UNIVERSITY OF GHANA

FROM MILLENIUM DEVELOPMENT GOALS TO SUSTAINABLE DEVELOPMENT GOALS: AN ASSESSMENT OF MATERNAL HEALTH IN GA SOUTH DISTRICT

BY

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DECLARATION

I confidently make a declaration that this study is a result of my own research and has therefore not been presented by anyone for any academic award in this or any other university. References made in this work have fully been 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.

……. ……. …….....

DR. ALBERT AHENKAN DATE

(SUPERVISOR)

DEDICATION

This research is dedicated to the Apemah Family.

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Contents

LIST OF FIGURES

LIST OF ABBREVIATIONS

ANC	Antenatal Health care
CAC	Comprehensive Abortion Care
CARMMA	Campaign for Acceleration Reduction of Maternal Mortality
EC/UNFPA	European Commission/ United Nation Population Fund
FGD	Focus Group Discussion
GHS	Ghana Health Service
GMHS	Ghana Maternal Health Survey
GSS	Ghana Statistical Service
ICPD PoA	International Conference on Population and Development Programme
IDI	In-depth Interview
MDG	Millenium Development Goal
MDGs	Millennium Development Goals
MOH	Ministry of Heatlh
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NDPC	National Development Planning Commission
NHIS	National Health Insurance Scheme

OECD	Organization for Economic Co-operation and Development
PH	Postpartum Hemorrhage
PMTCH	Prevention of Mother to Child Transmission
PMTCT	Prevention of Motherhood and Child Commission
PPH	Postpartum Hemorrhage
SDG	Sustainable Development Goal
SDGs	Sustainable Development Goal
SSA	Sub Saharan Africa
UNDP	United Nations Development project
UNFPA	United Nations Population Fund
UNICEF	United Nations Children and Emergency Fund
USAID	United States Agency of International Development
WHO	World Health Organisation

ABSTRACT

Considering the global and national interests in improving maternal health as evident by Millenium Development Goals (MDGs) and Sustainable Development Goal (SDGs) ,Ghana is still battling with maternal mortality despite several initiatives introduced in reversing the trend. The study, therefore, sought to assess maternal health in Ga South District and the strategies put in place to achieve the maternal health targets in the SDGs. The study used a qualitative research approach and a case study design. The techniques for the qualitative approach include focus group discussions for pregnant women and in-depth interviews for health personnel and traditional birth attendants in four selected health facilities in the district. Primary data was obtained from (57) respondents and analyzed thematically based on the objectives. Secondary data was obtained by reviewing the district's annual health report. The findings from the study indicate that maternal deaths have been increasing in the district despite several interventions introduced. The main causes are severe malaria haemorrhage, pregnancy- induced hypertension, abortions and anemia. The study found other challenges including financial constraints, illiteracy, weak staff strength, energy crises, poor attitudes of midwives, and poor infrastructure. New strategies introduced by the district to reduce maternal mortality include pregnancy school, focus antenatal, running 24-hours of service and the involvement of community nurses for follow-ups on clients. The study recommends continuous sensitization within the district aiming at educating pregnant women on the need to resort to antenatal services. Government should skew resources to enhance service delivery in the health service. Similarly, there should be consistent monitoring and evaluations to check the conditions of health centres. Executing programmes and policies must include a strong human resource base, future policies and programmes must consider required human resources before their implementation.

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.0 Introduction

The chapter gives an overview of the study. It covers the background of the study, problem statement, objectives , research questions, significance of the study, scope of the study, and finally the organization of the study.

1.1 Background

The Millennium Development Goals (MDGs) became essential due to the growing urgency of sustainable development in the world (Sachs & McArthur, 2005). Almost all countries acknowledge the importance of economic development, sustainability, equity and equality, though specific objectives vary globally (UNDP, 2010). In the quest to enhance global development, there was the need to formulate unifying goals which served as benchmarks for countries to implement hence the emergence of MDGs and Sustainable Development Goals (SDGs).

The MDGs spelt out six principles essential for development in the 21st century. These principles are tolerance, equity, respect, equality, solidarity for nature, and shared responsibility (Sachs, 2010). Ghana together with one hundred and eighty-eight (188) countries committed in September 2000 in tracking eight time-bound targets and their associated indicators to enhance global development and economic growth. Out of the eight goals in the MDGs, three were health related. The health related goals were goals 4, 5 and 6 constituting child health, maternal health and disease control respectively. The prominence accorded to health targets in the MDGs affirms that good health is essential in reducing poverty and enhancing overall development.

Despite the developmental strategy of the MDGs, there can be no doubt that Sub-Saharan African countries (SSA) have the greatest problems in achieving the goals as compared to other regions (Sachs, 2010). SSA countries have the highest rates of poverty and illiteracy and the highest rates of child mortality, maternal mortality, HIV/ AIDS, and malaria (Okonofua, 2006).

Achievement of the MDGs specifically improving maternal health was the main focus of many countries, international communities and donor agencies (Okonofua, 2006). However, maternal mortality around the world today remains a challenge especially in developing countries (WHO & UNICEF, 2013). The World Health Organisation (WHO) (2005) emphasized that society's well-being has a direct link to the health of women and their children.

WHO (2005) defines maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental cause. Maternal mortality is basically measured in terms of the Maternal Mortality Ratio (MMR), defined as the number of maternal deaths per 100,000 live births (WHO 2005). MDG-5 calls for a 75 percent reduction in the MMR between 1990 and 2015 (UNDP, 2010).

Like all other countries, Ghana showed commitment in achieving goal 5 of the MDGs by dedicating special attention in reducing maternal deaths over the past two decades Ministry of Health (MOH), 2008 National Development Planning Commission (NDPC), 2016 & UNDP, 2010). Policies were formulated and implemented to improve maternal healthcare. These include the National Health Insurance Scheme (NHIS), free maternal health care programme which resulted in an increase in the access and utilization of health services, adolescent sexual reproductive health services, Comprehensive Abortion Care (CAC), and management of

Postpartum Hemorrhage (PPH, the establishment of Prevention of Mother to Child Transmission (PMTCT) centres and services training of midwives in life saving skills (MOH, 2008; NDPC, 2016 & UNDP, 2010).

MDG 5 had two foci for evaluating progress in maternal well-being and these were: decreasing the maternal mortality proportion (MMR) by 75% between 1990 and 2015, and accomplishing widespread access to contraceptives by 2015 (UNDP, 2010).

The persistence of maternal deaths despite intercessions and strategies proves there is a challenge in the implementation process. Majority of women in Africa remain without full access to the availability of maternal health care despite the efforts made by developed countries in helping curb this menace. Several reasons are provided for this situation particularly insufficient or the absence of appropriate family planning programmes inclusive in portions of maternal well-being (Thonneau, 2001; Blanc, Winfrey and Ross, 2013). The poor maternal well-being calls for an examination of the nature and relationship that exist between the distribution, execution and availability of health services and skilled health providers.

The failures of the MDGs have been described to be just another list of desirable goals with no systematic way of how to achieve them and no analysis of economic and other mechanisms which contribute to their realization (Vora, Mavalankar, Ramani, Upadhyaya, Iyengar and Iyengar, 2009).

With the end of the MDGs and their failure to achieve set goals, an unprecedented global consultative process emerged to develop the (SDGs). The United Nations General Assembly endorsed 17 goals and 169 targets following with several sessions of inter-governmental negotiations. There was a need to propose a more ambitious and comprehensive health agenda

that seeks to build and incorporate the unfinished agenda of the MDGs. The SDGS focuses on a more holistic agenda especially for health and well-being (Buse & Hawks, 2015).

The SDGs specifically goal 3 focuses on health, accompanied by nine targets and four implementation procedures. The targets address the main burdens of disability, illness and premature mortality, factors the MDGs have been criticized for not considering. Nonetheless, important questions have been raised for consideration at the international level as to whether these aspirations portray health as an indicator, outcome and determinant of sustainable development. Meeting these aspiration requires a paradigm shift from how health promotion and protection is approached. Similarly, implementing these targets requires a great deal of financial investment (Easterly, 2009).

Both the MDGs and SDGs emphasize the importance of health but in Ghana, it appears there are few studies on the challenges of the MDGs with a focus on maternal health at the facility level. Most studies in relation to maternal health are broad based and over generalized hence the study seeks to localize the challenges, prospects and the way forward for maternal health in Ga South District.

1.2 Problem Statement

In the 20th century, maternal health gained global attention as a public health issue (WHO, 2005). This focus was partly driven by the Safe Motherhood Initiative (SMI) introduced in 1987 at the International conference of safe motherhood in Nairobi which aimed at reducing maternal mortality and infant morbidity by half, by 2000 (Kyei-Nimakoh, Carolan-Olah and McCann, 2016). Though the initial focus of this initiative was not realized, it generated the needed impetus for more rigorous approaches and policies today. Arguably, if there has ever been one health

issue that has witnessed massive investments and attracted global consensus over the past decades, it is the death of mothers and children (WHO, 2010).

In SSA, women dying during childbirth or pregnancy were 510 in 100,000 in 2013 compared to a global maternal mortality rate 210 in 100,000 in same period (WHO, 2014 cited in Kyei-Nimakoh et al., 2016). It is further asserted that, this is the largest disparity between rich and poor countries of any health indicator (Ibid). For instance, with secondary data from the 2008 Ghana Demographic and Health Survey, Arthur (2012) established that wealth has significant effect on the use of maternal health services.

Similarly, in Ghana, there have been substantial efforts by government and policy makers to address the problem of maternal mortality (Buor & Bream, 2004; Arthur, 2012). The country invested largely in several initiatives in improving maternal health care in the attainment of MDG 5 (MOH, 2008; UNDP, 2010). These initiatives include, Campaign for Accelerated Reduction Maternal Mortality (CARMMA) and Family Planning Accelerated Programme (FPAP) among others. However, these initiatives have failed in reducing (MMR) required by MDG 5. Also, in the year 2008, there was a declaration by government in making maternal mortality a national emergency (Arthur, 2012).

Despite all these efforts and attention, progress towards the MDGs has been described as patchy and uneven (Kyei-Nimakoh et al., 2016; Fenny, Crentsil, & Ackah, 2017). Currently, the world is implementing a new development agenda (SDGs) of which maternal health is a priority (SDG 3, target 1). As Ghana has transitioned from MDGs to SDGs it is imperative that an assessment of its progress, prospects and challenges is made. What is the guarantee that SDGs can help reduce maternal mortality given that the MDGs failed to address the issue decisively? This study

argues the need for empirical studies that identifies specific contextual factors hindering efforts to improve maternal health in general and specifically, maternal mortality in Ghana. This study, therefore, seeks to examine the challenges, prospects and way forward of the SDGs regarding maternal health in the GA South District as a case study.

General objective

The overall objective of this study is to assess the challenges of MDG 5 in Ga South District.

1.3 Specific Objectives

The specific objectives of the study are:

1. To examine the trend of maternal deaths in Ga South District.

2. To examine the contextual challenges that hindered the achievement MDGs in Ga South District.

3. To explore the strategies to mainstream SDG 3 in Ga South District.

1.4 Research Questions

1. What is the trend of maternal deaths in Ga South District?

2. What are the contextual challenges that hindered the achievement of MDG Goal 5 in Ga South district?

3. What are the strategies for mainstreaming SDG 3 in the Ga South District?

1.5 Significance of the Study

The study goes beyond identifying the challenges that hindered the achievement of the MDGs in Ga South District and the strategies put in place to attain the SDGs health goal. Based on data analysis, recommendations were provided to reduce maternal deaths in the district. This study is essential for key stakeholders in the health sector including medical practitioners, the health ministry and facility heads. Similarly policy makers and researchers may find this study beneficial in the area of practise and policy making. In relation to the importance to practice, the study provides strategies to healthcare professionals in the industry whose main job is to improve the health of expectant mothers to avoid postpartum complications. The findings and recommendations of this study will help update professionals knowledge on basic obstetric care and cultural practices that contribute to maternal death since the study seeks to identify individual or client side as well as service provider side factors that contribute to poor maternal health. This study again will identify the root causes of maternal mortality in Ghana since limited studies have been carried at the district level on this topic. This study finally serves as a reference material for future research on maternal health in Ghana.

