking care of the pregnant women when they visit ANC. If there are lot
of staffs, then everything will move faster, and then the care is also delivered well” (Senior staff midwife, who has provided ANC for two years).

“Because the clients are a lot as compared to the number of staffs working. So, at the end of the day you know they would be delayed. The clients are too many, some referred from other facilities and all that so, it actually delays the whole process. For instance, usually the clients complain, because they are a lot and we don’t have enough midwives around. It prolongs the time that the client spends in the facility. It is not encouraging. They tend not to, come the next time just because of the long waiting time. So, it does affect it” (Senior staff midwife, who has provided ANC for two years).

The midwives again identified language barrier between them and some of the clients as barrier to the provision of quality antenatal care. One of the midwives said;

“the greatest barrier here is language because most of them are Fulani’s and Hausa. It becomes very difficult taking their problems and even history if you do not understand their language. Sometimes they come with a relative but something’s there are very sensitive issues that maybe the client may not want the relative to know. This result in the client giving wrong answers. So, our biggest hindrance is language barrier” (Midwifery officer, who has provided ANC for six years).
Another midwife also said:

“one thing particular is language barrier. The clients sometimes don’t understand what we say to them whereas we also sometimes don’t understand what they say, when they visit ANC. Example is the Krobo. I personally don’t understand the Krobo, so whenever a client who speaks only Krobo comes for ANC, I need to find someone who can interpret for me” (Senior staff midwife, who has provided ANC for two years)

There are some cultural practices in some communities like the intake of herbal preparation during pregnancy, which may affect the pregnancy since the composition of the herbal preparation may not be known and also practices like late antenatal attendance in the second trimester may also affect quality of antenatal care since the baseline blood pressure, scan and haemoglobin level may not be picked, for early intervention in case of any abnormality. Others avoid the intake of nutritious food due to their cultural or religious beliefs which may sometimes lead to anaemia in pregnancy. These are what the midwives said:

“We have unqualified health workers in the various communities who also provide health care to the pregnant women. They most at times give them herbal concoctions and other drugs. In some ethnic groups they don’t take in some specific foods such as eggs and snails. So, it affects our quality ANC delivery” (Senior staff midwife, who has provided ANC for eight years).

“Social norms such as preventing people to know you are pregnant for the first three months of your pregnancy prevents the provision of quality ANC. You know early antenatal report is very important because it helps in baseline assessment and take good care of the pregnant woman,
determine the initial status of the pregnancy so she will be well taken care of. But if the person reports late, it affects the ANC provided to her” (Midwifery officer, who has provided ANC for seven years).

“You will tell the client to maybe eat egg which is a source of protein and she will refuse due to social norms or assumptions that your baby will become a thief when you eat egg whilst pregnant. So, she wouldn’t eat the egg or other foods due to taboos in their communities. This affects the quality of ANC provided to them” (Midwifery officer, who has provided ANC for ten years).

The proximity of the antenatal health facility posed to be a significant barrier to the provision of quality ANC. When the antenatal health facility is not easy accessible to the clients, their patronage to the clinic is greatly affected; they tend not to attend the ANC as scheduled. However, continuity in seeking ANC is a paramount component of quality ANC.

“Proximity is one major thing that can affect the quality of ANC, because usually the clients do complain of not having money for transportation. Due to this some of them refuses to come for their ANC. They always tell you they didn’t have money for transportation when you asked them why they have been defaulting. This one also would affect the quality of the service we provide” (Senior staff midwife, who has provided ANC for two years).
4.5 Perceived promoters to quality ANC delivery

The perceived factors that were found to promote the provision of quality antenatal care were the interpersonal care process and clinical care process, which talks about, good interpersonal relationship between the ANC providers and their clients, respectful attitude of the midwife. The structure of care which deals with the availability of infrastructure like laboratory, scan services and other ANC logistics like sphygmomanometer, urine testing kits and weighing scale etc. Furthermore, the midwives stated that good care practices such as involvement of the clients in decision making, ensuring privacy and confidentiality during the ANC service delivery, home visiting, and health education during outreaches such as CWC are imperative in the delivery of ANC.

