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UNIVERSITY OF GHANA

DEPARTMENT OF PUBLIC ADMINISTRATION AND HEALTH SERVICES MANAGEMENT

IMPLEMENTATION CHALLENGES OF THE MILLENNIUM DEVELOPMENT GOAL TO IMPROVE MATERNAL HEALTH BY HEALTH CARE PROVIDERS IN THE TAMALE METROPOLIS OF GHANA

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL HEALTH SERVICES MANAGEMENT DEGREE

JUNE 2012

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DECLARATION

I do hereby declare that this work is the result of my own research and has not been presented by anyone for any academic award in this or any other university. All references used in the work have been fully acknowledged.

I bear sole responsibility for any shortcomings.

……………………………………… ……………………………….

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CERTIFICATION

I hereby certify that this thesis was supervised in accordance with procedures laid down by the University.

……………………………………..   ……………………………….

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(SUPERVISOR)

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DEDICATION

This work is dedicated to the Banchani family at Damongo.

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ACKNOWLEDGEMENT

This study would have been incomplete without the invaluable guidance and encouragement offered to me by my supervisor, Dr. E. K. Sakyi.

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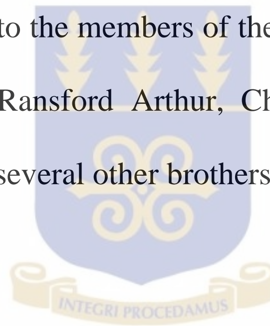

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LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
ASG	Africa Steering Group
BEmOC	Basic Emergency Obstetrics Care
BLP	Better Life Programme
CHIP	Children Health Insurance Programme
CSRP	Civil Service Reform Programme
DHMT	District Health Management Team
FEFO	First Expired First Out
FGD	Focus Group Discussion
FP	Family Planning
FSP	Family Support Programme
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GHS	Ghana Health Service
HIRD	High Impact Rapid Delivery
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information Systems
HRSA	Health Resources and Services Administration
IGF	Internal Generated Fund
IPT	Intermittent Preventive Treatment
IST	In-service Training
ITN	Insecticide Treated Net
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MPS	Making Pregnancy Safer
MVA	Manual Vacuum Aspirator
NGO	Non-governmental Organisation
NHIS	National Health Insurance Scheme
PAMSCAD	Programme of Action to Mitigate the Social Costs of Adjustment
PHC	Primary Health Care
PMM	Prevention of Maternal Mortality
PUFMARP	Public Financial Management Reform Programme
RMS	Regional Medical Store
SAP	Structural Adjustment Programme
SBA	Skilled Birth Attendant
SDHMT	Sub-district Health Management Team
SMI	Safe Motherhood Initiative
SSA	Sub-Saharan Africa
STI	Sexual Transmitted Infection
UN	United Nations
UNICEF	United Nations Children's Fund

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WHO	World Health Organisation

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ABSTRACT

This study examined the implementation challenges of the Millennium Development Goal to improve maternal health in the Tamale Metropolis.

The study used a qualitative descriptive study. Purposive sampling was used in the selection of participants for the study. The methods for data collection included in-depth interviews, focus group discussions and a review of documents. The study participants included midwives and health managers at the facility level.

The study revealed that the implementation challenges in improving maternal health care in the Tamale Metropolis are inadequate in-service training, limited knowledge of health policies by midwives, increase workload, risks of infection, low motivation, inadequate labour wards, problem with transportation, and difficulties in following the procurement act, among others.

Implementation of maternal health interventions should take into consideration the environment or the context under which the interventions are implemented by health care providers to ensure they are successful to improve maternal health in the Tamale Metropolis. The study recommends the involvement of midwives in the health policy development process to secure their support and commitment towards successful implementation of maternal health interventions.

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CHAPTER ONE

1.0 Introduction

This chapter gives an overview of the Millennium Development Goals with a focus on the health related MDGs. It presents the problem statement, objectives of the study, research questions, significance of the study, scope of the study and organization of the study.

1.1 Background

The United Nations (UN) Millennium Declaration was signed by 189 countries in 2001 and was translated into eight Millennium Development Goals (MDGs) for development and poverty eradication. Three of the eight MDGs (4, 5 and 6) are directly related to health, concerning child health, maternal health and disease control, respectively. The inclusion of health targets in the MDGs supports the contention that good health is important for overcoming poverty and achieving the wider goal of socio-economic development (UN, 2007).

Achieving the MDGs especially improving maternal health has increasingly become the central focus of many multilateral and bilateral donor agencies. Although the developmental agenda emboldened in the MDGs address all countries of the world, there can be no doubt that sub-Saharan African countries (SSA) have the greatest problems and stand to benefit most from the promotion of its principles, as compared to other regions of the world. In comparison to the rest of the world, SSA countries have the highest rates of poverty and illiteracy, as well as the highest rates of child mortality, maternal mortality, HIIV/ AIDS and malaria (Okonofua, 2006).

By December 31, 2010, ten out of the fifteen years for reaching the targets and indicators of the MDGs would have passed. A relevant question is whether SSA countries can meet the targets and monitoring indicators within the stipulated time-frame, and if so, whether such an achievement can be sustained? If results would be achieved in Africa, there should be positive

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signs during the first decade of the millennium to point to this direction. Africa as a whole is off-track to meeting the MDGs on reducing child mortality and improving maternal health (Singh, 2006; Simwaka, Theobald, Amekudzi, & Tolhurst, 2005; Stuckler, Basu, & McKee, 2010; UN, 2010).

Maternal and child health statistics are some of the indicators that show the greatest disparity between SSA and the rest of the world. The number of maternal deaths has shown no signs of abating in SSA African countries, with current trends indicating that Africa will not meet the target of reducing maternal deaths by 75 percent by the year 2015

While stronger health systems appear to be a prerequisite to achieving the health MDGs, there is currently little direct focus on systems strengthening. The drive to produce results for the MDGs has led many stakeholders to focus on their disease priority first, with an implicit assumption that through the implementation of specific interventions, the system will be strengthened more generally. Experience to date, however, suggests that if health systems are lacking capabilities in key areas such as the health workforce, drug supply, health financing, and information systems, they may not be able to respond adequately to such opportunities (Travis, Bennett, Haines, Pang, Bhutta et al, 2004). Furthermore, there is concern that already weak systems may be further compromised by over-concentrating resources in specific programmes, leaving many other areas further under-resourced.

Examining country situations in-depth indicates that policy reorientation to secure the health-MDGs for the poor may not be feasible in implementation by 2015. Attaining the ambitious targets pronounced in the MDGs will necessitate substantial acceleration of primary health care and further strengthen the health systems, with radical changes in policy as well as strong inter-sectoral co-ordination. Whilst aiming for such macro-level achievements, it is imperative to

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analyse the on-the ground realities of health systems at the country level (Accorsi, Bilal, Farese, & Racalbuto, 2010).

However, in the context of Ghana, it appears there are no enough studies on the challenges of the MDGs with a focus on maternal health at the facility level. Most research works are broad-based and over generalized (Ghana MDGs report, 2008, Aryeetey & Nimo 2004). The justification of this study therefore, lies in the attempt to examine the challenges of health care providers in their contribution towards improving maternal health in the Tamale Metropolis.

1.2 Problem Statement

Reducing maternal mortality and reaching the Millennium Development Goal to improve maternal health by 2015 appears to be very challenging in Ghana. The Ghana Demographic and Health Survey (GDHS) report (2008) indicates that the Maternal Mortality Ratio (MMR) has improved from 560 maternal deaths per 100,000 live births in 2003 to 451 maternal deaths per 100,000 live births in 2008. If the current trends continue, maternal mortality will reduce to only 340 per 100,000 by 2015, and it will be unlikely for Ghana to meet the MDG target of 185 per 100,000 by 2015 (Ghana MDGs report, 2008).

Governments over the years in Ghana have put in measures to address the problem of maternal health through the enactment and implementation of policies, legislations and services. For instance in 1987, the World Health Organization (WHO) and other UN agencies like United Nations Children Emergency Fund (UNICEF) launched the Safe Motherhood initiative which was accepted in Ghana. Since then, several Safe Motherhood programmes have been and continue to be implemented in Ghana. Other interventions that have been initiated include free antenatal care to all pregnant women, a policy of exempting all users from delivery fees in health facilities (Biritwum, 2004). In spite of these and other interventions initiated by the government

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to achieve MDG 5, and thereby, reduce by three-quarters the maternal mortality ratio by 2015, progress seems to be very slow.

The high level of maternal mortality in the country in the midst of the numerous policies and interventions is a manifestation that something is lacking in the implementation process. There is a multiplicity of factors involved in an attempt to explain these, but an examination of specific aspects of maternal health that pose threat to the chances of women's survival include issues of pre-natal and post-natal complications, unsafe abortion and other problems emanating from ignorance and lack of/or inadequate access to appropriate family planning programmes which constitute part of the preventive maternal health complications services (Bergsjø, 2001; Thonneau, 2001; Ross and Winfrey, 2003). A look at the above causes of maternal health problems calls for among other things, an examination of how the nature and relationship between the availability, distribution and execution of skilled health providers and health services logistics have impacted on the implementation challenges of the MDG 5 for improved maternal health care services, with the Tamale Metropolis as a case study.

1.3 Objective of the Study

The main objective of this study is to examine the challenges faced by health care providers in the implementation of the Millennium Development Goal to improve maternal health in the Tamale Metropolis of Ghana.

1.3.1 Specific Objectives

The specific objectives are:

1. To find out the challenges of midwives in the implementation of maternal health interventions in Tamale Metropolis.

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2. To find out the challenges of maternal health logistics in health care facilities in the Tamale Metropolis.

1.4 Research Questions

The research questions that this study addresses are:

1. What are the challenges of midwives in the implementation of maternal health interventions in Tamale Metropolis.?
2. What are the challenges of maternal health logistics in health care facilities in the Tamale Metropolis?

1.5 Significance of the Study

The results of the study will help:

Policy makers and planners to be more responsive to the issues of maternal health by realigning projects and programmes into the development plan agenda and review health policies in line with best practices.

Service providers assess the quality of their services and the areas to focus on maternal health interventions. It is also believed that they will be able to channel resources to areas where they are most needed.

The study will also be useful for academia and other researchers as it stands to contribute knowledge to the implementation literature on health policy.

1.6 Scope of the Study

The study focuses on challenges on maternal health within the health system in the Tamale Metropolis in the Northern Region of Ghana. The study is also limited to public hospitals with focus on maternal health.

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1.7 Organisation of the Study

The study is composed of six chapters.

Chapter one discusses the MDGs with specific reference to maternal health, and introduces the problem statement, research questions, objectives, significance, scope and limitation of the study, which are all concerned about maternal health in the Tamale metropolis. Additionally, key terms are defined.

Chapter two gives the relevant literature on implementation issues from both the theoretical perspectives and empirical works in the area. It also gives an overview of the theoretical framework adopted by the study. Chapter three gives an overview of Ghana's experience of implementation of a maternal health policy.

Chapter four provides the key methods for data collection for the study and a background to the study area.

Chapter five provides the results and discusses the findings of the study and chapter six draws conclusions and makes recommendations.

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CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents the views and the debates about implementation of policies and the lessons it offers to policy makers. The review is presented in seven main sections. The first and second sections present the concept of implementation and the approaches to policy implementation. The third section highlights the views on successful implementation and implementation failure. The fourth section deals with issues pertaining to implementation problems in developing countries. The fifth section addresses the implementation of health policies and narrows it down to maternal health policies. The sixth section discusses some maternal health policies in Ghana and the last section deals with the theoretical framework adopted for the study.

2.1 Concept of Policy Implementation

O'Toole (2000, p. 266) sees it as "*what develops between the establishment of an apparent intention on the part of government to do something, or to stop doing something, and the ultimate impact in the world of action*." Some scholars include here both the assembly of policy actors and action, on the one hand, and the cause-effect relationship between their efforts and ultimate outcomes, on the other (for instance, Mazmanian and Sabatier, 1989). Schofield (2001, p. 254) sees it as "*policy becoming action*". According to Van Meter and Van Hon (1974: 447-8, cited in Brynard, 2005) "*Policy implementation encompasses those actions by public or private individuals (or groups) that are directed at the achievement of objectives set forth in prior policy decisions*". They make a clear distinction between the interrelated concepts of implementation, performance, impact and stress. The observation is that impact studies typically ask "What happened?" whereas implementation studies ask "Why did it happen?" What is stressed among

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these definitions is the recognition that something has to be acted upon to bring about a desired outcome. It is also important to point out how to relate a policy to maternal health programmes that are implemented to achieve a desired objective such as to reduce the maternal mortality rate. There is the need therefore, to put into action effective interventions to reduce maternal mortality.

