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ORIGINAL ARTICLE

User and community coping responses to service delivery gaps in emergency obstetric care provision in a rural community in Ghana

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Abstract

The study sought to explore user and community responses to service delivery gaps in emergency obstetric care provision in rural Ghana. A qualitative design was employed to draw evidence from observations, interviews and focus group discussion among healthcare providers, clients and community members. Data processing and analysis followed a thematic approach. Findings reveal community interference in obstetric care delivery processes, reliance on unskilled providers, recourse to local oxytocin use, non-compliance to prescribed treatment and mistrust in healthcare providers as user and community coping mechanisms to perceived poor quality obstetric care. These behaviours have serious consequences on the life chances of pregnant and parturient women. The need to adapt to a more responsive and affordable maternal healthcare delivery system is essential for uptake of services in rural areas. Also, standardised guidelines to regulate health worker behaviour is critical to instil trust in the healthcare system.

KEYWORDS
coping response, emergency obstetric care, maternal health, service delivery

1 | INTRODUCTION

Globally, about 295,000 women lost their lives due to pregnancy and childbirth-related complications in 2018 (UNICEF, 2019). Emergency obstetric care (EmOC) is one of the four safe motherhood interventions aimed at curtailing preventable maternal deaths (WHO, 2009). EmOC is the practice of empowering selected health facilities with essential drugs, equipment and personnel to be able to provide life signal functions to avert loss of life during pregnancy or childbirth (Ijadunola et al., 2010). Its introduction contributed to significant decline in maternal death rate from 385 in 1990 to 211 in 2017 (WHO, 2019). Nonetheless, many more maternal deaths continue to occur in low- and middle-income countries (LMIC) (WHO, UNICEF, UNFPA, & World Bank Group, 2019). This is partly attributed to the poor quality of maternal healthcare delivery (Akachi & Kruk, 2017). Quality in healthcare is the degree to which the resources or services for healthcare agree with specified standards that will generally lead to desired outcomes (Roemer & Montoya-Aguilar, 1988). This contrasts with clients' understanding of quality in terms of human centred care (Parasuraman et al., 1988). The divergence has consequences on maternal healthcare delivery. According to Nakua et al. (2015), women who feel they have not received human centred care may not utilise service subsequently. Yevoo et al. (2018), also report that dissatisfied clients may withhold some reproductive information from health providers that may lead to wrongful clinical decision-making. Similarly Demir (2019), disclosed in a Turkish study that disgruntled clients became resistant to treatment procedures. While this has been partly established, little is known about how community members process and relate to events of quality associated with EmOC delivery. This study seeks to contribute literature in this area to guide in the delivery of good quality and acceptable obstetric care. Thus, the study seeks to explore user and community responses to service delivery gaps in emergency obstetric care provision in rural Ghana.

2 | METHODS

2.1 | Design

The study employed a qualitative case study design grounded within a constructivist paradigm. The design enabled the researcher to observe the manner in which clients and the wider community members responded to service delivery gaps. The researchers were also able to explore participants' experiences with emergency obstetric care and how they related to events emanating therefrom.

2.2 | Study area

The study was conducted in selected EmOC facilities in one municipality in a predominantly rural region in Ghana. The municipality was selected due to the fact that it recorded significant number of maternal deaths in the region (DHIMS, 2017). Additionally, it has the highest fertility rate in the country as polygamy is a common cultural practice. Census data showed that about three in five men are married to at least two wives (National Population Council, 2011). The high fertility is partly the result of high rate of poverty. The municipality, for example, is characterised by subsistence farming and poor physical and social infrastructure (GSS, 2019).

High fertility rate tends to affect quality maternal care delivery and outcome in the municipality. To improve positive maternal outcomes, the government of Ghana launched a free maternal care policy that comprised free antenatal, delivery and postnatal care services to all Ghanaian women (Asante et al., 2007). Currently the focused antenatal model is practised in the country where personalised care and attention are given to pregnant women according to their health needs. Skilled delivery ensures that women are delivered by skilled professionals in a health facility while postnatal care provides care for mother and baby for a period of 6 weeks after delivery.