1.6 Scope of the study

The study was conducted within the borders of Ga South District. Ga South district hospital and four health facilities within the district were used to assess the prospects, challenges and the way forward of the MDG 5 and SDG 3 in the district.

1.7 Organization of the study

The study is divided into six (6) chapters. Chapter one covers the introduction which comprises the background, problem statement, definition of terms, research objectives, research questions, the significance of the study, the scope of the study and organization of the study.

The second chapter examines the review of related studies; it gives relevant literature on maternal health issues both theoretical and empirical perspectives in the area. It further presents the theoretical and conceptual framework adopted in the study.

Chapter three presents the methodology used for the study. This includes the research paradigm, the research approach, sampling technique data collection process and procedure and administrative method.

The fourth chapter presents and analyses the key findings of the study while chapter five summarizes the key findings and draws conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter discusses the concepts of maternal health in Ghana, specifically issues relating to maternal mortality. This is presented in five main sections. The first section presents the maternal health situation in SSA. The second section highlights the causes of maternal death in Ghana (clinical and socio cultural). The third section addresses the concept of MDGs with emphasis on goal 5 health policies. The fourth section discusses the concept of SDGs. The theoretical and conceptual framework is presented in the last section of the chapter.

2.1 The maternal health situation in SSA

Maternal death in International Classification of Disease, 10th Edition as stated in Khan et al. (2006), defines maternal mortality as "the death of a woman while pregnant or within 42 days (or a year for late maternal deaths) of termination of pregnancy, irrespective of the duration, the site pregnancy, from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes."

Maternal health is a major setback in SSA. Assess and the use of improved maternal service pose challenges crucial for improved maternal-child survival. According to WHO (2005) "Maternal health can be defined as women's health during pregnancy, childbirth and postpartum period." Maternal mortality rate has startled globally. The United Nations in the year 2000 made a projection of the maternal mortality rate to be 529,000 with an occurrence of less than 1% in the developed countries. The UNFPA, WHO, UNICEF (2005) estimates maternal deaths annually at

536,000, above the UN's estimates for 2000. About 95 percent of these deaths occured in SSA and Asia (WHO, 2007). A number of studies in Africa have indicated deficiencies in the quality of maternal health services which can have an impact on obstetric outcomes. Ghebrehiwet et al. (2011) in their studies indicated that poor health delivery system leads to maternal deaths among women who do not have access to health facilities with an unproductive workforce due, the lack of drugs and equipment, to inadequate or poorly trained personnel, and clinical mismanagement of patients administrative delays.

Treatments aiming at avoiding such deaths have been available since the 1950s. It is estimated that the highest maternal mortality burden in the world is in Africa, a percentage of 98 is from SSA (WHO, 2007). Mother's death risk is about 1 in 22 in SSA compared to 1 in 210 in Northern Africa; 1 in 62 in Oceania; 1 in 120 for Asia; 1 in 290 for Latin America and the Caribbean (WHO, 2007). At a time when most countries are experiencing a reduction in maternal mortality rates (MMR), SSA has worsening maternal mortality (MM) indicators. WHO (2007) estimates that about "70 percent of all maternal deaths follow haemorrhagic complications (25 per cent), infection (15 per cent), unsafe abortion (13 per cent), eclampsia (high blood pressure leading to seizures – 12 per cent) and obstructed labour (8%)." Indirect causes of maternal death include poor quality health, the upsurge in medical fees, limited access to health facilities (Addai et al., 2006). According to Ayitey and Nimo (2005), "the bizarre situation in SSA is exacerbated by dwindling state resources, reducing investment into critical health-related interventions such as maternal health."

2.2 Maternal mortality in Ghana

Maternal health plays a crucial function in accomplishing advanced reproductive health in diverse societies. Ghana Maternal Health Survey in 2007 indicates that "maternal mortality rate

in Ghana is excessively high and is the second major cause of the death of females, with haemorrhage being the main cause of maternal death" (MOH, 2008). The main goal of maternal health care is early recognition and control of women vulnerable to complex pregnancy (Kerber et al, 2007). However, statistics show that about half a million women die every year in developing countries due to the complexities associated with their pregnancies (Addai et al., 2006). In developing countries, "for every 100,000 births MMR are expected to be 480 women, whilst in the developed countries one out of ten women die from pregnancy-related complications" (UNFPA, 2004) unfavorable conditions and inadequate nutrition health care In sub-Saharan Africa as well as high fertility rates exposes women of to risk complications during pregnancies headaches of being pregnant and childbirth are said to cause extra deaths and disabilities than any other reproductive health issue EC/UNFPA (2000).

This situation is exacerbated in developing nations. Health professionals are of the view that antenatal care in developing countries decreases the likelihood of women dying during pregnancy and childbearing, yet no one has systematically assessed its potential to actually improve maternal health. Campbell et al. (2001), reviewing maternal health policies specifically in developed countries, highlighted the role of politicians and governmental agencies accompanied by professional groups and female groups have all contributed in managing maternal health policies in the West. This simply implies that an effective coordination and communication among agencies and stakeholders are very crucial in ensuring successful progress of health policies.

A study by Fosu (1994) unveiled that health system, service-related factors and government interventions are accountable for the implementation of health policies. At the health service delivery level, factors ranging from continuing service-delivery, poor resources and

infrastructure, absenteeism, limitations on training, the staff at primary care level, and medical and social hierarchies are barriers that impeded the provision of an integrated health delivery.

2.3 Causes of maternal death

From the maternal health literature, maternal deaths is assosciated to several causal factors: clinical, cultural and economic. Regarding clinical factors, Abalos et al. (2014) and George (2007) identifies inter alia Haemorrphage, Anaemia, obstructed labour as some clinical factors contributing to maternal deaths globally and in India respectively. Also religiousity, cultural beliefs and ethnicity equally affect maternal health (Bulato et al., 2002; Aseweh Abor et al., 2011; Nhindiri et al., 1995). These are discussed below.

2.3.1 Clinical Causes

Haemorrphage refers to bleeding during pregnancy. This often happens under severe conditions. There is an indication of threatened abortions during pregnancy. The intensity of haemorrhage could be seen in anaemic women George (2007). With this situation, a small reduction of blood can be extremely fatal. Also, anemia in pregnant women also contributes to maternal deaths. This condition is often induced by parasitic infestation which is especially caused by malaria (Abalos et al., 2014). This normally contributes to maternal mortality by decreasing the ability of pregnant women to be able to resist infection.

Obstructed labour on the other hand, is as a result of abnormality of the birth canal due to mechanical blockage. This often leads to faecal and urine canal often gaining entry to the

reproductive system also known as fistilation (George 2007 & Abalos et al., 2014). Obstructed labour is often due to multiparity of foetus, pelvic disproportion and abnormal foetal. Again abortion is an involuntary or voluntary termination of pregnancy 24 weeks before gestation. It often bares the characteristics such as bleeding, the passage of placental tissue, lower abdominal pains. Hypertensive disorders during pregnancy are normally associated with protein in urine and facial and pedal oedema (Abalos et al., 2014). It is one of the most difficult obstetric emergencies to be prevented and managed yet they are the major cause of maternal deaths in Africa. Normally when that is not given much attention it progresses to eclampsia which is often characterized by brain damage, renal failure, convulsion and death.

Sepsis is a causal effect of one refusal to follow aseptic procedures, it occurs when the amniotic sac gets damaged before delivery occurs, when obstructed labour occurs or when vaginal examinations are too frequent. Its consequences in the long term include pelvic inflammatory disease, puerperal sepsis, in rare cases maternal tetanus and secondary infertility. Notwithstanding other aspects of the clinical causes of maternal mortality include renal failure cardiac disorders and ectopic pregnancy. Most of these conditions can be prevented or managed if the right conditions prevail. (George, 2007; Abalos et al., 2014).

2.3.2 Socio-cultural causes of maternal mortality

According to Bulato et al., (2002), Ghana's maternal mortality rates have been unacceptably high though maternal mortality figures vary widely across different regions and can be highly controversial. They emphasized that Ghana's best estimate suggest that roughly between 1,400 to 3,900 young women and girls die yearly due to complications related to pregnancy (Bulato et al., 2002).

Maternal death in literature has several causes. Some scholars have identified religious beliefs as one major cause. Similarly, researchers have shown that religion is an essential component of maternal health care utilization (Aseweh Abor et al., 2011; Nhindiri et al., 1995). Findings by Addai et al. (2006) and Navaneetham and Dharmalingam (2002) pre supposes that some socio-cultural activities, as well as religious beliefs and orientations have a significant influence on the antenatal health-care seeking behavior of women. According to Andersen and Newman (1973), religion may be referred as the perception of need in the sense that, religious beliefs can influence women's perceptions of need and the urgency of morbidity conditions and hence the need to seek appropriate care.

Based on prior empirical studies, ethnicity has been identified as a cause of the utilization of maternal health care services (Elo, 1992; Amankwah, 2015; Matsumura and Gubhaju, 2001). Ethnic groups portray different values, cultures and belief systems, which obviously influences attitude and ideologies in the use of health care services. According to Ekman and Emami (2007), ethnicity is a strong and rigid cause influencing maternal health care use in Vietnam. Based on their results, justifications made proved that ethnic majority influences the use of service in a positive way. Cultural practices and traditional beliefs could be a negative factor contributing to the utilization of maternal health services. For instance, in Sudd, Southern Sudan, traditional practices during pregnancy period and the delivery stage are deeply rooted in the lives of the people and hence it conflicts with the acceptance of modern antenatal care (Matsumura and Gubhaju, 2001). Also in Cameroon for instance, a major reason why women continue to seek care from traditional midwives in spite of modernized maternal facilities is the guarantee appropriate disposal of the placenta, which plays an important role in their culture (Defo, 1994).

Geographic location is a factor that influences the utilization of maternal health services. In such instance, it is likely for different regions to differently have access to health care personnel and infrastructure. A study by Addai et al. (2006) reveals the factors influencing the use of maternal health services in rural Ghana he discovered that living in the Central and Western regions increases the likelihood of improved pre-natal care in rural areas. He also found that, compared to the Upper and Northern regions, women living in rural areas of Central and Western regions were twice as likely to see a doctor for prenatal care. He deduced that the reason is due to the ease of the access to personnel and health facilities among women living in rural areas of Central and Western regions.

Marital Status is an influential factor in health seeking procedure. According to WHO (2005) unmarried women are less likely to seek maternal health services due to the absence of social and economic support from parents, guardians or spouses. Young women, especially at the adolescent ages, may lack decision making powers and social independent to seek maternal health services. (WHO, 2005).

In most parts of Africa, the decision-making power of women are limited especially in matters of reproduction. Making a decision in respect to maternal care is normally made by the husband or the family members (WHO, 1998). A research conducted in Nigeria, unveiled that in most instances, a husband's permission is needed before a woman can seek health services. Men play a vital role in taking a decision over when to seek treatment, be it orthodox or traditional in many cultural contexts (Oxaal & Baden, 1996). Men dictates the kind of measures and procedures needful for the management and delivery process of the wives. Women are therefore cautioned not to take any decisions in relation to their health care management until they seek the counsel

of their husbands.On some occasions women fall in dilemmas whether to opt for instructions given them by health professionals or to resort to the decisions of their husbands.

