SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES

UNIVERSITY OF GHANA

EXPLORING THE ETHICAL DILEMMAS IN THE CARE OF PREGNANT WOMEN IN GHANA: A CASE OF "MATERNAL-FOETAL CONFLICTS IN THE SHAI-OSUDOKU DISTRICT HOSPITAL''

ZAID HARUNA

(10935169)

A DISSERTATION SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF GHANA, LEGON, IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF A MASTER OF SCIENCE IN BIOETHICS DEGREE

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DECLARATION

I, Zaid Haruna, affirm that this dissertation on 'exploring the ethical dilemmas in the care of pregnant women in Ghana: A case of ''maternal-foetal conflicts in the ShaiOsudoku District Hospital' is the product of my own work supervised by Dr. Mary Amoakoh-Coleman of Noguchi Memorial Institute, University of Ghana. All ideas and information from other people's work, which were used in this dissertation, have been duly acknowledged and referenced.

NAME OF STUDENT

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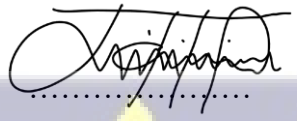

SIGNATURE

9th February 2023

DATE

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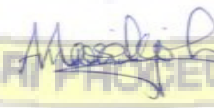
Noguchi Memorial Institute, University of Ghana.



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ABSTRACT

Introduction: The interplay of the mother and foetus raises moral and ethical issues for doctors, as well as those who decide whether to give birth in utero. Doctors have come to view the foetus as a separate patient in and of itself, rather than just part of the maternal body.

Legal and ethical considerations involving women's rights and the rights of the foetus have become more complicated with advances in medicine and technology. Some doctors have sought and won court orders to execute foetal therapies (mainly cesarean sections) without maternal permission.

Aim: To explore the ethical dilemmas in the care of pregnant women in the Shai-Osudoku District Hospital of Ghana.

Methodology: The study employed the use IDIs and FGDs as part of an exploratory qualitative study design. Focus group discussions examined the moral, legal, and social conundrums and decision-making processes in maternal-foetal conflict situations in Ghana's Shai-Osudoku District Hospital.

Results: The study found that the mother's decision to accept a particular treatment during maternal-foetal conflict is significantly influenced by her educational level, religious beliefs, and cultural values. There are no formal ethical guidelines or rules that health providers work with while addressing maternal-foetal conflict. In this circumstance, maternal autonomy is valued only when it is consistent with the medical prognosis.

Conclusion:

The study revealed that a mother's level of education and religious convictions significantly influenced her readiness to accept particular therapies for maternal-foetal conflicts at the Shia-Osudoku District Hospital, which does not rely on structured

ethical guidelines but rather treatment guidelines that are more medically oriented. The consent process is not structured to reflect the case for which it is been administered. The hospital recognizes and respects maternal autonomy only when her decision is in line with the medical prognosis, and does not take into account family, religious beliefs, and community customs when making decisions about maternal-foetal conflict situations.

ACKNOWLEDGMENTS

Alhamdulillah, Great things He has done, greater things He will do, Unto Allah be all glory, Amen. Unto my Life, my Inspiration, my Empowerment, my Wisdom, my Glory- Almighty Allah!

Unto Him who has given me His divine life and seated me with Himself in heavenly places. To Allah my love. You are the only reason I can find for living.

I would like to acknowledge my supervisor, Dr. Mary Amoakoh-Coleman. Your wealth of knowledge and experience are invaluable. I appreciate your wise advice and direction. I also want to express my sincere gratitude to the midwives, the director of the Shai-Osudoku District Hospital, and the research and development and quality assurance officers. To the mid-wives of Tamale Teaching Hospital, and Godfred Tweneboa, thank you for your support

I want to express my gratitude and my deep love for my beautiful wife, Miss Fatima Iddris, for sticking by me through good times and bad. I'm grateful to my friend Godfred Tweneboah for your support.

To my great mother Mrs. Atika Halidu and my lovely kids Mr. Aidan Sodanji Zaid, Mr. Aamil Saha Zaid, and Ms. Amjad Wunntiti Zaid. This is a heartfelt devotion from a father, son, and spouse who is appreciative. I appreciate your confidence in me. I will always be grateful for your unwavering support, prayers, advice, encouragement, and godly upbringing as well as for your unending love and concern.

DEDICATION

In honor of my stepmother Madam Fati Ibrahim and in her memory. I dedicate this work to Prof. Mike Yaw Osei-Atweneboana for support throughout this journey.

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LIST OF ABBREVIATIONS

ART	Artificial Reproductive Treatment
CS	Caesarian Section
DCT	Dichorionic Twin
DHRCIRB	Dodowa Health Centre Institutional Review Board
FGD	Focus Group Discussion
GHS	Ghana Health Service
IUGR	Intrauterine Foetal growth restriction
IDI	In-depth Interview
MMR	Maternal Mortality Ratio
MDG	Millennium Development Goals
MCT	Monochorionic Twin
UG	University of Ghana
USA	United States of America

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Most judgments in bioethics include matters of health care, which are frequently difficult choices needing careful consideration and the delicate balancing of rights, principles, beliefs, and interests (Begović, 2021a). It is not surprising that the beginning and end of life are when some of the hardest of these decisions must be made (Begović, 2021; Post, 1997).

In terms of law, medicine, or ethics, there is no relationship like that between a pregnant woman and her foetus (Begović, 2021a; Post, 1997). Pregnant women create a unique situation where a person (the woman) and a future person (the baby) both have interests that are comparable to and distinct from one another (Post, 1997). This particular confluence of circumstances creates a special biological, psychological, moral, and legal link between the mother and the foetus (Begović, 2021; Post, 1997).

Due to changes in maternal-foetal practice that have lately occurred, the foetus's clinical state has changed (Flagler et al., 1997). The indirect procedures that doctors have historically used to evaluate the condition of the foetus may yield extremely trustworthy indicators of the foetus's health and development, but the foetus itself is difficult to examine directly (Flagler et al., 1997; Murphy, 2009). The foetus cannot be known while it is developing; it can only be approximated using probabilistic reasoning and inference (Fasouliotis & Schenker, 2000b, 2000a). Because they were unable to interact with the foetus in a way that distinguished it from its host, doctors considered the pregnant female, of which the foetus was an essential part, to be one patient, the

maternal-foetal dyad. (Fasouliotis & Schenker, 2000; Flagler et al., 1997; Murphy, 2009).

This conceptual framework has been altered by improvements in high-definition ultrasound imaging and methods for tissue and blood collection in foetuses. (Fasouliotis & Schenker, 2000b). With the aid of these diagnostic instruments, a clinician can observe the foetus in all of the inherent uniqueness in anatomy, physiology, and biochemistry (Begović, 2021; Fasouliotis & Schenker, 2000b). Medicinal and surgical techniques used in utero are already beginning to offer replacements for medicinal delivery and newborn care when abnormalities are found (Begović, 2021; Fasouliotis & Schenker, 2000; Flagler et al., 1997).

The biological bond between a mother and her unborn child has not altered, but the way that connection is viewed medically now emphasizes duality rather than unity (Begović, 2021). The foetal organism is now seen as a distinct patient in and of itself by doctors, who no longer focus on mother diagnostic host information or a therapy method (Begović, 2021; Fasouliotis & Schenker, 2000b. The foetus' transition from an inferred to an observable entity led to the development of this novel approach, which has new and complicated ethical, social, and legal ramifications (Fasouliotis & Schenker, 2000; Flagler et al., 1997). There are moral and ethical questions raised by the mother-foetus interaction. Situations where it appears that the welfare of the mother and the unborn child conflict is of particular concern (Devettere, 2016; Post, 1997). In these situations, it is frequently seen as the duty of physicians and society to advance either party's welfare or make a decision (Begović, 2021; Post, 1997). In certain cases, issues that were formerly restricted to the doctor-patient relationship have entered the legal and

public policy realms, frequently with unfavorable outcomes (Begović, 2021; Devettere, 2016; Fasouliotis & Schenker, 2000).

A maternal-foetal conflict arises when a pregnant woman's interests' conflict with the interests of the foetus she is carrying, as determined by the woman's doctor (Fasouliotis & Schenker, 2000). Legal and ethical considerations involving women's rights and the rights of the foetus as a patient and future child have become more complicated with advances in medicine and technology. There are cases of maternal-foetal conflict where the law is involved, although, for a variety of reasons, most doctors avoid doing so (Apanga, Paschal, et al., 2018). It is possible to view this as affecting the occurrence and severity of any perceived conflict by considering whether the woman and the foetus have distinct interests and rights that deserve respect and protection (Begović, 2021). This conflict of interest often occurs when a woman who is pregnant chooses not to heed medical advice that her doctor believes is beneficial for the foetus (Begović, 2021; Flagler et al., 1997; Murphy, 2009). For instance, a blood transfusion, foetal surgery, or a cesarean delivery may be recommended for the safety of the foetus (Murphy, 2009). A conflict may also be seen in a pregnant woman's behavior if she smokes, consumes alcohol, uses drugs, or continues to work in a dangerous setting, which may negatively impact the foetus (Post, 1997). The struggle typically intensifies as the pregnant woman or foetus gets closer to term or viability (Begović, 2021a). At that moment, more defences of the foetus' legal and moral standing are made (Begović, 2021; Murphy, 2009; Post, 1997).

When this occurs, it generally poses an ethical dilemma for medical professionals, forcing them to choose between solutions that seem equally desirable or bad

(Fasouliotis & Schenker, 2000). These decisions typically have the potential to violate the mother's autonomy, the foetus's right to life, and both parties' rights to justice, and one of them could even suffer injury. Abortion, assisted reproduction (artificial insemination, in vitro fertilization, embryo transfer, and surrogate parenthood), foetal surgery, treatment of genetic disorders or foetal abnormalities discovered in prenatal screening, maternal rights versus foetal rights, selective reduction in multifoetal pregnancy, intrauterine treatment of foetal conditions, borderline viability: to resuscitate or not, foetal reduction, and maternal rights versus foetal rights are a few examples of such ethical dilemmas (Aderemi RA, n.d.; Begović, 2021; Fasouliotis & Schenker, 2000; Flagler et al., 1997).

In such cases, the woman's non-compliance may aggravate or frustrate the doctor (Devettere, 2016; Nocon, 1999). The obstruction could develop into misery. of a serious moral and professional quandary: to respect the woman's wishes and permit preventable harm; to ignore her wishes and permit preventable harm (Begović, 2021; Doukas & Elkins, 1993; Fasouliotis & Schenker, 2000; Lyng et al., 2005). If this could cause unnecessary injury to the foetus and perhaps the mother, some doctors having acquired court orders and succeeded to execute foetal treatments (mainly CS) without maternal consent in response to this conundrum, asserting expanded rights on behalf of the foetal patient (Doukas & Elkins, 1993; Lyng et al., 2005). These examples suggest the potential for a new benchmark for therapeutic exercise with significant repercussions for both criminal and legal systems responsibilities of doctors and expectant mothers (Begović, 2021; Fasouliotis & Schenker, 2000).

1.2 Problem Statement

Ghana is classified as having a high maternal death rate by the World Health Organization (WHO) (Asamoah et al., 2011). The country's current maternal mortality rate is 308 deaths for every 100,000 live births (Asamoah et al., 2011). The Shai Osudoku district reported 4,594 pregnant women to the health facility in 2021, while 4593 deliveries were documented for the same facility, along with 1 maternal death. Maternal death is still a bigger health challenge to the public despite various tactics adopted by the Ghana's Health Services (GHS) and international community (Asamoah et al., 2011). Direct maternal-foetal and indirect factors have been separated to form a list of causes of maternal mortality with bleeding (21.8%), abortion (20.8%), hypertension (19.4%), ectopic pregnancy (8.7%), uterine rupture (4.3%), and genital tract infection are the most common health issues (Ameyaw et al., 2021; Asamoah et al., 2011; Der et al., 2013). The remaining deaths, which accounted for 20.5% (130), were due to indirect maternal-foetal causes, such as infections beyond 81 percent of pregnancy-related deaths occur in the community or within 24 hours of being admitted to a medical facility, with the most common causes being diseases of the genital tract (9.2 percent), anaemia (2.8 percent), sickle cell disease (2.7 percent), pulmonary embolism (1.9 percent), and disseminated intravascular coagulation (1.3 percent) (Der et al., 2013).

The prognosis, gestational age, and the pregnant woman's life and values are taken into consideration when making maternal-foetal decisions. To prevent bias, it is crucial to include a range of viewpoints (such as paediatric, maternal-foetal, etc.) during the decision-making process. Many ethicists contend that pregnant women should be given the same rights as non-pregnant women, including the ability to make decisions

(Townsend, 2012). It is also crucial to recognize that mothers typically choose whatis best for their children and themselves as she made the decision to have and continue the pregnancy (Harris, 2000). Those who see the mother and the unborn child as distinct beings cannot ignore the mother's rights for the benefit of the unborn child, (Fasouliotis & Schenker, 2000). Other viewpoints include disregarding mother autonomy in favour of a more trustworthy alternative (Fasouliotis & Schenker, 2000).

For instance, a caesarean section could potentially save the mother and the child's lives, but if the mother prefers a normal birth that will kill both, her choice might be disregarded. (Fasouliotis & Schenker, 2000). This is not always true because there are other variables taken into consideration (Fasouliotis & Schenker, 2000). In addition to this difficult ethical conundrum, society also expects medical professionals to make ethical decisions on their behalf and to take responsibility for those decisions (Begović, 2021a; Post, 1997).

However, there will always be ongoing ethical, legal, and social friction over maternal and foetal care in a society where the state is unable to establish behaviour standards that will satisfy all philosophical viewpoints (Hornstra, 1998; Reid & Gillett, 1997; Scott, 2010).

In the absence of much or any empirical data on the topic in Ghana, it was interesting to discover precisely what the issues are in the Ghanaian context, how they have been solved, and recommendations for best practices. This study's goal is to assess how the ethical principles of autonomy, benefits, privacy, and decision-making that govern the care of pregnant women and their unborn children in Ghana are made.

1.3 Justification

The right to protect autonomy, fairness, and the assurance of non-maleficence to expectant mothers and their babies are considered to be the top priorities for improving approaches to maternal and child health services. Maternal and foetal care services are surrounded by ethical, legal, and social issues that raise many concerns throughout the world. However, the difficulties brought on by the aforementioned initiatives go beyond the scope of maternal-foetal conflict issues and pose a variety of distinct ethical, legal, and societal problems (Begović, 2021; Post, 1997). The success of mother and child health services is hampered by a lack of ethically good decision-making processes, especially in low-resource environments like Africa. It is vital to have rules to follow while making decisions during maternal-foetal conflict (Begović, 2021; Post, 1997). In order to apply morally, legally, and socially responsible decision-making techniques when faced with maternal-foetal conflict issues, the proposed research's findings will provide scientific data that will aid in providing contextual assistance. Additionally, the study will describe process assessment, and viewpoints of relevant stakeholders regarding how making informed judgments protects the right to autonomy, the right to a healthy foetus, justice, and non-maleficence. Furthermore, this research will increase the body of knowledge already known about the topic, adding to academics.