2.3 | Target participants and sampling

The study targeted and purposively sampled women aged 15–49 years who received any form of EmOC intervention at selected facilities during pregnancy and delivery between May and October 2019. It included frontline providers of maternal services and community members who witnessed complication / experienced care delivery. These were persons who either accompanied pregnant mothers to the facility or visited them while they were on admission. It further comprised relatives of women who witnessed the on-set of complications at home and these were identified using the snowballing technique.

What is known about this topic?

- Emergency obstetric care delivery is characterised by achieving positive maternal health outcomes
- Most parturient women are not satisfied with the quality of care provided in this regard.
- Dissatisfied clients may conceal reproductive information from health providers.

What this paper adds

- Service delivery gaps in emergency obstetric care provoke dissatisfaction and disruptions to clinical care.
- Women and community members adopt certain uncompromising and risky behaviours as coping mechanisms to service delivery gaps.
- Women and community members' behaviours compromise positive maternal outcomes.

2.4 | Data collection

The first author spent 6 months at the study facilities, observed proceedings pertaining to the provision of EmOC and compiled daily notes. The observation guide was adapted from Emerson et al. (2005). In-depth interviews and focus group discussions (FGDs) were also used to collect data. The interview guide was used to solicit information pertaining to individual participant's experience with quality of EmOC services while the FGDs explored group perceptions. Due to high workload, health providers were interviewed when they closed from work either within the facility, their homes or at convenient locations of their choice. Clients were interviewed after discharge from hospital at locations that ensured their privacy. The FDGs took place at agreed venues within the community and at a time convenient to participants. A total of four participants from three FGD failed to turn up for scheduled discussion while eight healthcare providers and six clients declined to participate in the in-depth interviews.

According to Guest et al. (2006), the smallest ideal sample size for data saturation is 15 in interviews and about three to six focus group discussions yield a greater level of saturation. It, however, took 17 clients, 21 health providers and six FGDs, with an average of seven members in each and a total of 52 members, to achieve saturation. Interviews with health providers were conducted in English by the lead author and lasted an average of 82 min while those with clients lasted for an average of 48 min. The FGDs were conducted in the local language (Dagbani) by a trained native research assistant who also moderated the FGDs. Sample questions of the interview guides for the in-depth interviews and FGD and the observational guide are captured in Table 1. The interview guides were pretested in a municipality with similar demographics and the feedback enabled modification before data collection.

Both interviews and focus group discussions were audio taped with consent from participants. To ensure voluntary participation, participants signed or thumb-printed consent forms to illustrate their willingness to partake in the study. A token was given to clients as appreciation while a warm 'thank you' was extended to health providers and community members for their participation.

2.5 | Ethics statement

Ethical approval for the study was obtained from the Ghana Health Service (Protocol number: GHS-ERC004/04/19) and the University of Cape Coast [UCC] Ethical Review Board (UCCIRB/CES/2019/03).

2.6 | Data analysis

Data analysis followed Braun and Clarke (2006), thematic analysis procedure. The first author transcribed all three data sets from audios to texts. The audio tapes and transcribed data were cross validated by an independent person. These validated transcripts were read thoroughly for content familiarity and thematic coverage by the first author. This was followed by slow reading accompanied by initial assignment of codes to each line. Governed by pattern of occurrence, similar codes were pulled together to form sub-themes and subsequently aggregated to form themes across transcripts. To ensure accuracy of the coding, the second author reviewed the codes and themes *to* determine their suitability and relation to the study objective. At this stage, changes were made to some codes and some themes were renamed. Member checking was done by gaining feedback from the data interpretations and conclusions from some randomly selected participants.