Other determinants of maternal health care is the access to social networks. This provide women with access to information on safe health care and reduce uncertainty about maternal health services. In developing countries, people living in urban areas may relatively have access to health facilities than their rural inhabitants, the proximity of rural inhabitants to health facilities could be a challenge due to the bad road and communication networks. According to Stock (1983) proximity to health care centres, especially in the developing countries, performs an important role in the willingness to assess health care services, most women prefer health centres close to their homes and therefore unwilling to travel long distances to seek health care. A study by Rahaman et al. (1982) in Bangladesh emphasized that geographical location is an essential determinant in seeking health care service, especially in rural areas. Similarly, proximity to health centres by Navaneetham and Dharmalingam (2002) plays a crucial role in the usage of health care service in both urban and rural regions

2.4 MDGs to SDGs; a focus on Maternal Mortality

The central focus of improvement of health in the MDGs reflects that international community attaches much concern and commitment to health in the developing world. Similarly, the position which enhancement of health takes within the MDGs shows that improved health is important to poverty eradication globally and also serves as a very important benchmark of human well-being.

2.4.1 Millennium Development Goals

The Millennium Development Goals (MDGs) marked an effective approach for global mobilization in achieving effective social priorities worldwide. They played a significant role in the reduction of poverty, poor education, disease control, environmental degradation and gender inequality globally. World leaders accepted the United Nations Millennium Declaration during the Millennium Summit of the United Nations (UN) in 2000 which spelt out the ambitions of the international community for the 21st century. The aim was to support freedom, equality, solidarity, hunger, tolerance, and respect for nature and shared responsibility for development through global partnership (UNDP, 2010; UN, 2012). It focused on how the world could be integrated by common values and motivated with a renewed determination to achieve peace and decent standards of living for everybody. Derived from this Millennium Declaration were eight Millennium Development Goals (MDGs) aiming at transforming the face of global development teamwork. The commencement of the Millenium Development goals was adopted by World leaders at the Millenium Declaration Summit of the United Nations in the year 2,000.

The international community showed its desires by this declaration, with a mission to have united common values striving with the conscious determination in achieving peace and security and every man, woman, and child and to have a decent standard of living. The MDGs identified and addressed certain key developmental human challenges. Specifically reducing poverty as well as other development priorities on the global agenda in a way that was easy to track and understand.

One hundred and eighty-nine (189) member states including Ghana endorsed the MDGs, in the year 2000 at the UN General Summit. The MDGs constituted eight (8) goals and sixty-four (64)

targets to be achieved by the year 2015. Goal one of the MDGs focused on the eradication of and hunger achieving universal primary education was the second target the goal 3 aimed at promoting gender equality and women empowerment jointly the fourth, fifth and sixth goals encouraged countries to enforce good health outcomes for the citizenry. Specifically, the fourth and fifth goals aimed at reducing child mortality and improving maternal health care respectively while goal six sought to combat HIV/AIDS, malaria and other diseases. The seventh goal focused on the sustainable environment and finally, the eight and last goal enforced global partnership for development.

The global commitment shown in achieving the MDGs provided an opportunity to refocus, review and scale up programs and resources by government donors, and civil society to improve the well-being of individuals and society at large. The MDGs determination to attain its objective sought to make the world a global village (MDG Reports, 2012).

There have been critical arguments on the basis for which the goals were formed (Fehling et al., 2006; Eyben, 2006; Hulme, 2010). The creation procedure of the MDGs framework, as Fehling et al (2006) describes, was pursued by Europe and Japan, United States and co-sponsored by the World Bankand the Organization for Economic Co-operation and Development (OECD). The target on gender was limited to parity in education based on the fact that the Japanese representative would not compromise to the broader targets initially proposed by the gender specialists (Eyben, 2006). A limited number of UN representatives influenced the initial rejection of a reproductive health goal. Hulme (2010) justifies that by saying, the 'unholy alliance' of the Vatican and conservative Islamic states made the goal disappear from the original MDG list. It was believed that the World Bank had significant influence in the setting of the main indicator of poverty reduction as the proportion of people living below $1 per day (Saith, 2006) day.

According to Guibou (2017), only 22% of the world's national discussed formally the formulation of the MDGs. He further emphasized that the involvement of developing countries and civil societies were minimal.

According to Amin (2006) and Bond (2006) as cited by Fehling (2006), the underlying conceptual and political agenda of the MDG framework that carried characteristics suited process of corporations and doctrinaire of rich countries (Fukuda-Parr, 2010). Saith (2007) formulates a provocative formula 'neo-liberal globalisation + MDGs = development'

In contrast, the MDGs described as the results of various global summits in the 1990s, yet some authors believe based on certain political reasons some 'hard-fought goals' were left out in the MDGs (Hulme, 2010). These goals include the importance of reproductive health agreed upon in the International Conference on Population and Development as well as the Fourth World Conference. The MDG goal 1 was also seen as being ambitious compared to the poverty reduction goal set at the 1996 World Food Summit in Rome (Pogge, 2004). With regards to education, Fehling et al., (2013) states that the goals in the MDGs were biased, he further explains that out of the three goals discussed at the Educational Forum in Dakar in the year 2,000 only two were included in the MDGs; the target of adult literacy, especially for women, and equitable access to basic and continuing education for all adults were not integrated into the MDGs

The main ideology in the formulation of the MDGs were for development partners and countries to collaborate as well as working hand in hand to increase access to the limited resources available which will therefore lead to the reduction of poverty, gender inequality, tackle ill-

health, poor access to universal primary education, poor access to portable water as well as environmental degradation. (WHO, 2009).

The MDGs as stated in the MDG report (2015) have been applauded for being one of the most successful anti-poverty movement and has therefore been a good stepping stone in achieving the SDGs. It further explains that though there were challenges in achieving the eight-time bounded goals they were generally successful globally. Data obtained from the report showed the availability of adequate resources and political will contributed immersely to achieving these time bound targets. The MDG report further states that setting up of goals and making efforts in achieving them especially in relation to improving health care aids in improving the well being of people.

Ghana's progress in attaining the MDGs has been mixed, the 2015 Ghana Millennium Development Goals (MDGs) report has indicated some targets were achieved these include, reducing extreme poverty by half, reducing the number of people who do not have access to potable drinking water, achieving gender equality and parity in universal primary education have been met while substantive progress has been made in reducing the HIV syndrome.

In contrast, the report reveals that progress has been slow in reducing the unequal share of women in agriculture wage employment as well as women involved in governance (MDG 3), reducing maternal mortality, child mortality as well as improving environmental sustainability. Though with the health targets there were series of interventions, legislations, policies, and programmes, they have generally not helped in improving the well-being of the populace.

2.6 Millenium Development Goal 5

The central focus of improvement of health in the MDGs reflect that international community attaches much concern and commitment to health in the developing world. Goal 5 of the MDGs, thus improving maternal health care, had two main targets including reducing maternal mortality ratio and (MMR) by 75% between 2000 and 2015, and improving the reproductive health of women. Though it is a significant achievement to have halved the maternal mortality ratio from 760 to 380 deaths from 1990 to 2013. It is considerably higher with respect to the target of reducing the rate by 75%. Based on current trends, maternal mortality is estimated as 358 deaths per 100,000 live births.

Ghana's maternal mortality rates remain high though there have been several efforts by the government and development agencies in reducing it. These complications one way or the other could be prevented when detected early or appropriate measures are considerd .The complications often include sepsis infection, hypertensive disorders, severe bleeding and unsafe abortions – these of accounts for about 65% of maternal deaths according to the WHO (2010). Though other socio cultural factors have influenced the upsurge of maternal mortality in the country the aforementioned clinical causes have been predominant. Nevertheless, these clinical causes according to the World Health Organisation and the Ministry of Health can be prevented, it is further stated that appropriate techniques, skilled birth attendants, and immerse political will by disbursing resources skewed towards enhancing maternal health care services these clinical causes could be lessened.

Several interventions in prioritizing health agenda, especially in developing countries through the enactment of policies such as free maternal health care had not produced the desired results. .

Progress toward achieving the targets of the health goals remained slow. In achieving proper health outcomes, there is an increasing consensus that strong health systems play a major role

Achieving MDG 5 depended on a nation's health system, access to health services in terms of physical, geographical, human resources, the level of household income and level of literacy of nations, among others which form which is the focus of this study. Strengthening reproductive and maternal health services similarly is beneficial to the health systems generally, and also enhances full access to appropriate reproductive health care services and itsimplication for economic productivity.

2.7 Sustainable Development Goals

The SDGs were formulated out of the quest to enhance sustainable development. Brundtland Commission (1984) defines sustainable development as the "ability to make development sustainable and to ensure that it meets the needs of the present without compromising the ability of future generations to meet their own needs."

There was a need for an active and broad process to develop a set of a new set of universal goals to succeed the expired United Nations Millennium Development Goals. The establishment of the SDGs was decided at the UN Rio+20 conference, by the governments of Guatemala, Peru and Colombia based on a proposal made by these countries (WHO, 2016)

The SDGs committed by Heads of State at the United Nations General Assembly set ambitious and higher targets as compared to the MDGs. The SDGs being the 2030 agenda focused more on unifying the three major dimensions of sustainable development which include economic, social and environmental development. It further recognizes that eradicating poverty and inequality, preserving the planet and an inclusive economic growth are inextricably linked (WHO, 2016).

Despite the number of SDGs: 17 goals and 169 targets, all are interlinked, reflecting the fact that sustainable development in a country requires multidimensional and multispectral policy interventions (Tangcharoensathien et al., 2015) and this includes reducing hunger and poverty, environmental protection, food in security and hunger, universal health coverage (UHC) employment, and decent work. These are all issues tackled by equity framework interwoven with health advancement.

The SDGs have been praised for their very broad and inclusive approaches to development. The SDGs are indeed supremely ambitious (WHO, 2016). They seek to do nothing less than to transform the world, international systems that govern finance, trade, business relations. They are fairly concerned with fairness in the distribution of benefits as a backbone of stable and cohesive societies. If we consider health in the SDGs in light of the factors that contributed to progress toward the health-related MDGs, there are reasons for concern. On the other hand, the SDGs have been criticized as utopian, impracticable, unaffordable and far too numerous (Loewe, 2012). Some critics point out that the progress towards many of 169 targets will virtually be an important measure, raising rhetoric or reality prevailed when the targets were defined. As compared to the MDGs which had three health goals, health does not occupy a central role in the SDGs. The SDGs has one major health goal. Thus, the goal 3: to "Ensure healthy lives and promote well-being for all at all ages … though a number of other factors that affect health indirectly some of which include poverty reduction, improved sanitation, women empowerment, and sustainable environment". The limited agenda toward health in the SDGs may mean less progress in rectifying the pitfalls in the SDGs.

According to WHO (2005), there are new and complex threats to health, the climate is changing with extreme weather events- like droughts and floods, storm and heat with new records in

history. These new threats to health are much bigger and more complex than records in history the problems that dominated the health agenda 15 years ago. More and more pathogens are developing resistance to mainstay antibiotics. All around the world, health is being compromised by the same powerful forces; population aging, rapid unplanned urbanization, and globalized marketing of unhealthy products. Under the pressure of these forces, chronic non-communicable diseases like heart diseases. This shift in the disease burden has profound implications: this indeed has been identified as threats in achieving the current health targets in the sustainable development goals.

Some scholars argue that health in the SDGs agenda is given less prominence than it deserves. Out of the the 17 goals found in the SDGs , the third goal was the only one allocated to improving the health and well being of people. On the other hand three of the eight-MDGs were directly focused on health and two others on nutrition, water supply, and sanitation.The issue then is whether the health target will therefore be given the necessary attention and political will in helping curb the difficiencies in the health system. And also whether the SDGs will be able to ammend pitfalls left by the MDGs especially in the area of improving maternal health care. The SDGs are seen as extremely broad, with many vague and aspirational targets such as goal 8 “Achieving higher levels of economic productivity through diversification, technological upgrading and innovation, including through a focus on high-value-added and labor-intensive sectors.”