1.4 Research Question

- What types of maternal-foetal conflict scenarios affect the management of expectant mothers at the Shai-Osudoku District Hospital in Ghana?
- What ethical guidelines are used to guide decision-making in the maternal-foetal conflict at the Shai-Osudoku District Hospital in Ghana?

- How does maternal autonomy and the preservation of the foetus affect the ethical decision-making processes of medical personnel during the maternal-foetal conflict in the Shai-Osudoku District Hospital in Ghana?

1.5 Objectives of the study

1.5.1 General Objective

To explore the ethical dilemmas in the care of pregnant women in the Shai-Osudoku District Hospital of Ghana.

1.5.2 Specific Objectives

The specific objectives are:

- To explore the maternal-foetal issues conflicts that occur in the management of expectant women at the Shai-Osudoku District Hospital in Ghana.
- To describe the ethical guidelines followed when making decisions on the maternal-foetal conflict issues at the Shai-Osudoku District Hospital in Ghana.
- To examine how the autonomy of the woman and the preservation of the foetus influences the ethical decision of medical personnel during the maternal-foetal conflict in the Shai-Osudoku District Hospital in Ghana.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A literature review's main objective is to provide vital information about what has been done and what needs to be done by researchers, research projects, and research fields (Boote and Beile 2005, Snyder 2019). The literature that is pertinent to this topic is extracted and summarized in this chapter using a narrative method of literature review. A narrative review was used to get a thorough understanding of the subject, identify major areas of research surrounding it, point out gaps in the literature, and refine and clarify research questions (Griffith University 2021). This literature review primarily serves as a guide for the study objectives and to examine the key concepts that are relevant to my research topic.

2.2 Background

In all aspects pertaining to the reproductive system and its functions and processes, reproductive health is a condition of physical, mental, and social well-being rather than only the absence of disease or infirmity. Therefore, reproductive health entails that people can have pleasant and safe sexual relationships, that they can reproduce, and that they have the choice of whether, when, and how frequently to do so (Gual-Castro, 2016). This final requirement includes the rights of men and women to information about and access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as to other methods of their choice for regulating fertility that are not illegal, as well as the right to access the most appropriate health

care services that will enable women to have a healthy pregnancy and delivery and give couples the best chance of conception. In keeping with the definition of reproductive health, its treatment is described as the wide range of approaches, procedures, and services that support reproductive health well-being and address its issues (Gual-Castro, 2016). Even though these rights are there, occasionally problems occur as a result of maternal-foetal problems that are experienced throughout pregnancy.

The medical professionals that created the technology to aid in human reproduction did so for two reasons. A utilitarian ethics that presupposed that such technologies would produce more benefits than damage was combined with paternalistic care to aid women having trouble getting pregnant. Modern methods including prenatal testing for abnormalities in the foetus, prenatal diagnosis (with the option of abortion), and in utero therapy of the foetus were approved due to their clear advantages. Pressure to accept antenatal diagnosis and foetal monitoring has undermined the idea of pregnancy as a natural and rewarding process after normal conception, long before adverse effects were quantified and before it became clear that the clinicians' assumptions of the benefits to women and their children had been overly simplistic (David, 2002).

The debate over moral principles and legal restrictions has lagged behind, as opposed to driving, advancements in maternal-foetal medicine. The key issues of contention are the woman's autonomy and the moral standing of the foetus. Western secular ethics prioritizes personal autonomy, but society continues to grant males more agency than women when it comes to sex and reproduction. Men frequently force their partners into inappropriate sexual behaviour (Dickensen, 2002).

Although unintended pregnancies are disproportionately detrimental to women, it is anticipated that they will accept the pregnancy and the responsibility to care for the kid as their default behaviour. The definition of full autonomy for women includes complete personal control over the foetus and equality in sexual behaviour. But what is the foetus' moral standing? While the male nly contributes his half of the chromosomal DNA, the intracellular biological processes of the foetus are in direct continuity with those of the mother (David, 2002). The development of the foetus' moral status occurs gradually over the course of pregnancy, and is symbolised by developmental milestones like the neural tube's formation, the completion of macroscopic organogenesis, the functional maturation of the lungs, liver, and kidneys, the increasing electrical maturation of the cerebral cortex, and finally birth. The relationship that emerges from the woman's increased awareness of the foetus, which extends to her spouse, her family, and eventually everyone she meets as the pregnancy becomes increasingly visible (Dickensen, 2002).

The responsibility she feels for the welfare of the unborn child is based on her connection to the foetus. The act of birth is a significant moral event. The lady gives her new infant the status of a person by "giving birth." The baby's transition to extrauterine life has required sudden, radical, and irreversible alterations in its circulation and respiration since, unlike the foetus, it is not obligated to rely on the mother. The law upholds the idea that a foetus is not a person at any stage of development, and recent case law has established that any intervention in pregnancy that is thought to be essential to benefit the foetus or lower the risk of harm to it requires the woman's agreement. After birth, the infant is recognised by law as a person who, if

not given proper care, is entitled to special protection under the Children Act (David, 2002).

The health of the child is the responsibility of both parents and of society as a whole, unlike the unborn. Respecting the pregnant woman's autonomy while delivering the potential advantages of maternal-foetal medicine presents practical challenges. Health care personnel are primarily driven to reduce hazards to her and her foetus, in contrast to the woman, who sees pregnancy as a gratifying natural experience. The woman's positive opinion of her pregnancy is disturbed by the offer of screening and antenatal diagnosis of a foetal abnormality, but she may find it difficult to decline what seems to be a routine aspect of antenatal care and something she does not fully understand and cannot easily discuss in the crowded minutes she spends with the professionals in the antenatal clinic. She frequently agrees to the tests offered, only to subsequently realize their true significance for her in both positive and negative ways (Dickensen, 2002). Techniques like ultrasound imaging and foetal heart rate monitoring bind the physicians to the foetus and give the impression that the foetus is a patient for whom they are solely accountable. When the physicians' ideas about what is best for the foetus conflict with the woman's, their relationship with her may suffer (Dickensen, 2002). Such disagreements have two root causes: the first, which can be resolved through effective education and stems from the woman's lack of precise knowledge and understanding, must be accepted; the second, which results from deeply ingrained cultural differences between the woman and the healthcare providers, must be tolerated. This could lead to a negative consequence that was possibly avoided (David, 2002).

Experts in maternal-foetal medicine are aware that poor prognoses occasionally turn out to be incorrect and that women who initially resist necessary procedures frequently

change their minds after some time has passed and it becomes evident that tragedy is imminent (Dickensen, 2002). The goal of ethical treatment should be to maintain the woman's autonomy over herself and her unborn child as well as her faith in the medical professionals who are taking care of her. Therefore, it is wrong to try to utilize the legal system to compel a competent woman to receive treatment against her will. Innovations in maternal-foetal medicine must respect the woman's autonomy in addition to being helpful and unlikely to seriously harm the foetus. In addition to being able to be quantified retrospectively by the auditing techniques used in evidence-based medicine, the balance between benefit and damage can also be projected in the future (David, 2002).

2.2 Issues Related to Maternal Mortality in Ghana

According to the Ghana Statistical Service (2021), Ghana's population is predicted to be around 30,832,019 million. Since 1990, the country has made some progress in lowering maternal fatalities. The nation's goal of a 75% reduction in MMR by the end of 2015 was not achieved, according to the most recent data. The Maternal Mortality Rate (MMR) in Ghana decreased from 760 per 100,000 live births in 1990 to 570 in 2000 and to 380 in 2013 (World Health Organization, 2014), which represents a 50% decrease in MMR in 23 years, according to the World Health Organization (WHO) report, Trends in Maternal Mortality: 1990-2013.

Despite these advancements, there is still more work to be done and Ghana's development is still far from ideal. Ghana was ranked 154th out of 179 countries in the 2015 State of the World's Mothers report, which ranks the well-being of mothers in

various countries. The evaluation is supported by a number of indicators. Ghana received a poor overall ranking due to its 1 in 66 lifetime risk of maternal death, rate of 78.4 deaths per 1,000 live births for children under 5, expectation of 11.5 years of formal education, gross national income per capita of US$1,770, and the fact that only 10.9 percent of government seats are held by women. In addition, Ghana is one of the 11 nations with the largest disparities in urban child survival, meaning that impoverished urban children have a 3–5 times higher mortality rate than their wealthy counterparts (Save the Children, 2015). These women and children are more susceptible to illness because such injustices are frequently reflected in their living circumstances. Poor health outcomes are caused by things like inadequate sanitation, food insecurity, and restricted access to perinatal care, and skilled birth attendance. Average health indicator figures frequently conceal inequalities, as the report notes (Save the Children, 2015), even when it seems like those indications are moving in the right direction. Therefore, data collection and analysis techniques need to be carefully considered, especially for disaggregated data, which can be used to plan healthcare (Kyei-nimakoh et al., 2016).

Direct maternal-foetal causes account for the majority of maternal deaths in Ghana. The top five causes of pregnancy-related deaths were haemorrhage, genital tract sepsis (including septic abortion-related complications), ectopic pregnancy, abortion-related complications, and infection, with the first four accounting for roughly two-thirds of all deaths, according to a retrospective cohort study conducted in one of Ghana's major teaching hospitals (Lee et al., 2012). According to a different study that used data from a 5-year retrospective survey, the main causes of maternal mortality were haemorrhage, abortion, hypertensive disorders of pregnancy, sepsis, and obstructed labour. Along

with severe infectious disorders like viral hepatitis and malaria, it also includes noninfectious conditions like anaemia (B. Asamoah et al., 2011). Similar findings have been reported by other researchers (E. Der et al., 2013; Gumanga et al., 2011).

The United Nations Development Program and other UN agencies created the MDG Acceleration Framework in 2010 as a result of the slow progress made by many countries in achieving the MDG targets. The MDG Acceleration Framework offers a methodical method for nations who are not meeting MDG targets to discover solutions to the issue and accelerate progress (MOH, 2011). As a result, the framework varies for each nation and is designed to focus on areas of the Millennium Declaration that a nation has had difficulty implementing. Justifiably, Ghana's MDG Acceleration Framework Country Action Plan, published in 2011, focuses on MDG 5, in a bid to strengthen efforts to remove barriers to reducing maternal deaths (Kyei-nimakoh et al., 2016). Family planning, competent delivery services, and emergency maternal-foetal and neonatal care are three areas that have been highlighted as needing priority interventions (MOH, 2011). Evidence-based best practices are incorporated into policy guidelines for reproductive healthcare in Ghana to improve care. One proven method to stop postpartum bleeding, for instance, is aggressive management of the third stage of labour. The International Federation of Maternal-Foetals and Gynecology and the International Confederation of Midwives jointly introduced this approach in 2003 (Kyei-nimakoh et al., 2016). In order to expedite placenta delivery and stop postpartum bleeding, active treatment of the third stage of labour consists of three elements. Later, Ghana adopted it in accordance with the National Safe Motherhood Protocol published by the Ghana Health Service in 2008 (Ghana Health Service, 2008). However, a recent evaluation study notes that despite receiving training in the implementation of the

procedure, all the components are not consistently followed by maternal health staff when attending births for a variety of reasons, including insufficient support from colleagues and a heavy workload (Schack et al., 2014). Likewise, a criteria-based audit of the quality of care given to patients with severe pre-eclampsia and eclampsia revealed a mean adherence rate of 15 to 85 percent to nine important clinical care procedures (Browne et al., 2015), exposing important practice gaps.

Strategies for the prevention and treatment of the main causes of maternal fatalities are included in the national guidelines. These include employing oxytocin/misoprostol to treat haemorrhage and post-abortion problems; magnesium sulphate to treat eclampsia; and clean delivery kits and antibiotics to prevent sepsis. The use of criteria-based clinical audits as a beneficial tool for detecting gaps in maternal-foetal treatment and giving focused information on areas requiring quality improvement or intervention is supported by data from studies in resource-poor settings (Browne et al., 2015; Kidanto et al., 2009; Wagaarachchi et al., 2001).

Despite numerous adopted techniques, Ghana's potential effectiveness at lowering maternal fatalities is constrained by a number of issues. The shortage of healthcare professionals, infrastructure problems, inadequate emergency response capabilities, healthcare policy concerns, and sociocultural variables are among the nation's most pressing reproductive health difficulties. There is little doubt that the Millennium Development Goals (MDGs) have made it possible for more focused and intentional activities to be taken to eradicate disparities in societies. In Ghana, prior tactics must be carefully considered, and where necessary, adjustments must be implemented. According to the most recent data, Ghana has not yet achieved either of the MDG5 targets (substantial reduction of maternal mortality rate (MMR) and universal access to

reproductive health). Although Ghana is aware of its numerous maternal health problems and has taken some corrective measures, it is also acknowledged that, if effectively implemented, the evidence-based standards and practises such as calcium supplementation, skilled birth attendance, Family Planning, effective antenatal clinic services for maternal health can help lower MMR (Kyei-nimakoh et al., 2016).

The nation must make sure that the policies it adopts meet its own demands as it realigns itself to draw on such expertise and prior experiences. Additionally, if the post-2015 target of reducing the worldwide MMR to less than 70 per 100,000 live births by 2030 is to be met, long-term objectives need to get higher emphasis and sustained attention. Ghana can significantly lower its MMR by ensuring adherence to evidence-based clinical care protocols, bolstering its primary healthcare system and midwifery workforce, upgrading its transportation and emergency response infrastructure, and strengthening measures to increase skilled attendance at birth (Kyei-nimakoh et al., 2016).

2.3 Ethical Issues Faced in Maternal and Foetal Health

Conflicts involving a woman acting in a way that could harm her unborn child or is disapproved of by the majority of people in society sometimes arise in the context of concerns relating to maternal and child health (Simpson & Chez, 2001). Conflicts arise when a mother's requirements, actions, or preferences put the unborn in danger (Schroeter, 2007). Abortion, assisted reproduction (artificial insemination, in-vitro fertilisation, embryo transfer, and surrogacy), selective reduction in multifoetal pregnancy, intrauterine treatment of foetal abnormalities, substance misuse, and disobedience to caregiver instructions are the most prominent examples (Aderemi,

2016). Such a woman may encounter wrath rather than support from society and healthcare professionals. The rights of both the mother and the foetus must be considered, nevertheless. For the health of women and children, a number of areas are particularly crucial.