3 | FINDINGS

3.1 | Characteristics of study participants

Study participants consisted of 17 clients, 21 healthcare providers and 52 community members. Women who received EmOC interventions were mostly uneducated, poor and in polygamous marriages. The background characteristics of female participants in the focus groups were same as clients who received EmOC. However, the men had attained some considerable level of education and earned more income than the women. The health worker category consisted of 18 midwives, an obstetric nurse, an anaesthetist and a specialist gynaecologist. These were drawn out of a total of 25 midwives, two house officers, two medical officers and three anaesthetists who made up the total population at the study facilities. Of the midwives, 12 had a Post-secondary certificate while the rest were diploma holders.

A total of three themes and 10 sub-themes were generated following the analysis. These are presented in Table 2. Tables 3–5 cover characteristics of study participants.

3.2 | Poor emergency transport system and inadequate supply of essential staff

3.2.1 | Communal response to emergency transport gap

It was observed that due to lack of emergency transport system, women who required EmOC were often transported to the facility in a tricycle accompanied by a number of relatives riding motorcycles. This was done to commiserate with the woman as she journeys through labour and delivery. The crowd often ended up blocking the entrance of the labour ward, restricting the movement of health providers and causing delay in the provision of responsive care.

TABLE 1 Sample questions

Interview questions (clients 1–3 and health providers 4 & 6)	FGD guide	Observation guide
1. How satisfied are you with the quality of EmOC received? 2. What factors affect your satisfaction / dissatisfaction? 3. How do you cope with events of satisfaction / dissatisfaction? 4. How satisfied are you with the quality of EmOC provided? 5. How satisfied are your clients with the quality of EmOC provided? 6. How do your clients cope with events of satisfaction / dissatisfaction?	1. What do you think of the quality of EmOC provided in the facilities? 2. Why do you think this is so? 3. Can you please tell me about how you cope with the nature of care provided?	1. What are people doing? 2. What are they trying to accomplish? 3. What specific means or strategies do they use? 4. What do members talk about, characterise and understand what is going on?

Notes: The use of what, why and how questions enabled in-depth thick narratives of factors underlying quality of EmOC and coping mechanisms by clients. During the interview process, prompts and probes were also used to widen the conversation for detail information.

TABLE 2 Summary of user and community coping responses to service delivery gaps in emergency obstetric care provision

Theme	Sub-theme
1. Poor Emergency Transport System and Inadequate Supply of Essential Staff	• Communal response to emergency transport gap • Response to inadequate critical staff
2. Poor Utilisation of Skilled Delivery	• Reliance on unskilled providers in community • Recourse to local oxytocin use for rapid delivery
3. Perceived Mistrust in Health Providers	• Mistrust in care delivery • Perceived extortion • Non-compliance to needful intervention

TABLE 3 Clients

	No of participants
Age	
Below 20	1
20–29	5
30–39	4
40–49	7
Education	
None	13
Basic	2
Secondary	1
Post-secondary	—
Tertiary	1
Occupation	
Unemployed	6
Informal	10
Formal	1
Marital Status	
None	1
Monogamy	4
Polygamy	12
Type of obstetric complication observed	
Post-partum haemorrhage	12
Pre-eclampsia	3
Placenta praevia	1
Maternal distress	1

TABLE 4 Health providers

	No of participants
Gender	
Female	18
Male	3
Age	
20–29	8
30–39	9
40–49	1
50 and above	3
Rank	
Staff midwife	11
Senior staff midwife	5
Senior midwifery officer	3
Deputy director midwifery services	1
Obstetrics and gynaecology specialist	1
Years in practice	
1–10	16
11–20	3
21–30	—
31–40	2

Caught up with the burden of the crowd, the health providers often deployed security personnel to dispel the crowd gathered. Such security actions, however, were shown to produce uneasy calm as the relatives subjected health providers to harassment and verbal abuses because they felt being prevented from providing needed community social and emotional support to their labouring woman. A health provider affirmed:

> '…Sometimes, a case can come and about 10–20 of the relatives will crowd around here. You will talk and talk but they will just be standing or sitting down and blocking the passage…'. (# Pr. 8 H/W).