The OECD on the other hand presumes that the SDGs are better strategies in resolving societal challenges. According to OECD, the SDGs are classified under five main Ps: planet, people, peace, prosperity, and partnership and also includes 17 goals with 169 targets (OECD, 2017).

These goals have triggered a consensus and inclusive approach towards the replacement of the MDGs.

2.8 Theoretical framework

Incrementalism Theory

Incrementalism, also known as disjointed incrementalism or muddling through is a policy making process which produces decisions marginally different from past experience. Incrementalism implies that policy choice at a particular time is a marginal adjustment from a previous policy decision. According to Bendor (1995) incrementalism is often designed to tackle governmental considerations specifically social related issues such as environmental affairs, unemployment, foreign policy, crime control, unemployment, and numerous societal issues as evidenced by the MDGs and SDGs.

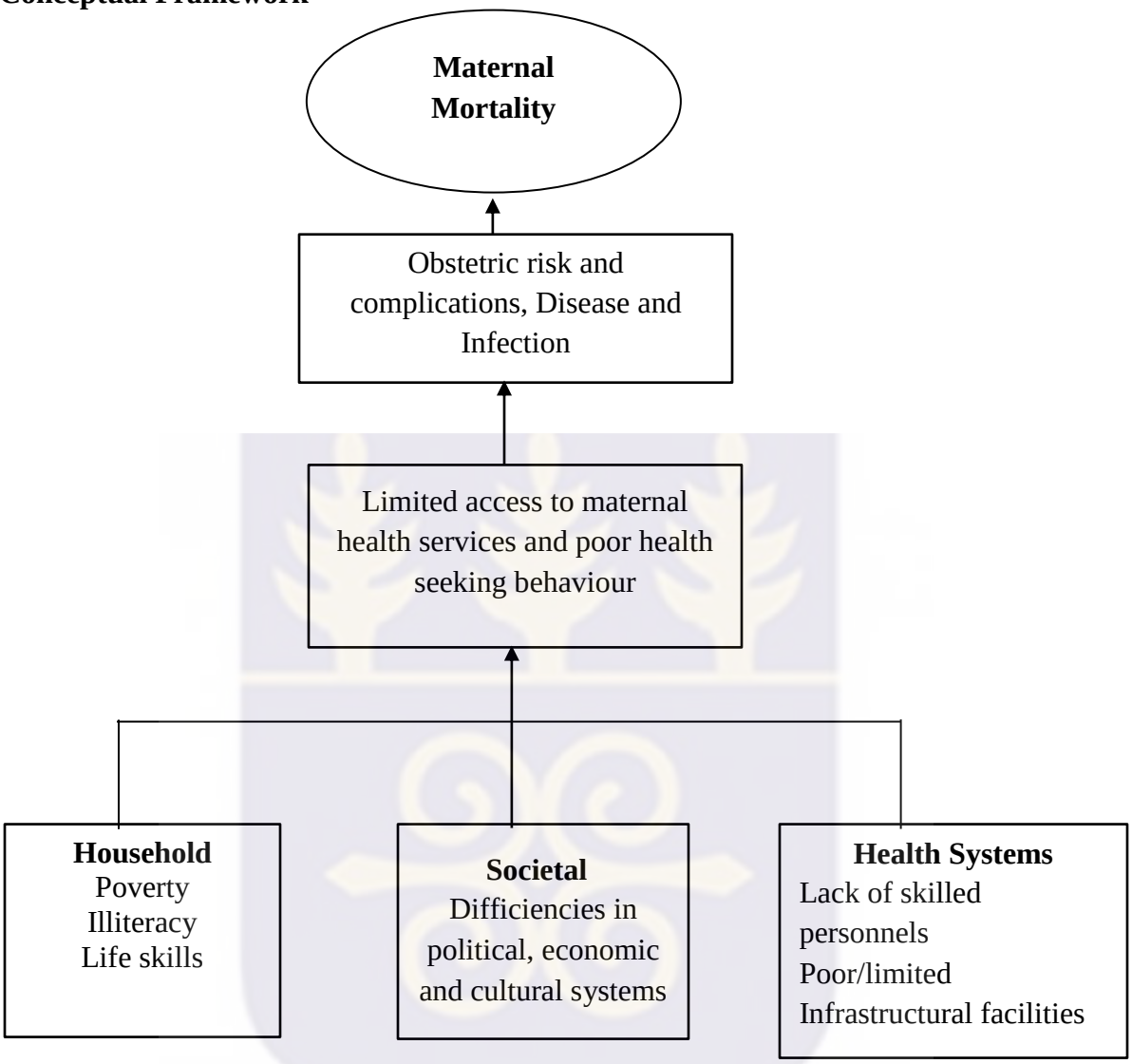
Incrementalism theory basically emphasizes the multiplicity of actors involved in the process of policy-making and envisages that policy makers will build on past policies, aiming at incremental rather than wholesale changes. The theory has been successfully applied to explain domestic policy making, foreign policy making, and public budgeting.

Incrementalism deals with the pitfalls of past policies instead of pursuing abstract ideas. Lindblom (1959) argues not only is the theory of incrementalism descriptively accurate but also normative. This is based on his belief that policy changes must first be accepted by existing organizations and client groups in order to take hold and be implemented . The incremental theory is used for this study on the bases that maternal healthcare in Ghana over the years attracted major concerns, it is not a new health care dimension, but was introduced due to the lapses in enhancing quality maternal care. Incremental theory is regarded as the continuation of

existing government activities with only small (incremental) adaptations to provide for changes that may occur (Hannekom, 1987 cited in Fox & Bayat, 2006). Similarly, the SDGs are seen as an expansion of the MDGs (Sachs 2012), but if the SDGs are to galvanize governments and civil society to confront the interlinked social, economic, and ecological development (Steffen et al. 2011), they need to avoid the shortcomings of the MDGs (Griggs et al. 2013).

It also seen as resolving the pitfalls found in the MDGs. though all health-related MDGs are inclusive in the SDGs with newer targets. The thirteen targets (four cross cutting and nine specific) related to the health goal in the SDGs are seen as ambitious and raised to a level more challenging than the SDGs, Some of the ambitious targets include the reduction of maternal mortality ratios to 70 per 100,000 live births, reducing one-third of pre mature mortality, halving global deaths and injuries from road accidents, ending preventable deaths in newborns and children and universal health coverage (Tangcharoensathien et al., 2015).

2.9 Conceptual Framework



Causes of maternal Death

Figure 2.1: Conceptual Framework showing the causes of maternal mortality.
Source: *Authors own construct 2017*

The framework demonstrates the causes of maternal mortality having a negative impact on the achievement of MDG goal 5(b) in Ghana. The objectives are fully not captured in the framework but the second objective which focuses on the causes of maternal deaths in Ga South District. Socio-economic factors, political, pregnancy related complications, cultural and religious beliefs

have the tendency to affect the health status of a pregnant woman which can result in maternal death in the long run. Socio Economic factors which include the marital status, illiteracy and poverty can induce maternal mortality. WHO (2005) affirms that about 25% of pregnancies are unwanted and 50% unplanned. Most of the unwanted pregnancies are from adolescent who feel stigmatized as a result they prefer to resort to abortion mechanisms. Because most of them are financially constrained they resort to the services of quack doctors to terminate the pregnancies. These quack doctors do not render services based on appropriate medical standards which often lead to pregnancy complications resulting to deaths. In addition, illiteracy similarly is a cause of maternal death. Illiterate women most often do no appreciate the essence of antenatal services, they also do not conform to the directions given to them by the midwives. Inability to be educated on the dangers of labour and pregnancy complications can lead to maternal deaths.

Religious and cultural beliefs play a major role in the maternal health outcome, specifically on pregnant women. Societies where much value is placed on religious and cultural beliefs have the tendency of pregnant women seeking for medical attention from the health centres but instead leveraging the services of traditional birth attendants.

In some cultural settings women are not permitted to eat certain kinds of food during pregnancy, some of these foods are highly nutritious to make unborn baby and mother healthy, but instead they are seen as deadly or taboos which makes them anaemic.

Political factors indirectly influence maternal health care. Health policies such as free maternal care and National Health Insurance have influenced maternal health care over the years. Free maternal health care means that women can easily seek for medical services without thinking about cost. On the other hand, policies that do enhance maternal health services can influence

maternal health care. Political instabilities indirectly affect the nature and quality of health care. Each government comes with its own policies which means that a change of government means changes in policies and programs which affect the quality of health care.

The consequence of these leads to pregnancy related complications or obstetric challenges. Some of the complications include sepsis, obstructed labour, eclampsia and anaemia. When these are not treated with urgency it further leads to maternal mortality. Most of these complications are directly caused by the other socio-cultural factors. For instance, a woman financially constrained might not eat nutritious meals which would lead to anaemia.

In conclusion, the framework specifies how issues related to the causes of maternal deaths hindered the achievement of MDG 5 in Ghana.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents detailed methodology used for the research including the profile of the study area providing an insight into the social context of the study.

It covers the research paradigm, study design, the population and sample size, sources of data, sampling methods, administration instruments, the methods of data collection, data management, limitation of the study and ethical consideration.

3.1 Research Paradigm

The study adopted a qualitative research approach. Qualitative research begins with an assumptions of a worldview, the likely use of a theoretical lens, and the study of the research problems inquiring into the meanings individuals or groups assign to a social or human problem. In qualitative study, data is collected in a natural setting, sensitive to the people and places under study. Data analysis is specifically inductive with institute patterns or themes. The ultimate report in a qualitative study is usually made of voices of human subjects, the reflexivity of the researcher and a multifaceted description and interpretation of the problem that signals a call for action (Creswell et al., 2007). Qualitative methods were used to explore the views of the subjects to get a better understanding of maternal healthcare in Ga South district. Qualitative techniques such as in-depth interviews (IDI) and focus group discussion (FGD) were used to gather the qualitative data. Though the study was mainly qualitative, the first objective which was to explore the trend and causes of maternal death was analysed using a quantitative approach by reviewing archives as well as undertaking in-depth interviews and focus group discussion on

maternal health in the district and similarly to examine the trend of maternal death in the district for a period of ten year.

3.2 Study Design

The study used a case study design. Case studies emphasize detailed contextual analysis of a limited number of events or conditions and their relationships. This allowed the study to have a detailed knowledge of the entire district as a unit for an extensive data. The study was limited to Ga South District. The district had a major hospital and five health centres. The study was limited to the district hospital known as "Akowe" and three health centres which include Oblogo Health centre, Mallam, and Amanfrom. A case study method was particularly useful in this study to explore and validate the study area in its natural environment. A case study design was used to carefully select a few key informants to study them in detailed and in a specific context to obtain good qualitative data to achieve the aims of the study. This approach is valuable for health science research to develop theory, evaluate programs, and develop interventions because of its flexibility and rigor (Yin, 2003).

3.3 Data Collection Process

The study was initiated by reviewing secondary data obtained from several sources which had direct bearing on the objectives. Primary data was obtained from conducting of interviews and focus group discussions. The questions prepared were designed to answer the thematic issues related to the study. They were designed based on the research objectives and were pretested to identify its relevance and suitability to the study. To ease the data collection procedure, relevant instruments and tools, some of which include tape recorder, field log, and pens were put into use to have a more detailed account of the data collection process, after which they were transcribed

for further analysis. Based on the nature of the study, observations were taken into consideration in addition to the perceptions and experiences throughout the research process.

3.4 Sources of data

The study made use of both primary and secondary data to efficiently address the aims of the study. The secondary data was necessary in analyzing the first research objective that sought to examine the trend and causes of maternal death in Ga South District. The primary data was taken based on in-depth interview with health professionals and focus group discussions. Fifty-seven respondents (57) were engaged in an in-depth interview and focus group discussion in the GA south District. The participants were health personnel of diverse background from selected health facilities as well as pregnant women who went for antenatal and post natal health care in the district hospital or the health centres. Traditional health attendants in the district were also interviewed for the study.The health personnel include the deputy district director of health services, the facility heads and midwives.