Fixsen, Naoom, Blase, Friedman, & Wallace (2005) define implementation as a specified set of activities designed to put into practice an activity or program of known dimensions. They explained further that implementation processes are purposeful and are described in sufficient detail such that independent observers can detect the presence and strength of the "specific set of activities" related to implementation. In addition, the activity or program being implemented is described in sufficient detail so that independent observers can detect its presence and strength.

Accordingly, Fixsen et al have categorised the purposes and outcomes of implementation to be as follows:

Paper implementation means putting into place new policies and procedures (the "recorded theory of change") with the adoption of an innovation as the rationale for the policies and procedures. Thus, paper implementation may be especially prevalent when outside groups are monitoring compliance (e.g., for accreditation) and much of the monitoring focuses on the paper trail. It is clear that paperwork in file cabinets plus manuals on shelves do not equal putting innovations into practice with benefits to consumers.

Process implementation means putting new operating procedures in place to conduct training workshops, provide supervision, change information reporting forms, and so on (the "expressed theory of change" and "active theory of change") with the adoption of an innovation as the rationale for the procedures. The activities related to an innovation are occurring, events are

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being counted, and innovation-related languages are adopted. However, not much of what goes on is necessarily functionally related to the new practice.

Performance implementation means putting procedures and processes in place in such a way that the identified functional components of change are used with good effect for consumers (the “integrated theory of change”). It appears that implementation that produces actual benefits to consumers, organizations, and systems require more careful and thoughtful efforts.

2.2 Approaches to Implementation

There is no consensus as to the number of approaches to policy implementation. However, the popular ones are the top-down and bottom-up approaches, even though earlier attempt has been made to synthesise the two approaches (Matland, 1995). This review focuses on the top-down and bottom-up approaches to implementation as it offers a lesson for national, regional and local managers involved in health policy interventions. Even though, the review takes it from public policy perspectives, it is expected to draw out lessons on how maternal health programmes and interventions can be implemented to bring the desired outcomes.

2.2.1 Top-Down Approach to Policy Implementation

Top-down models see implementation as the degree to which the actions of implementing by officials and target groups coincide with the goals embodied in an authoritative decision (Matland, 1995). The top-down approach was dominated by the assumption that implementation begins with policy or legislative objectives, and that the processes of implementation will follow on in a fairly linear fashion from this. Such assumptions are a direct by-product of the rational, perfect public administration model which builds upon the bureaucratic assumption of the separation of policy from implementation; the presence of a myriad control measures and tight boundaries to discretion (Schofield, 2001).

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Top-downers have exhibited a strong desire to develop a generalisable policy advice. This requires finding consistent, recognisable patterns in behaviour across different policy areas. Belief that such patterns exist and the desire to give advice has given the top-down view a highly prescriptive bent and has led to a concentration on variables that can be manipulated at the central level. Mazmanian and Sabatier (1989), for example, believe that implementation studies should address four central questions:

- To what extent are the outputs or outcomes of the implementation process consistent with the objectives enunciated in the original statute?
- Were the objectives successfully attained? Over what period of time?
- What factors affected policy outcomes or caused the goals to be modified?
- How was the policy reformulated over time in the light of experience?

Sabatier and his co-authors then went on to specify a series of six conditions for the effective implementation of policy: policy objectives should be clear and consistent; causal assumptions embodied within the policy must be correct; legal and administrative structures must be sufficient to keep discretion within bounds; implementing agents must be skilled and committed; there must be support from interest groups and other 'critical sovereigns'; there must be no major socio-economic upheavals or disturbances. So far as these conditions are present, a policy will be effectively implemented to achieve the desire results. It therefore, stands to reason that, maternal health programmes should be developed by central government agencies and by putting in place the necessary structures which are then given to the local level structures for implementation. An important question that remain unanswered, is whether those at the top level of the policy formulation process understand the conditions that pertains at the local level of implementation

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and if these interventions are implemented without the local level participation will actually lead to a reduction in maternal mortality.

The first strength of the top-down approach is the importance it attaches to legal structuring of the implementation process - one of its major innovations. Secondly, the framework emphasises the importance of selecting implementing institutions supportive of the new programme and suggests creating new agencies as a specific strategy. Thirdly, the six conditions of effective implementation have proven to be a useful checklist of critical factors in understanding variations in programme performance and in understanding the strategies of programme proponents over time.

The first criticism of the top-down model stems from the top-down researcher's emphasis on the role of central government and the specific working of the primary legislation as being the embodiment of the policy objectives. This approach fails to recognize the role of political rhetoric in policy formulation (Schofield, 2001). Secondly, policy is not made in a vacuum: there are other actors, other organisations and an overarching set of institutional structures within which political outcomes are bargained. (Jordan 1995).

Thirdly, it is doubtful whether the top downers' prescriptions for successful implementation could ever be met in reality. Top downers seem to want an altogether unrealistic mixture of clarity and simplicity that seems to deny and renounce the very existence of politics. Fourthly, by viewing the implementation process from the top and tracing the influence of one policy through successive layers of administration, top downers run the risk of accrediting anything and everything that happens at the bottom to the effects of the statute or policy in question. Fifthly, it is often difficult to identify a specific occasion when a policy is made or packaged up ready for

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implementation, because policies become shaped and are made and remade as they are implemented (Hill, 1981, cited in Jordan 1995).

Finally, it is doubtful whether the application of discretion by those at the bottom is as deviant and pernicious as some top downers seem to portray. It may be that, in certain situations, the exercise of discretion is not only inevitable (i.e. legally and politically legitimate) but also desirable because by constraining it one loses the skill and expertise of those closest to the problem.

2.2.2 Bottom-up Approach to Policy Implementation

The bottom up approach starts by identifying the network of actors involved in service delivery (Cline, 2000; Blair, 2002) in one or more local areas and asks them about their goals, strategies, activities, and contacts. It then uses the contacts as a vehicle for developing a network technique to identify the local, regional, and national actors involved in the planning, financing, and execution of the relevant governmental and non-governmental programmes (Sabatier, 1986).

Policy implementation occurs at the microimplementation and macroimplementation levels (Matland, 1995). At the microimplementation level, local organizations react to the macrolevel plans, develop their own programs, and implement them; at the macroimplementation level, centrally located actors devise a government program.

Bottom-uppers argue that the goals, strategies, activities, and contacts of the actors involved in the microimplementation process must be understood in order to understand implementation, for that matter it is considered a democratic control (Long & Franklin, 2004, Mischen & Sinclair, 2007). It is at the microlevel that policy directly affects people (Matland, 1995). In the view of Sabatier (1986) the bottom-up focuses on local implementation structures, and thus is better for assessing the dynamics of local variation.

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The role of *street-level bureaucrats* is emphasized as key to successful policy implementation (Jordan, 1995; deLeon & deLeon; 2002; Bastien, 2009). Street-level bureaucracy is a concept developed by Lipsky (1980) to refer to the role actors who implement policy changes have to play in the process. He emphasizes that such individuals are not simply cogs in the process, but rather have substantial ability to mould policy outcomes. Street level bureaucracies are schools, welfare departments, lower courts, legal service offices, hospitals among others.

The literature suggests four sets of influences on street-level bureaucratic actions in implementing policy (Meyers & Vorsanger, 2003 cited in May & Winter, 2007). One set is the signal from political and administrative superiors about the content and importance of the policy. The policy sets forth policy intentions (goals) that are signalled by the wording of the policy and by various pronouncements by politicians and guidelines that are offered in support of the policy. A second set of influences is the organisational implementation machinery. One important aspect of this for street-level bureaucracy is the extent to which organisations delegate authority to make decisions to the frontlines or limit that discretion. A third set of considerations is the knowledge and attitudes of the street-level bureaucrats concerning relevant tasks, their work situation, and clients. A fourth set is the contextual factors concerning workloads, client mix, and other external pressures. Contextual factors within the implementing environment can completely dominate rules created at the top of the implementing pyramid, and policy designers will be unable to control the process.

In summation, the work of the bottom-up writers can be characterised in three ways (Schofield, 2001). First, their focus on the actions of local implementers, as opposed to the central government; secondly, their attention is given, not so much to the goals of a policy, but rather the nature of the problem which a policy is designed to address; thirdly, the bottom-up approach

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seeks to describe networks of implementation, and in so doing, has made an important *methodological* contribution to implementation analysis. Bottom-uppers are, therefore, concerned with the motives and actions of actors.

Jordan (1995) presented the following two strengths of adopting the bottom view of policy implementation. Bottom up models are relatively free of predetermining assumptions about cause and effect, hierarchy or other structural relations between actors, or what should or should not occur during the implementation process. Again, bottom up models are far more capable of dealing with complexity and are well suited to situations when policies are layered upon each other. And because the point of departure is what actually happens on the ground, bottom uppers do not find themselves caught in the linguistic or methodological trap of having to differentiate policies from meta-policies and post-legislative fine-tuning.

However, it has been suggested that bottom-uppers are likely to over emphasise the ability of the periphery to frustrate the center, and for that matter, the failure to recognize that central actors and central policy are in themselves contingent factors to the local situation (Schofield, 2001). Furthermore, it fails to start from an explicit theory of the factors affecting its subject of interest. Because it relies very heavily on the perceptions and activities of participants, it is their prisoner, and, therefore, is unlikely to analyse the factors indirectly affecting their behavior or even the factors directly affecting such behaviour which the participants do not recognise.

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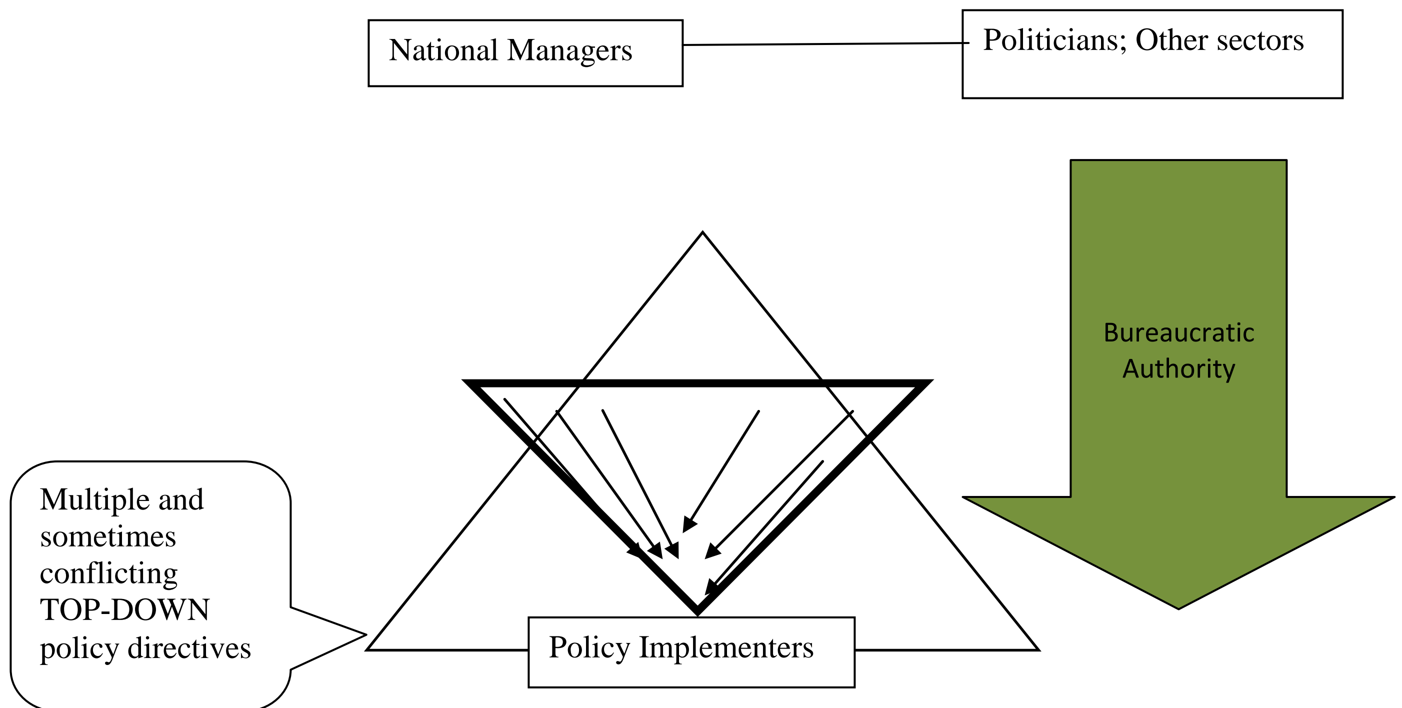

Figure 1: The Bottom-Up View of Policy Implementation
Source: Adapted from Gilson and Erasmus (2008): Tackling implementation gaps through health policy analysis. EQUINET, policy series 21.