3.2.2 | Response to inadequate critical staff

There was apparent shortage of essential health staff and this weakened the capacity of health providers to be responsive to all women. As a result, some relatives devised a coping method by becoming bedside care givers to their sick relatives. They stayed in the wards, amidst protest from the midwife on duty and assumed the bed side nursing role of midwives such as feeding and empathising. Some attempted to share bed with sick relatives and aside pushing down the sick person because of the nature of the bed, they snored loudly and caused inconvenience to the rest of the patients. The tempo of snore was sometimes so intense that the midwife on duty could not decipher it from the groans of sick persons. This created extreme anxiety in health providers as they wade through the crowded space to attempt to attend to patients:

TABLE 5 Community members

	No of participants
Gender	
Female	31
Male	21
Age	
Below 20	5
20–29	18
30–39	25
40–49	3
50 and above	1
Education	
None	33
Basic	16
Secondary	2
Post-secondary	—
Tertiary	1
Occupation	
Unemployed	11
Informal	39
Formal	2

'…. "They come to sleep by their patients on their bed at night". One day, one of them snored so loudly that I thought a patient was in pain. I got there and realised the patient was on the floor and the care taker was the one lying on the bed…' (# Pr. 4 H/W).

Also as community-based facilities, utilised by members bonded by a spirit of social cohesion, it was a norm for relatives to visit the sick on admission. They, however, did so without recourse to official visiting hours. At almost every moment in time, scores of relatives thronged the wards to empathise with sick relatives. The wards eventually became avenues of socialisation as visitors exchanged greetings with each other amid loud noise and chats. Consequently, health providers' clinical activities were often disrupted by disturbances and magnitude of loud noise coming from visitors. Poor recoveries of some clients were partly attributed to such behaviours. A health provider recounted in an interview:

'…They come at 12 midnight to visit people, is it normal? The patient perhaps didn't sleep the whole day and is now sleeping, they are coming to worry her…' (# Pr. 5 H/W).

In a FGD, some participants indicated that such behaviours were borne out of lack of trust in health providers and quality of maternal care provided:

'…Here, we don't trust the services of the hospital…' (# FGD1).

3.3 | Poor utilisation of skilled delivery

3.3.1 | Reliance on unskilled providers in community

The findings indicated that pregnant women largely utilised the antenatal component of maternity care (where they paid comparatively lesser charges) but failed to access skilled delivery, where complications could be detected and managed. They are either delivered at home or by a Traditional Birth Attendant (TBA) during which those who developed complications die at the hands of the TBA or are survived by care provided in health facilities. Observation data revealed that lack of emergency transport and weak referral systems often delayed arrival of cases to the hospital culminating in a 'dead upon arrival syndrom':

'…Some women are brought here dead. They are delivered at home by a TBA and when they start bleeding, they will say oh let's wait, it will subside. Then when they see that the woman is gasping for air that is the time they will be rushing with her here by which time they are dead…' (# Pr. 2 H/W).

Clients who arrived at the facilities in a bad state deliberately or ignorantly delayed at home hoping to overcome their situation. They disclosed that such behaviour was due to out of pocket payment system which was perceived as high. This led to delayed access to care which worsened the life chances of parturient:

In interviews, some participants from the client category said:

'…Some of us give birth at home because we don't have the money to pay at the hospital. So we do it at home and then come to the hospital in case of complications…' (# C 2).

3.3.2 | Recourse to local oxytocin for rapid delivery

According to health providers, there was widespread use of local oxytocin (herbal concoction) by women to augment labour. The herbal medicine was perceived to be effective in causing rapid contractions to quicken delivery but without corresponding dilatation of the cervix. Almost all the women who were delivered at the health facilities or encountered complications had taken this concoction earlier. While some delivered en route to the facility and obtained severe tears as a result of undilated cervix, others ruptured or delivered immediately upon arrival and bled severely afterwards on account of forced labour and delivery:

'…. They give them the local cynto called 'calgoteem'. They give this and you will see the hyper contractions, sometimes before the woman enters the hospital she ruptures…' (# Pr. 20 H/W).