This is what the midwives said about the perceived promoters to quality ANC delivery:

“When go out for home visiting and other outreaches, we do inform them that we have midwives in our facility and they should feel free to come for ANC when pregnant. We sometimes go out to give health talk too; even during CWC. This create awareness and hence increases their utilisation of ANC. So, home visiting and health education improves the provision of quality ANC” (Senior midwifery officer, who has provided ANC for fourteen years).

Another midwife also said:

“Giving health talk, ensuring privacy during the service delivery, and home visiting. You go to their homes to trace defaulters and remind them to come for ANC. These helps a lot in providing quality ANC” (Senior staff midwife, who has provided for three years)
This is what another midwife also said:

“Good communication skills and explaining the procedures to the client; everything that you will do you have to explain to the client. And you must also involve the client in "decision making. These promote quality ANC delivery, yea” (Senior staff midwife, who has provided ANC for eight years).

Again, a midwife said:

“Getting the right equipment to work with in the facility improve the rendering of quality ANC. This is because if we have the health work force, qualified and they being trained regularly but do not have the equipment to work with, then it means that there would be a problem. We would not be able to deliver the work. We would not be able to deliver the services effectively and efficiently as we should” (Senior staff midwife, who has provided ANC for two years).

Proximity of the ANC facility which is under the structure of care promotes the provision of quality ANC, continuity of care is being maintained when the facility is close to the clients.

This are what the midwives said:

“Accessibility is a factor, because when your facility is far away from the community it will affect the attendance. But when the clients are nearer to the facility or the facility is situated in the middle of the community, just as we are, and the roads are also good, they will utilise the ANC” (Midwifery officer, who has provided ANC for six years).

“For some mothers accessing the antenatal facility is very tedious which makes them refuse quality ANC and therefore goes to the TBAs who are in the community with them” so when the
facility is at the center of the community it helps the pregnant women to patronize the service”.

(Staff midwife, who has provided ANC for two years).
CHAPTER FIVE
5.0 DISCUSSION OF THE FINDINGS

5.1 Introduction

This section interprets and discusses the significance of the results obtained in this study in relation to other studies done on our research problem. This study revealed how midwives perceive quality antenatal care to be, the factors hindering its provision and what promotes its delivery.

5.2 Perception on quality antenatal care

Quality ANC relates to pregnant women being cared for in order to have incident free pregnancy and a healthy baby (Yabo, Gebremicheal, & Chaka, 2015). It is the attention, education, supervision, and treatment which the pregnant women receive from the onset of pregnancy, in order to ensure complication-free pregnancy, labour and post-partum care (Ojong et al., 2016). Quality ANC is defined as an appropriate, satisfactory, low cost and accessible service that makes women capable of choosing a healthy life (Helena, 2016). Quality ANC gives the opportunity to detect early and manage pregnancy-related complications and conditions such as anaemia, hypertensive diseases in pregnancy and malaria (Aniebue, U. & Aniebue, P., 2010). This is not different from what was explored in this study. There is early detection and intervention in pregnancy-related complications, as a component of quality antenatal care; and it also helps improve the health of the mother and the unborn child. These midwives perceived quality antenatal care as having all the required logistics to give the necessary care to the pregnant woman to deliver safely. It encompasses the structure of care, clinical and interpersonal care processes which involve the provision of privacy, education and counselling, providing
good attitude towards the client, scans services and antenatal laboratory investigations to help the expectant mother give birth safely.

In the current study, the midwives also associated quality antenatal care to the satisfaction of the clients. Quality ANC was described to be the care rendered to the expectant mothers from the day of conception until she delivers, which meets the perceived needs and expectations of the clients. This conceptualisation of what quality ANC is, falls in line with a study done by Yabo et al. (2015) among pregnant women in Ethiopia. They described quality ANC to be the care that is satisfying to the clients and has sustainability.

Concurrently, Baffour-Awuah et al. (2015) description of what quality antenatal care also reflects exactly what was found in this study. According to Baffour-Awuah et al (2015), midwives perceive quality antenatal care to comprise of the confidentiality of care, workflow, early detection and intervention of complications, pleasant association between the midwife and the pregnant woman, the client’s satisfaction, effectiveness of monitoring and supervision.