Human reproduction-related concerns are becoming more and more contentious for medical practitioners. The wellbeing of the woman and baby in a case involving a pregnancy at 36 weeks of gestation having placental insufficiency, a condition in which the foetus is not receiving enough oxygen.

The woman opposed the Caesarean delivery, saying she was putting her confidence in God that everything would work out fine. The doctor had advised it for the benefit of the foetus. The doctor then thought of requesting a court order to allow a surgical birth without the woman's consent (Hellsten et al., 2013a). Important issues are raised by this situation. What kind of moral standing does the foetus have, especially those who are reasonably far along in gestation? What justifications exist for giving the woman's wishes top priority

There are more ethical concerns in foetal-maternal conflict than we realize in the daily practice of maternal-foetals. A pregnant woman is supposed to identify herself to the medical professional. It is anticipated that blood and urine samples would be obtained. The agreement to participate in these examinations is sometimes taken for granted, not the least since it is seen as a deliberate decision made after reading a variety of educational pamphlets and reading materialIt is common to think of an alternative management strategy as "out of the box." It is especially challenging for the woman to refuse testing when doing so seems to be the only course approved by both her family and peers, even though it is not necessarily unethical to do so (Yeo & Lim, 2011). When

discussing the rights of the foetus as the unborn child, ethicists have argued that it is the doctor's responsibility to safeguard this patient from harm. There are circumstances in which a woman's autonomy may be questioned; in these cases, a group of individuals decide a woman's physical rights in the name of safeguarding her unborn child. The framework tends to add diverging interests between these 2 patients when the foetus is viewed as a separate patient from the pregnant woman. Circumstances like viability and normality add to the complexity. More crucially, there is a lack of emotional closeness between the child and the prospective mother (Yeo & Lim, 2011). Without rights, there cannot be a quarrel. The rights of the foetus as a recognized entity, notwithstanding its unresolved status, cannot be disregarded in any ethical discussion. If the foetus is a patient, it is subject to the beneficence-based obligations of a doctor, including the duty to safeguard and advance the foetus' social role and subjective and deliberate interests. The patient status of a foetus is not necessarily absolute, though; it might vary depending on whether the reigning authority considers religious, philosophical, or purely consequentialist factors. The concept of when or if we believe the foetus has attained an independent moral standing, which can be characterized in numerous ways, such as by viability or religious conviction, can alter when or if this is the case. It might also depend on whether or not we believe that a foetus' moral position is contingent on the pregnant woman's free choice to present herself (and her foetus) as a patient (McCullough & Chervenak, 2008).

Due to the fact that both the pregnant patient and the foetus must be taken care of, maternal-foetal care is special. The moral standing of the foetus varies depending on the region where the treatment is being addressed and at various stages of pregnancy. In order to adhere to the law of the land, the framework for maternal and foetal best

interests must allow for consideration of each situation separately (Yeo & Lim, 2011). The complex concept of autonomy applies to the foetus as a patient. A foetus is thought to have a dependent moral status, which viability grants.

The procreative beneficence principle posits that the couple has a moral duty to make every effort to avoid having children with disabilities. In this scenario, the mother chooses the child she believes will have the best quality of life, whether that be for herself, the unborn child, or the others around the unborn child (Yeo & Lim, 2011). The decision, whether to take action or remain inactive, is based on the advantages and negatives, including opportunity costs and context-appropriateness. This is consequentialism in action. The context is maternal-foetal decision-making at prenatal screening, prenatal diagnosis, selective procreation, foetal therapy, multiple pregnancies, serious perinatal conditions like pre-eclampsia toxaemia (PET) and intrauterine foetal growth restriction (IUGR), induction of labour for foetal-maternal conditions, foetal monitoring, caesarean birth, and a variety of other clinical scenarios (Yeo & Lim, 2011).

The rights of the unborn child become a problem and potential conflicts of interest can appear in the daily management of the pregnant lady patient. Foetal beneficence is typically the deciding factor when comparing the risks and benefits of surgery, continuing a pregnancy, having a caesarean section, and vaginal delivery. The welfare of the unborn child comes into conflict far less commonly when the dangers of continuing a pregnancy in a woman with a medical condition, an abnormal foetus, or situations necessitating a difficult caesarean birth. (Yeo & Lim, 2011).

We must take into account the situation while deciding on a framework to address foetal-maternal conflict in maternal-fetuses. There are numerous variations for each

circumstance, including the doctor's capacity to advise (competence, information), the woman's motivations (choice, autonomy), the significance to the life and health of the fetus/woman (benefit), and the rights of both the foetus and mother (moral protection from harm) (Yeo & Lim, 2011).

2.4 Moral Status of the Foetus

If a human being is a living thing, then other people have a moral duty to care for and advance that person's interests. The moral standing of humans can be either independent or dependent (Asim et al., 2009). Living people are capable of creating their own moral standing; some traits of the human entity give rise to other people's obligations to it. We refer to this as independent moral position. The language of personhood or human persons typically expresses this idea (in the ethical sense). The majority of world philosophical schools in the field of ethics concur that only unique individuals can produce their own autonomous moral position. Other people have independent moral status, which implies that they are morally required to act in a way that protects and advances the interests of human persons rather than having the option to do so. When the state's authority enforces an individual's autonomous moral status, that person acquires legal status (Asim et al., 2009). Dependent moral status can also exist in living humans. By this, we mean that the individual in issue plays a part in society that is governed by duties to uphold and advance the interests of all individuals playing that part. The fact that a human being does not have to be an individual human being in order to be granted dependent moral status is an important aspect of dependent moral status. It is possible to grant dependent moral standing to different but not yet

individuated human beings. It is also conceivable to grant legal status to separate but not yet individuated human beings (Asim et al., 2009).

Because it could interfere with a pregnant woman's freedom to control what happens to her body, the moral position of the foetus requires special attention. Which should take precedence if this happens? There are three main ways to think about a fetus's moral position: as having the same rights as a living baby; as having no rights; or as having rising moral status as gestation progresses (Isaacs, 2003).

If the unborn child is accorded full moral rights, the mother and the unborn child are treated as two distinct patients. This may produce a major conflict between mother and foetal rights because of the foetus' reliance. Choices are central to the idea of a person's autonomy (Dickensen, 2002). The autonomy of a person is their right to decide how to live their own life. We would say that a woman has the right to smoke cigarettes even though it is bad for her health. Smoking, however, can also have some mildly negative effects on the foetus. Despite our disapproval, no society prevents pregnant women from smoking. However, alcohol, and particularly excessive drinking, can harm the developing brain of the foetus. Cocaine can harm the blood flow to the developing fetus's brain, resulting in intrauterine stroke and foetus mortality. If the foetus has completed legal rights, this may inspire lawmakers to pass laws prohibiting maternal behaviours like excessive drinking or cocaine use that could harm the foetus (Isaacs, 2003).

In fact, women who harmed their offspring by abusing cocaine have received severe prison sentences in the United States of America (USA) (12 years in one recent case). Giving the foetus complete rights could violate a mother's autonomy and result in a coercive and punishing attitude toward expectant mothers. It seems unfair that one

woman gets imprisoned for accidently killing her unborn child due to cocaine addiction, while another woman is allowed to abort her viable unborn child due to the fact that it has Down' syndrome. There is also a hazy boundary between what is considered detrimental to the foetus and what is not, which is another issue with maternal pressure (Isaacs, 2003). Should we make diabetic moms take their insulin by force? It is known that the degree of control of maternal diabetes affects the outcome for the foetus. It is possible to disregard religious convictions. An adult Jehovah's Witness has the right to decline a blood transfusion, however in the USA, a pregnant Witness who was bleeding out was compelled to get a transfusion in order to preserve her unborn child (Sullivan, 2000).

Others contend that a foetus has no moral status separate from that of its mother and that, instead, it obtains moral position upon birth. The response to the question of what the immediate moral importance of birth is that infants, unlike foetuses, are a part of a social world. The moral status is bestowed upon one's entry into society. This view would grant a pregnant woman the moral right to abort a viable foetus, but not the right to kill her unborn child, according to one consequence. If she were to decide at the end of her pregnancy that she did not want her (normal) child, she could morally kill the viable foetus; yet, if she were to give birth that same day, she could not kill the newborn child either legally or morally (Isaacs, 2003). The distinction between an early abortion and a late termination of a viable fetus which would have lived unless forcefully stopped from breathing is significant. Women's rights activists frequently portray the foetus as a burden that exists solely to exploit the mother. A parasite or even a tumour have been used as comparisons for the foetus. It is cruel to attribute the foetus with cancerous traits. Making the foetus the bad guy suggests that the decision to end a pregnancy is

being transferred to the foetus. The third option is that the foetus gains moral stature as gestation progresses. We should take into account that the moral position of the foetus does indeed rise with gestation because of the moral difference that many people see between an early abortion and the termination of a viable full-term foetus (Isaacs, 2003). By giving the foetal complete rights, we are suggesting that society must uphold those rights, just as it would with a live newborn. However, as was already mentioned, the mother's autonomy to determine what happens to her own body and the unborn' rights may collide. If there are no rights for the foetus, then even a live foetus is not protected if the mother endangers it. A viable foetus has a higher moral status than a freshly fertilized ovum if the moral status of the foetus rises with gestation, and it could be permissible to step in if the mother's actions endanger the foetus soon after conception. Because of its complete reliance on the mother's body up to delivery, the foetus is not a separate biological entity from her. If it also impacts what happens to the mother's body, it would appear that the mother has significant "rights" in deciding what happens to the foetus. There isn't a lot of conflict overall. In a mutualistic, as opposed to parasitic, relationship, the mother acts as the foetus's moral defender. If there are significant differences in the interests of the mother and the foetus, the mother has a responsibility to assess both and make a decision that is best for them both. Early in the gestation period, if conflicts do occur, the competent mother's rights to personal autonomy should take precedence over the baby's less significant rights; nevertheless, as the foetus matures and gains more moral weight, the position becomes less clear-cut.

2.5 Clinical Maternal-Foetal Issues

2.5.1 Birth Defect Screening

In some nations, every expectant mother is eligible for a Down syndrome screening. In order to ensure that the patient has enough information to make an informed decision, good screening practices mandate that she get pre- and post-test counselling. The agreement further states that, in the event of a screening positive result, a diagnostic test was provided. The choice of a more invasive diagnostic test is based on weighing the risks of having a kid with Down syndrome against those of having a child who might miscarry as a result of a diagnostic procedure like amniocentesis. A 1 in 300 cutoff risk has been adopted during the first trimester of Down syndrome screening (Kagan et al., 2008). A diagnostic test is provided when the risk is estimated to be greater than 1 in 300. In this case, the test is screened positively. The choice (and presumed goodness) of the expectant mother and the miscarriage of a perfectly healthy foetus are at odds with one another. The risk for a foetus with a 1 in 50 risk is 6 times greater than the 1 in 300 cut-offs. Almost always (49 out of 50 times), the foetus is healthy. The operator's competence is frequently taken for granted. In 49 out of 50 cases, a miscarriage following an amniocentesis resulted in a healthy foetus. That healthy foetus has not decided to accept the possibility of becoming "collateral damage" as a result of the pregnant woman's decision. The autonomy of the mother over the rights of the "unborn child" is a reality of screening. The number of Down syndrome foetuses found during each miscarriage can be valued. This is solely a consequentialist argument. Most secondary birth defect prevention measures are held to the same moral and ethical standards. Other suitable instances include non-lethal significant structural

abnormalities and thalassaemia screenings. The decision made by the pregnant woman is at the heart of this moral-ethical conflict, making it necessary to educate the patient who is making the decision through appropriate moral and ethical counselling (Yeo & Lim, 2011).

Foetal abnormalities found beyond 24 weeks and the gestation of presumed viability are two other frequent clinical scenarios. Prenatal screening raises countless questions, such as whether a foetus with a severe irreversible deficit of cognitive developmental capacity has lost its moral right to be protected from harm or whether lethal foetal anomalies diagnosed after 24 weeks should always be discussed on a case-by-case basis by the ethics committee. These are just two examples. The scenario will certainly get more challenging as expectations rise as a result of genetic advancements, especially when there is a desire for testing the "unborn child" for less severe illnesses or the existence of specific genetic features for selective procreation (ACOG Committee Opinion No. 410, 2008).

2.5.2 Inducing Labour for Suspected Placental Insufficiency

The most frequent reason for inducing labour is suspected placental insufficiency. These situations include post-term pregnancies, pregnancies complicated by IUGR or PET, maternal medical conditions, and pregnancies with small gestational gestation. The rate of induction of labour has steadily increased throughout time, and it is not unusual to see an induction rate of 20% in modern maternal-foetal populations (National Collaborating Centre for Women's and Children's Health, 2008). A 35–40% chance of a caesarean section results from labour induction in pregnancies with an unfavourable cervix, endangering the mother's ability to reproduce in the future (Pennell et al., 2009).

A legitimate benefit for the foetus must be weighed against the clear compromise to mother interests.

2.5.3 Preterm Births

The sufficiency of the placenta determines the health of the normally formed foetus in pregnancy. In order to protect the foetus, the timing of delivery must strike a balance between the risks of foetal asphyxiation due to placental insufficiency and neonatal asphyxiation due to immaturity of the lungs. Every additional day of gestation increases the chance of survival in a very preterm foetus by 2%. This benefit continues with a 1% increase in survival for every extra day of gestation up to 32 weeks. Gestational age has the greatest impact on foetal survival up to 27 weeks and intact survival up to 29 weeks in IUGR pregnancies. A foetus born before 27 weeks has a 3-fold higher risk of morbidity than one born between 27 and 32 weeks, in addition to higher mortality (Baschat et al., 2007).

While a healthy foetus may remain inside the uterus in a pregnancy plagued by severe early-onset PET, the mother may continue to experience its side effects, such as renal impairment. The mother must be ready to accept the danger of severe sepsis and puerperal infection in the event of a preterm premature rupture of the membranes in exchange for an increase in neonatal survival. The maternal-foetal conflict is complicated by the doctor's responsibility to both the pregnant mother and the unborn child given that the foetus's final survival rate is 1 percent per 1 to 2 days of continuous pregnancy (Yeo & Lim, 2011).

2.5.4 Caesarean Section

Maternal-foetal conflict is well-illustrated by caesarean sections. The attending physician has a unique ethical dilemma since he or she must weigh the obligations to the best interests of two interdependent people. This is best demonstrated by an example from Pennsylvania (ACOG Committee Opinion No. 321, 2005). Contrary to the pregnant woman's wishes, a caesarean delivery was carried out by the hospital care for a pregnant woman with probable macrosomia after obtaining a court order. The mother then gave birth to a healthy 11-pound baby via vaginal delivery at another hospital without any complications. The possible advantage to the foetus from avoiding a vaginal delivery must be evaluated against the danger of a caesarean section to the mother in this clinical circumstance. The risks of a caesarean section are numerous, with severe bleeding, challenging lower segment rips, and challenging intubation being common occurrences. The risk of uterine rupture in labour (0.15 percent to 1.9 percent) (Dekker et al., 2010), placental previa (0.8 percent to 4.2 percent), or a pathologically attached placenta is not insignificant for many of these moms who later become pregnant again (12 percent) (Gielchinsky et al., 2002).