2.3 Views on Successes and Failures of Implementation

A policy implemented has a set of desired objectives and outcomes. The extents to which these objectives and outcomes are achieved or deviated can only be assessed in the process of implementation or given a time-table specifications which are set to determine the success and failures of such a policy. The views on the successes and failures of implementation are discussed below.

2.3.1 Successful Implementation

The failure to specify what is meant by *successful implementation* causes considerable confusion (Matland, 1995). Giacchino and Kakabadse (2003, p. 3) define 'success (or a case of successful policy implementation) to mean a policy implementation initiative in which the strategic action adopted by the administrative arm of government was considered to have delivered the *intended*

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policy decision and to have achieved the *intended* outcomes'. However, they were quick to point out the limitation as few policies managed comprehensively the intended objectives.

There is no single model of "effective implementation" (Ripley & Franklin1982); rather, implementation models vary according to policy type and contextual factors (Ripley and Franklin 1982; Lowi 1964, 1972, cited in Long & Franklin, 2004). They further argued that there are a number of internal and external factors that must support the process for implementation to succeed. These factors include the number and nature of the actors involved, the nature of conflict over the policy in question, and the expectations concerning the goals and outcomes of the policy (Refer to Long & Frank, 2004).

Matland (1995) and Mischen and Sinclair (2007) refer to the work of Ingram and Schneider (1990) with the common definitions of success in the implementation literature, including: agencies comply with the directives of the statues; agencies are held accountable for reaching specific indicators of success; goals of the statute are achieved; local goals are achieved, or there is an improvement in the political climate around the programme. In determining which of these definitions is appropriate, the decision hinges on whether the statutory designer's values should be accorded a normative value greater than those of other actors, especially local actors.

For Imperial (1998) successful implementation results when the participants in an intergovernmental setting reach agreement on the scope and substance of a policy or programme. In the view of Gilson and Erasmus (2009), the key things that cause policies to succeed include the nature of the policy and the meaning assigned to it and the work environments.

Cline (2000) stresses that communication is considered to be necessary if one wants to successfully implement a policy. However, important differences arise when the exact function of communication is discussed. One way to view communication is to emphasise the need for

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clarity and consistency in form and content in order to increase the likelihood of compliance and execution of a particular policy. Of course, if communication among parties is lacking in these respects, the resulting distortions could very well lead to implementation failure.

In contrast, Marsh and Mcconnel (2009) contend that claims that a particular policy has been a 'success' is common place in political life, and the key problem is that these claims or assessments about policy outcomes do not establish any systematic criteria for assessing success or failure.

The process of implementation and the way that challenges or obstacles are addressed can determine whether policies achieve their intended outcomes (Long & Franklin, 2004). Granted, there may be flaws in the policy itself; however, the implementation process can weaken the impact of the policy. In some cases, through adaptation of the policy based on implementation experiences, it may improve upon the policy.

However, Cline has suggested that by viewing the implementation problem in terms of success and failure dichotomy, it should be looked out in terms of outputs, processes, and outcomes.

2.3.2 Implementation Failure

Policy failure can result from *non-implementation* or from *unsuccessful implementation.* In the former case, a policy is not put into effect as intended. Unsuccessful implementation, on the other hand, occurs when a policy is carried out in full and external circumstances are not unfavourable, but the policy stills fails to produce the intended results or outcomes (Hunter and Marks, 2002). In the words of Ayee (2000, p. 10) "implementation failure could be… failure to achieve objectives and failure in terms of policy efficiency".

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The point about policy failure is that it suggests there can be no sharp distinction between formulating a policy and implementing it. Barrett (2004), reviewing the literature, noted the key common factors deemed to be perceived as the "implementation failure" include:

- Lack of clear policy objectives; leaving room for differential interpretation and discretion in action;
- Multiplicity of actors and agencies involved in implementation; problems of communication and co-ordination between the 'links in the chain';
- Inter- and intra-organizational value and interest differences between actors and agencies; problems of differing perspectives and priorities affecting policy interpretations and motivation for implementation;
- Relative autonomies among implementing agencies; limits of administrative control.

In a nut shell, maternal health programmes implemented at the local level may be failing when indicators like the maternal mortality rate, level of contraceptives acceptance by women, low delivery by skilled attendance at birth, low antenatal visits, among others, seen as outputs in policy statements that have been translated into action are not met.

2.4 Problems of Policy Implementation in Developing Countries

It has been observed that policy implementation is one of the major problems confronting developing nations. Makinde (2005) has identified four factors that could lead to implementation of policies. These critical factors are Communication, Resources, Dispositions or Attitudes, and Bureaucratic Structure. The four factors operate simultaneously and they interact with each other to aid or hinder policy implementation. By implication, therefore, the implementation of every policy is a dynamic process which involves the interaction of many variables.

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Makinde went further by explaining that there are usually problems that lead to implementation gap which can be traced to the policy maker and the policy environment. There could be implementation gap as a result of many factors, which could arise from the policy itself, the policy maker, or the environment in which the policy has been made.

Using the Nigerian experience, Makinde enumerated a number of problems that plagued the Better Life Programme (BLP) and the Family Support Programme (FSP) in Nigeria. These problems include the lack of continuity of projects by successive governments, lack of participation of beneficiary groups, failure of the policy makers to take into consideration the social, political, economic and administrative variables when analyzing for policy formulation, bribery and corruption, inadequate provision of manpower, inadequate maintenance of equipment and inadequate monitoring of projects.

Similarly, since independence, Ghana has embarked on a number of policies and programmes to improve the living conditions of its people. However, the extent to which these policies and programmes have impacted on the lives of people appears not to be highlighted by commentators. Ayee (2000, p. 47), for example, has noted that

> *"the vagaries of policy implementation have become the "missing link" in the realization of the goals and outcomes of public policies and programmes in Ghana. From Nkrumah's Seven Year Development Plan, to Structural Adjustment Programme, Programme of Action to Mitigate the Social Costs of Adjustment (PAMSCAD), decentralization, education, agriculture, privatization, water and health policies and programmes, Civil Service Reform Programme, Public Financial Management Reform Programme (PUFMARP), incomes policy (for instance, Central Management Board overseeing the implementation of the controversial Price Waterhouse public sector pay review)and the Value-Added Tax, the main reason for their underachievement of objectives is ineffective or poor implementation.*

Hutchful (1994, cited in Ayee, 2000), for instance, has catalogued a number of implementation problems of public policies in Ghana, using the PAMSCAD experience. They include long delays in commencing the programme; non-availability of local counterpart funds, particularly for the community initiative projects; inherent defects in the design of PAMSCAD, in particular

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the large number of projects and the tenuous links between them; scattering implementation over several sectors and sector ministries, giving rise to problems of coordination and conflicts over jurisdiction; absence of coordination and oversight of large number of agencies involved at the center as well as the regional and district levels; the credibility of PAMSCAD; implementation of the rest of the redeployment package was negligible; and lack of integration of PAMSCAD into the core design structural adjustment.

Again, Ayee further listed other forces or factors that have worked against the successful implementation of public policies in Ghana to include natural disasters; external factors such as the adverse global economy; static policies pursued by successive governments, inadequate involvement of the agencies expected to implement policies and programmes; inadequate skilled manpower; inadequate policy instruments, poor policy design and piecemeal or ad hoc approach to problems and issues.

Moreover, Sakyi (2008a) has elucidated a number of constraints to the implementation of the civil service reform in Ghana. These are summarised to include the lack of political support for the reform; paucity of institutional capacity and human resource capacity; inter-agency conflicts; fragmentation and lack of ownership of reform; reform programmes were overly technological and absence of an overall framework for reform coordination. The review has highlighted a number of problems that hinder the implementation of policies in the country indicating that it is not usually the problem of policy formulation, but it is usually the problem of implementation in Ghana and other developing countries.

2.5 Implementation of Health Policies

The implementation of health policies in both developed and developing countries seem to present different level of experiences. In the case of developed countries, health policies tend to

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be implemented more successfully. For instance, the successful implementation of a Children Health Insurance Programme (CHIP) in the United States has been reviewed by Hanley and Iachini (2000). The implementation of the programme, involves a joint effort with the Health Resources and Services Administration (HRSA) to coordinate activities of all departments under the Department of Health and Human Services and virtually all federal agencies. Funding was also provided on a timely basis for the programme. Again, Campbell (2001), reviewing the maternal health policies in developed countries, has highlighted the role of Government and politicians, government agencies and professional groups and women's groups have contributed in shaping maternal health policies in the West. This indicates that effective coordination and communication among agencies and stakeholders are crucial in ensuring successful implementation of health policies.

On the other hand, health policy implementation in developing countries appears to be plagued with a number of challenges. A study by Awenva, et al (2010) identified major barriers to the implementation of the mental health policy in Ghana to include low priority of mental health to the MoH, and to society at large; the very low level of human resources in mental health, from psychiatrists to nurses and other health professionals as impeding the provision of quality mental health care; insufficient funding for mental health; lack of awareness of the policy by mental health professionals, primary health care workers, other professional groups and the general public, and the absence of training in policy implementation, among others.

Similarly, an analysis of the maternal and child health policy of Pakistan by Siddiqi, Haq, Ghaffar, Akhtar and Mahaini (2004) indicates that despite increasing emphasis, several gaps have remained: lack of an overarching comprehensive MCH framework; aspects of nutritional status have been overlooked; ensuing provision of emergency obstetric care has received

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inadequate priority; lack of financial risk protection mechanism for the mother and child, among others. Mayhew (2000) has lamented that both health system/service-related factors and social context factors can affect policy implementation. At the health service delivery level, factors ranging from continuing segregation of service-delivery, limitations on training, poor resources and infrastructure, absenteeism of staff at primary care level, and medical and social hierarchies have all constrained change and impeded the provision of an integrated service.

Also, Badasu (nd) referring to the works of (Agyepong, 1999; Waddington, & Enyimayew, 1989; 1990; Nyonator & Kuntzin, 1999) and Witter, Arhinful, Kusi, and Zakaria-Akoto (2007), have shown that the implementation of the User Fee and the Exemption policy in Ghana has some outcomes and challenges. There were suspicions about the lack of drugs in public health facilities whilst they were found in private pharmacies. There were also shortfalls and unpredictability of funding. In addition, guidelines for monitoring were not enforced. At the national level, oversight information on numbers of deliveries carried out and delivery types and reimbursement amounts were not available. There was also misinterpretation of the package to the extent that the understanding was that the exemption covered deliveries only, but not complications during pregnancy or post-partum, among others.

Additionally, Witter, Dieng, Mbengue, Moreira, and Brouwere (2010) have reviewed the policy of exempting users from delivery fees in Senegal. In the process of implementing the policy, a number of challenges were encountered ranging from communication of policy, adequacy of kit, management and administrative issues, among others. Moreover, awareness at community level was patchy, and there was little clarity of understanding of what the policy meant in practice.

It can be deduced from these studies that, most of the time, no consideration is given to constraints that may hamper the smooth implementation of policies. It can also be concluded

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that, the implementation of policies, sometimes, may have unintended outcomes (positive or negative) which may not have been foreseen in the designed of such policies.

Furthermore, Okiwelu, Hussein, Adjei, Arhinful, and Armar-Klemesu (2007) have found out that, the Safe Motherhood initiative being implemented in Ghana has its goals and aims stated in broad terms, with no clarity and specification. Again, the main types of interventions implemented by the programmes were not integrative in nature as some programmes did not implement all the listed interventions, whilst other programmes implemented other interventions that are not part of those stated in the policy document. In effect, by not following a policy according to its stated aims and objectives and not specifying clearly, what the policy meant, may lead to implementation failure.