5.3 Perceived barriers to quality ANC delivery

Findings from the study revealed several barriers to the delivery of quality ANC in the municipality. In the current study it was found out that poor attitude of the midwives or poor interpersonal relationship with the pregnant women, which falls under the interpersonal care process can affect the delivery of quality ANC. When the expectant mother seeking antenatal care is shouted on or abusive words are used by the midwives, when attending to the pregnant women during ANC, they withhold details of their history or problems and even sometimes tend not to attend the next scheduled ANC visit. This affects the continuity of ANC rendered to the pregnant woman. As a midwife, having accurate clinical and personal information on your client
helps to provide valid and reliable care, hence quality antenatal care (Kelley, Docherty, & Brandon, 2013). This finding was not surprising as it had been reported by several studies from different geographical area that antenatal care providers’ poor attitude and behaviours, or even perception of them, were significant barrier to the continuous seeking of antenatal care (Asuquo, Etuk, & Duke, 2000; Smith, Murray, Yousafzai, & Kasonka, 2004; Pell et al., 2013). Heaman et al. (2015) in their study on health care providers perceptions on barriers and facilitators of the use of ANC reported same. They reported that negative treatment by the health service providers significantly prevent the pregnant women from receiving the quality of antenatal care they need. Similarly, Rifat et al., (2017) seconded that the midwives abusing and disrespecting the pregnant women could cause the pregnant women to refuse antenatal care services (Rifat et al., 2017). Moreover, this study found out that the unavailability of infrastructures such as laboratory services and ultrasound scan or logistics such as functioning sphygmomanometer, weighing scale, urine testing kits etc, which falls under the structure of care, can greatly hinders the provision of quality ANC. The unavailability of laboratory and ultrasound scans delays diagnosis and even sometimes contribute to wrong diagnosis, delay treatment and management of pregnancy-related issues during the antenatal cares services. These finding are similar to a study done by Graner et al. (2010) on the health provider’s perception on the provision and use of antenatal and delivery care. They pointed out clearly in their study that structural constraints such as inadequate equipment affect the quality of care rendered to the pregnant women. Another study conducted in Tanzania also affirm the fact that lack of material resources in the antenatal facility hinders the provision of quality antenatal care (Bremnes et al., 2018). They went further to elaborate that limited human resources is a major challenge in delivering quality antenatal
Filby et al. (2016) in their study conducted in Australia attributed the inadequate number of antenatal care providers to be a challenge affecting its provision.

In the current study, low staff strength in the antenatal care facility prevents the provision of quality ANC. With the small number of midwives who attend to pregnant women, the midwives have to rush in rendering antenatal care as there are always a lot of pregnant women waiting to be attended to. The midwife therefore do not get ample time and attention for the pregnant women. The antenatal care provider may miss very important details of the health issues which the pregnant woman may be having, hence not providing the needed care. Heaman, et al. (2015) in their research again agrees that low number of antenatal service providers in the facilities hinders the delivery of quality antenatal care. Similarly, Bremnes et al. (2018) indicated in their study that insufficient health care providers particularly makes it difficult implementing the day-to-day midwifery activities, which antenatal care is no exception.

The geographical area which falls under the structure of care, in which the antenatal facility is situated happens to influence the delivery of quality antenatal care. Where the pregnant women find it difficult to access care, they tend to miss out some of the scheduled visits. Some of the pregnant women even stop attending the antenatal clinic all together, resulting in discontinuity of care. These defaulted pregnant women might be having a peculiar pregnancy-related problem which may need constant monitoring and care. This finding is supported by what was reported in a qualitative study in South Sudan by Wilunda et al. (2017). In their study, geographical barrier was determined to be a main barrier to the provision and utilisation of antenatal care services.