Some women confirmed that it was a cultural norm to hasten labour using herbal concoctions:

'…. It is a common cultural practice here to use herbal medication in order to hasten delivery' (# C 13)

Some community members also intimated that the use of local concoctions was meant to enable labouring women achieve rapid labour and avoid mistreatment by some health providers who often yelled and shouted at them for not pushing enough:

'…. Our women use the local herb to escape from midwives' mistreatment…' (FGD 3).

By using the local concoction, it was assumed that women in labour can push enough to meet health providers' expectations. Unfortunately, such deeds only increased risk of complication leading to maternal death:

'…My friends will say, why should they come to the hospital to be shouted at when they can do their own thing at home. Some take the concoction for this reason but they end up dying in the process…' (# C 10).

3.4 | Perceived mistrust in health providers

3.4.1 | Mistrust in care delivery

Community members did not trust the nature of care provided. They perceived that health providers were not doing enough to provide effective and safe care to women. To get around this, some relatives sometimes argued, offered alternative treatment procedures or refused to donate blood. Some relatives were also shown to poorly co-operate with service providers due to perceived weak trust in how blood donations were managed. A FGD participant disclosed:

'…They asked me for blood but I told them that I can't donate because it is the farming season and I need to be strong to farm. When even we donate, they store some and sell to other people. So who should be donating blood for them to be selling to people and making money…?' (# FGD 2).

3.4.2 | Mistrust associated with perceived extortion

According to some health providers, frequent payment delays of the National Health Insurance Scheme (NHIS) had caused chronic shortage of essential obstetric drugs and other supplies. For this reason, all expectant mothers were required to bring along mackintosh and perineum pad during admission for infection prevention and estimation of blood loss, respectively. When they failed to produce these items, midwives picked and used from their personal stock and after which clients / relatives replaced or paid for the cost of items. Some relatives, however, perceived this as a deed of extortion. They thus complained about excessive demand for money to purchase items, drugs and other supplies such that midwives were perceived as trading their wares in the guise of providing needed care for women:

'…They have turned the Maternity ward to a business centre whereby they sell all kinds of items and materials to the suffering women and I think this shouldn't be the case because it is a hospital…'(# FGD 1).

Observational data revealed that some facility managers were aware of actual and perceived extortion of clients but failed to act partly because of inadequate finances for clinical and administrative functions:

'…. It is because the Health Insurance is not paying timely and clients are not making the work easier by bringing required items. That is why they sell the items to them and they are complaining…' (# Pr. 5 H/W).

Clients' claim of perceived extortion was also related to the fact that drugs sold in the facility pharmacies were more expensive than local retail shops:

'…They wrote certain two drugs for me. The total cost was 109 cedis ($17.39). A friend in town told me he had the drug in his shop. I took it to his shop and got both drugs at 84 Ghana cedis ($13.40). Just imagine the difference…' (# FGD 1).

As such, while some refused to purchase obstetric drugs from the pharmacy on grounds of extortion, others carted left over medications home for future use when required at the hospital:

'I took the rest of the drugs home so I can use them the next time but I was called to return them' (# C 12).

Such extreme acts of non-corporation made service delivery very difficult as health providers sometimes had to halt treatment to chase after drugs from clients' homes. Health providers indicated that sometimes they settled on less efficacious drugs that relatives bought from

drug peddlers in town for management of cases due to their resistance to purchase prescribed drugs from the hospital pharmacy.