2.6 Interventions to Reduce Maternal Mortality in Ghana

A number of interventions have been put in place to reduce the high incidence of maternal mortality in Ghana. Some of these interventionss that have been put in place over the years include the following:

The Safe-Motherhood Initiative (SMI) is a National Reproductive Health Service delivery, which is delivered through the Primary Health Care (PHC) Programme. The major components of the Safe Motherhood programme include antenatal care, labour and delivery care, postnatal care, family planning, prevention and management of unsafe abortions, and health education.

Prevention of Maternal Mortality Programme (PMM) is a component of the Safe Motherhood Initiative with the overall objective of promoting maternal health. The programme focuses on interventions that improve the availability, quality and utilisation of emergency obstetric care. Activities range from improving services at health facilities to improving access to care.

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Making Pregnancy Safer (MPS) Initiative is a major component of the Safe Motherhood Initiative. It is delivered through the PHC programme. The interventions are in four parts: care during pregnancy, care during and after delivery, postpartum family planning, and community component.

Maternal and Neonatal Health Programme (MNH) is one of the key components of the Safe Motherhood initiative. It includes antenatal care, labour and delivery care, postnatal care, etc.

Maternal Health Project emphasises the prevention and promotion of safe motherhood interventions, including dissemination of a revised Reproductive Health Service Policy and standards and protocols for reproductive health programmes; strengthening of institutional capacities to provide essential obstetric care, implementing exemptions for supervised delivery in deprived areas; strengthening post abortion care services; ensuring contraceptive commodity security; intensifying health promotion activities in safe motherhood and family planning.

Intermittent Preventive Treatment in Pregnancy (IPTP) is to control pregnancy associated with malaria. The programme is based on the assumption that every pregnant woman living in areas of high malaria transmission has malaria parasites in her blood or placenta, whether or not she has symptoms of malaria. The intervention includes integrating IPT package of interventions within the Safe Motherhood programme, iron and folate supplementation, deworming, case management, and ITN.

High Impact Rapid Delivery (HIRD) programme promotes high-priority, cost-effective interventions to improve maternal and child health at the district level. This program provides specific funding for service delivery with an aim to increase focus on and funding for reproductive and child health services by DHMTs (MOH, 2008).

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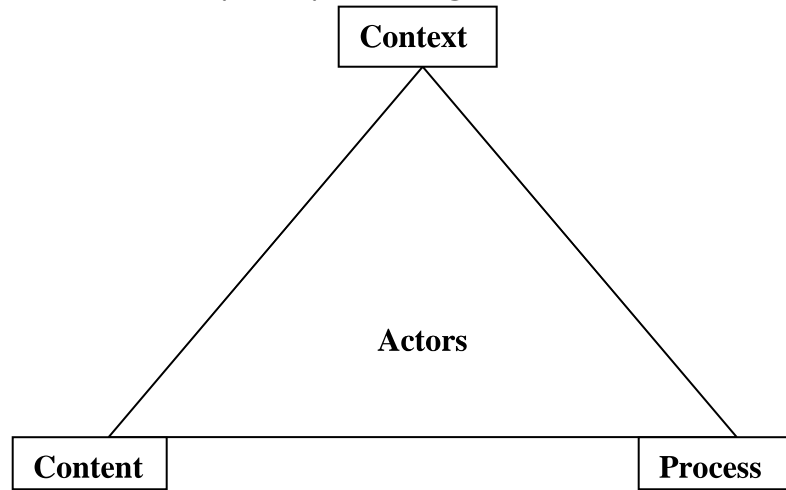
2.7 Theoretical FrameWork

2.7.1 Walt and Gilson 'Policy Analysis Triangle'



Source: Adapted from Walt and Gilson, 1994.

Walt and Gilson (1994) developed a policy analysis framework specifically for health, although its relevance extends beyond this sector. Their policy triangle framework is grounded in a political economy perspective, and considers how all four of these elements interact to shape policy-making and implementation. The framework has influenced health policy research in a diverse array of countries, especially in developing countries, and has been used to analyze a large number of health issues, including mental health, health sector reform, tuberculosis, reproductive health and antenatal syphilis control (Gilson & Raphaely 2000, cited in Walt et al, 2008). Their model identifies and examines factors that have affected, or will affect, implementation of a new or revised policy/programme and circumstances that have influenced its outcome.

The Walt and Gilson policy analysis triangle points to the importance of interactions between policy content features, contextual features, processes and actors that can lead to the successful implementation or failure of a programme. This study adopts the framework focusing on only the

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contextual features. This has been informed largely by the works of Walt et al, (2008) and Green et al (2010), who have commented that health policy analysis in low and middle-income countries is attracting increasing attention. The bulk of research has focused on policy content, particularly evaluating technical appropriateness. However, the nature of the policy process, context and actors seem to be ignored. For the purpose of this study, context is used narrowly to denote resources that have a wider implication for maternal health. These include human resources in health and logistics for maternal health. It is assumed in this study that these factors will affect the implementation of maternal health interventions and therefore, have an influence on maternal health outcomes. The context (environment) in which maternal health interventions are implemented will either lead to successful implementation to improve maternal health or implementation failure.

The Walt and Gilson framework has helped to explain why certain policies get into the political agenda and others do not. Again, it has helped policy analysts to identify the multiple stakeholders in policy implementation and which stakeholders are likely to oppose a policy. This study used the framework as a result of the fact that that health policy analysis in low and middle income countries remains in its infancy and the absence of explicit conceptual framework to underpin analysis (Gilson & Raphaely 2000). Moreover, the model has been developed specifically for analyzing health policies in developing countries. One criticism of the framework is that some factors may not neatly fit into the main concepts of the model. The main concepts used in the preferred framework are explained below.

Content: policy content refers to a particular policy goal or set of goals and the particular actions planned to achieve those goals (Raney, 1968 cited in Khan, 2006). Modern health paradigms

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require that attention be paid to health policy content in promoting health systematically and effectively.

Context: refers to systemic factors political, economic and social, both national and international which may have an effect on health policy (Buse, 2008; White, 2010).There are a variety of contextual factors that may affect how policy is implemented, and it is important to consider such factors when analysing policy implementation, as they can have a substantial impact upon how policy is made, changed, or implemented.

Process: refers to the way in which policies are initiated, formulated, negotiated, communicated, executed and evaluated. In developing countries, health planning repeatedly leads to health plans that never appear to be implemented or only partly.

Actors: are at the center of the policy analysis framework. 'Actor' is a short-hand term, and may be used to denote individuals, groups, or even an organization. Some refer to actors as policy elites and decision makers, while others prefer to call them stakeholders (Mehriziet, Ghasemzadeh & Molas-Gallart, 2009).

2.8 Conclusion

The review has sought to explain the concept of implementation as a set of activities designed to achieve an objective. The approaches on policy implementation have also been discussed focusing on the strength and weaknesses of the top-down and bottom-up approaches to implementation. The views on successful implementation and implementation failure have also been reviewed, giving the myriad views on policy success and failures. The problem of policy implementation in developing countries, and in particular Ghana, reveals that inadequate human resources, corruption, poor communication have hampered the implementation of policies in developing countries. The implementation of health policies, particularly maternal health policies

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are as a result of failure to take into consideration factors that may hamper implementation of such policies.

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CHAPTER THREE

AN OVERVIEW OF MATERNAL HEALTH POLICY EXPERIENCE IN GHANA

3.0 Introduction

This section gives an overview of Ghana's experience of maternal health policy implementation. Even though, there a number of maternal health policies being implemented in Ghana such as the abortion policy, national population policy among others, the review is limited to the free maternal health care policy.

3.1 The Free Maternal Health Care Policy

In 2004, the Government of Ghana implemented a free maternal health care programme in the four most deprived regions of the country. This was later extended to the other regions in the country. The exemption package covered all normal and assisted deliveries, including caesarean sections and the care and treatment of complications. Apart from transportation, logistic and other supply costs, women were supposed to face no direct costs at all in delivering.

The aim of the policy was to reduce the financial barriers in using the maternity services. It was expected that this would lead to a reduction in maternal and perinatal mortality. Under the policy, it was intended that the government would absorb the GHC 8 cost for each delivery in government institutions and pay the GHC12 cost of delivery in private maternal homes.

The policy led to increases in facility based-deliveries of between 10% and 35%. Complex (and costly) interventions such as caesareans were also on the rise. Health professionals considered that postnatal follow-up - a free service - improved after deliveries became free (Witter and Adjei, 2007). Implementation of the policy was evaluated as successful, but a shortfall of funding resulted in it being implemented inconsistently (Witter and Adjei, 2007). Facilities

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became increasingly indebted and many reverted to charging. The number of facility based deliveries declined as a result (Witter, Arhinful, Kusi, and Zakaria-Akoto 2007).

In 2008, the policy was practically reinstated with financial support from the British Government. In one year of implementation approximately 433,000 more women had received health care than would have otherwise (Stewart, 2009).

The scheme was publicised through meetings with traditional rulers, broadcasts and durbars (public meetings) at churches and other public places. The trends in utilization-both up, when the scheme was functioning, and down, when it stopped - suggested that women were cost-aware and informed about the charging regime (Witter, Arhinful, Kusi, and Zakaria-Akoto 2007).

3.2 Funding of the Policy

The policy was funded through Highly Indebted Poor Country (HIPC) debt relief funds, which were channeled to the districts to reimburse public, mission and private facilities according to the number and type of deliveries they attended monthly. A tariff was approved by the Ministry of Health which set reimbursement rates according to type of delivery (e.g. normal, assisted or caesarean section) and type of facility. Mission and private facilities were reimbursed at a higher rate, because they did not receive public subsidies (MOH, 2004). Women would then only have to bear the costs of reaching facilities.

The policy of user fee exemptions was superseded by a new National Health Insurance Scheme, which has reached effective coverage of just under 20% of the population (MOH, 2007). This provides protection against user fee costs for a wide range of health services, including maternal health care, for formal sector workers, those in the informal sector who take up voluntary coverage, children of members, pensioners and a small category of ‘‘indigents’’.

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3.3 Achievements of the Policy

The free maternal health care policy has some positive impact on health services utilization by women in the country. The exemption scheme was felt to have had a very beneficial effect in terms of encouraging women to come in early, so that complications were detected and better managed, saving lives. This was reflected in the increase in more complex interventions. Witter, Arhinful, Kusi, and Zakaria-Akoto (2007) reported that in the Gomoa district, for example, there were 86 caesarean sections in 2002; 138 in 2003 and 190 in 2004 (or 1.4%, 2% and 2.6% of supervised deliveries in those respective years). The district hospital in Abura/Asebu Kwamankese also reported a doubling of numbers of caesareans. For Central region as a whole, 3.8% of supervised deliveries were caesareans in 2004. The regional reproductive health report showed a declining trend in facility-based maternal mortality: 450 per 100,000 in 2001, dropping to 206 in 2002, 159 in 2003 and 134 in 2004.

A study by Health Systems 20/20 (2009) in Nkoranza on the impact of the NHIS on maternal health indicators revealed that, out-of-pocket payments for delivery decreased by about one-third after the NHIS was implemented. Adjusting for inflation, average delivery expenditures declined from GHC11.1 (about $13) to GHC7.5 (about $9). There were significant changes in how women paid for delivery care: while 30% had to sell agricultural produce to pay for the delivery, only 3% at do so. Overall, the proportion of women who did not have to pay for their delivery increased from 28% to 52%.

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3.4 Problems in the Implementation of the Policy

A number of studies have evaluated the free maternal health policy since its implemention in the country identifying several challenges the policy has encountered. For instance, Ofori-Adjei (2007) has found out that, while the policy was considered favourably by both service providers and users, there were significant problems with its implementation. The implementation of the policy did not have adequate financial backing and a system of standardised charging was not applied. Failure of prompt and adequate reimbursement to the clinical facilities led to near failure of the policy. Also, many facilities at one point reverted to collection of user fees.

The policy was more beneficial to the rich than to the poor. The evaluation clearly showed that quality of clinical care was consistently poor and was not affected by the implementation of the exemption policy. Other barriers to skilled delivery care identified included costs of transportation, medicines and other supplies, long distances to health facilities, cultural and social barriers and preference for services of Traditional Birth Attendant (TBA). An effective monitoring system was not put in place and therefore many of the deficiencies in financial flows, quality of care and issues related to poverty were not documented.