Contrarily, a macrosomic baby is more likely to suffer from morbidities such clavicular fracture, hypoxia, and brachial plexus injury during vaginal birth. The doctor's role includes appropriate communication with the woman who serves as a surrogate for the unborn child and determining whether the woman is an adequate representation of the foetus, in addition to making a challenging clinical decision about the best timing or method of delivery in the interests of both the woman and the foetus. The doctor here needs assistance. Since every case has a unique set of circumstances, including the legal and sociopolitical position of the society, there is no set methodology for handling such

circumstances. Despite the fact that the woman's activity may have caused harm to the foetus, the ethics committee supports the woman's autonomy and rights. The advice given states that when providing care for pregnant women, professionals should understand that, most of the time, the interests of the pregnant mother and her foetus converge rather than differ. It is always in the best interest of both the mother and the foetus to advocate for healthy behaviour in pregnant women, refer them when appropriate for substance abuse treatment and mental health services, and maintain a positive doctor-patient relationship (ACOG Committee Opinion No. 321, 2005).

2.5.5 Surrogacy of Foetal Rights to the Pregnant Woman

The protection of the foetus from damage is typically attributed to the mother's activities, even though the foetus can theoretically be viewed as a separate entity, independent from the pregnant woman. Rarely does the court have to get involved, but when it does, it is usually when a pregnant woman can't make decisions because she's abusing drugs or has a mental disorder (Dimond, 2001; Ethics committee guideline no. 1, 2006). Other instances, the woman's decision (in the best interests of the foetus) is hampered by a dearth of proper medical information pertaining to her high-risk pregnancy. Due to the pregnant woman's ignorance of potential difficulties, the foetus is thus put in danger. The inadequacies of the physician in healthcare education are frequently cited as the cause of this ignorance. For instance, in cases of multiple pregnancies, a knowledgeable doctor can make a significant impact by instructing the expectant mother on how to prevent injury to the foetuses (Yeo & Lim, 2011).

2.5.6 Multiple Pregnancy

Negative pregnancy outcomes are substantially more common in multifoetal pregnancies than singleton pregnancies. A multifoetal pregnancy increases maternal and perinatal morbidity and mortality because the high risk affects both the mother and the foetuses. Despite the doctor's warnings about the numerous risks of pregnancy, the sub-fertile woman frequently exercises her autonomy by choosing artificial reproductive treatment (ART). In her desperation to become pregnant, the hazards are frequently not fully considered. In the context of high-order multifoetal pregnancy, particularly when a foetus is terminated in order to protect its co-twin, there can be significant tension between the best interests of the woman and the foetuses (Yeo & Lim, 2011).

2.5.7 Chorionicity, Multifoetal Pregnancies and Foetal Reduction

There may be a conflict of interest between the two foetuses when a twin pregnancy experiences problems. When there are dichorionic twins (DCT), one twin may be abnormal and endanger the remainder of the pregnancy. When one twin in the same womb fails, the other can still develop and grow perfectly independently in DCT; this is more frequently the norm than the exception. The delivery may be the last option to save a growth-restricted foetus in a severely preterm pregnancy when the foetus's condition is not reassuring. The healthy co-twin is harmed by early birth and the associated mortality and morbidity in order to safeguard that twin. Alternately, the mother could decide to carry the pregnancy to term even if it means the IUGR twin would suffer injury or die (Yeo & Lim, 2011).

A monochorionic twin pair (MCT), on the other hand, shares a placenta with a vascular anastomosis. There is a 30% possibility that the remaining foetus will suffer severe harm, such as cerebral palsy or developmental delay. In comparison to the DCT, onethird of MCTs experience certain significant problems. TTTS, or twin-to-twin transfusion syndrome, is a well-known MCT complication (Yeo & Lim, 2011). Twins share a vascular circulation, thus when one of them passes away, the other experiences hypovolemia shock from transfusion into the dead twin via veins tying the two foetuses together. Treatment for TTTS involves foetoscopic LASER vascular coagulation. Often, this is a last-ditch operation to preserve the foetuses at the price of the woman's health. The afflicted foetuses suffer significantly from mortality and morbidity. The knowledgeable woman finds the thought of a significant (in the range of 10% to 20% or more) chance of single or double foetal mortality frightening (Roberts et al., 2008). Even with the finest care, many TTTS survivors experience lasting disabilities. TTTS frequently takes precedence over legal viability. Many women might elect to end a challenging MCT pregnancy because they cannot accept the significant residual hazards of LASER treatment. Therefore, it might be argued that a doctor's actions could be viewed as unethical if he does not determine chorionicity and provide information to help the woman's decision. There are yet further complicated combinations of problems that are challenging to address in depth without a context, such those that occur with triplets (Yeo & Lim, 2011). But as ART spread, these problems started to appear more frequently in modern maternal-foetal populations. Essentially, about 25% of trichorionic triplets experience early preterm delivery, which causes serious difficulties for the remaining foetuses. The chance of an early preterm delivery drops to 5% with a foetal decrease from a triplet to a singleton pregnancy (Papageorghiou et al., 2002).

When there is an MCT pair present in a dichorionic triamniotic triplet, the situation is different. Higher hazards are involved when a triplet is reduced to a twin.

2.5.8 Following ART, the practice of foetal reduction is already well-established

The foetal reduction operation is used in Singapore, at the woman's intentional request and with ethics committee approval, to ensure that a multifoetal pregnancy has the highest chance of continuing to term. To put it lightly, it is difficult due to the accompanying moral quandary and required technical expertise (Yeo & Lim, 2011).

2.5.9 Foetal Surgery

A procedure known as intrauterine foetal surgery is opening the uterus while the mother is pregnant, performing a surgery, and then replacing the foetus in the uterus (AlfaroLeFevre, 2004). Although there are significant dangers to both the mother and the foetus, foetal treatment can be utilized to treat anatomic defects. Some claim that using medical technology shouldn't change the natural world, hence this intervention shouldn't happen (Judson et al., 20110). Others would counter that the child's quality of life is enhanced by the surgical procedure. In every situation, the risks and advantages of surgery for significant foetal malformations must be taken into account. Despite a successful operation, the foetus may still not survive, have other major issues, or be born prematurely (Taylor et al., 2005). A caesarean birth and weeks of bed rest may be necessary for the mother. Despite the dangers, a baby who would not have survived without the successful foetal surgery may be born. To strike a balance between the best interests of the foetus and possible risks to the mother, parents require assistance. They could feel under pressure to undergo surgery or other unclear foetal treatments (Taylor et al., 2005). Women require sufficient information before making a decision, just like

in any situation involving informed consent. They ought to be aware of the options that are accessible, if certain methods are still considered experimental, and their prospects of success (Aderemi, 2016)

The doctor has a responsibility to be aware of recent developments in medicine in order to make an informed decision regarding the lady patient. Novel techniques typically go through two stages of development: a phase of exuberant claims of success, followed by a phase of relative notoriety when unreported difficulties surfaced. True worth frequently becomes apparent after years of accumulated experience. Open foetal surgery for spina bifida and diaphragmatic hernia are two excellent instances. These only arise in experimental and research settings, where there is a severe conflict between maternal and foetal interests (Lyerly et al., 2001).

The main reason for doing these treatments was to benefit the foetus. With complications like pulmonary oedema occurring in up to 30% of pregnant women, the risk to the mother of carrying out such a pregnancy after a hysterectomy with protracted tocolysis is not negligible (Golombeck et al., 2006). A lady and her unborn child are most susceptible to the doctor's knowledge or lack thereof. The interest of the foetus frequently comes at a measured risk to the mother in high-risk maternal-foetal situations. A framework that incorporates the ideas of beneficence and autonomy is the most effective way to handle the problem of ethical quandaries. In order to support a deliberate choice for the benefit of the pregnant patient and her foetus, the doctor has a moral obligation to use medical knowledge while counselling the patient (Yeo & Lim, 2011).

2.6 Abortion

One of the most frequently used treatments for problems with maternal health is abortion. It has developed into a contentious political issue that divides people into prochoice and pro-life groups. The pro-choice movement advocates for the freedom of every woman to decide how to use her reproductive organs in accordance with her own moral and ethical principles. The pro-life movement is adamant that abortion is murder and robs the foetus of his or her fundamental right to life. This highly charged subject will be discussed by both sides for many years to come. Depending on how far along a pregnancy is, there are both medical and surgical methods to abort it (Aderemi, 2016). Medical interventions can be made up to 9 weeks' gestation, whereas surgical interventions can be made up to 14 weeks.

2.7 Ethical Dilemmas

A decision that might go against ethical ideals is referred to as an ethical dilemma (Lagana & Duderstadt, 2003). The term "ethical dilemma" is frequently used to describe situations in which it is difficult to decide which course of action is the most important (Narrigan, 2004). The term "ethical dilemma" is frequently used to describe situations in which it is difficult to decide which course of action is the most important (Schroeter, 2007). It can also be described as an instance in which the professional's obligations and the patient's rights diverge (Simpson & Chez, 2001). These circumstances frequently arise in perinatal and neonatal care because the welfare of the mother and her newborn must be taken into account (Aderemi, 2016).

Rapid advances in science and technology have made it possible for challenging problems to arise. What medical procedure is ideal for a patient? Who makes the

decisions? What does a nurse's position as a client advocate entail? What legal obligations does the hospital have in relation to the choice? (Aderemi, 2016). It uses the ethical decision-making process to get to the core of an ethical challenge. Making decisions in situations involving ethical dilemmas requires a step-by-step process of analytical and intellectual reasoning (National Center for Health Statistics, 2005). Responsible ethical reasoning is therefore methodical and logical. It is the application of a problem-solving procedure that is governed by moral standards and laws. The ideal ethical course of action is one that preserves both the integrity of all parties involved and the client's best interests (National Center for Health Statistics, 2005).

2.7.1 Steps in Ethical Decision-Making

Clarifying the process or the ethical challenge is the first step in the ethical decision making process. This is referred to as problem identification. The queries can include: Whose issue is this? What's the aim? Who should decide this matter? Who will be impacted by the choice? What ethical and moral principles are related to the problem? (Aderemi, 2016). Afterward, more information will be gathered in order to examine the issue's causes and effects. This is to help you get as much specific information about the problem as you can so that you may decide with confidence. the primary parties involved, their perspectives, and interests, the client's general nursing, medical, and social situation, as well as any pertinent legal and administrative staff considerations (National Center for Health Statistics, 2005).

Investigate potential options for the issue: Choose an option. Determine all the options that are available to you, then weigh the results of each option in light of both the short-

term effects on the individuals involved and the long-term effects on the institution and society.

Make a choice: Consider the suggested alternatives. Certain were more conceivable than others. Choose the solution that you find most acceptable. The optimal choice is one that is in line with one's principles, does not put one's life in danger, and does not go against the law. A smart option in terms of professional ethics is one that satisfies the client's needs while also upholding everyone's integrity. This decision must be guided by ethical principle and code of the profession. Rely on those principles, which you judge to be most important and of which you feel most sure (National Center for Health Statistics, 2005).

Take a position: Consider the options you've chosen. Some seemed more conceivable than others. Choose the solution that best suits your needs. The greatest choice is one that is in line with one's principles, doesn't put one's life at risk, or breaks the law. A good professional decision is one that satisfies the client's interests while also upholding the integrity of all parties involved. The ethical standards and code of conduct for the profession must influence this choice. Rely on the principles that you believe are most important and that you are most confident in (National Center for Health Statistics, 2005).

2.7.2 Ethical Reasoning and Approaches

In the shared conceptions and principles that underpin most ethical dilemmas, the capacity for ethical reasoning is regarded as being of utmost importance (Paul & Elder, 2005). A person's way of thinking, or what should be done while making ethical decisions to arrive at a final judgement, greatly influences their ability to reason

ethically (Treviño et al., 2006). According to Knobe (2005), In the past, studies on ethical reasoning have emphasized moral principles and the welfare of others while ignoring the moral character that conveys an ethical and altruistic attachment to others (Arjoon, 2000). Ethical theory and moral philosophy have frequently been used interchangeably (Ahmad et al., 2005; d'Anjou, 2011) and is still a significant factor in reasoning while making ethical decisions. Treviño et al. (2006) It has been suggested that the fundamental elements of ethical reasoning are moral awareness (the existence of an ethical issue), judgement (determining what is right), intent (the meaning of an act), and ethical motivation (the desire to act morally). Conflicts between ethical principles might be regarded as ethical issues in reproductive medicine. The phrase "ethical ideals" refers to any moral guidelines, precepts, and considerations that are pertinent to reproductive ethics. Role-related obligations, virtues, and rights as well as examination of the effects of acts are among these issues. Examples of more specific values that are frequently pertinent to moral questions in reproductive medicine include, among others: respect for life, scientific freedom, reproductive freedom, the welfare of procreators and potential procreators, the welfare of offspring, the welfare of society, the welfare and autonomy of women individually and collectively, and the welfare of society as a whole. There are various methods for allocating priorities when resolving value disputes (Hellsten et al., 2013b). We must think about the following issue in order to recognize these strategies: at what level of generality should the ordering of competing ethical ideals be done? When attempting to respond to this query, we observe that there are four primary options:

The level of generality at which it is appropriate to assign priorities to ethical ideals that clash must be taken into account in order to distinguish between various strategies.

There are four basic options when we attempt to respond to this question: The first strategy entails classifying values or groupings of values according to a hierarchical ranking. The rating is finalized once it has been determined and is applied uniformly to all situations and problems. This strategy is demonstrated by an ordering proposed by Robert Veatch (1981), in which a collection of non-consequentialist principles is always given precedence over the beneficence principle. This method has a problem in that it does not fully address the complexity of morality. We can always come up with an instance in which a value or collection of values that is presumptively placed first is superseded by other values. For instance, under Veatch's ordering, there are circumstances in which the non-consequentialist concept of autonomy is superseded by the beneficence principle, or more particularly, the notion that we should prevent harm to others (Hellsten et al., 2013b).