The participants were selected purposively and conveniently, since the study's intention was to interview participants who work in the area of maternal health to get specific results or outcome. Participants were identified after obtaining a written consent from the district health administration to the various units where the respective respondents have been assigned to work.

3.4.1 In-depth interview

In-depth interview assists a study to access the perspective of respondents by collecting verbatim transcripts in order to understand people's views in their own words. It is normally a face-to-face interview with a single participant and a researcher with an assistant who pose questions in an unbiased manner and learn from the participant's response while asking follow up questions and

taking notes. In-depth interviews grant the the opportunity to interview participants who have special knowledge on the topic under consideration. In this study, in-depth interview was used to access participants' views and understanding on maternal health and how it can be improved. An interview guide was used to keep participants within the confines of the objectives of the study. The indepth interviews lasted for about fifteen minutes for each participant. Interview was conducted in the offices of the respective respondents. The respondents involved in the interview included the deputy district director of health, the facility heads in three health centres within the confines of the district. Their consent was sought before recording was undertaken.. Some of the respondents were on busy schedules hence asked for the interview to be rescheduled on another day. The sessions were very productive since the research was a major concern to the health directorate. Most of the respondents especially the midwives were very passionate about the study and appealed that the government should intervene in issues relating to maternal health care. In-depth interview was to ensure that vital questions were asked while respondents brought out their thoughts and perception on the topics. The interview guide was in three categories. One was for the deputy director of the district. The second was for midwives and the third was for the focus group discussion.

3.4.2 Focus group discussion

Focus group discussion was used to collect information from pregnant women. Focus group discussion (FGD) is a qualitative research technique in which participants are informally interviewed in a group of 6-12 in a convenient place with a moderator who ensures a free, open discussion by all group members. Members of the group were homogenous excluding close friends and relatives (Dickinson & Neuman, 2007). FGD has advantages when gathering information on people's talk, exploring opinions, norms, values, experiences and practices,

wishes and concerns. The social interaction of people and group dynamics help people in a FGD to build on each other's answers and give new insights on the topic. Because participants build on each other's ideas and question each other, they generate more data within the same time than individual interviews (Beyeza-Kashesya et al., 2010). The hallmark of focus group discussion is the clear-cut use of group interaction as data to explore insights that could otherwise remain hidden.

The interaction was based on a carefully planned series of discussion on topics set up by the researcher who took notes and recorded information given out. Participants were also encouraged to ask questions , comment on ones experiences and points of view as well as exchanging anecdotes. Though topics were initiated by the moderate for discussion, and fully exercise authority about what is discussed there was no interference with the respondents view point during the talk – in process or sessions. (Krueger, 2002).

A total of two FGDs were conducted for the study, each consisting of nine (9) members lasting for sixty minutes. The participants were pregnant women. This together with the IDIs and records on maternal health in the district provided adequate information for the study. The focus group Discussion was held at the maternal health unit of the district hospital. Participants were organized by the assistant of two midwives and the head of reproductive health. The focus group discussion lasted for about twenty-five minutes. Questions were brief and the participants to respond accordingly. In the discussion, some pregnant women were very much involved whereas others because of their condition were a bit reserved. The dominant language spoken in the discussion was Twi because most of the participants were comfortable in speaking the local dialect. In cases where the answers from the pregnant women were not clear. Further elaboration was sought from the midwife.

3.5 Population, Sample and Sampling Procedure

The population of the study consisted of health personnel, pregnant women who attended antenatal clinic, traditional birth attendants and women who attended post natal clinic within the GA South District. Sample of fifty-seven (57) participants were selected from the population by means of purposive sampling technique. The purposive sampling technique was used in the selection of health personnel who were relevant to the field of study. These included the deputy district director, midwives and facility heads. Dickinson and 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 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. Convenient sampling approach was used in the selection of pregnant women who came for antenatal. Out of fifty-seven respondents used for the study, Sixteen (16) health personnels were involved in the in-depth interview, made up of four (4) facility heads, the deputy district director, two (2) reproductive health nurses and nine (9) midwives. Also two (2) traditional birth attendants were interviewed. The midwives were selected based on over 5years of working experience. Twenty-four (24) participants were selected based on convenient sampling technique to form a focus group discussion in the district hospital. In addition, fifteen pregnant women, five from each health centre were also engaged in indepth interview.

3.6 Research Instrument

The face-to-face interviews, focus group discussions, and archival analysis were used as the tools for data collection. Three sets of interview guides were used for the data collection. One set was used to interview the district director of health services, the district public nurse and the public health nurse at the integrated health unit of the GA South District Hospital. The second set of interview guide was used to recruit midwives for the study at the selected facilities in the district. The last set was used for the two focus group discussions involving women who attended antennal at GA South District Hospital. The administration of the research instrument was done immediately a letter of introduction was obtained from the University of Ghana.

3.7 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 Ga South 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.

3.8 Data Management

The data obtained from In-depth interview (IDI) and Focus Group Discussion (FGD) were transcribed. There was a translation from local language to English language based on questions set on the interview guide, notes and audio recordings were taken by the researcher. The data transcribed was analysed thematically according to the objectives.

3.9 Ethical Consideration

Ethical approval was received from the office of the Regional Director. The District Director of Health in the district also permitted the researcher to undertake the study. The researcher also

sought permission from the facility heads and also the head of midwives before the study was undertaken. In addition, verbal consent was sought from IDIs participants before employing data collection materials such as tape recorders . Similarly, there was assurance of data confidentiality. Finally, an informed written consent in addition to the schools Identity card of the researcher was considered among pregnant women before engaging them in the study.

3.10 Limitation of the Study

The first limitation was time period. The limited time did not permit the researcher to engage more respondents for the study. Another limitation was geared towards the sampling technique specifically purposive sampling. On various occasions the researcher had to reschedule meetings with medical personnel due to their busy schedules. Obtaining ethical approval from the district before using the various facilities posed a lot of challenges to the study. There was a lot of bureaucracy in the health directorate and researcher would have to conform to them. Introductory letter received from the University of Ghana Business School Department of Public Administration and Health Service, was not sufficient enough for ethical approval. The office of the regional health directorate demanded for a copy of the research proposal deffered approvalfor several weeks. The Director of Health in the district was on leave and the researcher had to wait for weeks for him to resume before ethical approval was obtained.

This, indeed, delayed the data collection process. One major challenge was the absence of record on maternal deaths in the district from 1998 to 2011.The researcher then changed her first objective to examine the trend of maternal deaths from ten years to five years. Language was finally a barrier since some of the respondents especially the pregnant women spoke languages that were not conversant to the researcher. The researcher had to ask for further assistance from other respondents and some midwives.

3.11 Study Area

3.11.1 Population, structure and composition

GA South Municipal is one of the ten regions in the Greater Accra Region of Ghana its capital is Weija. The district is among the new districts and municipalities created in 2008 by the then president John Kuffuor. The population of Ga South Municipality, according to 2010 population and Housing census is 411,377 representing about a tenth 10.3% of the regions total population. A female constitutes 51.1% and males represent 48.9%. The population of the municipality is youthful (36.1%) depicting a broad base population pyramid. The Ga south municipal was carved out from the Ga west district in November 2007 and was established by Legislative Instrument 2134 in July 2012 with Weija being the Municipal capital. It lies at the south-western part of Accra and shares boundaries with the Accra Metropolitan Area to the south east, Ga Central to South East, Akwapim South to the North East, Ga West to the East, West Akim to the North, Awutu Senya to the West, Awutu Senya East to the South East, Gomoa to the South West and the Gulf of Guinea to the South. It occupies a total land area of about 341.838 square kilometers with about 95 settlements.

3.11.2 Fertility, mortality and migration

The districts recorded a total fertility rate of 3.9 based on the 2010 population census. Per 1000 women the general fertility rate is 111.4 ranging from women between ages 15-49 years this figure in the region is seen as the second largest. The Crude Birth Rate (CBR) which represents the number of live births occurring in a given geographical area among the population is 3.18 per 1000. The crude death rate which represents the total number of deaths within a year according to 2010 population census in the district was 4.2 per 1000. Violence, suicide, homicide

contributed to 11.3% of the total deaths whereas 89.7 percent accounted for the other causes of total mortality within the Municipality. A greater portion of migrants representing 66.6% were born in other regions in Ghana while 31.4 percent were born in the Greater Accra Region. For those born in other regions other than greater Accra, Eastern region constituted 24.6%, Central region 24.9 percent and Volta, 19.5 percent.

Based on the census, the second highest Total Fertility rate which is represented as 3.9 is Ga South Municipal which is above the regional average of 2.6. Besides, both GFR and CBR of the Municipality are quite higher than the regional averages of 111.4 and 31.8 respectively. The high levels of Total fertility rate, General Fertility Rate and Crude birth rate in the Municipality could be low mortality among males and less usage of contraceptive.

3.11.3 Structure of Households and composition

The district records 404,130 as a household population out of which it has 100,701 households. Per household the average household size is 4.0. 40.8% is represented by children accounting for the largest number in the household structure. 12.6 percent consist of spouses. 33.3 percent of the total number of households in the municipality is made of nuclear households (Children, spouse (s) and head)

3.11.4 Marital status

Twelve years and older constituting 45% of the total population were married. Contrary those who have never married consist of 42.1 %. Consensual unions constitute 5.3%, widows consist of 2.8%, 1.9 percent are separated and 3.0 are divorced. Between the ages 30 to 34, about 70% of females are married and the remaining males. At age 65 and above, widowed females account for as high as 48.8 percent while widowed males account for only 9.5 percent. Among the

married, 14.5 percent have no education while about 4.8 percent of the unmarried have never been to school. More than three-quarters (79.7%) of the married population are employed, 4.3 percent are unemployed and 16.0 percent are economically not active. A greater proportion of those who have never married (58.3%) are economically not active with 6.0 percent unemployed.

3.11.5 Literacy and education

Of the population 11 years and above, 87.9 percent are literate and 12.1percent are non-literate. The proportion of literate males is higher (92.6%) than that of females (83.6%). A little more than half (53.8%) of the literate population indicated they could speak and write both English and Ghanaian languages. Of the population aged 3 years and above in the municipality, 11.2 percent has never attended school, 38.5 percent are currently attending and 50.3 percent have attended in the past.

3.11.6 Economic activity status

About seventy percent of the population 15 years and older are economically active while 28.9 per cent are economically not active. Of the economically active population, 92.0 percent are employed while 8.0 percent are unemployed. For those who are economically not active, a larger percentage of them are students (50.8%), 24.9% perform household duties and 2.7 percent are disabled or too sick to work. Five out of ten unemployed are seeking work for the first time.

3.11.7 Health Care System

Health services in the Metropolis are managed at three (3) levels: The first is the Regional directorate: main responsibility is supervision, monitoring, planning, evaluating, training, and coordinating of all health programmes in the district. The other roles played by the regional directorate is conducting research and coordinating NGOs and other agencies in promotion and provision of health. The second is managed at the Municipal level. Their responsibility is

similarly planning, organizing programmes and also implementing activities in the various health centres. Similarly, all records within the eight health centres are brought to the municipal office. They intend provide monthly reports to the regional directorate. The third is the community level: the health centres provide health assistance at the community level by staff, community health nurses others and also supported by volunteers from the community.