Similarly, Witter, Arhinful, Kusi, and Zakaria-Akoto (2007) in a study of the exemption policy in Ghana have identified funding as a major challenge facing the policy. For instance, there were shortfalls and unpredictability of funding. Funds were issued at the start of the financial year, without guidance for managers as to how they had been calculated, how long they should last or when they would be replenished. The funds were not adequate for a full year and further installments were expected but not received until the next financial year. The failure to reimburse adequately and promptly had negative effects at all levels of the system. Patients, having been

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told they would receive free services, were reported to be angry when they were asked to pay, and staff were suspected of taking a cut of the funds.

3.5 Conclusion

The free maternal health care has impacted positively on maternal health, however sustainable funding of the policy has been a major barrier in implementing it successfully.

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CHAPTER FOUR

METHODS OF DATA COLLECTION

4.0 Introduction

This section presents the method employed for data collection. It describes the sampling technique employed, data collection techniques which were in-depth interviews with key informants and focus group discussions, the research instrument used, the study site, data processing and analysis, and the profile of the study area.

4.1 Study Population

The study population in this study comprised of Midwives, Medical Superintendents and Health Services Administrators in two public hospitals in the Tamale Metropolis (See Table 1).

4.2 Sampling Technique

The study used purposive sampling technique in the selection of participants to gain a deeper understanding of the challenges of maternal health. The lists of practicing midwives were obtained from the Human Resource/Personnel Units of the hospitals from which the midwives were drawn to participate in the study. The selection criterion for the midwives was midwives who have been practicing for over five (5) years. Those selected formed a group of eight participants each for a focus group discussion.

The Medical Superintendents and Health Services Administrators were selected based on their experience, knowledge and involvement in the implementation of health programmes at the facility level.

Neuman (2007) has noted that, purposive sampling is used to select cases that are especially informative and when a researcher wants to identify particular types of cases for in-depth investigation. Moreover, the purpose is less to generalize to a larger population, but rather to gain

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a deeper understanding of the issues under consideration. Kumekpor (2002) has also opined that purposive sampling is useful in studies evaluating the causes of success or failure of projects. In such cases, projects which are known to have failed or succeeded are studied to identify causes or factors of failure or success.

4.3 SAMPLE SIZE

The sample size for the study comprised of twenty eight (28) participants from which information was solicited on the implementation challenges of maternal health care in the Tamale Metropolis. This is shown in the table below.

Table 1: Study Population and Participants Selected for the Study

Participants	Population (N)	Sample (n)
Midwives	64	24
Medical Superintendents	2	2
Health Services Administrators	5	2
Total	**71**	**28**

Source: Field Survey 2011

4.4 Data Collection Techniques

Data collection activities included:

4.4.1 Focus Group Discussions (FGDs)

The FGDs were led by the researcher as the moderator who kept conversations flowing, asked follow-up questions and sought clarification to issues that were not clear in the course of the discussions. An assistant moderator trained by the researcher took notes and also operated the tape recorder. The groups were homogenous with respect to the profession. All the participants in the FGDs were females. In all, three (3) FGDs were held with midwives.

The FGDs took place in the conference room and labour ward of the hospitals. Permission was sought from participants before recordings proceeded, although objections were raised by the

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participants for the fear that their voices might be heard on the radio. The researcher had to explain the purpose of the research was only for academic purposes. However, one group refused to be tape recorded. Each FGD lasted between thirty (30) to forty five minutes (45).

FGD was used because it allows for the exchange of views and opinions through discussions with a group who are known to be concerned with, and knowledgeable about the issues discussed. Again, FGD is used to obtain knowledge, perspectives and attitudes of people about issues, and sought explanations for behaviours in a way that would be less easily accessible in response to direct questions (Wong, 2008).

4.4.2 In-depth Interviews

In-depth interviews were held with health managers (Medical Superintendents and Health Services Administrators) who were the key informants. These interviews were conducted in the offices of the key informants and were tape- recorded, lasting between twenty (20) to thirty (30) minutes in length, upon their permission. In all, four (4) in-depth interview sessions were held. The in-depth interviews sought information about the challenges in the implementation of maternal health interventions at the facility level, difficulties with the processes and guidelines in the implementation of such interventions, challenges with IST programmes, challenges of logistics for maternal health, training capacities of logistics personnel, challenges in the logistics management system, among others.

In-depth interview was used because it is useful in situations where either in-depth information is needed or little information is known about the area under discussion. Moreover, the flexibility allowed to the interviewer in what he or she asks of a respondent is an asset as it can elicit extremely rich information (Kumar, 1999). It also allows for intensive and systematic note-taking.

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4.4.3 Document Collection

A variety of documents were collected as secondary sources of information. The documentary data were mainly from policy documents and annual reports of the MOH, Ghana Health Service (GHS), the Tamale Metropolitan Health Directorate annual reports and Annual Review Reports of the hospitals. These sources were to verify some of the information obtained from key informants and participants in the FGDs.

4.5 Research Instrument

A semi-structured interview guide was developed for the study. Two sets of semi-structured interview guides were developed. The first set of semi-structured interview guide was for the midwives and the second set for Medical Superintendents and Health Service Administrators. The semi-structured interview guides had four main sections soliciting information on challenges of maternal health in the Tamale Metropolis. The first section deal with issues about education and training, the second section center on working conditions and maternal health logistics at the facility level, the third section deal with implementation of maternal health policies and the last section deal with motivation in the profession with issues pertaining to salaries, promotion, transportation to work among others. Semi-structured interview questions have the advantage that they make room for the use of follow-up questions or probes (see Kumekpor, 2002).

4.6 Data Processing and Analysis

The data from the in-depth interviews, FGDs and field notes were transcribed verbatim. After transcription the data were organised into retrievable sections by assigning a code to each FGD and interview respectively using word-processing file. The researcher had to familiarise himself with the data by listening to the tape recordings from the FGDs and interviews over again to

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ensure that the appropriate transcription and coding were done. This was followed by preliminary coding data by identifying how the respondents conceptualise certain key phrases and words. From the various themes and categories that emerged, the data were analysed thoroughly.

4.7 Study Setting

The fieldwork for data collection was undertaken in three weeks in March, 2011, in two public hospitals in the Tamale Metropolis. The hospitals included the Tamale Teaching Hospital and the Tamale Central Hospital. These hospitals were selected because they are the main referral centers for health care services in the Metropolis. Moreover, considering financial and time constraints, it would have been impossible to cover all the health care facilities in the Metropolis. A more practical reason is that, considering the busy schedules of health professionals, it would have been difficult to get more participants in the study.

Tamale Metropolitan area is one of the twenty (20) administrative districts in the Northern Region. It serves as Metropolitan and Regional capital. It is located in the centre of the region, approximately 175km east of longitude 1^0west and latitude 9^0 north. Savelugu/Nantong District bound it to the north, to the south by West and East Gonja, to the east by Yendi District, and to the west by Tolon/Kumbungu District.

The Metropolis has a total population of 402,843 (projected at 2.9% regional growth rate from the 2000 census). The actual growth rate of the Metropolis is 3.5% that is higher than the regional and national growth rates of 2.9% and 2.8% respectively. It has a surface area of 1011 sq. km, which forms about 13% of the total land area of the Northern Region. Its population density stands at 384 persons per sq. km.

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In urban Tamale where there is ethnic diversity, Dagombas still constitute almost 80% of the total population. There are people from other regions and ethnicity in the metropolis. Almost all the people in Tamale rural areas are Dagombas.

Islam is the predominant religion in the metropolis, with about 84% of the population affiliated to it. Christians constitute 13.6% (with Catholics forming 43.7%), traditional worshippers constitute 1.6%, and others form less than 1%.

4.7.1 Health Care System

Health services in the Metropolis are managed at three (3) levels:

1. Metropolitan Health Administration level: responsible for overall planning, monitoring, supervision, evaluating, training, coordinating of all health programmes in the metropolis. It is also responsible for conducting operational research and linking up with other agencies and NGOs in health provision and promotion.
2. Sub-district level: each with a management team known as the Sub-district Health Management Team (SDHMT). The SDHMTs are responsible for programme planning and implementation of health activities in their various sub-districts
3. Community level: health services are provided at the community level by sub-district staff and supported by trained community volunteers.

The Metropolis has forty (40) health facilities, excluding the Teaching Hospital. There are fifteen (15) Government owned health facilities in the Metropolis comprising three (3) health centers, nine (9) clinics and three (3) hospitals. The hospitals are Tamale Teaching Hospital, Tamale Central (Old) Hospital and West Hospital.

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4.8 Conclusion

The study used a qualitative approach. In-depth interviews and FGDs were the main methods for data gathering, using a semi-structured interview guide. Processing and analysis of data were done through content analysis. The next chapter presents the results of the study.

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CHAPTER FIVE

PRESENTATION OF RESULTS AND DISCUSSION

5.0 Introduction

This chapter presents the results from the data gathered from the fieldwork. The results are discussed under two broad themes: skilled birth attendants and logistics systems challenges of maternal health. Finally, inferences from the results are discussed with reference to the theoretical framework adopted for the study: the Walt and Gilson Policy Analysis Triangle (1994).

5.1 Skilled Birth Attendants Challenges

5.1.1 Inadequate In-Service Training (IST)

Participants in the focus group discussions stated that the in-service trainings organised by the Ghana Health Service (GHS) are ineffective. The content of most of the IST programmes does not address the scope of maternal health. Most of the IST programmes take a long time to be organised, usually more than a year. Most midwives complained that this is affecting the quality of care of maternal health services in the metropolis. This is because they lack current practices and knowledge in topics such as family planning, breast-feeding, and infection prevention, among others. Also, it was reported by the midwives that the selection processs for participation in such IST programmes was unclear. Midwives also reported that most of them were not aware of such training programmes, and by the time they became aware, participants for such programmes would have already been selected.

> *Since I started working in this facility for about four years now, I have never been part of any in-service training programme. For almost two (2) years now, none of us here have attended any IST. I am still relying on what I have learnt from school to attend to clients. Sometimes, you encounter difficult situations,*

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especially management of the third stage of labour that you were not taught in school. You have to do try an error to save the mother and the child.
What is even annoying is that, some times we hear of such training programmes from our colleagues and by the next moment the training programme is going on and we do not know the criteria they use to select people for such programes. Most of the time, it is our boss who attend such programmes only (Midwife).

Management in the health facilities also complained about their inability to organise such IST programmes as a result of inadequate funds. The IST programmes are mostly organized and funded by the GHS, and there is usually a delay in the release of funds, which has affected the frequency of such IST.

We as a facility do not organise any IST. It is the GHS who organise such programmes. Mostly funds have to be released from the Headquarters to the Regional Health Administration Directorate, based on the availability of funds, they will invite our midwives for training. We as a facility, we are now putting in place an IST committee to see to the organization of such programmes depending on how much we are able to generate from our Internally Generated Funds (IGF) (Medical Superintendent).

5.1.2 Limited Knowledge of Maternal Health Policies and Guidelines

Majority of the midwives do not know the maternal health policies in the country and only a few are aware of the free maternal healthcare and the safe motherhood initiative. Others also hear of such policies from colleagues or from their immediate supervisors. It was also revealed in the FGD that of the few policies that they were able to mention, most of the midwives did not know the content of such policies and what specific issues they were addressing. Furthermore, several interpretations were assigned to the policies.

I know that the free maternal health care covers only delivery and when pregnant women come here to deliver they are not charged anything. But I'm not sure if complications, antenatal and caesarean sections are covered (Midwife).

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When asked about implementation guidelines for such policies, interview informants reported that they do not have any guidelines from the GHS. They explained that there were directives from the GHS to implement such policies, but no policy guidelines were issued to that effect.

> *As of now, we have not received any guidelines from the GHS and we are doing just as we have been told to do. It was a directive issued from the GHS to all public health care facilities in 2007 to start providing free services in the areas of antenatal care, normal delivery as well as child welfare services free of charge to women and their new born babies. The bills are forwarded to the NHIS for refund per the directives* (Medical Superintendent).