In the second method, a ranking of values is created that is constant throughout all instances in which a certain problem occurs. As an example, consider the debate over whether to comply with single women's requests for artificial insemination, in which the core conflict is between the woman's right to choose whether or not to have children and, possibly, the need to protect the unborn child from damage. The idea that requests for artificial insemination by single women should never be honoured and that this issue should always be settled by giving precedence to the prevention of alleged harms to the child as an example of the type of prioritizing in question. Additionally, the approach in question selects a preferred option for each issue and gives preference to the selected value in each instance when the issue occurs. This method appears to be adopted by many authors in reproductive ethics, despite the fact that its rigidity would seem to be a downside. This method's difficulty is comparable to that of the first method. The belief

that a certain ethical value, or collection of values, should always take precedence typically betrays an oversimplification of the moral situation, even when we concentrate on a specific topic. We frequently have examples of the kind in mind when a value or set of values that is purportedly given precedence for a certain issue is really superseded by other moral concerns (Hellsten et al., 2013b).

The third method ranks values for each concern in the context of each individual scenario. This method aims to compromise or strike a balance between the primary ethical principles at stake in a particular situation. This entails giving a value priority in certain instances while giving a different value priority in other instances of the type in question. This strategy is known as "casuistic" or case-based reasoning (Hellsten et al., 2013b). The so-called casuistry method avoids many of the oversimplifications made by the first two methods. Additionally, it does a good job of capturing how bioethical judgments are typically made and ought to be made. It achieves this by seriously recognizing the heterogeneity in instances among ethical dilemmas in the therapeutic setting. There are typically a number of ethically significant ways in which an ethical conflict can vary from one instance to the next, and these changes can have an impact on the conclusions that should be drawn. However, despite being more adaptable than the first two, this strategy falls short of the level of adaptability required to fully address the complexity of bioethics. The so-called casuistry method avoids many of the oversimplifications made by the first two methods. Additionally, it does a good job of capturing how bioethical judgments are typically made and ought to be made. It achieves this by seriously recognizing the heterogeneity in instances among ethical dilemmas in the therapeutic setting. There are typically a number of ethically significant ways in which an ethical conflict can vary from one instance to the next, and these

changes can have an impact on the conclusions that should be drawn. However, despite being more adaptable than the first two, this strategy falls short of the level of adaptability required to fully address the complexity of bioethics (Hellsten et al., 2013b). This kind of in-depth critical analysis of a problem cannot be applied to the third strategy.

The fourth approach is better to the third because, while acknowledging the overall validity of case-by-case decision-making, it also recognizes that there may be broader social factors for some situations that provide justifications for adopting a consistent policy across all cases. As a result, it permits such extensive concerns to be taken into account. Furthermore, the fourth strategy merely offers the option for prioritizing topics on a degree of priority rather than mandating it. According to its claims, there is a presumption in favour of ranking values in the context of certain circumstances, although this assumption may occasionally be overruled. As a result, the fourth method enables us to consider the "big picture" in order to consider where we are headed and where we should be heading in terms of human reproduction and to develop policies that take this into consideration. The fourth approach is also casuistic because it employs the same kind of reasoning as the third approach. Having terminology to distinguish between these two forms of casuistry is useful (Hellsten et al., 2013b).

2.7.3 The Application of Ethical Framework in Maternal Foetal Issues

It should be highlighted that the effectiveness of an ethical framework in addressing problems serves as a crucial litmus test. The mother's refusal to provide the foetus the necessary care is one of the problems with maternal-foetal complications. The fact that doctors believe the foetus has a relatively high moral status is one of the reasons these

cases worry the medical experts participating in them. These conflicts frequently occur very late in the course of pregnancy, at a time when, according to our paradigm, the foetus has a strong moral standing. However, the late-gestation fetus's moral standing is not quite as high as an infant's according to the framework. It is not quite the same as having complete personhood (Hellsten et al., 2013b). The pregnant lady, on the other hand, is fully a person. This makes it difficult to defend forcing an invasive procedure on a cognitively capable pregnant lady against her will. The fact that she has a higher moral standing than the foetus does not logically prove that forced therapy is always wrong. It does, however, lend credence to the notion that there ought to be a very strong presumption in favour of honouring the woman's desires. To put it another way, it would need extremely strong evidence to support defying her wishes. Almost always when forced maternal treatment is considered, the justifications are not strong enough (Hellsten et al., 2013b).

2.7.4 Multicultural Issues in Maternal-Foetal Issues

In order to establish a polarization between two very distinct bioethical frameworks when discussing intercultural concerns in maternal-foetal issues, we frequently begin by defining the terms. There are two main schools of thought: relativism, which emphasizes the relativeness of cultural belief and value systems, and universalism, which emphasizes the universality of human rights. It is likely that two opposing bioethical positions, Universalist liberal individualism and Relativist communitarian collectivism will develop as long as these polarizations persist. Due to the seeming incompatibility of these perspectives, it would seem illogical for them to engage in a fruitful discussion and agree on ethical issues. However, it frequently seems that both

viewpoints make an effort to satisfy the general demand for rights protection when it comes to the preservation of human rights. Individualists advocate respect for individual rights, whereas relativists urge respect for the rights of social groups and cultural institutions. Therefore, despite their seeming inconsistency, they each assert that their requests are reasonable in light of international law and basic human rights. What logical foundation supports these demands? (Hellsten et al., 2013b).

In Western pluralist and multicultural democracies, bioethical reasoning is often founded on liberal notions of justice, calling for the universalization of individualist principles including respect for individual autonomy, preservation of human rights, and the promotion of equality and tolerance. No matter their gender, ethnicity, lifestyle, or cultural heritage, liberal individualism mandates that we treat everyone equally. It also assumes that people are autonomous moral agents capable of making their own decisions about their moral standards and manner of life. On the other side, this means that we must respect people's right to choose their own way of life and level of cultural identity. To put it another way, neither the state nor another person has the right to define what constitutes "the good life" for another person (Hellsten et al., 2013b). We are expected, within the liberal Universalist ethical framework, to accept variety in cultural backgrounds and tolerating varied lifestyles in today's pluralist society. This means that in matters of maternal-foetal medicine and reproductive health, we must respect a patient's autonomy and rights, including the right to uphold one's cultural values and beliefs. There are boundaries to tolerance, even within a liberal framework. Differences in ideas and lifestyles are only acceptable provided they do not cause harm to or infringe upon the rights of others. The actual harm, however, is occasionally challenging to identify or demonstrate (Hellsten et al., 2013b).

The most challenging ethical and intercultural problems in today's pluralist society typically include competing rights and interests of many people. There is also the issue of one's autonomy's standing. In maternal-foetal medicine, for instance, there may occasionally be disagreement about whether a mother's rights or those of her unborn child should come first. For instance, while those who support abortion defend women's autonomy as moral agents and their right to control their bodies, those who oppose it might contend (on the basis of their religion or another reason) that the foetus is already a moral being and as such has rights that must be taken into account (Hellsten et al., 2013b).

Medical personnel frequently have to choose between opposing rights and interests of the patients. In the majority of maternal-foetal difficulties, this would frequently be the decision between upholding a pregnant woman's autonomy over her own body and preventing harm to an innocent kid. In addition to abortion-related concerns, rights and interests may clash when a woman's actions or way of life (such as using drugs, smoking, drinking, engaging in dangerous sexual activity, or having sex without protection) may directly or indirectly endanger the health of the foetus (Hellsten et al., 2013b)

In a pluralist society, it may be challenging to reach consensus on whose rights and interests should be safeguarded in any given situation due to the diversity of our value and belief systems. On occasion, it can appear that a woman's rights and interests in avoiding outside intervention and control should take precedence. At other instances, it may appear that the respect for a mother's autonomy is superseded by the child's rights and interests in having a respectable quality of life. But generally speaking, these differences can be discussed, if not always definitively settled, within a common ethical

framework that in and of itself admits that all people have some universal and equal rights (Hellsten et al., 2013b).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methodology that was used in the study. The chapter has been divided into three components. The first part discusses the philosophical foundation of the study design. The second section provides the study site, the participants in the study as well as the inclusion and exclusion criteria. The third part further explains the sampling procedures, the content of the interview guide, a detailed description of data collection and analysis techniques, and ethical considerations of the study.

3.2 Study design

This study employed the use Focus group discussions (FGDs) and in-depth interviews (IDIs) as part of an exploratory qualitative study design. The focus group discussions (FGDs) used case studies to identify the moral, legal, and social conundrums and decision-making processes in maternal-foetal conflict situations in Ghana. The Shai-Osudoku District Hospital's Mother and Child Health Unit is medical staff and a client (pregnant woman) with a maternal-foetal conflict was interviewed in-depth in order to collect qualitative data.

3.3 Study area

In the Shai-Osudoku District of Ghana's Greater Region, the Shai-Osudoku District Hospital served as the study's location. According to the 2021 Population and Housing Census, 107,828 people are living in the Shai-Osudoku District, with 50.3% of men and 49.7% of women. The population of the district makes up 1.9% of the population of the

Region. Additionally, rural areas are home to around 43.1 percent of the district's population. The district has a 95: sex-to-dependency ratio and a 76.4: dependency-to age ratio.

The district's recorded 92.1 births per 1,000 women aged 15 to 49 represent the average fertility rate with a total fertility rate of 3.0 and a crude birth rate of 23.5. According to the 2021 annual year report the Shai-Osudoku district recorded 4,594 pregnant women reporting to the health facility with 4593 deliveries recorded for the same facility with 1 maternal death, and in 2022 mid-year recorded 2409 deliveries with 3 maternal deaths. The district hospital recorded about 11 maternal-foetal conflict situations with 7 resolved, 1 unresolved but transferred to a higher facility and losing 3 in the process. At 22,691, or 43.7 percent of the district's population, migrants make up the majority population.

The study population included health service providers who render maternal-foetal care at the Shai-Osudoku district hospital. Maternal-foetal service providers will include midwives and gynecologists. Pregnant woman and or a client with a maternal-foetal conflict where possible. The Shai-Osudoku District Hospital has a zero maternal mortality policy which during the previous five years has produced incredible outcomes. Over the years, the district hospital recorded more than 2,000 deliveries per year, yet as the Ghana News Agency reported in 2015, "the facility has never recorded a maternal fatality" (Adu et al., 2021). This makes the hospital well positioned to help guide the development of guidelines on the best practices for maternal-foetal conflicts.

3.4 Sampling Technique

Purposive sampling was used for the qualitative study. The purposive sampling method is one of the non-probability sampling methods used in qualitative research.

Participants was selected from the maternity and labour ward of the Shai-Osudoku District hospital. Participants for the study included midwives who had served at least three years in the hospital, medical officers and or gynecologists who had also served three years with experience in the subject of interest and a client or pregnant woman with a maternal-foetal conflict situation. When a researcher chooses study participants who can give relevant data to help address the research objectives, this is known as purposeful sampling (Cresswell & Plano Clark, 2011; Green & Thorogood, 2004). Additionally, the purposive sampling method is typically employed in qualitative studies to allow the researcher to choose people who display particular characteristics, experiences, and knowledge regarding the research topic to make the most of the available resources (Cresswell & Plano Clark, 2011; Patton, 2002). Maximum variation purposive sampling, homogenous samples, typical case purposive sampling, extreme case purposive sampling, critical case purposive sampling, and expert purposive sampling are only a few examples of purposive sampling approaches (Patton, 2002). Maximum variation purposive sampling is the type of sampling method that is used to capture varied experiences and opinions relating to the issue under investigation (Patton, 2002). In this study, the maximum variation purposive sampling method was used to ensure that a range of perspectives relating to the maternal-foetal conflict situations are explored in the hospital and the ethical, legal, and social moral decision-making approach adopted by the health providers and client.

Once the study reached saturation (no fresh information is being revealed by the data) and the topics are entirely explored, recruiting terminates. This happened when the information provided by the respondents is reflected in the data obtained.

3.5 Data Collection Method and Technique

To explore and understand participants' informed knowledge, viewpoints, and general worldviews, it was necessary to use the appropriate data collection techniques. Face-to-face recruitment of participants was carried out. A total of five (5) personnel were trained to conduct the in-depth interviews. A semi-structured questionnaire was used for in-depth interviews to explore the study participants' views and ideas on maternal-foetal conflicts and how they deal with such situations. The midwives and medical officer each underwent one session of the in-depth interview.

The in-depth interview was conducted in English, Twi and Ga since they were the languages convenient to the interviewer and study participants. The IDI session was recorded and transcribed verbatim. IDI interviews conducted in Twi and Ga was translated into English by personnel proficient in English and both Twi and Ga.

The variables to be explored in this study revolves around the ethical judgments made by healthcare professionals regarding the patient's right to autonomy, justice benefit, no harm, and moral obligations to the unborn foetus as patients.

Two Focus group discussion (FGDs) were organized for midwives, medical officers and or gynecologists present at the time of study (one for Midwives and One for Gynecologist/medical Officers). The FGDs was made up of 7 members who have knowledge and have experienced the case under study. The FGD guide and two maternal-foetal case scenarios were used for the group discussion session. Two FGDs

(one for midwives and one for medical doctors) were organized.

3.6 Pre-testing

Each interview guide was pre-tested with midwives and gynecologist who had experienced a maternal-foetal conflict situation. The main objective was to assess the intelligibility of the questions and, to improve any of them. The Pre-test interviews were conducted at the Tamale Teaching Hospital in the Northern Region of Ghana.

Table 1 study participant category

Category of Participants	Data Collection Method	Data Collection Guide
Midwives	In-depth Interviews and FGD	Interview Guide and Case Scenarios
Medical officers/ maternal-foetalian specialist and Facility Manager	In-depth Interviews and case scenario FGDs	Interview Guide
Pregnant woman and or a client with a maternal-foetal conflict where possible	In-depth Interview	Interview Guide

3.7.0 Data Analysis

All IDI and FGD audio recordings were verbatim translated into written form. Each transcript was checked at least once for accuracy to spot any mistakes or missing text. "..." was used to indicate that there was no sound or that some information was missing where the recording could not be heard. After that, all transcripts were loaded into NVivo 12, a qualitative research programme. To make sense of the varied accounts of the interview respondents, a narrative inductive approach was applied. This method of qualitative data analysis was utilized to draw attention to significant elements of the stories that best reflect the process of arriving at ethical decisions. The transcribed

information was summarized into categories based on how the ethical principles are employed in the decision-making process. The classification also drew attention to the various elements that affected the decision-making of the health care practitioner.

3.7.1 Inclusion Criteria

The study included health service providers who rendered maternal-foetal care at the Shai-Osudoku District Hospital. Maternal-foetal service providers included midwives and gynecologists who have served three (3) to ten (10) years in the labour ward and have been confronted with maternal-foetal conflict situations.

3.7.2 Exclusion Criteria

- Midwives and Gynecologists with less than three (3) years' experience working in the labor ward were not included in the study.
- Midwives and Gynecologists who are not willing to talk to the research team were not included in the study.

3.7.3 Data Storage and Use

The information gathered was only utilized for academic purposes. Researchers would ensure confidentiality regarding the information they obtained from participants both during and after the study, and both paper copies and electronic versions of the data were kept in secure storage. Data was kept secret and would be deleted three years after the study's conclusion.