3.5 | Non-compliance to essential obstetric interventions

Perception of poor quality of EmOC weakened adherence to obstetric interventions. A midwife reported that a pregnant woman with two previous caesarean sections (CS) was monitored and counselled against delivering at home. She was expected to be booked for CS ahead of labour to prevent risk associated with normal delivery in her peculiar case. As time drew closer, the midwife called to notify the woman and her family on the need for her to report at the hospital for preparations towards CS. The husband of the woman resisted this move, however. The woman in question subsequently went into normal labour at home but ruptured midway losing her baby. She was rushed to the facility where she was treated but not without irreparable damage to her womb. The below quote illustrate the lack of adherence to obstetric intervention.

> 'I had an issue with a client recently. She had 2 previous C.S at 38 weeks. Automatically we didn't want her to go into normal labour and rupture so we booked her for caesarian. When I called to notify the husband, that his wife was due, he told me the wife is not nine months pregnant so he cannot bring her and actually refused. She delivered at home and nearly died' (# Pr. 9 H/W).

4 | DISCUSSION

Access to quality maternal health services and especially EmOC has been and remains a challenge in many LMIC. However, studies have largely focused on the factors associated with poor quality maternity care and clinical interventions to service delivery gaps. Missing in the literature, is how communities cope with challenges associated with perceived poor quality maternity care. This study, thus, explored user and community coping responses to service delivery gaps in emergency obstetric care provision in rural Ghana. The findings generally highlight significant gaps in the healthcare system that impacted negatively on use of EmOC.

The lack of infrastructural and human resources for smooth operation of health facilities in rural areas have largely compromised the health outcomes especially of women in these areas. More-so, the inability of health facilities to engage communities on their challenges, perhaps due to logistical constraints, further dwindled clients' trust in the healthcare system. The study findings reveal that the situation in Ghana is partly due to the inability of the NHIS to adequately fund healthcare in the country. This is worsened by an unequal distribution of essential health staff across the country thus denying the rural woman access to specialist care (Kyei-onanjiri et al., 2018). These issues are sources of dissatisfaction among clients and communities leading to a resultant scheme of reactions. According to Al-awamreh and Mohammad (2019), a dissatisfied client may not only fail to utilise same service again but will actually go ahead to inform several others about their experience and that may affect future patronage. The findings in this study buttress this earlier claim and further contend that dissatisfied clients would not only totally fail to utilise care, but also would delay in doing so and will eventually turn up very late to be helped. The delay in presentation of an obstetric complication imposes pressure on limited resources in health facilities and affects quality of care provided (Patterson et al., 2019). It is revealing to note from this study that such delays in presentation, among others, attest to people's revolt at an unfriendly healthcare system. Therefore, the delivery of EmOC signal functions especially in community owned facilities, should reflect community needs in order to promote uptake of such critical interventions aimed at sustaining maternal health.

It is worth mentioning that health providers were equally dissatisfied with the quality of care due to scarcity of resources to promote best clinical care. The general feeling of dissatisfaction in this study appears a norm in most other studies (Aiken et al., 2017; Mgawadere et al., 2019). This should be expected because according to Patterson et al. (2019), as long as resources remain scant, it affects the provision of care and its perception. In the case of clients or patients, the literature points largely to a non-utilisation angle due to perception of poor quality service (Alanazy et al., 2019; Wesson et al., 2018). The evidence from this study further reveal other related behaviours such as interference in service provision, health risk coping mechanisms, low confidence in healthcare, trust and mistrust issues between providers and clients which altogether impact on healthcare delivery. These findings are not alien to this research as study participants elsewhere exhibited similar characteristics in protest of perceived poor quality service (Demir, 2019; Yevoo et al., 2018).