5.1.3 Workload and Shortage of Midwives

Workload was a major challenge in the provision of quality maternal health care services. Most of the midwives complained that they attend to more clients than usual and these reduce the time spent with clients. They omit certain aspects of needed care for women resulting in incomplete medical examination. The midwives further explained that the workload was a result of the fact that their numbers were inadequate. There are shortages of midwives in the health facilities and because of this, one midwife has to attend to more clients than usual. The midwives have an overwhelming range of duties and responsibilities. Combining these duties and responsibilities, in addition to attending to patients, sometimes lead to loss of concentration. Besides, they do not have enough time for rest and leisure, unlike the doctors who have been provided with a lodge to rest after work. Midwives considered the workload to be the cause of stress, and resulting in bent waist as you have to bend low when attending to deliveries.

> *We are just working here like we are machines. When you arrive for work in the morning, you will be on your feet till the evening. On the average one midwife has to attend to about 60 to 80 pregnant women in a day and you have to ignore certain aspects of care that are very crucial. You have to also perform other duties such as assisting doctors in obstetrics and gynecology cases, conducting normal vaginal delivery, keeping of records at the labour ward… and if I want to mention all, it will take us another two hours* (Midwife).

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> *When you close from work and you get to the house, you are not able to sleep well because you will be experiencing some waist pains* (Midwife).

Key informants also reported that the shortage of midwives in the metropolis is partly as a result of the perceived conflicts in the Northern Region. This has discouraged most health professionals from accepting postings to the metropolis for fear of their lives and their families. Moreover, specialists like Gynaecologists and Obstetricians are not adequate in the health facilities to attend to special cases that midwives are not competent to handle.

> *Every year, a number of health professionals are posted to this facility from other places, but they refuse to come simply because, they think they will be caught up in the ethnic conflict in the metropolis. We have even sent out notices to trainees in health training institutions about the lucrative opportunities we offer, but most of them have turn down our offer.*
> *This year alone about 3 midwives have left this facility to other regions and the reason for their leaving was that they were scared of their lives* (Health Services Administrator).

5.1.4 Feeling of Humiliation

Midwives reported of feeling of humiliation in the workplace among doctors and their superiors. Other health professionals marginalise midwives and show little respect for their profession. Their low status and marginalization has brought about a lukewarm attitude to work.

> *The doctors are claiming we are not their colleagues because midwifery is for people who have had weak grades in their secondary education and therefore, not academically brilliant, so the only profession we can settle on is midwifery* (Midwife).

Most midwives complained that the level of interaction between them and their superiors are minimal. They are not given the opportunity to seek clarification on an issue they do not understand with their superiors. Additionally, they reported that their participation in decision making is limited. They are not consulted on any new development that is to be implemented. It

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is only top management who takes and implements such decisions; their views and opinions are not sought.

> *There is no team work in this facility. The level of apathy is high in this facility as people are not prepared to exchange information and ideas* (Midwife).

Moreover, a culture of intimidation is created in the environment in which they work. They have been shouted at in the process of performing their duties and this makes them feel they are not part of the facility. Most midwives have been shouted at by doctors and their superiors because they failed to follow a procedure or did not seek permission before carrying out an assignment.

> *Shouting is the order of the day in this facility. You are always shouted on by your boss in an attempt to seek clarification to something you do not know the process of starting it or when you commit a simple mistake like not dressing up a bed. They always expect that we should be perfect human beings in everything that we do. You are not given the opportunity to even explain yourself when you flout a simple procedure in front of your boss* (Midwife).

5.1.5 Inadequate Supervision and Evaluation

The midwives reported that there was no time for supervision by the senior midwives. In most instances, senior midwives are attending meetings, training programmes, travelling, among others. The midwives elaborated that the focus of supervision is on mistakes and gaps in work, rather than real evaluation of the quality of work. These errors are translated into "punishment" as they are denied certain vital entitlements like off duty hours, depending on the gravity of the error. Failure to follow certain aspects of care like taking the blood pressure of a client, follow-up on clients laboratory tests, among others, were seen as common types of errors. The midwives also reported that, sometimes they are viewed as trusted professionals and there is no need for supervision.

The evaluation process follows a routine traditional style that is confidential, non-participatory, and is not based on merit. Although they were not able to tell the basis of their evaluation, most

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of them consider it to be unfair, inadequate, takes a long time and sometimes they are never informed about the results of the evaluation for them to improve upon their performance.

> *There is no one to always give you guidelines as you are working. Most of the time our boss just walks in stand for some few minutes and leave without talking to anyone. When you are given your evaluation report, you always feel like weeping, because most of the comments are not pleasant at all. After all these "donkey work" our boss will not appreciate it* (Midwife).

5.1.6 Problem of Communicating with Clients

The midwives reported of the difficulty in communicating with women and their families due to their low educational status and illiteracy. Most of the midwives are not able to speak the local dialect and this makes communication difficult between them and the clients.

> *I cannot speak Dagbani and most of the pregnant women I attend to cannot speak English. I have to rely on colleagues who have to do the interpretations for me* (Midwife).

Moreover, the clients do not disclose full information about their conditions that will enable the midwives to write a full report of their cases and that could lead to the identification of possible causes of complications. This has forced most of the midwives to display feelings of harshness toward clients and their families when providing care. They also spent a lot of time trying to get information from clients who are not cooperative in their interaction.

> *Some of the patients do not report early to seek treatment. They resort to self medication and when there are complications, they rush to the facility. About three days ago, a young lady attempted to abort a pregnancy by using a tablet called cytotec recommended only to be administered by health professionals. She did not disclose this to us when she was rushed in here. We have to "push her to the wall" and she confessed that it was her friends who influenced her to take that table.* (Midwife).

Again, some of the pregnant women who attend antenatal clinic ignore completely some basic maternal care practices instructed to follow like nutrition, iron-folate supplementation,

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intermittent preventive treatment of malaria during pregnancy, among others. These uncooperative attitudes of clients have sometimes forced midwives into difficult situations, making them prescribe the wrong diagnosis for such cases.

5.1.7 Risk of Infections

The midwives complained that in the course of performing their duties, they are exposed to various risks of infections, including HIV/AIDS and Tuberculosis. This is as a result of the fact that most of the infection prevention items for delivery are inadequate or lacking. The midwives reported that there is high risk of infections and this has discouraged most of them from performing deliveries. The midwives complained that these occupational risks occur when they get in contact with blood and body fluids during child birth. This has pulled away a number of midwives currently practicing in the area of delivery.

> *This job is too risky. We come in contact with blood and other body fluids. In the process of performing our work like delivery and caesarian sections, some of our clients who have contracted deadly diseases like HIV/Aids, tuberculosis and hepatitis B, which can easily be transmitted to you, especially when you do not wear protective gadgets* (Midwife).

5.1.8 Aging Workforce

The retirement of aging midwives is also contributing to the diminishing cadre of practicing midwives. The majority of practising midwives are over fifty (50) years old in the facilities, and many would be retiring very soon. Also, most people are not interested in the profession and the intakes to midwifery training schools are limited.

> *Over sixty percent (60%) of our midwives are over 50 years old. This year, seven of them will be retiring and this will have serious consequences on our workforce strength. We have been facing this problem every year, and we do not have authority to recruit midwives ourselves. It is the GHS who post midwives to our institution and we do not have control over that. For about two years now, no fresh graduate midwife has been posted to this facility* (Medical Superintendent).

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5.1.9 Low Motivation

The questions exploring motivation were centered on several themes, including salaries, promotion and transportation to work. It is believed that those engaged directly in implementing a policy should be motivated well enough to ensure the successful implementation of such a policy. The midwives complained that motivation in the profession is nothing to write home about. Most of the midwives agreed that their salaries were too meager and they have not seen any increment in their salaries for a long time. The delay in the payment of salaries is also frequent and most of them have to find other ways of complementing their income.

> *If you want to compare the work that we do in relation to our salaries, it is nothing to write home about. The salary is too small that it can not take you home considering the economic conditions in the country and the numerous responsibilities at your hands. For about four (4) years now, I have been receiving the same salary even though I know that from time to time there have to be an adjustment in salaries. There was even a time my salary stop coming for about three months. I have to make several complains to the authorities before it was finally restored. I do not even receive extra duty allowance for the time work that I do. The delay in the payment of salaries is also worrying. At the end of the month, it usually takes a week or more before your salary reflects in your account* (Midwife).

Apart from low salaries, delays in promotion have also been mentioned by the midwives as a factor causing dissatisfaction in the profession. They believe the current system of promotion is not fair and usually takes a long time, and at times it is not effected at all. At times, there have to be follow-ups to ensure they are promoted, and in so doing they have to bribe the officials to ensure that they are promoted.

> *I will be going on retirement next year and I have applied for promotion since last year and up till now I have not heard anything from the authorities. When I decided to trace up I was given excuses here and there that they are still processing it* (Midwife).

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Personal transportation to work was also reported by the midwives. Most of them do not have personal means of transport to work and they have to rely on public transport to work. As a result of this most of them have come to work very late.

> *Every day I have to pick a taxi to work which cost me GHC 3.00. I have to stand by the road side in order to board a taxi. Most of the cars that pass by are always full. You have to stand for along time before you finally get one to board, by the time you get to work it is late and you are blamed for coming to work late* (Midwife).

5.2 Health Logistics Challenges

5.2.1 Limited Equipment and Supporting Infrastructure

The environment under which most midwives operate is very appalling. Most of the midwives reported that there are no sufficient equipment like Manual Vacuum Aspirators (MVA), surgical gloves, wheel chairs, among others, to enable them perform their duties successfully. This has sometimes resulted in a feeling of frustration among midwives.

> *Most of our equipment are not in good shape at all. Most the wheel chairs are broken down, and this has made the movement of patients in and out of the operating theater very difficult for us. At times there are frustrations all over you, because when you go to the store room to request for surgical gloves, you are told the stocks have run out* (Midwife).

The rooms under which they examined pregnant women are too small and do not have adequate ventilation.

> *The room in which I examined pregnant women is too small. When you want to examine a pregnant woman, you have to pack your documents, table and seat to one corner of the room so that there will be enough space to lay the stretcher for the woman to lie down. After examining her, you arrange everything back and write your report. The room is also warm all day. As you can see, there is no ceiling fan or air conditioner to reduce the heat in the room. It is like you are working in an "oven"* (Midwife).

Also, essential infrastructure like water and electricity are most of the times interrupted.

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> *The electricity and water supply systems are not reliable. There are usually intermittent power outages that usually put us in difficult situations, especially during caesarian sections, the power can go off without any prior notice and we do not have a stand by generator* (Midwife).

Drugs needed to perform Basic Emergency Obstetric Care (BEmOC) are sporadically or completely unavailable.

5.2.2 Inadequate Ward Space for Delivery and Resting

The in-patient wards for delivery are too small to accommodate a large number of pregnant women who come to deliver. Deliveries are done one at a time and pregnant women have to form a queue waiting for their turn. Sometimes, most of the pregnant women have to lie on the bare floor due to the fact that the delivery beds are not enough.

> *You can see for yourself. The delivery beds are not enough so when we finished with a delivery case the mother and the child has to lie on the floor* (Midwife).

5.2.3 Problem with Transportation

Transportation difficulties, such as inadequate and unreliable means of transport were mentioned by the key informants. The ambulances at the facilities serve multiple purposes and may not be available at certain times. When patients are to be referred to another facility, the patient has to bear the cost of fueling the ambulance, which most patients are not able to afford. Most of the ambulances are over-aged.

> *Our budget is insufficient to buy fuel for our ambulance and let alone purchase a new one. At the moment we have one ambulance that we use for the referral of pregnant women and other patients in complications we can not handle to other facilities. We are sometimes caught in the 'web' because we usually have multiple cases that we have to use one ambulance for all the cases one at a time* (Health Services Administrator).

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Moreover, trucks to convey maternal health logistics from the Regional Medical Store (RMS) to the health facilities are lacking. Most maternal health logistics are kept in RMS for a long time before they are finally delivered to the facilities.

> *Currently we do not have trucks that will convey logistics from the RMS to the hospital. We sometimes use our official vehicles or hire trucks to convey the logistics to the facility* (Health Services Administrator).

5.2.4 Difficulties in Following the Procurement Act (Act 663, 2003)

Managers at the facilities level complained about the difficulties encountered when using the Public Procurement Act (Act 663, 2003) in the process of procuring essential commodities for maternal health. Key informant interviews show that the Public Procurement Act (Act 663, 2003) does not allow for emergency purchases. Most of the times, there are shortages for essential commodities for maternal health in the facilities which require urgent replenishment, but because the procurement law has to be followed, it delays the process of purchasing such commodities.