3.8.0 Ethical Issues

Approval for the study was sought from the Dodowa Health Centre Institutional Review Board with ethics approval number DHRCIRB/209/10/22. Permission was sought from

the leadership and management of the Shai-Osudoku District Hospital accompanied by a letter of introduction from the University of Ghana and the ethical clearance letter. Substantial and established steps was taken to obtain individual informed consent from each participant. Efforts were made throughout the study to ensure confidentiality and all data collected was anonymized for participants. Participants were compensated for their participation, time, and inconvenience with a gift value of GHC 20 in the form of refreshment.

3.8.1 Informed consent

Information about the study was provided to all prospective participants in either the relevant local language or English. There was no technical language, and the information was simple to comprehend. The participants had enough time to process the information and pose questions. Before participating, those who agreed to take part in the study were required to complete a consent form.

To confirm their agreement to participate in the study, participants who are illiterate were needed to thumbprint after having the information delivered to them in the local language that they can understand. Additionally, each participant gave their consent for audio recording.

3.8.2 Confidentiality and Privacy

All participants received guarantees about their privacy and that their identities would not be revealed until the study's conclusions were shared this is to ensure safety and anonymity of study participants. By giving each participant an ID number, this assurance was given. Care was made to choose discussion and interview locations that wouldn't be overheard. All qualitative data was anonymized, given a unique code

number, and stripped of any personally identifiable information. Participants' information and replies could only be matched by the data analysis team because electronic files were password-protected.

3.8.3 Right of withdrawal

The right to withdraw was explained and it was made clear to participants that they could withdraw from the study at any stage without running the danger of any unfavourable outcomes.

3.8.4 Risks and Benefits

This study poses no significant risks to participants and participants will not directly benefit from the study. However, it was explained to participants the study outcome could improve the decision-making process in addressing complex maternal-foetal issues.

3.8.5 Voluntariness

It is optional to take part in this study. Refusal won't harm you in any way or have an impact on how you receive medical care or your line of work. Before the discussion begins, we are pleased to answer any questions you may have.

3.8.6 Compensation

Participants were not compensated for the loss of time. Participants during the IDI and FGD session were offered simple refreshments to an amount of GH¢20.

3.8.7 Funding

The investigator financed the study.

3.8.8 Safety considerations

Directly, this study did not pose any potential risk, nonetheless, due to the ongoing COVID-19 pandemic, interacting with other people can increase participants' and research team members' risks of contracting COVID-19, an infectious illness, which can be fatal. To ensure the safety of potential participants and the research team, measures were kept in place have been listed below.

- Participants were provided with hand sanitizers to clean their hands whenever necessary before, during, and after the interview and deliberative or discussion events.
- All research team members were provided with hand sanitizer and ensured to sanitize their hands whenever necessary before, during, and after the interview or deliberative or discussion events.
- Spatial distancing of at least 1.5 meters was enforced among the research team and the research participants; and where possible interviews and deliberative/discussion events was conducted outdoors.
- The research team members and participants will also be required to wear face mask during interviews, discussions, and any engagement.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter reveals the results from the in-depth interviews (IDIs) and focused group discussions (FGD) carried out. One FGD was organized for a team of seven midwives with two case scenarios to understand how they will deal with maternal-foetal conflict situation, was used. The scenarios were carefully selected to reflect the day-to-day maternal-foetal challenges at the hospital.

The findings are presented in accordance with the study's objectives, its sub-themes, and the codes that emerged from the data analysis with examples of participant quotations.

This study unearthed important ethical issues such as the impact of religious and educational level on maternal-foetal conflict decision making. Also, issues regarding seeking informed consent from pregnant women were revealed. Further, maintaining the right to autonomy of the pregnant woman and dealing with conscientious objection were unraveled. However, the status of the foetus was largely dependent on the discretion of the health service provider.

4.1 Demographic characteristics of respondents

In total, twelve (12) stakeholders consented and participated in the study. Table 2 shows the demographic characteristics of the first category of respondents. Ten (10) midwives (4 staff and 6 senior staff midwives) along with a gynecologist and a quality assurance

officer were interviewed. All of the midwives that took part in the research were female and had Tertiary levels of education and had worked in hospitals for three to ten years. Most responders were between the ages of 28–45 range.

At the time of the study, 2,409 deliveries had been performed by midwives between January and June 2022, during which period there were three (3) maternal deaths. The district hospital reported 11 maternal-foetal conflict situations, of which 7 were resolved, 1 was unresolved but moved to a higher facility, and 3 were unresolved with mothers losing their lives in the process.

Table 2 Demographic characteristics of respondents

Variables	**Total number of Respondents (N=12)**
Sex	
Male	**2**
Female	**10**
Age group (Years)	
28 – 39	**11**
40 – 45	**1**
Category of Health Personnel	
Midwives	**10**
Quality Assurance officer	**1**
Obstetrician & Gynaecologist	**1**

Number of **Years** served	
1 – 5	**8**
6 – 10	**4**
Level of Education	
Tertiary	**12**
Number of Maternal-foetal Conflicts	
Recorded	**11**
Resolved	**7**
Referred	**1**
Unresolved (Death)	**3**

4.2 Knowledge of maternal-foetal conflicts

Maternal-foetal conflicts, according to the majority of the midwives who took part in the in-depth interview, occur when a mother's (maternal) goals conflict with the babies, and she requires emergency care because of her pregnancy. The definitions given by the respondents are presented below.

"When a Caesarean session (CS) is needed during a prolonged labour with a disturbed baby but the mother refuses because of her religious convictions, a maternal-foetal conflict arises." (IDIR2-midwife)

"When a pregnant woman needs urgent medical care that can save both her foetus and her life but she does not agree with their medical assessment based on her own readings online" (IDIR4-midwife)

"Maternal-foetal disagreements arise when pregnant women are engaged in activities like smoking or drinking that could harm the development of the foetus." (IDIR7midwife)

Over the period from January to September 2022 the eleven (11) maternal-foetal conflicts were recorded by the facility and the details are below.

Table 3 Types of maternal-foetal conflict situation

Maternal-foetal conflict situation	**Summary**
Pre-eclampsia	A 23-week-old first-time mother presented to the labour ward with pregnancy-induced hypertension and proteinuria, both of which have grave, and fatal repercussions for both the mother and the foetus. The medical team chose to perform a CS, but the mother refused to have it done since, according to her religious leader, she will die if she goes through with it.

Refusal of blood transfusion	A pregnant woman of Jehovah's Witness faith who was anaemic arrived at the labour ward and required blood transfusion during delivery. The woman and her husband were informed of the development but they submitted a card from their church (power of attorney) saying they would not accept blood transfusions that could save the mother and the foetus lives.
Surgical procedure	A pregnant woman who is bleeding heavily from the vagina arrived at the clinic and requires surgery because the baby's heart was still beating when she arrived. But for reasons that are best known to her, she chooses not to have the procedure.
Immunological diseases	A pregnant woman with a known hepatitis B which can infect her baby is told to get a vaccine and immunoglobulins. But she says she cannot afford it and more so she has had that condition during her previous births without a vaccine and the children did not get infected.

Caesarean section	The case of a pregnant woman with prolonged labour and a distressed baby was informed of the need for CS to save the baby and mother. The husband and family believed that their wife could deliver virginally as proclaimed by their religious leaders. The family insisted that if their pastor does not give permission and the CS was done their wife could die.
Abortion	A woman with an ectopic pregnancy and problems reported to the maternity department. The medical staff upon assessment asked that a surgical intervention be performed quickly in order to terminate the pregnancy and save the mother's life. Despite being made aware of the scenario, the mother and family are refusing to allow the team to continue with the course of therapy because they feel it is taboo to terminate the life of an innocent child.

4.3 Challenges and factors associated with maternal-foetal issues

The most frequent issues and contributing factors identified as being tied to maternal-foetal conflicts during the interview and focus group session were maternal autonomy,

educational status of mother, cultural norms, and religious beliefs. It was highlighted how crucial religious conviction affects a woman's autonomy in these situations. Most women's acceptance or rejection of a certain style of therapy was significantly influenced by their degree of education. According to the midwives, women with lower levels of literacy were more receptive to the instructions and counsel given by healthcare professionals, but women with better educational status were discovered to examine the internet and other medical platforms before making a choice. Instead of listening to what the healthcare professionals who are now caring for them had to say, they more heavily relied on the context of an internet-based search.

> *"Some of the women who visit the hospital are from strong religious families and place more faith in their pastors and prophets than the midwives who are taking care of them. Often, the women say that their pastor advised them not to accept a particular treatment. This is due to their regard for and conviction that their pastor is always right, which conflicts with the medical position at that time." (IDIR3-midwife).*

> *"When you describe the necessary treatment care for a woman who is in labour with problems. She will request you consult her husband because tradition mandates that a man make all decisions. Occasionally, the woman may hint that she is uncomfortable with her husband's decisions when they don't sit well with her, but she never challenges them out of fear." (IDIR5-midwife).*

"Some women believe they know everything because of their educational background. Most of the time, the more educated women who arrive at the labour ward with complications are the ones who are the hardest to treat, so when you explain what needs to be done, they assume that because they are educated, they will rather consult the internet for answers than pay attention to the midwives who are caring for them." (IDIR6-midwife).

"The resolution of the maternal-foetal conflict issue is threatened by these pastors and prophets. Even though we are all Christians and believers in God, there are instances when you are trying to save a pregnant woman's medical predicament, and then pastors come with promises and prophesy regarding the condition that is parallel to the medical procedure needed." (FGDR2-midwife).

4.4 Guidelines for addressing maternal-foetal conflicts

The study revealed that the doctor determines what is in the best interest of the mother and foetus, but the woman makes the final decision. It also revealed that, despite the absence of structured guidelines for resolving maternal-foetal conflict situations at the hospital, they refer to the hospital's standard operating procedures and standard treatment guidelines in making a decision. The midwives and quality assurance officer indicated that Act 29, section 58 of the Criminal Code of 1960, as modified by PNDCL 102 of 1985, of Ghana's constitution also supports the work of the health worker in such situations.

"When the expectant mother arrives and exhibits fear owing to her health. We take our time and fully explain everything, including why the requested intervention is necessary. We occasionally sit by them, comfort them, offer advice, and give them all the emotional support they require to get through the experience. Before they are asked to consent to the procedure, we complete all of this." (IDIR9-Quality Assurance).

"Sometimes, especially when it is the mother's first pregnancy or after several failed attempts of having a child. We advise her on the medical condition, and if she still decides to make the choice that will endanger her and the baby, we try to persuade them, but if they refuse, we recommend them to our superiors. . ." (FGDR7-midwife).

"In most maternal-foetal cases, we bring in a psychiatrist to assess the woman's mental capacity for soundness and always they do not find anything wrong with their ability to make informed decisions" (FGDR1-midwife)

"We always try as a hospital to respect the beliefs of your clients when rendering services to them. This is because when something goes wrong during the treatment the family could sue the health professionals and the hospital. We provide information to all parties involved (husband and pastor) and get their support. Most of these cases lead to the breakdown of marriages which has a social implication on the woman and family at large." (FGDR5-midwife).

"Most of the time, it takes a while to find a solution, especially in situations where you have to make a choice to save one. Since you want to save the mother because saving the unborn requires murdering the mother. All officers required to take the decision are usually brought on board to assist in the decision-making. At that point, whether the woman agrees with it or not, the law requires us to save the mother and let the foetus go." (IDIR3-midwife).

4.5 Clinicians versus the patient's decision

The midwives stressed that a health professional has the right to override a woman's decision if it will harm the woman herself. Also, they indicated that when a woman is delirious and no one else is available to make decisions for her, the physician is entitled to act in her greatest benefit.

"The law gives the clinician the right to overrule the patient whenever the decision made by the patient will not help the mother or the unborn child. So, in case when the woman is delirious and can't make decisions for herself or when there is no next of kin to make the decision, the clinician is mandated to make the decision he/she deems right for both the mother and unborn child" (FGDR1).

Further discussions during the focus group discussion of Case Study 2's case study 2 revealed that most doctors and midwives will refer to the aforementioned and disregard either parent's consent or decision in favour of making the choice they believe to be right, even though these choices frequently have the potential to violate the mother's autonomy, the foetus's right to life, both parties' rights to justice, and one of them may

even suffer harm. Furthermore, the participants had to witness the respective effects of the family and healthcare systems.

> *"The family will in time grow to appreciate the decisions we have for them as being the right decision" and "by taking these actions were are helping to achieve the goal of reducing maternal mortality" Even though the law they are relying on explicitly stated that they must weigh the ethical concept of justice for the mother or the foetus, this means that they make these decisions out of goodwill and to lower the incidence of maternal mortality. "……' and such a woman consents to it or if she cannot give such consent, it is given on her behalf by her next of kin or the person in loco parentis"*

4.6 Maternal Autonomy

The IDI and FGD revealed that while decisions are being made for the mother and foetus in the hospital, the autonomy, privacy, and informed consent rights of mothers are respected and given first importance. According to the responses, a woman's health needs will always take precedence over her choices as long as they are in line with the proper medical process. In this circumstance, maternal autonomy is valued only when it is consistent with the medical prognosis.

> *"We will always follow the woman's decision regardless of what the husband says when the woman arrives at the hospital, provided that she is not mentally ill, awake, and capable of making decisions." (IDI9-gynaecologist).*

> *"In terms of strength and pain tolerance, women are highly strong. Rarely, unless the mother already has a mental illness, have I observed cases where a*

woman's mental capacity was impacted by birthing pain. A woman's capacity to make an informed decision is therefore unaffected by any amount of suffering she endures." (FGDR3-midwife).

The study also revealed that, in circumstances where the woman is incompetent or when her decision endangers the unborn child, the husband or guardian and religious authorities are consulted.

Additionally, they admitted that there were moments when they had to favour a man's judgment over women. When the woman insists the man makes the choice orally or in writing, also when the woman is not aware that she is making the decision, or when the woman is mentally ill or not sane enough to make the decision. But when a man makes a decision that, in some way, negatively affects both the mother and the unborn child, they refer the matter to the high hospital management committee for resolution. If they are unable to do so, legal action is then taken, and the law will then determine what steps should be taken.

The following are some explanations as to why the mother's autonomy might not be respected:

"In the event where the woman is not sane or is mentally unstable, we rely on the man to make the decision. However, if the husband makes a decision that is not in the best interests of either the mother or the child, we refer the matter to the hospital authorities or pursue legal action to have a decision made." (FGDR2-midwife).

"When problems arise during labour, the mother may bleed excessively and any attempt to continue could endanger both her life and the life of the unborn child. We ask her husband to make decisions for her to undergo the medically recommended procedure." (FGDR3-midwife).