As women are told about deficient care or experience this themselves, they adopt certain behaviours subsequently as coping mechanisms to events of dissatisfaction (Mgawadere et al., 2019). The use of local oxytocin (herbal product) by women in this study to hasten delivery was a means to avoid perceived harsh treatment from health providers due to long period of stay in facilities during delivery. It was also regarded as a widespread cultural practice. Pregnancy-related taboos and norms have demonstrated to have a negative impact on maternal health (Yarney, 2019). Such health averse practices are especially ubiquitous in rural areas where women already lack the needed resources required for healthy motherhood thereby increasing their susceptibility to unpleasant maternal and neonatal outcomes (Miteniece et al., 2019). The particular herbal product used by women in this study is said to possess properties that speed up labour contractions but without corresponding dilatation of the cervix leading to uterus rupture in some cases (Zamawe et al., 2018). It also has anticoagulation properties that make clotting of blood difficult during bleeding. These adverse effects of the product possibly contribute to the high cases of PPH in the region which

have resulted in several maternal deaths (Kyei-onanjiri et al., 2018). Strangely, most women are unaware of the health impact of these practices (Yarney, 2019). It is important that health facilities address the issue of harmful cultural practices in their maternity care education package to discourage adherence. Education may further be promoted using media houses and other approaches in localities as a means of reaching out to the general public and to stakeholders to influence change.

High cost of treatment was also a disincentive for community members as it was to participants in a Turkish study (Demir, 2019). This might be strange as the two places have different demographics such that it may be unlikely to report similar findings. Seemingly, the issue of cost has a largely universal connotation. As such, as much efforts are made to improve upon clinical quality of care and reduce maternal deaths, so should services be made more affordable to facilitate access? It is worth noting that the cost of care in this study was sometimes perpetuated by some health providers. Such behaviours further dwindled clients' trust leading to resistance to treatment in some cases. Patterson et al. (2019), have disclosed that trust in midwives' competency, intentions and integrity, among others, led to a perception of positive child bearing experience among women in Scotland. Conversely, issues of mistrust and heightened suspicion of midwives' activities clouded the delivery of healthcare in Nigeria and that resulted in negative child bearing experience (Okonofua et al., 2017). Clients' non-compliance to treatment due to suspicion of the provider and of their choices of treatment may worsen their conditions in the short term or subject them to complications later in life.

The study further discovered that the word-of-mouth propaganda and polarised state of the NHIS in Ghana equally contributed to lack of trust in hospital care. The lack of political commitment to the promise of free healthcare led to unmet expectations. Per this finding, the antecedents of patient dissatisfaction may not necessarily be tied solely to health provider unfriendly behaviour as is consistently reported in the literature (Afulani & Moyer, 2019; Sigalla et al., 2018). Beyond this, are compelling root causes such as the lack of political will to the course of maternal health and cultural influences that require equal attention if the quest for preventing maternal mortality in Ghana and other developing countries is to be realised. The evidence calls for complete re-organisation of the current healthcare system devoid of political manoeuvring if it has to impact on maternal health.

5 | IMPLICATIONS FOR THEORY AND PRACTICE

The study displays evidence of a deficient and non-regulated healthcare system in this part of the country where clients or patients ultimately pay the price for insufficiency. Dissatisfied women and the wider community may adopt certain health risk behaviours as coping mechanisms. These may have serious consequences on life chances of pregnant and parturient women especially in deprived areas. It is important that government bridges the gap of health inequity in the country by providing the necessary human, material and financial resources in rural areas to allow for proper handling and treatment of cases in a manner that equally promotes client satisfaction.

6 | STRENGTHS AND LIMITATIONS

A key strength of this study lies in the use of qualitative methods to triangulate perspectives of health providers, community members and women seeking EmOC. The use of in-depth interviews, FGD and observations provided deep insight into how service delivery gaps provoked wide ranging coping mechanisms. One of the limitations is that the findings reflects experiences of participants in a rural area in Northern Ghana which may be non-generalisable to other settings. Furthermore, the use of qualitative methods restricted participation. Future studies utilising quantitative methods are encouraged to determine patterns of convergence and disagreements. Nonetheless, the use of varied categories of participant and data collection methods potentially enhanced the trustworthiness of the findings.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

Data is not publicly available due to ethical reasons.

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