> *There are at times things are needed so urgently and you are being asked to follow the procurement law. If you do emergency purchase it is difficult to convince the auditors why there was such an emergency purchase and you have to do a lot of documentation to convince them.*
> *The Act is very strict. You can not procure without the requirements of the law. And the way the law is, it does not allow you to address some emergencies. If you require anything, the tender entity committee looks at it and approves it, then you go and invite bids, the bids come in, you open the bids in front of the public, and after that a committee is formed to evaluate the tenders, after evaluation, the tenders go to the tender entity committee for final approval… and a supplier is selected* (Health Services Administrator).

5.2.5 Weak Supply Chain for Maternal Health Logistics

The facilities faced supply chain problems, ranging from forecasting, warehousing and storage, inventory control and logistics management information for maternal health.

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Interviews with key informants revealed that staff at the logistics department have not received adequate training on the use of Microsoft Office Excel for forecasting. Also, the rates of consumption of maternal health logistics are not known in the facilities and as a result, they can not project the future consumption levels that will be needed.

Moreover, most of the storekeepers are not trained in basic storekeeping procedures. There are no order by which stocks are issued out like, the First Expired First Out (FEFO) method of issuing out stocks, and providing the appropriate temperature control for the logistics in the store room.

The feedback from user departments for maternal health logistics are not channeled to the stores department.

> *The feedback from the user departments are not channeled well. When they run out of stocks, they do not report early for you to start the procurement process. The next thing is that they just come and tell you that they need this item urgently. We do not also have a monitoring and evaluation team that will make timely information for us to take decisions* (Health Services Administrator).

5.2.6 Human Resource Capacity

The management of logistics for the delivery of efficient health care require experts to manage the logistics systems. It was reported by the logistics officers that most of the staff do not have training in logistics. This has slowed the work of the logistics department. The officers complained that most of the staff had their previous training in accounting and are not well conversant with the procurement processes and the procurement law. Besides, there are no refresher trainings for these staff to acquire any knowledge in logistics systems.

Again, roles and responsibilities of each staff involved in the management of the logistics system are not clarified or documented. This has put the staff in a difficult situation as they do not know which of them is in charge of the various logistics functions.

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Most of our staff are not permanent. They are mostly National Service Personnel with background in Accounting and they will be leaving very soon. This means that we do not have permanent staff that we can train in logistics management (Health Services Administrator).

5.3 Discussion

This study considers the implementation challenges of the MDG 5 to improve maternal health by health care providers using the Walt and Gilson Policy Analysis framework (1994),focusing on contextual factors that affect policy implementation. The implementation of a policy depends upon the interactions of many variables including, the environment or conditions in which the policy is formulated and implemented.

The implementation of policies, such as to improve maternal health, depends on contextual features to be successful in implementation. The findings from the study have been grouped into skilled birth attendants and logistics systems challenges as contextual factors that affect the successful implementation of MDG 5 in the Tamale Metropolis of Ghana.

The United Nations fifth Millennium development Goal (MDG 5) aims to improve maternal health. This goal is structured around two key targets: First, to reduce maternal mortality rates by 75% between 1990 and 2015, and Second, to achieve universal coverage of skilled care at birth by 2015. Inequitable access to maternal health is a big challenge globally.

There is also inequality of access to skilled care at delivery. The inequalities to maternal health are discussed with reference to the contextual factors in the Walt and Gilson Model (1994).

As a useful starting point, the provision of adequate in-service training (IST) is considered vital in developing and keeping midwives with up to date practices in the field of maternal health care. The provision of adequate IST will go a long way to reduce maternal mortality. The clinical competencies of midwives need to be addressed through frequent IST and their curricular must have relevance in modern health care delivery practices. For instance, several studies have found

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out that the clinical competencies of health providers in providing BEmOC are very low and through the use of other life-saving equipment (MOH, 2008; Al Serouri, Al Rabee, Afif & Rukeimi 2009; Nyango, Mutihir, Laabes, Kiggbu & Buba, 2010). One of the major reasons explaining why so many countries still have inadequate numbers of skilled midwifery providers is because those grappling with human resources have not paid attention to the need for 'proficiency' in the various competencies required to assist women and newborns. For too long it has been accepted that as long as the health worker received some (often too little) training in midwifery, this was sufficient (Fauvea et al, 2008). There has to be a clarity as to the understanding of competence- ability to perform aspects of the job and competencies, the basic knowledge skills and behaviours required of a midwife to practice safely in any setting (Ireland et al 2007).

The implementation of any policy requires that those involved in implementing such a policy have adequate knowledge of the policy. Those engaged in the implementation of a policy must be engaged in the formulation process of the policy. This will ensure the success of such a policy as their commitment and support will be high. Most of the policies in developing countries tend to be implemented through a top-down approach and are not communicated to those engaged in direct service delivery of health services. In essence, the dissemination of maternal policies at the local level is weak. Communication is also an essential ingredient for the success of a policy. Failure to communicate a policy effectively may lead to implementation failure. As discussed earlier, by specifying and given clarity on the policy and ensuring that the policy is transmitted to the appropriate personnel, given adequate information and instructions of how the policy is to be implemented must be given priority. Besides, different meaning and interpretations assigned to the policy are minimal. In Thailand and the United States, most health professionals have low to

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moderate knowledge about the national policy, and their levels of involvement in policy formulation and implementation is low (Kunaviktikul et al, 2010; Deschaine and Schaffer, 2003).

The low motivation of health professionals has contributed to the high exodus of health professionals out of the country, to international organizations and to the private sector. This has created shortages of midwives resulting in heavy workloads in health care facilities. Moreover, the low status and recognition accorded to midwives have discouraged people who want to pursue that profession. Marginalisations of midwives also mean that they face feelings of disappointments and confusion (Hassan-Bitar & Narrainen, in press) and can not be able to take their own initiatives. To be able to achieve the MDG 5 requires well motivated and dedicated midwives who will show commitment towards the delivery of quality maternal health services. Several studies have shown that the low motivation in the health sector has impeded the implementation of most policies and reforms in Ghana (Sakyi, 2008b; Agyepong et al, 2004). The low motivation of health professionals have forced some to supplement their income by engaging in other occupations.

Attention has focused recently on the importance of adequate and equitable provision of health personnel to raise levels of skilled attendance at delivery and thereby reduce maternal mortality (Graham & Bullough, 2001; WHO/ICM/FIGO 2004; Campbell and Graham 2006; Makowiecka, Achadi, Izati, & Ronsmans, 2008). However, the human resource crisis in health care means that many countries are far from reaching the health-related MDGs. Factors contributing to this crisis include mal-distribution and low workforce productivity together with an acute shortage of skilled workers in the government health sector (Rolfe, Leshabari, Rutta, & Murray, 2008). The effects of shortage of health professionals for maternal health are reduction in quality of services;

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increased workload; reduced time for the patient; and poorer infection control (Gerein, Green, & Pearson, 2006). When adequate skilled personnel are provided, they can better respond to the needs of maternal care, thereby, helping to reduce maternal mortality.

To enable midwives function effectively, there has to be the provision of an "enabling environment". Provision of an adequate environment for midwives will ensure delivery of quality maternal health care and reduction in maternal levels. A skilled attendant should have the necessary equipment and medicines and adequate referral means to be effective in reducing maternal mortality. The environment can also be viewed broadly to include the political and policy context in which skilled attendants must operate, the socio-cultural influences, as well as the more proximate factors such as pre-and in-service training, supervision, deployment and health systems financing. The enabling environment should also ensure there are sufficient skilled attendants with the necessary skills, satisfactory pay scales and career advancement opportunities; continuing education opportunities to maintain and upgrade skills; supportive supervision mechanisms; and possibilities of skilled attendants to refer women and newborns directly to higher level care if necessary (WHO, 2004 cited in Nanda, Switlick, & Lule, 2005).

Improving access to maternal health logistics is an essential component of strengthening maternal health programs and outcomes (Lule et al, 2005). Maternal health challenges in the entire health system come with deeply embedded issues of human resources, infrastructure competing priorities and community engagement. The shortages of maternal health logistics have a direct barrier to the utilization and positive outcomes at health facilities (Bergeson-Lockwood, Madsen, & Bernstein, 2010; Madsen, Bergeson-Lockwood, & Bernstein, 2010). Maternal health logistics often require a more highly trained health care provider who is available all the time. These providers are trained sufficiently on how to use these logistics. An efficient logistics

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system should be responsive to the needs of the end-users, that is the patients. Improving logistics systems and ensuring product availability requires focusing on the customer regardless of the supply chain being considered (Nanda, Switlick & Lule, 2005). A reliable and efficient transportation system should be a key to the success of logistics systems and should be able to respond to emergencies and also ensure that products are in constant supply.

A legal system that does not allow for easy access to logistics have implications on the way health logistics are procured, and could be detrimental to achieving quality maternal health care. Laws and legislations could impede the successful implementation of health policies, especially during the formulation of such policies, when provisions were not made to take consideration of such legislations. This should serve as a lesson to policy implementers of health interventions that, there is always the need to ensure that legislations are less rigid to allow for effective implementation of health interventions.

Furthermore, the logistics management system should effectively function in each of the components to ensure that there are no hindrances in handling maternal health logistics. In many developing countries, logistics systems for public health facilities have been centralized, with central ministry offices responsible for planning, forecasting, procurement, warehousing and the distribution of essential drugs, contraceptives and vaccines. These systems have been notoriously inefficient and in many cases incapable of providing adequate supplies on a timely basis (Bossert, Bowser, & Amenyah, 2007).

In essence, the availability of resources is an important ingredient in ensuring the success of policy implementations. As reviewed earlier, without adequate resources, implementation of health policies would encounter challenges as resources to ensure the execution of such

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programmes are insufficient or lacking. Working on the systems that will ensure time delivery of logistics is crucial for achieving MDG 5.

5.4 Conclusion

Contextual factors affect the successes and failures of policy implementation. Implementation of maternal health policies depend to some extent on the availability of requisite personnel and resources for successful implementation. The challenges of maternal health in care facilities in the context of this study lies within midwives' constraints and logistics challenges. The next section presents a summary of the study findings and lessons for policy implementation.

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CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATION

6.0 Introduction

This section gives a summary of the study findings, offers some useful recommendations and draws conclusion. It also offers policy lessons for health policy makers and analysts.

6.1 Summary of Key Findings

From the results of the study, the following key findings emerged as the challenges facing health care providers in the implementation of maternal health in the Tamale Metropolis.

Inadequate In-Service Training (IST) programmes for Skilled Birth Attendants (SBA), infrequent, inadequate and ineffective, affecting the quality of maternal health services and resulting in low competence in maternal health care delivery. There is little awareness of any impending IST and selection process for participation is not transparent.

Skilled Birth Attendants have limited knowledge of maternal health policies and initiatives in the country because such information is not widely made available to them. Additionally, there is a lack of policy guidelines from the GHS on how to implement these policies.

The shortage of midwives in health care facilities has resulted in an increase in workload of the limited staff and the quality of time and attention due patients. The perceived conflict in the north is partly responsible for the shortage. Lack of trained specialists like Gynecologists and Obstetricians, adds to the workload of midwives.

There is a general feeling of marginalization by doctors and superiors which has affected midwives' attitude to work. There is also a culture of intimidation and humiliation which has led to the low status and feeling of inferiority among midwives and has strained the relationship with doctors and their superiors.

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There is low supervision by senior midwives as a result of their busy work schedules, and there is no real or transparent evaluation processes to enable midwives assess, know and improve on their performance. Consequently, there is unfair punishment meted out on midwives in case of poor performance on the work.

The inabilities of midwives to speak local dialects and illiteracy of women they deal with have caused a communication gap between the two parties. Clients fail to disclose full information about their condition, making it difficult for midwives to diagnose cases and write complete medical report for examination.

Infection delivery items are lacking in these centers, exposing midwives to various risks of infections in their work. This has discouraged most of the currently practicing midwives to move into other areas of specialty.

Most practicing midwives are aging and approaching their retirement. There is also a general lack in interest in the profession and intakes into midwifery schools are few in the country. Motivation among maternal health workers is very low. Salaries are generally meager and pay increment is usually delayed. As a result, midwives have to supplement their income doing extra jobs. Promotion is infrequent or delayed among midwives, and personal transportation to work is a problem, making them report to work late.