Map of Study area

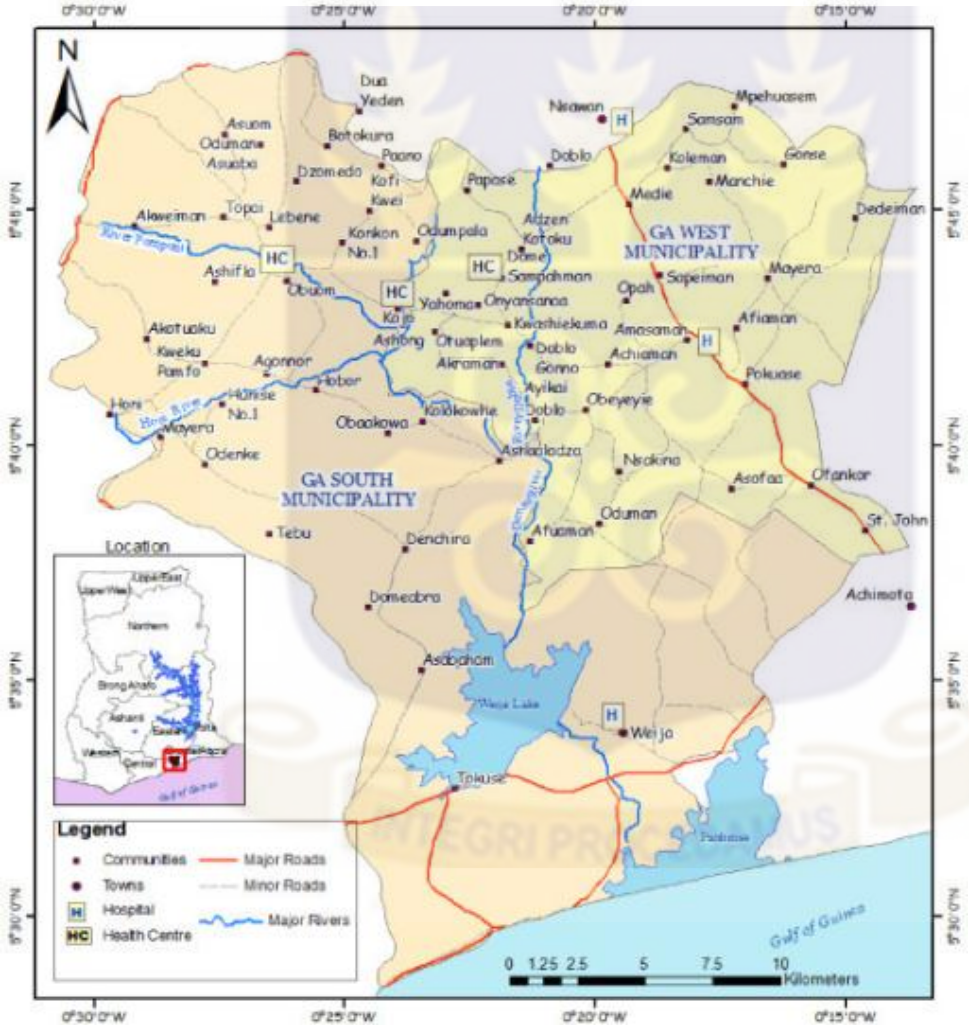


Figure 3.1:Map of Ga south district

Source: Ghana Statistical Service

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.0 Introduction

This chapter specifically focuses on analysis of the data obtained from secondary and primary sources in relation to the field of study. It covers data obtained from the focus group discussion, indepth interviews and the review of secondary data on the trend of maternal deaths in the district between the years 2012- 2015.

4.1 Demographic characteristics of respondents

This section covers the demographics and views of respondents on maternal health in the district. The ages of the respondents engaged in the, IDI ranged between twenty four (24) to fifty-nine (59) years old. Among the Fifteen (15) health personnel chosen for the IDIs, nine of them had at least (5) years working experience. One of them had twelve years working experience, whereas three (4) of them have more than fifteen (15) years working experience and the last respondent had thirty (30) years of experience and the oldest among them. The two traditional birt attendants were over 50 years. The levels of education among the IDI respondents ranged from two year post-secondary in auxiliary nursing to master's degree in public health. They were nurses and midwives with one medical doctor who was the district director of health services and holds a master's degree in public health. This was followed by two public health nurses who have advanced diploma in public health nursing. The rest were midwives, community health nurses and one health care assistant (clinical). The traditional birth attendants specified that they had over fifteen years experience with basic secondary education.

4.2 Trend of maternal deaths in Ga south district

To analyse the trend of maternal deaths, data was obtained from the annual report of the district from 2013-2017 hospital and analysed for trends in maternal deaths in the district.

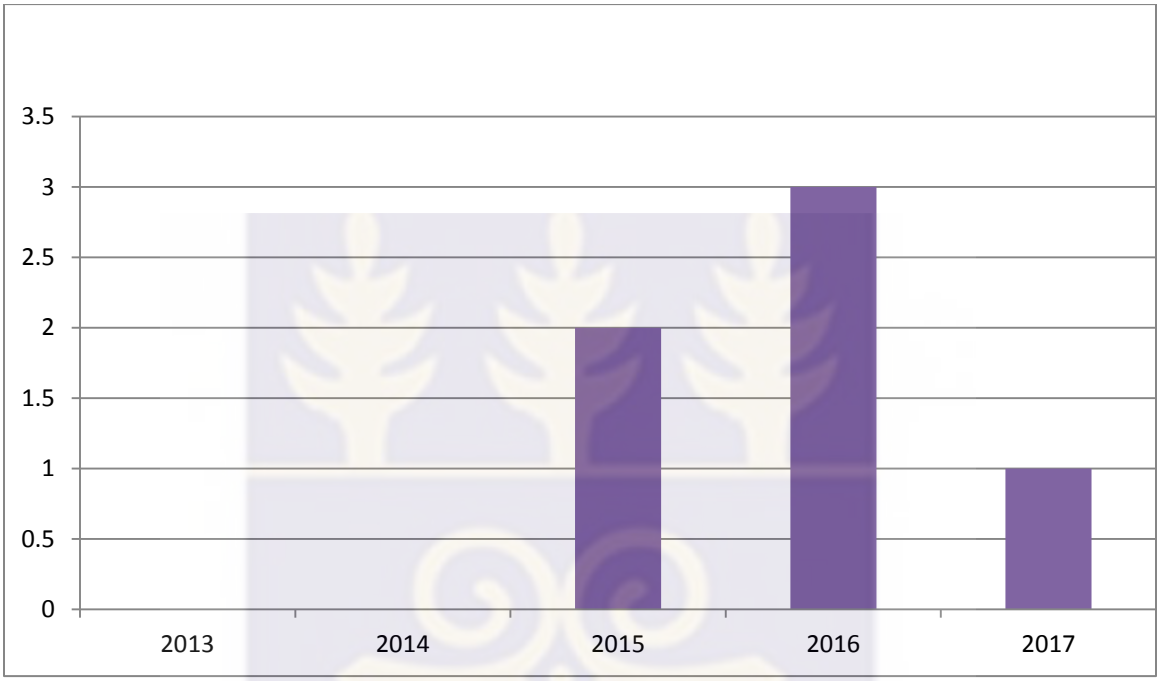


Figure 4.1: Trend of maternal deaths in Ga south district

Fig 4.1 shows the trend of maternal death in Ga South District from the year 2013- 2017. Data obtained showed that in the year 2013 and 2014 there were no record of maternal deaths in the year 2015 two deaths were recorded and this number shot up to three persons in the year 2016. Already in the year 2017 one death has already occurred. The low maternal death recorded in the year 2013 and 2014 does not give a true reflection of what was happening on the ground because by then there was absence of a gynecologist and obstetrician and hence severe maternal health issues were transferred to referral centres. Also three health facilities specifically Oblogo, Mallam and Aplaku all within the catchment area of the district were not delivering pregnant

women because they lacked the requisite tools and materials needful for the delivery of babies. This is backed by the assertion made in the MDG Report (2015) which states that supervised delivery can reduce the risk of complications in Child birth. Similarly, this is in consonance with the work of Loudon (2000) who stated that countries such as Norway, Sweden , Denmark made a lot of effort to reduce maternal mortality but they could not have marked reductions in high mortality ratios till they skewed their efforts in the provision of skilled labour for pregnant women. This was achieved mainly by enforcing the potentials and skills of nurses, doctors and other health personnel. The above results are in sync with notions in incremental policy where new policies or approaches do not depart significantly from previous policies but only see marginal changes (Linblom, 1959), thereby making it to look like "business as usual". Although MDGs had given way SDGs but maternal mortality had not improved but rather downward decline was the trend. Again, 2017 was just in the first quarter but the case of maternal deaths had reached almost same level as first quarter of 2016.

The results and interviews with district health officers affirmed the trend. According to the health personnel specifically the midwives, some cases referred after 48 hours were not recorded against the district. Interviews with two traditional birth attendants indicated that some patients after resorting to their services prefer delivering in their home towns or spiritual homes. They further explained that in cases beyond their control they direct clients to nearby hospitals. They believed that other complication or death were not recorded.

Most cases needed to be referred especially when it comes to surgical operations. Most often than not referred cases were not followed up to deduce if patients returned to the district safely or not. The senior midwife mentioned the causes of the deaths.. Two persons died as a result of unsafe abortions and stated that these terminations were performed by people who lacked the

necessary skills and also if they even did, they performed them in environment which lacked appropriate medical standards.

> *"we have cautioned adolescents over and over against the practice of abortions. But they never take heed to advices. They visit illegal or traditional persons for the act to be performed. Most of them leave them with fatal consequences. Sometimes these babies do not die but rather live these women with series of complications which leads to their deaths."*

Similarly other conditions that causes maternal deaths in the district include pre-eclampsia, eclampsia and hronic hypertension. Pre eclampsia and eclampsia they stated normally have been the causes of maternal deaths. This is in consonance with the MDG report 2015 which stated that women die yearly as a result of pregnancy related complication which includes pregnancy related complications, haemorrhage, eclapsia unsafe abortions and many more.

> *"Women die as a result of anomalous or excessive bleeding which is caused by a placental implantation, an initial loss of pregnancy or abnormality during the child birth process. Obesity, pregnancy at old age normally causes these conditions.''*

4.3 Challenges that hindered the achievement of MDG Goal 5 in Ga South district

Data collected from health personnel, pregnant women and traditional birth attendants specified the challenges below.

4.3 .1 Financial Constraint

Three midwives mentioned financial constraint as a major hindrance in accessing maternal health care in the district. This is reflected in the following areas, patronage of drugs, nutritious diets, and transportation cost laboratory and the cost of ambulances. Nutrition is similarly a challenge, most pregnant women are constrained financially hence are unable to eat nutritious diets to aid the development of the foetus as well as their own personal development.

> *In fact lack of funds is a serious challenge hindering the access to maternal health care in the health centre. We sometimes had to prepare breakfast for some pregnant women should they come for antenatal. Some of them are malnourished and with this condition it creates abnormality and sometimes excessive low pressure*
>
> *(Midwife IDI)*

Three midwives also spoke on behalf of the pregnant women in relation to access to maternal health services. They complained that though most of them had the health insurance cards, they had challenges in patronizing drugs. They also emphasized that the continuous laboratory test scans and vaccinations sometimes became a problem to the pregnant women since they were financially constrained. They further explained that most of the health centres do not even have the facilities such as the laboratory centers and hence they have to patronize that of the private vendors which is very much cost involving.

> *"this is my first pregnancy I didn't know being pregnant was cost involving. I am having series of complications during this period, I initially thought of aborting the baby but I was scared of losing my*

life and that also the fact I may not be able to deliver again if I should terminate this pregnancy. I barely get financial support from loved ones and relatives adding to the fact that the father of the baby has refused the pregnancy. I have to face the consequences on my own. I am indeed struggling."

(pregnant woman FGM)

This is affirmed by Ikamari (2004) that most individuals are not able to afford charges made by health centres due to financial constraint. He explains further that high cost of fees may push individuals to resort to services to quack doctors or traditionalist.

4.3.2 Delay

Two heads of facilities and a midwife in the IDI emphasized delayance as a major challenge that hinderd the achievement of MDG goal 5 in the district They further explained that delayance happened in four dimensions.. Delay in: arriving at health centres, recognition of the problem, appropriate action, within the health facility.