In addition, interpersonal care process, where language barrier and other social and cultural factors falls, were found to be a hindrance to the implementation of quality antenatal care. Some of the communities had the notion that pregnant woman should not attend antenatal clinic for the
first three months till the abdomen start showing after the first three months. This could delay the utilisation of antenatal care. Some may worsen their pregnancy-related complication if any and may even get to the point which may be nearly impossible to intervene. This would make it difficult to render the quality of care for the pregnant woman to delivery safely and healthy.

Some of the midwives also complain that the difference in the languages spoken by them and the client hinders the implementation of quality antenatal care. The language difference makes it difficult in understanding information and the client communicating their health issue to the midwives and involving the clients in decision-making concerning their health (Andrulis, & Brach, 2007; Harmsen, Meeuwesen, Van Wieringen, Bernsen, & Bruijnzeels, 2003). It makes it difficult to even take the personal and medical history of the client, hence a major challenge in rendering the appropriate and necessary care to the pregnant woman. When health workers are posted into the communities, language should be considered. Those who understand the language of the community can be posted there since the involvement of a third party in history taking can breach confidentiality. A situational meta-analysis conducted by Nair et al. (2014) revealed that language is a major challenge in providing quality of care in maternal, new born and child health; hence quality antenatal care.

5.4 Perceived promoters to quality ANC delivery

Ensuring a good interpersonal relationship between the midwife and the pregnant woman is a major facilitator in providing quality antenatal care (Boller, Wyss, Mtasiwa, & Tanner, 2003). Interpersonal relationship such as respect for the pregnant women happens to be essential in the delivery of quality ANC (Sword, et al. 2012). The findings from this study was not different. In the current study it was found out that good interpersonal relationship between the midwives and
the clients promote the implementation of quality antenatal care. It empowers the expectant mothers to adopt a positive approach concerning their health and that of the baby in utero (Attarha, Keshavarz, Bakhtiari, & Jamilian, 2016).

Good care practices such as the involvement of the pregnant women in decision-making concerning their health, privacy and confidentiality during the delivery of service, home visiting, outreaches, and health education was found to be imperative in delivery of quality antenatal care. The home visiting for instance is done to trace defaulters, motivate and empower pregnant women to seek early antenatal care. In agreement with findings from my study, Nair et al. (2014) in their study entitled “Facilitators and barriers to quality of care in maternal, new-born and child health: a global situational analysis through Meta review” reported that engagement of the client in decision-making, respecting them, ensuring privacy and confidentiality promotes the delivery of antenatal care. A study conducted in Ethiopia on the assessment of quality antenatal care services provided among pregnant women, it was recommended that midwives should involve the pregnant women in decision concerning their health, as a means of providing quality antenatal care (Yabo et al., 2015).

Additionally, in the current study, the availability of infrastructure and all the necessary logistics like functioning sphygmomanometer, weighing scale, urine testing kits etc, were found to promote the delivery of quality antenatal care. Most of the midwives commented that having a laboratory and other logistics such as ultrasound scanning machine promote quality antenatal care. Without those logistics and tools, it is almost impossible to implement an evidence-base intervention, and even if implemented, may be suboptimal (Tunçalp, et al., 2015). Some of the midwives interviewed in this study made it clear they having all the necessary infrastructure and logistics in their facility help them to deliver an evidence-base care and ensures the continuity of
care. It enables them to implement the quality of care that meets the needs and demands of the pregnant women (Ismail & Essa, 2017).

5.5 Limitation of the study

Because of time constrain all the correspondent were selected from the Public and CHAG facilities, the private facilities were not included in the study if more facilities were used, there might be a different perspective.

5.6 Strength of the study

1. The respondents were confident and willing to contribute to the study.

2. All the respondents consented to audio recording so verbatim transcription was done.
CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 Introduction

This chapter presents the conclusion and proposes recommendations based on the findings of the study.