"Sometimes the woman agrees that the husbands should make all decisions as soon as they arrive at the hospital. Most of these cases are driven by cultural or religious reasons, but once she stated that to the medical team, we will always consult the husband when making decisions about treatment procedures." (FGDR7-midwife).

"The only time we involved any pastor or prophet in any decision-making process is when the pastor is an immediate family member then we will involve him in the decision making, apart from that we do not allow them to be part of any decision making" (FGDR5-midwife).

4.7 Foetal status issues

In terms of foetal status and issues related thereto, all of the midwives who were interviewed concurred that a foetus is given a status at 28 weeks. As a result, if there are any problems, they make sure to inform the woman of all available options for potential intervention.

"In our facility, when a foetus reaches 28 weeks, we start treating it like a person and consider it to be living. In general, we try to explain problems or complications to patients and do everything we can to rescue the foetus, even if it is 20 weeks old." (IDI1-midwife).

"At 28 weeks, we treat the foetus as a living being and give it a priority. As healthcare professionals, we advocate for it and work to protect it, but there are times when we lack the resources to do so. In these cases, we may transfer the woman to a higher facility so that it can receive the care it needs." (FGDR6midwife).

"Even though the foetus is made a priority and considered during decision-making, at any point in time if it possesses risk or damage to the life of the mother, we will save the mother at the risk of the foetus and even the law gives us that right to do that" (FGDR5-midwife).

"Honestly speaking this issue always causes a lot of problems. Until the baby is born or delivered the baby cannot have rights over the mother, even though it is a human. The law supports us to always prefer the mother over the foetus whenever it will cause so much harm to the mother." (FGDR6-midwife).

CHAPTER FIVE

5.0 Discussions

This chapter discusses major outcomes of the study on the maternal-foetal conflict situation in the Shai-Osudoku District hospital. The discussions are under: maternal-foetal conflict situation (factors such as educational level, Religious/cultural), guidelines for redress, clinician versus client rights, maternal autonomy and foetal status.

5.1 Maternal-foetal conflicts Situations

Conflicts between a mother and her unborn child can arise when the mother's wants, demands, or behaviours could harm the foetus. Examples include abortion, assisted reproduction, and selective reduction in multifoetal pregnancy, treatment of foetal abnormalities, substance misuse, and disobedience to caregiver instructions (Aderemi, 2016). Since Ghanaian society is still highly pronatalist and views reproduction as a necessity in every marriage, the effects of maternal-foetal conflict also have familial and societal repercussions (Dyer et al., 2020).

The study showed that midwives at the facility had the same perspective of maternal-foetal conflict as was previously stated, but they also acknowledged that mothers and healthcare professionals are the primary arbitrators of the conflicts. Religion continues to be a powerful moral and even political force in the world, yet it is frequently believed that it is in opposition to maternal health. The study revealed that, religious and cultural

beliefs were the most notable influencers on the decisions made by mothers during maternal-foetal issues among the many challenges that have been identified.

The health workers stated categorically that in their practice, they do not and will not include religious leaders in their decision-making unless the religious leader is a family member; even then, the woman's decision was priority. The study finding demonstrates the extent of the influence of religious values on the mothers. Religious authorities tell the woman to forgo medical treatment and instead rely on faith since that is what they believe. The midwives during the study revealed that some women, out of fear of defying cultural norms, refuse to make any decisions during maternal-foetal difficulties and always send the healthcare provider to the husband for a decision.

In a study to investigate conceptions, information, and perspectives around pregnancy, delivery, and maternal care-seeking behaviour in metropolitan Accra, Ghana (Aniteye & Mayhew, 2013), it was found that these cultural and religious beliefs in decision making confirm the socio-cultural threats to pregnancy among women living in Ghana (Claire Andre & Manuel Velasquez, 2023).

However, Act 29, section 58 of the Criminal Code of 1960, as modified by PNDCL 102 of 1985, of Ghana's constitution allows the healthcare professional to rescue the mother first regardless of the mother's, the family's, religious or the community's agreement in an emergency abortion situation (*Criminal-Offences-Act-1960-Act-29*, n.d.).

The study also revealed that, in all situations, unless the sanity of the woman is challenged, the mother's decision is what is prioritized in the end. Even in cases where

the woman is in intense pain when the family, religious leader's beliefs, and society tries to influence the decisions of the mother by pressuring the healthcare givers, the decision of the mother is what is considered the final decision. The only time the women's decision is averted and the health provider's is allowed is in life-threatening situations where the law gives the health care provider autonomy to make the decision, stating that there are legal and ethical principles guiding that concept.

The study's findings demonstrate that pregnant women educational level largely influences how makes decisions on whether they would like a normal vaginal birth (NVD) or a cesarean. They generally resort to the use of the internet or rely on informal information about treatment procedures from their society. Roudsari, 2015 in their study also recognizes the social attitudes regarding various delivery methods can help societies move toward a favorable understanding of maternal health services, which can ultimately result in the promotion of maternal and child health are largely dependent on the maternal educational level (Roudsari et al., 2015).

A study conducted by Wang et al, (2021) support the finding of the study that, mother with a higher level of education had a lower likelihood of adopting a proposed treatment without objecting to its methods. In their study they demonstrated that, a mother's inclination to have a cesarean section (CS) in the event of a maternal-foetal conflict is strongly influenced by her degree of education (Wang et al., 2021). Also, mothers with lower levels of education are more prone than those with higher levels to readily conform and accept the CS (Wang et al., 2021).

5.2 Ethical guidelines

In this study, the methods frequently employed by healthcare professionals to resolve moral conundrums were further examined. In the lack of formal rules, the midwives reportedly utilized their own discretion to steer clear of ethical dilemmas concerning informed consent during maternal-foetal conflict. In a study done in Ghana, Aniteye and Mayhew (2013) found that midwives who provide abortion care frequently use their discretion in an effort to strike a compromise between their religious beliefs and obligations (Aniteye & Mayhew, 2013). The GHS's efforts to reduce maternal and infant mortality may be derailed if decisions addressing maternal and foetal conflict were left up to an individual's discretion. Such delicate and life-altering decisions could result in additional treatment hurdles (Claire Andre & Manuel Velasquez, 2023).

Despite not having any written policies or instructions for resolving all ethical dilemmas at the hospital, they do follow common treatment protocols. The mother and her family are constantly informed of the situation when there are maternal-foetal conflicts, and the mother is given counselling during the entire operation.

Healthcare practitioners must act in accordance with the ethical concept of beneficence so as to produce in the lives of others a higher balance of benefits over harms. This method instructs medical professionals to choose the therapeutic path that will most likely protect and improve patient health based on evaluations of the medical benefits relative to the burdens associated with the various treatment options. Doctors must also prioritise the medical needs of their patients over their own and other parties' interests when making these challenging comparisons (Fasouliotis & Schenker, 2000c).

From our findings, in the absence of clear guidelines. Midwives and gynecologists weigh the advantages and disadvantages of each medical procedure for the mother and foetus depending on the specific situation involving a maternal-foetal conflict.

According to the study's findings, midwives frequently notify their line managers a gynecologist and quality assurance officers—when they are unable to obtain the pregnant woman's agreement for the surgery. At this point, the mother is given further justifications for the surgery, and the family is also called in to back the medical staff's case against the mother. Before the treatment can start, the woman is asked to sign a document that the midwives agree is not comprehensive enough if she agrees to a certain intervention.

This complies with the ethical standards for interventions for the welfare of the foetus published by the International Federation of Gynecologists and Maternal-Foetalians (FIGO), which vehemently supports that in cases of maternal-foetal conflict, the medical team must fully inform the mother, counsel her with empathy and patience, and provide any necessary support services (Fasouliotis & Schenker, 2000c). Due to this, FIGO's ethical guidelines emphasize that the medical team must act with respect, compassion and support when dealing with maternal–foetal conflict.

5.3 Clinicians versus maternal-foetal benefit

According to the beneficence and utilitarian principles, one must act in a way that results in more advantages than costs in other people's lives. Based on estimations of the medical benefits in relation to the costs of the various treatment options, physicians are

instructed to propose the treatment regimen best likely to protect and advance patient health. Additionally, it is required of the doctors when making these difficult comparisons to put patient needs ahead of their own and other parties' interests (Fasouliotis & Schenker, 2000c).

The utilitarian and beneficence principles require one must behave in a way that produces a larger balance of benefits than costs in the lives of others. Based on assessments of the medical advantages in relation to the costs of the various treatment options, doctors are instructed to propose the course of therapy that is most likely to safeguard and promote patient health. The doctors must also put the needs of the patients ahead of their own and other parties' interests when making these challenging comparisons. (Chervenak & Kurjak, 2022)

According to the study, depending on the particular circumstance involving a maternal-foetalmaternal-foetal conflict, gynecologists and midwives analyses the benefits and risks of each medical therapy for the mother and unborn.

The study showed that, beneficence for the pregnant woman always takes precedence during decision making involving maternal-foetal conflict situation.

The midwives indicated that, responsibility of beneficence (if treating the mother and foetus as one patient) is obviously to propose treatment where foetal treatment is only mildly linked with maternal and foetal loads and large potential benefits to the foetus. Because it is imperative that the benefits to the mother and the foetus outweigh the burdens to the mother and the foetus, the utilitarian principle, which requires decision-

makers to consider the distribution of costs and benefits across a single patient's maternal and foetal components is not ethically significant.

The study showed that, in situations where the mother's and the foetus' interests conflicting, the arguments made in favor of maternal autonomy may be deemed to be unconvincing if the foetus is given full personhood. The midwives argued that in this case, where the pregnant woman and the foetus (28 weeks) are accorded equal moral status, the mother's power to reject a particular course of action is restricted if doing so would cause the foetus more harm than to herself.

A classic example of maternal-foetal conflict, according to the midwives who contributed in the study, is a pregnant woman who has a full placenta previa and insists on vaginal birth rather than a caesarean section. The midwives said that the then-current medical thinking was that trying such a vaginal delivery would almost surely end in the deaths of both the mother and the foetus. In that situation, the woman's right to request an improper intervention (a vaginal delivery) was rejected, despite the fact that she possesses an extremely strong negative right to be left alone, and reject assistance.

5.4 The autonomy of the woman and Foetal Status

5.4.1 Maternal Autonomy

The woman's autonomy is especially protected by the absolute right to maternal autonomy, which also holds that any treatments or interventions that the court mandates are never acceptable. It also forbids using words like "soft persuasion" to try to persuade a woman who is refusing to have a child. To demonstrate the pregnant

woman's competence as a responsible decision-maker, it is indicated by this concept that she gets a thorough explanation of her condition and available treatment alternatives. Despite the therapy team's disagreement, once she has decided to decline an intervention, it must be fully accepted without any attempts to persuade her otherwise (Begović, 2021b; Behrens, 2018).

The study demonstrated that the gynecologists and midwives at the Shai Osudoku district hospital respected the mother's autonomy and rely on her to make a decision after receiving all relevant expert advice. The medical professionals added that the pregnant woman is frequently given information on the specifics of the procedures and types, potential pharmaceutical side effects, potential adverse events following the treatment procedure, and complications during counselling.

Because informed consent is required, detailed information delivery through counselling is essential for mother and child health. Pregnant women must be educated on the many aspects of treatment methods (Centre for Reproductive Rights, 2021). The midwives indicated that before the women sign the consent document, they are given the chance to ask questions.

The study found that even when a mother makes a decision that goes against medical advice and puts her life in peril, gynecologists and midwives focus more on how to protect the mother even at the risk of losing the foetus. They stated that legal action is taken in situations where the mother agrees to save the foetus at the expense of her own life, and if the mother develops a life-threatening condition during the course of

resolving the issues, the mother will be saved regardless of her consent to save the foetus at the expense of her life. According to Act 29, Section 58 of the Criminal Code of 1960, as amended by PNDCL 102 of 1985, which states that: The widely accepted notion of informed consent, which allows competent persons to accept or reject medical treatment, combines the rights to physical integrity and autonomy. When making medical decisions, a clinician must adhere to the informed consent principles and respect the preferences of a mentally competent adult. These recommendations acknowledge that only those who are willing to accept the risk should make decisions that could have an impact on their health (Aderemi RA, 2016).

However, it has been argued that the right to privacy is not unalienable and that, if viability has been attained, it may be legally overridden (Aniteye & Mayhew, 2013; Claire Andre & Manuel Velasquez, 2023). In cases of maternal-foetal conflict, both at term and earlier in pregnancy, some courts have taken the side of the foetus, while others have taken the side of the pregnant woman. (Claire Andre & Manuel Velasquez, 2023).

The argument that in cases of maternal-foetal conflict, the pregnant woman's autonomy must come first, is supported by the fact that it is more difficult to justify interventions that are riskier and more invasive (Begović, 2021b; Behrens, 2018; Buchanan, 2008). Early 19th-century utilitarian liberalism proponent John Stuart Mill and Immanuel Kant both made substantial contributions to the establishment of autonomy as a fundamental aspect of human existence. Each individual of sound mind, according to Kant, should first live in moral autonomy, making moral decisions about themselves, and then permit all other people to do the same. Following philosophers and jurists, who enlarged Mill's

definition of autonomy to include various forms of self-expression, defined autonomy as a person's capacity to govern (Chervenak & McCullough, 1991; Claire Andre & Manuel Velasquez, 2023).

Now, it is possible to say that the governing principle affecting patient rights is patient autonomy. Patients' rights to autonomy are violated when family members or other medical personnel exert pressure on them or act on their behalf without their permission. For instance, a patient can refuse medical treatment that the doctor thought was nice (Laufer-ukeles, 2018; Nairobi & Washington, 2020).

Pregnant women should not be subjected to forced therapy, according to those who oppose it, because everyone has the fundamental right to freedom of choice and control over their own lives (Claire Andre & Manuel Velasquez, 2023). This right is violated when a pregnant woman is forced to receive medical care against her will or to act in a certain way. The choices a woman takes throughout pregnancy are influenced by her unique situation, values, and preferences. Others have no right to dictate to her what others believe is best for her and her foetus, robbing her of her ability to decide for herself and live her own life (Aniteye & Mayhew, 2013; Claire Andre & Manuel Velasquez, 2023; Dyer et al., 2020; Nairobi & Washington, 2020).

5.4.2 Foetal Status

There can be no conflict without rights. Any ethical discussion cannot ignore the rights of the foetus as a recognized entity, ableist's unsettled status. The status of the foetus has been improved by recent advancements in foetal diagnosis and therapy. As a result, there has been discussion among the medical community about whether or not the

unborn should be recognized as an individual patient who, under the correct conditions, requires evaluation and therapy (Claire Andre & Manuel Velasquez, 2023; Fasouliotis & Schenker, 2000c).