4.3.2.1 Delay in arriving at health centres

Two heads of facilities emphasized that after a client discovers the particular health facility to access there is a further delay of how to arrive at the facility especially during labour cases. Some of the causes of delay as they spelt out include availability of a vehicle, transportation cost, traffic conditions and distance to the health centre. Clients on several occasions try accessing emergency ambulances by calling but their efforts always remained futile. The condition of roads and nature of terrain and the proximity to health facilities are considerations. Inhabitants often walk or improvise means transportation to get to health facilities, because. Most often patient's

condition deteriorate on the way to the health centres which sometimes makes treatment extra challenging on arrival the patient is still alive. An example was given of a Tanzanian women bleeding to death waiting for a taxi. A decision to seek care may be timely, but impaired access prevented utilization.

> *"sometimes when a woman is in labour it can be really appauling, most at times the taxi drivers are afraid to pick these women up , also people who accompany these women bargain to have reductions in the cost of transportations. And all these factors have been a major cause of quality maternal health care over the years."*(head of facility IDI)

4.3.2.2 Delay in recognition of the problem

The other dimension of delay according to two midwives was early recognition of the problem. They further explained that most women are ignorant about labour signs and they would not seek for medical attention when they discover complications. For instance they indicated that there were instances when pregnant women detected spots of blood in a small quantity and they often regarded that symptom as normal. Interestingly they further explained that society accepts that pains must be endured with stoicism till an expulsion of the foetus.The delay in recognizing obstetric emergencies as they explained can be fatal.

> *"we keep on informing these women to report to a health facility anytime they discover strange complications. Some of them wouldn't do that till the situation is further exacerbated. We keep on telling them not to be their own midwives and that that is why they have been trained. Even with me anytime I notice any complication when am pregnant I consult my colleagues for*

advice how much more a lay person. When it happens like that it further complicates our work especially if the situation could have been resolved at early stages."(Midwife IDI)

4.3.2.3 Delay in taking appropriate action

An additional complication is a situation where the nearest facility is not equipped with essential resources to manage the condition. A further delay occurs in transporting the patient to the proper facility. The respondent specifically the two heads of facilities and two midwives stated the ability to take an appropriate action as a major cause of delay. They explained that after a challenge is recognized the ability to deduce the appropriate plan or action becomes a hindrance. Furthermore, the knowledge to locate the appropriate facility becomes a problem, financial constraints also induce the kind of action to be taken especially for women who highly depended on their partners for survival. The absence of their partners in an emergency situation can be problematic. The consequences have been that clients resort to the services of traditional midwives, shrines or spiritual homes.

Some of these issues are beyond us , we only have to hope for more health facilities in communities to help ease some of these problems. We also try to enforce the notion of prevention being better than cure. Hence we organize the pregnancy school to educate these pregnant women on how to manage their pregnancies.

(Midwife, IDI)

The above explanations by the heads of facilities and midwives raises fundamental issues of effectiveness of institutions charged with the responsibility of addressing maternal mortality. Firstly, the fact that pregnant women will still resort to shrines and

other traditional homes for delivery will seem to suggest that there is some dissatisfaction with services received in the health facilities. Secondly, despite claims of organizing pregnancy school to sensitize women on need to adhere to safe maternal practice, the situation has not yielded desired results. Essentially, what it means is that there are multiplicity of factors that contribute to maternal deaths.

4.3.2.4 Delay within the facility

Three heads of facilities stated the health facility as a major cause of delay sometimes. In the health facilities sometimes there are no gyanaecologist, obstetrician and anesthetics, They therefore contact the referral centres for assistance. They further explained that on some occasions the referral centres complain about lack of beds, the absence of the specific health professional and also sometimes due to financial reasons the centre has to delay. Interestingly, they emphasized some midwives delay patience having complications during labour with the hope that they may be able to deliver. Finally they explained that finding ambulances to transport pregnant women who have been referred has over the years been a major challenge in respect to maternal health care in the district.

> "*I will sincerely not blame the clients fully for delay, we are also part of delays. We sometimes are the cause of delay. On a whole though our reason has never been deliberate but at least sometimes we have to be proactive in our dealings."*

Similar studies by Thaddeus, S., & Maine, D. (1991) emphasized that delays most often increases complications during pregnancy.

4.3.3 Illiteracy

Data collected from the district unveiled that illiteracy is a major constraint in respect to access of maternal health services. Most of the inhabitants especially those who assessed health care in Amanfrom district were highly illiterate. Most of the inhabitants living in the centre were from Niger. According to the head of midwifery in the unit, sometimes pregnant women patronize wrong drugs when they are given prescriptions. During antenatal most pregnant women are unable to communicate labor complications effectively. Similarly they are unable to detect labour signs which lead to delivery at home under which they incur infections.

Some of them similarly do not know the essence of antennal, they wait till the final trimester before they report to the health centres. This they said could be very challenging since most often they do not have health records on them.

> *"Illiteracy, ignorance, negligence is really a setback caused by pregnant women. They refuse to report for antenatal health care at the early periods of their pregnancy. Sometimes they default their checkups and hence it becomes challenging to have a concise health records on them. On one occasion one woman reported when she was in labour. We later discovered she had fibroid which needed urgent attention. This challenge could have been curbed if she reported at the health centre earlier." (midwife IDI)*

Similarly midwives complained about challenge with communication due to illiteracy and low educational status. Some midwives are unable to speak the local dialects specifically Ga and

Twi. They sometimes have to find translators (patience or a health worker) due to this patience are unable to communicate their conditions very well which leads to assumptions and guesses.

This is affirmed by a report by the UN (2013) that "The risk of maternal death is 2.7 times higher among women with no education, and two times higher among women with one to six years of education than for women with more than 12 years of education." Similary other studies has shown that education is an important determinant of health. Atinga et al., (2015) and Ochako et al., (2011) found out that well educated women better used professional assistance compared to young women with no formal education. Undoubtedly, education contribute to higher autonomy in making decisions about their health and health care utilization.

4.3.4 Weak Staff Strength

Most midwives complained of weak staff strength. Ratio of pregnant women to midwives is very low. They emphasized that the over the years have been characterized by limited of staff and also the absence of supportive supervision due to an embargo on recruiting new staff members, non-replacement following retirement and death , migration of staff to other countries. The midwives play both antenatal health roles and labor roles at the same time. When a midwife is on duty and a client is supposed to be referred, the midwife accompanies the client because in the ambulance the client is still given medical attention. They complained bitterly that over the years this has been a challenge. Aside that the midwife responsible for antenatal health care has to pause his work if there is a labour case.

> *"madam it sometimes looks like we complain too much but it is because there has been no intervention. We are over pressured, we know out there, there have been complaints of how impatient some midwives could be, but*

the reality is the workload on us. I report to work as early as 6. 00am if am on morning shift. I attend to over fifty clients a day aside that I have to attend to labour cases in addition. When it gets to the peak season that is in between April and May I sometimes have to stay throughout the day. I have been working over 10years and this situation has not been any better."(midwife)

Aside the shortage of midwives they were limited numbers of other health personnel like pharmacists, lab attendants and gynecologist. The district hospital have only one gynecologist. Even with that there are specific days that she reports to the health Centre. Some cases which could be handled in the hospital has to be referred because of the absence of the gynecologist.

This is confirmed by a study by Pathmanathan and Liljestrand (2003) countries such as Cuba, Iran, Bangladesh have enforced minimizing maternal mortality ratios and emphasized that maternal mortality could be reduced by using new dimensions of medical care, Similarly, they emphasized that the success of these countries in achieving that was as a result of their commitment to give training to sufficient resources for health care and enforced that skilled personels attended to most of the births. Also a study by Chen et al., (2004) stating that "Human survival gains are being lost because of feeble national health systems. On the front line of human survival, we see overburdened and overstressed health workers, too few in numbers, without the support they so badly need."

Similarly the limited number of midwives led to inadequate supervision. Senior midwives are occupied by training sections, attending meetings, travels among others. The essence of supervision is to detect early gaps in work as well mistakes instead of the quality of delivery

4.3.5 Lack of Medical Facilities

Inadequate medical facilities was a major challenge that hindered the achievement of the MDGs in the district.The conditions for which most midwives operated is very unpleasant. Some midwives complained about the limited number of equipment which includes wheel chairs, surgical gloves, manual vacuum aspirator. This leads to feelings of frustration. Responses from midwives indicated that there was lack of delivery beds in their respective hospitals. Most of the beds were not the standardized ones for deliveries which indeed pose challenges to the clients as well as the midwives. Most of these women express their displeasure and discomfort accompanied by the intensive pains they endure during their laboring period. According to the midwives mostof the pregnant women who suffer these misfortunes assure them that in their next deliveries they will resort to the services of the private hospitals.

> *"We have complained about delivery beds over and over again. The beds are not standardized sometimes we have to adjust the beds with so many pillows. Women in labor sometimes feel so much uncomfortable and prefer to sometimes lie on the floor. We had one recently and there has been no one to even fix it up. Its been lying here for almost a year and nothing has been down about it. In fact some of these challenges make this work so difficult.''*

They also complained of lack of laboratory services in the district. The district had only two laboratory facilities. Most of the clients went for private laboratory services which most often cost them dearly. Sometimes they even have to travel a few miles for laboratory services as well as scans. They further affirmed that it was not too safe for these pregnant women to go for laboratory test somewhere else because some of them sometimes do not have specialized attendants and hence some of the reports turn out not being valid.

4.3.6 Energy Crises

Unreliable power supply was cited by the midwives and some other medical personnel's indeed hindered the achievement of MDG goal 5 in the district. According to them it posed a lot of inconveniences in terms of access to antennal services, laboratory services and many more. They affirmed that they had a generator but sometimes fueling it was a challenge.

4.3.6.1 Unfavorable atmosphere for antenatal services

Two midwives and some pregnant women complained that when pregnant women came for antennal they feel uncomfortable due to the high temperature in the rooms. Especially in the mornings when most women report for antenatal the room becomes so much congested with limited air circulation. Sometimes the midwives themselves feel so much uncomfortable. They emphasized that congestion in a way leads to infections such as tuberculosis and many more. They emphasized that at a point they had to offer antennal services outside the premise which also was not so conducive because of burns from the sun.

> *Look it hasn't been easy at all; this work is just by grace. This dumso challenge really really disturbed us. If you should come here in the mornings during that time, trust me it's so appalling.*

> *Everyone will be funning themselves. People coughing sneezing because they felt so much uncomfortable. This you should know easily transmits diseases. Now is better we hope it continues like this.* (Senior Midwife IDI)

This is related to a study, Nilsson et al (2013) explains that energy is one of the issues that enjoyed consensus, before and after Rio, as an important area for SDGs to address.

4.3.6.2 Delivery

Four midwives spoke about the challenge of the power crises during child delivery. They spelt out that especially during night time is challenging. They sometimes they would be delivering a child and suddenly the lights go of. They now have to resort to other devices such as torchlights lamps and many others. They emphasized this act could be very dangerous since this could lead to the death of the child.

> *It hasn't been easy during the power crises. We have a generator though but sometimes fueling it was so much expensive. Look at the size of the health centre and just look at this small generator here due you think it has something better to offer. Last year we had to use the torch light of the security man at dawn to aid in delivery process. You know how dangerous that can be. Sometimes we needed these pregnant women to go for labs and scans, but because of the power* outrages *they have to delay a sometimes access them some days after*.

4.3.6.3 Preservation of drugs

They similarly complained that the power outages affected them in terms of the preservation of drugs. They emphasized that most of the drugs are preserved in humid environment with extremely low temperatures. The inconsistencies of the power supply affected these drugs. Though they tried limiting the numbers that were being stocked, some of them could not withstand the harsh environmental conditions.