6.2. Conclusion

This study explored the midwives’ in the New Juaben Municipal area’s perception of what quality antenatal care, barriers and promoters in quality antenatal care. The midwives perceived antenatal care to be a holistic and safe care that is provided to pregnant women using all the necessary resources to meet the needs and demands of the pregnant women. Quality antenatal care was said to be dependent on the structure of care such as the infrastructures, staff number and characteristics, and geographical access to the antenatal clinic; clinical care process such as ensuring privacy and confidentiality during the care and discussing health issues that concern the client together to arrive at an informed decision. Interpersonal care processes such as attitude of the midwives towards the pregnant women. Moreover, they revealed that poor personal attitude of the midwives, limited material resources, uneasy access to the antenatal clinic and difference in the languages among the clients and midwives highly hinders the delivery of antenatal care. The midwives mentioned the availability of infrastructure, easier access to the antenatal clinic, and good interpersonal relationship between the midwives and clients to promote the implementation of quality antenatal care. Again, good care practices such as involving the clients in decision-making concerning their health, ensuring privacy and confidentiality to be critical in improving quality antenatal care.
6.3 Recommendations

Based on the findings of this study, it is recommended that;

1. The District directors should liaise with the midwives to create more outreach points closer to the people since they complained of proximity as a barrier to quality antenatal care.

2. The hospital management should attach a laboratory personnel to the antenatal units to take specimen blood from the client to the laboratory.

3. The human resource officers should send health personnel’s who understand the language of the people during postings into the communities or if possible they can train people in the community to interpret the language to the midwives, since language barrier is a barrier to quality antenatal care.

4. The public health personnel should educate the community members on early antenatal attendance for identification of pregnancy related complications and early intervention.
REFERENCE


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APPENDICES

Appendix 1. Information sheet

PARTICIPANT INFORMATION SHEET

Title of the study
Midwives’ Perception of Quality Antenatal Care; A study in the Health Facilities in the New Juaben Municipal Area in the Eastern Region of Ghana.

Introduction
I am Bernice Yaa Ofosu Ntiamoah a student from the University of Ghana, School of public health, Legon. My contact number is 0208423614 and email bendy.ghana@gmail.com

Background and Purpose of the study
Motherhood is often considered pride and life-fulfilling experience by many women worldwide and the society at large, most maternal deaths and pregnancy complications including stillbirths are preventable. These deaths and pregnancy complications can be prevented by the utilization of antenatal care in pregnancy, skilled delivery, care, and support in the postnatal period. Quality Antenatal care improves birth outcomes, it gives the opportunity to promote the utilization of skilled attendance during delivery and healthy actions such as exclusive breastfeeding, early postnatal care, and family planning. This is the reason I am researching on Midwives’ perception of quality antenatal care: A study in health Facilities in the New Juaben municipal Area in the Eastern Region of Ghana, to add up to the understanding of the specific dimensions of antenatal care, which can ultimately improve delivery of Quality ANC, hence improving the health outcomes of women and their infants.
Nature of research

The midwives in the Municipal area will be purposely selected for the study. Purposive sampling technique allows to identify and select participants who are especially knowledgeable and experienced with the phenomenon of interest, hence are able to best answer the research question. Maximal variation sampling method will be employed to select the midwives from the various ranks. An estimate of ten midwives who has provided antenatal care services for more than a month and is available at the time of the study and consents to participate in the study will be interviewed for the study.

A face-to-face in-depth interview with the aid of an interview guide will be used to collect the data from the midwives. The interview would be recorded, so you are to indicate yes or no on the consent form to confirm or decline the recording.

Duration / what is involved in the study

If you agree to participate in this study, you will be asked to answer questions about yourself as well as questions on quality antenatal care. You will also be required to answers questions on what hinders the provision of quality ANC and what motivates midwives to provide quality ANC.

All these questions will be asked in a form of face-to-face interview using a pre-tested interview guide. The interview will take a maximum time of 45 minutes.

Participant involvement

If you agree to participate in the study, you will be required to answer some questions on issues pertaining to the quality of antenatal care delivered at the health facilities.
Potential risks of the study.

Some questions that will be asked may make you feel uncomfortable. These questions will, however, be of benefit to me, other researches, policymakers and other healthcare providers. Apart from the above-mentioned risk and the time (45 minutes) you will spend answering the questions or doing the discussions, the study will cause you no other harm. The information you give will not affect your work.

Benefits of the study.