The environment under which most midwives operate is not favourable, with inadequate ventilation in the already small treatment rooms, etc. There is inadequate equipment and supporting infrastructure to deliver quality maternal health care. Essential utilities services, like water and electricity are often interrupted.

Transportation problems such as inadequate and unreliable means of transport, over-aged ambulances, and the situation where referred patients pay for the cost of fueling the ambulance

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have compounded the problem of women in labour who have to be referred to other facilities resulting in deaths in some instances is needless. Trucks to convey logistics from the Regional Medical Stores are lacking and there is usually a delay in carting logistics from the RMS to the health facilities.

The Public Procurement Act does not allow for emergency purchases. The Procurement Act itself is already difficult to follow and does not make it possible to do emergency purchases without first following it as a matter of procedure.

Lack of data makes it difficult to make informed decisions of taking inventory of current stock in the facilities, or to know the accurate records of patients. There is no basic shelving in most of the stores at the health facilities, making it difficult for storekeepers to organize and distribute products. Scattered data in various sources shows the logistics management information system is not properly utilized and there is a lack of properly trained personnel to manage its use.

6.2 Conclusion

It can be drawn from the findings of the study that contextual factors affect the implementation of maternal health interventions by health care providers in the Tamale Metropolis. Implementation of maternal health interventions should take into consideration the environment under which the interventions are implemented by health care providers to ensure they are successful to improve maternal health in the Tamale Metropolis. The challenges emanating from maternal health care delivery in the health system indicate that human resources for health and logistics have a direct bearing and influence on the way maternal health interventions are implemented. To ensure that such interventions are successful, these issues need to be given priority in the implementation phase.

The findings of the study also call for the provision of frequent IST to update midwives knowledge and skills so as to provide quality maternal health care. The top-down approach to policy implementation has contributed to the limited knowledge of maternal health policies among midwives and their support and contribution towards the success of such policies are minimal as revealed by participants in the study. The low motivation in the health sector has not been given priority, and most health policies have not factored this concern in the formulation of such policies. Without the requisite and adequate human resources in health, implementation of health policies will be a mirage stemming from a dissatisfied workforce that will migrate to other sectors where conditions of service are perceived to be better.

The absence of efficient logistics systems in health care facilities in the Tamale Metropolis has contributed to the challenges of delivering quality products to the final consumers that is patients. Without adequate supply systems, programmes and policies designed to reduce maternal mortality will not be achieved. The inability to have skilled personnel to manage the supply chain also means that products can not be handled well and the quality of such products may be compromised and, therefore, may not lead to improvement in health of women their babies in the Tamale Metropolis.

6.3 Recommendations

Health facilities should frequently provide IST programmes that are well designed to address the full scope of maternal health care delivery, to enable midwives upgrade their knowledge and competency level in these issues taking into consideration the enabling environment for improve maternal health care. This should include an effective referral system, communication and transport, drugs and supplies, a well functioning health system among others. There is also the need for skilled birth attendants to be given opportunities fir career advancement and continuing

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education opportunities to upgrade their skills and knowledge for improve maternal health. Additionally, information about such training programmes must be openly circulated to all midwives and the selection process for participation to be transparent. Funds for the organization of these programmes must be released on time by the GHS, to ensure that such programmes are regular.

Health professionals, including midwives should be a part of the health policy development process through to its implementation, to secure their support and commitment towards that policy. Furthermore, the policy and its guidelines must be communicated clearly enough to the full understanding of all the midwives, since the success of its implementation depends on the level of knowledge of the midwives.

Team-work should be promoted among midwives, doctors and their superiors to ensure their commitment to the facilities through participation in decision-making and open forum to exchange ideas and information. If doctors and superiors respectfully treat midwives as colleagues, rather than subordinates, this will boost their self-esteem and confidence, and consequently enable them give their best to the health practice.

Human resource policies and plans should be developed and implemented to address the low pay scales, promotion, career advancement, working conditions and transportation to work that midwives have complained about. Motivation of this nature inspires midwives to excel in their work, with heartfelt dedication and commitment.

Midwives in the FGDs also spoke about the need to put in place a system to ensure that their promotions are not delayed. They called for the decenttralisation of the human resource function of the GHS to the regional levels, which will ensure that promotion related activities and other

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functions such as salaries can be addressed at this levels, rather than the centralised system, which they consider to be inefficient.

The MOH and the GHS must ensure that adequate infrastructure and equipment are provided to enable health care facilities run efficiently. Thus, a transportation system, such as an ambulance should be put in place by the health care facilities to respond to emergency situations. Adequate warehouse and storage facilities should be constructed by the health care facilities to ensure the safety of maternal health products.

Management of maternal health logistics must be assigned to highly trained health care providers who are able to use the logistics management system, are available all the time and know how to use these logistics. Thus, the functions of such personnel will include forecasting, inventory control and management-documented store procedures. Maternal health logistics must be easily accessible and in constant supply, with the availability of an efficient transportation system to ensure that regular supply.

Additionally, monitoring teams must be put in place to track the consumption of user departments in the facilities and report early for replenishment of stock. The procurement Act should be reviewed and made flexible enough to allow for emergency purchase, since a rigid legal system could impede access to and procurement of logistics.

6.4 Lessons for Policy and Future Research

A number of important lessons emerged from the findings of the study that should serve useful lessons to health policy implementers and policy analysts in developing countries. Unless these bottlenecks in the health system are taken into consideration, any attempts at achieving a reduction in maternal health may not achieve the desired objectives.

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One important lesson that emerged out of the study findings is the top-down approach to policy implementation of health policies in the country, without stakeholder consultation expected to implement the policy has brought about weak dissemination of policies. These policies are mostly formulated at the national level and may be disseminated to implementers at the local level without guidelines accompanying such policies, even though these guidelines may exist. The guidelines are mostly kept at the national level without conscious efforts to disseminate them. Local level implementers often use their own discretions, resulting in several meanings and interpretations assigned to the policy.

Moreover, most health policies have demonstrated a weak link towards addressing the paucity of human resources in health in the contents of the policies. These policies are designed most of the time, specifying how programmes are to be executed, but have failed to address the issues of motivated workforce and capacities of personnel driving the implementation of such policies.

Furthermore, most policies are implemented without the provision of adequate resources to ensure smooth implementation. Without adequate resources and infrastructure in place, health policy implementations in developing countries run into difficulties, because no consideration is given to the required infrastructure and resources. It is expected that future policy implementation would take into consideration the required infrastructure and resources before implementation proceeds.

It is also important to consider institutional bottlenecks that tend to hamper successful policy implementation. Most policies in developing countries often conflict existing laws and legislations, creating bureaucratic implementation. In so doing, the policies fail to achieve their intended purpose.

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This study has some limitations that need to acknowledge. Firstly, since the study was limited to two public hospitals, the findings may have limited generalisability to all health care providers in the Tamale Metropolis. Secondly the methodology of the study presents limitation in terms of small sample, especially the external validity, which refers to the extent to which the findings can be generalized. Further studies employing quantitative methods are needed so that the findings can be generalized, and make the study more replicable. Moreover, the study findings only consider implementation challenges faced by health care providers. Future research can explore the challenges faced by users in maternal health care (patients), especially at the household and community level. Moreover, the study uses only contextual factors in the Walt and Gilson framework to assess health policy implementation. Future research can extend to the other variables in the model, especially actors in health policy implementation, focusing on the challenges of Non-governmental Organisations (NGOs) in health. The study did not include other categories of skilled birth attendants such as Obstetricians and Gynecologists, thus the findings could not be assumed to apply to all skilled birth attendants in the Tamale Metropolis.

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APPENDICES

APPENDIX 1

SEMI STRUCTURED INTERVIEW GUIDE FOR MANAGEMENT AT HEALTH FACILITY LEVEL

I am an MPhil student from the University of Ghana Business School, University of Ghana and I am undertaken a research on ***the Implementation challenges of the Millennium Development Goal to improve Maternal Health faced by health care providers in the Tamale Metropolis****. All information that you provide will be considered private and confidential and any report on this study will not use your name. There are no risks involved in taking part in the study. I kindly implore you to help me answer the following questions as objectively as possible.*

Position of Officer(s)……………………………………………..
Sex……………….. Years of Experience………………………………..

Policies and Programmes on maternal health

What maternal health policies are implemented in this hospital?

Do you have any document to guide in implementing these policies? What are the problems encountered?

What are the problems in communicating these policies to staff involved in direct service delivery?

Are there financial constraints in implementing these policies?

Human Resource Issues

What are the estimates for SBAs in this hospital? (Probe for breakdown for midwives)

Do you experience shortage in terms of SBAs?

What is the number of SBAs that have left this metropolis? What reasons can be assigned for their leaving?

Education and Training

How many in-service training do you organize for SBAs in a year?

What are the problems in organizing these training programmes?

Maternal Health Logistics

Could you please, explain the logistics systems for maternal health commodities?

In your opinion, what are the problems associated with the following: a. procurement b. forecasting c. warehousing d. inventory management e. logistics management information systems f. storage g. quality control

Are there guidelines in procuring these commodities? What are the problems in using these guidelines?

Do you experience shortage of maternal health logistics?

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Do you have adequate trained personnel to manage this procurement process?
What are the problems associated with the financing of these logistics?
What are the problems associated with records keeping?
What are the problems with forecasting these logistics?

Recommendation
What other challenges has not been discussed?
In your opinion, what recommendations will you make to overcome these challenges?
Thank you for your time.

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APPENDIX 2

FOCUS GROUP DISCUSSION GUIDE FOR SKILLED BIRTH ATTENDANTS

I am an MPhil student from the University of Ghana Business School, University of Ghana and I am undertaken a research on the ***Implementation challenges of the Millennium Development Goal to improve Maternal Health faced by health care providers in the Tamale Metropolis****. All information that you provide will be considered private and confidential and any report on this study will not use your name. There are no risks involved in taking part in the study. I kindly implore you to help me answer the following questions as objectively as possible.*

Education and Training

Tell me about your education and training?

What are the barriers to in-service training as an SBA?

In your opinion, what will you suggest making such training relevant to your work?

Working conditions

What about the workload? Are you attending to more patients than you expected? How difficult has it been?

Do you receive support from your colleagues?

Do you have enough logistics to enable you perform your duties?

Have you receive adequate training on how to use them?

Have you ever been humiliated or shouted at by other professionals or superior in performing your duties?

Have you received guidance or assistance from your supervisor?

Have you received feedback on your work practices? (Probe further on supervision, evaluation of performance in participation.)

Policies on Maternal Health

Are you aware of the policies on maternal health ? Can you name such policies?

What issues do these policies address?

What is your role towards contributing to the success of these policies?

Motivation in the Profession

What are the factors that are causing dissatisfaction in this profession? (Probe for a. salaries (remuneration) b. incentives b. promotion c. working conditions d. transportation to work e. continue education)

Recommendations

What other problems are you facing as a SBA?

In your opinion, what will you suggest to overcome these problems?

Thank you for the time.

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APPENDIX 3

In-depth Interview with Key Informants

No.	Position	Sex	Age	Years of Experience
1	Medical Superintendent	M	52	21
2	Medical Superintendent	M	49	16
3	Senior Health Services Administrator	M	38	10
4	Health Services Administrator	M	31	4

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APPENDIX 4

Participants in the Focus Group Discussions

FGD No.	Participants No.	Sex	Age (Years)	Profession	Years of Professional Experience
1	1	F	57	Midwife	21
	2	F	52	Midwife	11
	3	F	48	Midwife	10
	4	F	54	Midwife	11
	5	F	48	Midwife	8
	6	F	53	Midwife	13
	7	F	52	Midwife	12
	8	F	52	Midwife	10
2	1	F	48	Midwife	12
	2	F	46	Midwife	11
	3	F	59	Midwife	23
	4	F	53	Midwife	16
	5	F	56	Midwife	13
	6	F	53	Midwife	15
	7	F	47	Midwife	12
	8	F	55	Midwife	17
3	1	F	47	Midwife	12
	2	F	51	Midwife	12
	3	F	54	Midwife	16
	4	F	51	Midwife	14
	5	F	49	Midwife	10
	6	F	55	Midwife	16
	7	F	54	Midwife	13
	8	F	49	Midwife	10