According to the study, a foetus at 28 weeks is given a foetal status by the hospital. The fact that the foetus's organs are completely developed and visible on ultrasound serves as the foundation for considering the foetus separately from the mother, and this was one of the major ethical questions brought up during the study. The pregnant mother and her doctor can be held liable in this situation for the requirements of the foetus. Fasouliotis & Schenker stated in their study in 2000 that there is ethical disagreement over when the foetus acquires a distinct moral standing. There are those who contend that this is something that is learned from the moment of conception or implantation, those who contend that it is something that is learned over time and results in a graded moral status, and those who contend that while a foetus is still inside its mother, it lacks an independent moral status (Fasouliotis & Schenker, 2000b).

Others have suggested that the consideration of the foetus as a patient does not necessitate the possession of an independent moral status and suggested that a foetus may be regarded as a patient when medical interventions can be reasonably expected to result in a greater balance of good over harm for the child the foetus can become. However, universal agreement on the aforementioned issues appears to be far from achieving due primarily to religious, social, and cultural differences (Brown, 2021). As a result, the concept of the foetus as a patient is predicated on the bonds that can be formed between a foetus and the child it may become rather than on the purported and hotly contested separate moral status of the unborn (Hostiuc, 2014; Metz, 2022)

Another matter that the study brought to light was the debate over viability, which refers to a developmental stage after which others cannot care for the foetus sufficiently if it is born outside of the woman's body. The midwives implied that even if a foetus requires technological care, it acquires the position of a patient once it is old enough to survive the newborn period and grow up to be a child with autonomous moral standing. Once viability is recognized, vigorous management, including the use of all diagnostic and therapeutic options to improve the perinatal outcome, is the ethical standard of care (Chervenak & McCullough, 2017).

However, the study also revealed that when the foetus has not yet reached viability, the only way to establish a connection between a pre-viable foetus and the future child is for the pregnant mother to decide to give her foetus the status of a patient. Technological variables are not considered in the case of a pre-viable foetus because they cannot be applied to a foetus with no possibility of survival. According to Fasouliotis and Schenkar, a person qualifies as a patient when the woman whose reproductive system the intended recipient of the embryo or embryos does so (Fasouliotis & Schenker, 2000c).

5.4.3 Strengths and limitations of the study

This study adds to our understanding of maternal-foetal conflict, particularly in the setting of Ghana, a country that places a high priority on cultural and religious beliefs. The results may be skewed because the study team was unable to speak to the participants directly, the team had to go through the research and development unit of

the hospital to gather the study participants for interview. However, a follow up with the participants on phone during the break and off day provided the real situation at the hospital with reference to the topic.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

Conflicts between the mother and the foetus are difficult for everyone concerned and raise a number of tough moral, legal, and societal issues. The results of the study showed that a mother's educational level and religious upbringing had a significant impact on her willingness to accept particular therapies for maternal-foetal conflicts at the Shia-Osudoku District Hospital. The health facility relies on treatment guidelines that are more medically oriented when handling maternal-foetal conflict situations despite the lack of established rules to follow in resolving these difficulties.

The hospital recognizes and respects maternal autonomy when a choice must be made, but only if it is consistent with the medical prognosis. The family, and religious beliefs and community customs are not taken into consideration when making crucial decisions about maternal-foetal issues that will not only affect the mother but the entire society. The foetus's interest in survival is guaranteed between weeks 20 and 34 of gestation, the foetus' status is established.

6.1 Recommendation

The Shai-Osudoku District Hospital and the Ghana Health Service management should work together to create a structured manual for handling maternal-foetal disputes at the facility level.

Similar to this, when making important decisions about maternal-foetal difficulties that will not only affect the mother but the entire society, it is important to take the family, community, and religious beliefs and norms into account.

Further research is needed to examine the viewpoint of the pregnant women involved in a maternal-foetal conflicts.

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APPENDICES

INDEPT INTERVIEW (IDI) GUIDES

DI with Midwives and Doctors involved in Maternal-foetal

A. Demographic

1. Name:…….. ……

2. Sex: a) Male b) Female

3. Age in years: ……

4. Which category of health worker are you? a) Midwife b) Medical Officer c) CHN d) Gynecologist e) CHO

5. How many years have you served in this hospital? ……

6. What is your rank in the hospital?

……

7. Have you ever had any form of training in medical ethics before? a) Yes b) No

8. If "Yes" which topic: ……

B. General knowledge about maternal-foetal conflict

9. What is your understanding of maternal-foetal conflict? Any examples that you have been faced with?

10. What are the challenges associated with making decisions during the maternal-foetalmaternal-foetal conflict? [Probe for ethical challenges]

11. In your opinion, what are the complexities/challenges (ELSI) associated with maternal-foetal conflict? [Probe for challenges, autonomy, foetal status, informed consent, privacy, family]

12. How have you addressed these issues in your field of work? [Probe how issues such as
13. Professional conduct, consent, foetal status and right to autonomy for the mother have been addressed]
14. Which of the issues are unresolved and why?

MATERNAL-FOETAL CONFLICT CASE SCENARIOS

Case 1

A second-time mother who is 28 years old attended your facility for all of her prenatal care (ANC). Her history shows that she gave birth vaginally to her first child. Arrived 39 weeks pregnant and reported to be in labour at 4 o'clock at the labour ward's triage. The woman was admitted after dilation of 5 cm and assessment. After a VE, the woman was still 5 cm at 4 am. Oxytocin was added to the labour process. After VE at1 p.m. there was meconium stain grade 2 and a compromised baby. The family was informed that the woman should be prepared for theatre but Husband insists that, their pastor says she can deliver so we should give the woman more time

How will you address such an issue

1. Will you consider the woman's request over that of her husband
2. Whose autonomy is considered, woman or man?
3. Are religious leaders' decisions considered in childbearing?
4. When should a man's autonomy be considered in maternal foetal issues?
5. What does the pain a woman endures during labour affect the mental capacity to make informed decisions?

6. Does clinical presentation and current status of the foetus give it a right to decide how and by what and what mode of delivery?

Case 2

A pregnant woman at 39 weeks was rushed from a health facility to Shai-Osudoku hospital due to preeclampsia seizures and required an emergency CS to save mother and baby. The team tries to stabilize the mother whiles preparing her for theatre. The husband pleads he needs his wife even if the baby dies. After stabilizing the woman doctors realized foetal heart was very low and going through all the procedures before the baby is removed baby might have died. The mother agreed that they should save the baby at expense of her life

1. How does the doctor and or midwife reconcile both demands of the mother and the husband
2. How will the doctor solves this maternal and foetal dilemma
3. What are the factors that could affect a person's ability in making an informed decision
4. At what point does a clinician's independent decision outweighs the patient 5. Is there any ethical principles or backing that gives the doctor the right to make a decision irrespective of the mother's or father's decision in this case (globally, nationally, specific setting)
6. what are the consequences of the decision that is taken by the provider a.

to the family

b. health delivery system

Focus Group Discussion Guide

The purpose of this study is to try to explore how ethical decisions are made when faced with a maternal-foetal conflict situation in your facility. This conflict situation may arise when the interest of the mother varies or poses harm to the life of the foetus or vice versa.

During this focus group, we are trying to get your opinions about the different maternal-foetal conflict situations you have encountered in your working environment. We are very interested in your opinions because you have all provided maternal-foetal care and you are knowledgeable in your field of work. First, we will talk as a group and we will have a few questions to prompt conversation. After a group talk, we will talk with each of you individually to see what your opinion is about each of the different maternal-foetal conflict experienced. We would like you to remember the following about this focus group meeting:

1. We were reporting what the group says and the individual opinions in reports to other university and or for publication will not use your names in reports. The only piece of identifiable information would be connecting answers with the maternal-foetalmaternal-foetal conflict situations you worked on; that means that only people who are familiar with the details of this research project could possibly identify you and what your opinion is.

3. We plan to have a tape recording of this focus group to help us with taking notes. This recording will not be shared outside the research team without your permission.

4. There are no right or wrong answers here. If you disagree with each other, we would like to hear it because it will help us give better recommendations.

Focus Group Prompts

1. What kind of instances involving maternal-foetal conflict come to mind?
2. Do you have any knowledge of any ethical, judicial, or social frameworks that have been applied (at the international, governmental, or institutional levels) in situations involving maternal-foetal conflict?
3. What are the ethical, legal and social confederations taken during maternal-foetalmaternal-foetal conflict? (Autonomy, Justice, Beneficence and Non-Maleficence) probe.
4. Have you ever taken part in a maternal-foetal conflict situation's decisionmaking process? Probe
5. What would you do and why if you could alter only one aspect of the maternal-foetal scenario decision-making process at your facility?
6. What were some of the most difficult issues that needed to be resolved before making the choice?

INTERVIEW GUIDE FOR PREGNANT WOMEN

The purpose of this study is to try to explore how ethical decisions are made when faced with a maternal-foetal conflict situation in your facility. This conflict situation may arise when the interest of the mother varies or poses harm to the life of the foetus or vice versa.

During this IDI, we are trying to get your opinions about the different maternal-foetal conflict situations you have encountered during your pregnancy or last pregnancy. We are very interested in your opinions because you have encountered a maternal-foetal conflict situation before or now. First, we will ask you some few questions about your situation and how you came to an agreement for the particular health decision, we will also want to see what your opinion is about each of the decision of the maternal-foetal conflict experienced. We would like you to remember the following:

1. We was reporting what the group says and the individual opinions in reports to other university and or for publication will not use your names in reports. The only piece of identifiable information would be connecting answers with the maternal-foetalmaternal-foetal conflict situations you encountered; that means that only people who are familiar with the details of this research project could possibly identify you and what your opinion is.

3. We plan to have a tape recording of this focus group to help us with taking notes. This recording will not be shared outside the research team without your permission.

4. There are no right or wrong answers here. If you disagree with each other, we would like to hear it because it will help us give better recommendations.

CONSENT FORM FOR PARTICIPANT

My name is Zaid Haruna, a final year student in MSc Bioethics from the School of Public Health College of Health Sciences of the University of Ghana.

The purpose of this study is to try to explore how ethical decisions are made when faced with a maternal-foetal conflict situation in your facility. This conflict situation may arise when the interest of the mother varies or poses harm to the life of the foetus or vice versa.

During this focus group, we were trying to get your opinions about the different maternal-foetal conflict situations you have encountered in your working environment. We are very interested in your opinions because you have all worked with these maternal-foetal conflict. First, we will talk as a group and we will have a few questions to prompt conversation. After a group talk, we will talk with each of you individually to see what your opinion is about each of the different maternal-foetalmaternal-foetal conflict experienced. We would like you to remember the following about this focus group meeting:

1. We was reporting what the group says and the individual opinions in reports to other university and or for publication will not use your names in reports. The only piece of identifiable information would be connecting answers with the maternal-foetalmaternal-foetal conflict situations you worked on; that means that only people who are familiar with the details of this research project could possibly identify you and what your opinion is.

3. We plan to have a tape recording of this focus group to help us with taking notes. This recording will not be shared outside the research team without your permission.

4. There are no right or wrong answers here. If you disagree with each other, we would like to hear it because it will help us give better recommendations.

UNIVERSITY OF GHANA DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE HEALTH

SCHOOL OF PUBLIC HEALTH

Ref No.: .....

19th October, 2022

The Board Chairperson
Dodowa Health Research Centre
Dodowa

Dear Sir/Madam,

APPLICATION FOR ETHICAL CLEARANCE
ZAID HARUNA

I submit to your office for consideration the application of **Zaid Haruna,** an MSc Bioethics student with the Department of Population, Family and Reproductive Health, University of Ghana, School of Public Health, Legon.

His proposal titled: **"Exploring the Ethical Dilemmas in the Care of Pregnant Women in Ghana: A Case of ''Maternal-Foetal Conflicts in the Shia-Osudoku District Hospital"** is attached for review**.**

Your cooperation would be very much appreciated.

Thank you.
Yours faithfully,

Prof Richmond Aryeetey
(Head of Department)

COLLEGE OF HEALTH SCIENCES
P.O. Box LG 13, Legon, Accra, Ghana.

· Telephone: +233 (0)28 910 9021/22 · Email: pfrh@ug.edu.gh · Website: www.publichealth.ug.edu.gh

UNIVERSITY OF GHANA DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE HEALTH

SCHOOL OF PUBLIC HEALTH

Ref No.: ..... 19th October, 2022

The Director
Shai-Osudoku District Hospital
Dodowa

Dear Sir/Madam,

LETTER OF INTRODUCTION
ZAID HARUNA

I write to introduce to you **Zaid Haruna,** an MSc Bioethics Student with the Department of Population, Family and Reproductive Health, School of Public Health, University of Ghana, Legon.

As part of his academic requirement, he is undertaking a research on the topic "**Exploring the Ethical Dilemmas in the Care of Pregnant Women in Ghana: A Case of ''Maternal-Foetal Conflicts in the ShiaOsudoku District Hospital''.**

She would need assistance on pertinent information in your facility to enable her carry out him research work successfully.

We would be grateful if he is accorded all the necessary assistance.

Thank you.

Yours faithfully,

Prof Richmond Aryeetey
(Head of Department)

COLLEGE OF HEALTH SCIENCES
P.O. Box LG 13, Legon, Accra, Ghana.
· Telephone: +233 (0)28 910 9021/22 · Email: pfrh@ug.edu.gh · Website: www.publichealth.ug.edu.gh

ETHICAL APPROVAL

In case of reply the number and date of this letter should be quoted.

My Ref. DHRC/1RB/250/11/22
Your Ref. No.

Dodowa Health Research Centre
Ghana Health Service
P. O. Box DD1
Dodowa

Email: irbdodowa@gmail.com

23rd November 2022

Haruna Zaid
School of Public Health Sciences
P.0. Box LG13,
Legon, Accra-Ghana

Dear Sir,

ETHICAL CLEARANCE

TITLE OF PROTOCOL: EXPLORING THE ETHICAL DILEMMAS IN THE CARE OF PREGNANT WOMEN IN GHANA: A CASE OF 'MATERNAL-FETAL CONFLICTS'

Protocol ID: DHRCIRB/209/10/22

Principal Investigator: Haruna Zaid

Upon addressing the comments raised, the IRB has approved your proposal.
The approval requires that you submit a periodic report on the progress of the project during the implementation period and a final full report to the Institutional Review Board (IRB) on completion of the study.
The IRB may observe or cause to be observed procedures and records of the study during and after implementation. Please note that any modification of the project must be submitted to the IRB for review and approval before its implementation.

You are required to report all serious adverse events related to your study to the IRB where applicable within seven days verbally and fourteen days in writing. You are also to inform the IRB and your Institution before any publication of the research findings.

This certificate is valid till 22nd November 2023. Please quote the protocol identification number in all future correspondence in relation to this protocol.

.....
Mrs Gifty Ofori Ansah
(DHRCIRB Chairperson)

CC: Dr. John Williams (Director, Dodowa Health Research Centre, Dodowa)