There is no direct benefit when you participate in the study. However, your contribution will help correct the various barriers hindering the delivery of quality of ANC. Your answers or contribution will help the policy makers plan interventions and programs for quality antenatal care.

Costs

There will be no cost incurred since the researcher will go to the facilities to interview the participants.

Compensation

You will not be paid any money for partaking in the study neither will you pay any money. However, you will be given a soft drink and pastries to refresh yourself for loss of time.

Privacy

Privacy will be ensured when interviewing you.
Confidentiality

All the information relating to you that will be collected in the study will be kept confidential and will not be revealed to anyone except required by law or regulations. Your name will not be needed and hence will not be recorded in the study. All the information that will be collected including the audio recordings will be kept in a highly secured cabinet for five years and will not be accessible to anyone except the researcher.

Voluntary to participate / withdrawal

You taking part in the study is voluntary. You have the right to withdraw from the study anytime without penalty. You can also choose not to answer any of the questions that I will ask you.

Outcome and Feedback

The data will be used for academic purposes. Feedback of findings will be given to the participants at the end of the study.

Feedback to participants

Feedback of findings will be communicated to the participants through letter writing.

Funding information

This research is self-sponsored

Sharing of participants information / Data

The data would be owned by the principal investigator.
Provision of information and consent for participants

A copy of the information sheet and consent form will be given to you after it has been signed to keep. If you consent to recording the interview please thick YES to confirm your acceptance and NO to decline recording.

Whom to contact for further clarification /Questions?

If you have any questions or concern about the study please contact:

1. The principal investigator; Bernice Yaa Ofosu Ntiamoah. Tel: 0208423614
2. The supervisor, Dr Ernest Maya. Tel: 0508131270

With regards to ethical issues about this study, participants could contact GHS-ERC administrator, Ms Hannah Frimpong via the following numbers: + 233 302 681109, Mobile: 233(0)243235225 or 0507041223 and email: Hannah.Frimpong@ghsmail.org
Appendix 2. Participant Consent form

Study title: Midwives’ perception of quality antenatal Care: A study in Health Facilities in the New Juaben Municipal area in the Eastern Region of Ghana.

Participants’ statement

I acknowledge that I have read or have had the purpose and contents of the Participants’ Information Sheet read and satisfactorily explained to me in a language I understand (English). I fully understand the contents and any potential implications as well as my right to change my mind (ie withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name or Initials of Participant: …………………….. ID Code: ………………………..

Participants’ Signature ………….OR Thumb Print………… OR Mark………….

Date: ………………………

Permission to Record       Yes ☐       No ☐
INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher’s name: ..................................................

Signature: .......................... Date: .............................
Appendix 3. Data collection tool

SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

INTERVIEW GUIDE

A qualitative study from New Juaben Municipal area in the Eastern Region of Ghana to access the perception of midwives on quality antenatal care in health facilities.

Health Facility ............................................ ID............................................

Part I: Background characteristics

1. What is your age as at your last birthday?
2. How long have you worked as a midwife?
3. How long have you been providing ANC services?
4. Please may I know your rank?

Part II: Knowledge on quality ANC

5. What is ANC?
6. Let’s say a client has just entered your consulting room for antenatal care, can you tell me all you will do for her?
   Probe: Is that all, anything else?
7. In your view, what constitute quality antenatal care?
8. Does the time you spent with a client affect the quality of antenatal care?
9. How do you make decision about the care of the client who comes to you for antenatal care?

10. Are the client’s interested in being involved in their decision making?

11. What is the average time you spend providing ANC to a client?

Part III: Barriers and promoters

12. Do you have all the things you need to provide quality ANC?

   Probe: How does that affect the provision of quality ANC?

13. Are there any community factors that affect quality of antenatal care?

   Probe: Any Taboos or cultural practices?

14. What are the factors that promotes antenatal care?

15. What are the barriers that hinder the provision of quality antenatal care?

16. Does the staff number affect the quality of antenatal care?

   Probe: what about physical setting of the facility?

   Probe: what about the provider’s characteristics?

17. Can you give me an instance where you gave your client emotional support?