> *You see these power outages do not help us at all. Most of our drugs went bad. Others too couldn't perform effectively. Our air conditions were not put to use sometimes, because of they are mostly faulty.*

4.3.7 Religious Fictions

According to the midwives a major challenge that hindered the achievement of MDG goal 5 target 2 was the influence of religious and cultural beliefs. They said most pregnant women will like to resort to their religious or cultural beliefs instead of medical instructions given to them. Sometimes they combine both approaches which make it dangerous to their health care. They sometimes combine both traditional medication as well as the instructions given to them in the health centres. They complained that some patients do not believe in the transfusion of blood, caesarian sessions and many others. This is in line with thinking that maternal health of women is mostly managed by specific cultural settings. Similarly according to WHO (2005) pregnant women sometimes per instructions of their husbands and in laws are compelled to act even if these decisions or actions may be dangerous to their health.

> *Trust me you can't take away the cultural and religious fictions of these pregnant women. Some time back we needed to transfuse*

blood for one client but she refused. In fact some of us were even pleading for her to understand but she refused. She opted to resort to traditional medication for which it did not succeed; finally she was brought back to the health centre for emergency treatment. We could not handle it, we later referred her to Korlebu Teaching Hospital for further treatment. (midwife IDI)

I have to be sincere to you; I cannot do away with my religious and cultural belief. This child was given to me by God and hence I have to follow His precept. my religion tells me not to transfuse or receive blood from any one. I belief the God who created me will repair every any worn out tissue in my body. I wouldn't want to act smarter than him. (Pregnant woman, FGM)

Religious and traditional practices are barriers to maternal care utilization as evidenced by studies by Sackey and Sanda (2009) that some women do not assess to maternal health services due to religious perceptions to their health practices based on their believe that certain birth complications are best treated at spiritual centres.

4.3.8 Unethical behaviour of Midwives

A number of respondents from the focus group discussion stated that one major factor that hindered the achievement of MDG 5 is the attitude of midwives. Some pregnant women complained about the cold reception they received whenever they came for antenatal care. They further attitudes of midwives in service delivery especially during antenatal health care. They

sometimes scream at them, embarrass them anytime they default or made mistakes. Sometimes they complained that the mistakes they made were not deliberate and hence they expected the midwives to sympathize with them but it turns out to be otherwise.

Interestingly some of the health personnel's similarly commented on the attitude of some of the midwives , the complained that some of them were unapproachable and did not create a good atmosphere of convenience for the pregnant women. That pre supposes that these pregnant women do not feel oblige to visit antenatal health services.

> *Sometimes the way some of these midwives talk to us seems like we are kids. They scream at us any time we default. They are can be very impatient. Sometime back I was having some complications came to the health centre and they didn't attach any urgency to my plight. I was in serious pain and what they kept on telling me was to stop screaming and be matured am not the only pregnant woman in the world. I felt really weakened but I had to gather courage till they attended to be at their own convenience.* (pregnant woman FGM)

> *A number of midwives complained that the attitude of some of their colleagues were un called for. Though they complained about the pressure on the job. They sometimes behave unprofessional in terms of their attitude towards some pregnant women. They scream at them and sometimes embarrass them in the presence of the other clients. Some of them been cautioned so many times to manage their attitudes.* (Senior Midwife IDI)

A study by Mannava et al., (2015) indicates that negative behaviors and attitude are clustered into two dimensions. Negative interpersonal interactions between health providers and patient which normally encompasses verbal abuse, inappropriate communication as well physical abuse. Secondly negative behaviors of providers in terms of actual service delivery which is normally manifested as deficiencies in the availability of services, lack of privacy during patients care and the unwillingness of health providers to accommodate traditional practices.

4.3.9 Effect of TBA's

The district over the years has been challenged by the attitude of Traditional health attendants (TBA). A remark made by three health personnel's. Over the years this has been a major setback for the district. They emphasized the fact that some pregnant resort to the services of traditional health attendants. These attendants sometimes perform deliveries on unhealthy conditions which has severe implications on the women or the child. They complained that they have called them for training on several occasions but most of them turn deaf ears to them. On few occasions they visit them at their various places to equip them with extra skills and ideas, but they similarly refuse to take need to their counsel.

> *The services of the traditional birth attendants we can't say is not important, but their approaches of delivery have always been a problem. We have called them severally for free tuition but they never resort to our call. We sometimes send community nurses to them to give them assistance. They most often turn them away. We tried working it from the side of the pregnant women by telling them not to get involved in their services. They respond in affirmation but at the end they do otherwise.* (Midwife IDI)

Sometimes they opt for the services of the TBA's when they are referred to bigger facilities. Some of the pregnant women emphasized that the refuse to attend antenatal because their parents did not and that deliveries were most at times done by older women in the family.

This is affirmed by Ghebrehiwot (2004) stating that the influence of cultural believes disproportionately leads to low patronage of health facilities which leads to an upsurge of maternal mortality figures.

According to Salihu (2005) the rist assosciated with delivery by TBAs can be compounded by their inability to mobilize resources necessary to refer clients to health centres in case of emergency, delaying women from accessing life- saving interventions which increases the chances of death. Normally delivery at homes increases the chances of infections and whenever complications arose there were few options or approaches to handle them. Salihu (2005) further states that deliveries by TBAs is normally associated with conditions that are unhygienic and also some lack basic equipment's such as gloves.

In contrast some scholars such as Abalos et al., (2014) emphasize that TBAs play an important role in maternal health care. They are mostly trusted because of their roots in the community, their cultural knowledge and similarly their experiences in inequality, poverty and desease.

Perhaps another feature that should not escape analysis is the practice where medical personnel tend to treat patients unequally. Due to the huge numbers that turn up for delivery and given that medical facilities are not adequate to cater for all pregnant women, some medical staff use the situation to make cash demands from these women who find themselves in such conditions. The effect is that cash inducements now become the criteria for securing medical attention. Pregnant women who are unable to "grease the palms" of medical officers are neglected. Therefore some

pregnant women will resort to quack or unqualified medical centres and traditional homes were such cahs demands are not made or at least not envisaged.

4.4 The new approaches being employed to achieve the sustainable goals.

4.4.1 Introduction

The study explored the new strategies being employed by the district to aid in attaining the health agenda in the SDGs.

4.4. 2 Enforcement of a Pregnancy School

Pregnancy school was spelt out by three midwives during the indepth interview as a strategy employed to reduce maternal mortality. This strategy was in existence but was enforced in the last two years in the district. The midwives stated that the essence of this school was to educate the women on the essence of antenatal, dieting during pregnancy sex during pregnancy, hygiene and many more. Initially, they indicated that there was low patronage. Most of the women refuse to partake but with consistent advocacy and advertisement the numbers began to increase. They affirmed that this strategy has been very helpful. Most pregnant women attested to the fact that they were ignorant about most things and that the pregnancy school has been of immerse help to them.

> *During our antenatal we realized that most of the pregnant women were ignorant on labor signs dieting and many others. We enforced this programme was sustainable by organizing on a forth night basis. We normally start as early as 8:00am till 10:30am. Trust me this exercise has been fruitful. They report urgently when they encounter complications. Some of them invite other pregnant*

> *women for this school. The school serves as a forum for them to view their challenges and all questions bordering their minds* (Midwife IDI).

Most of the pregnant women in the focus group discussion spelt out how rewarding the pregnancy schools have been. They said they have been so much informed on how to manage their pregnancy in terms of hygiene, sex during pregnancy, and many more. They spelt out that they have been awaiting a forum like that to be educated. Especially with those who had challenges with reading and writing. They applauded the nurses for trying their best to educate them in about two local dialects.

> *I was able to know the stages of my baby's development on weekly bases due to images shown to us during the pregnancy school. I was also told the impact of certain activities such as carrying of heavy loads on the baby, Interestingly I was a culprit of that and I decided to desist from that practice immediately after I was educated*. (Pregnant woman FGD).

According to Hailu et al. (2014) a study conducted in Ethiopia reports that women who are educated in health care information are more likely to utilize institutional child birth services as compared to women who do not receive such information. Mpembeni et al., (2005) indicate that women who had knowledge of their pregnancy and its related complication were most likely to opt for facility delivery as compared to women who are ignorant about pregnancy and its related factors.

4.4.3 Focus antenatal

Focus antenatal stated by three midwives was a new approach employed by the district to aid effective maternal health care. According to the midwives the Ministry of Health (MOH) set new guidelines to enhance antenatal services, placing more emphasis on refocusing antenatal care, emergency preparedness, birth planning and identification, management and prevention of life threatening complications during pregnancy and childbirth. They further explained that ANC visits are instrumental by setting standards for a range of other health services, thus promoting comprehensive integrated service delivery.

According to the midwives each client has been assigned to a specific midwife. The midwife has to consistently follow up on the client periodically. They make numbers available and encourage these pregnant women to alert anytime they needed medical attention. Though this strategy was from the health directorate most hospitals were not employing them and it made it challenging to follow up on clients especially if they were not consistent during antenatal.

Practicing this strategy they said, has been very instrumental. They receive positive feedbacks, they sometimes visit their clients to examine them especially in their final trimester. Though some midwives complained that sometimes these clients abuse the opportunity by calls pertaining to the same issue which has been rectified, and sometimes it distorts their privacy, on the whole they believe it has been rewarding.

> *"Focus antennal has been good so far. This has really improved antenatal care. We are able to follow up on our clients especially when they do not report for antenatal; they receive prompt attention anytime they receive all forms of complications. As*

> *compared to the previous this year the health centre there has been a massive turn out for antenatal health care because of this strategy. Pregnant over the years don not feel stigmatized because of this practice."(midwife IDI)*

This can be related to a similar study conducted within two districts (Busia and Lugari) in Kenya by Birungi and Onyango-Ouma (2006) . The findings emphasized that the practice of focus antenatal helps in enhancing service delivery.

Pregnant women during the focus group discussion; they similarly commended the district for enforcing focal antenatal. They said they are now able to communicate with the midwives for prompt medical care and indeed that has been helpful. They are able to freely discuss challenges confronting their respective midwives which they believe it's comforting.

> *Madam this practice has been so helpful. I was called yesterday by my midwife to remind me for antenatal service today. Trust me I have forgotten. That's why you see me here today. Sometimes when I gave her excuses she will reschedule me for another day without getting furious. I promised her she will be the God mother of my child. She is indeed a gift to me*. (Pregnant woman, FDI)

On the other hand some of the pregnant women contradicted by saying that approach has not been so effective. Because on several occasions they try calling their midwives and they do not get through to them. Though they added that they would not say is deliberate or not but the whole idea was that it has wholly not been too effective.

I have to be frank with you. For me this strategy has not been effective enough. Anytime I call my midwife she never picks. I sometimes ask my husband for assistance to send her a message since am not good with these technologies. She doesn't respond. When I meet her for antenatal the response I get is I didn't see them. In fact she doesn't show any remorse. So frankly with me I found my own midwife somewhere else to be assisting me. Am tired of her.

4.4.4 Running 24-hour services

The districts, according to three head of facilities have introduced the 24-hour services for their clients. They believed that the district employed the strategy to improve maternal health care. Especially on occasions when women were in labor at night. Sometimes they had to deliver at hospitals that were totally new to them. They affirmed that this strategy has been helpful since initially clients preferred hospitals that offered the twenty four hour service. Theey also stated that this has induced more women enrolling in the health centre for antenatal health service. They were sure of delivering at the same place. During the focus group discussion most of the pregnant women said one reason for enrolling in the health centres within the district was the twenty four hour services they rendered.

The facility that was wasn't practicing the 24 hour services put two midwives on call on daily basis. The midwives interestingly spelt out the fact that on average they received most labor cases at night and hence the 24 hour service has been of immense help.

On three midwives complained that though the approach has been helpful, it has in a way increased their work load. They sometimes get home and they are suddenly called to attend to clients.

> *"we know the 24hour services have been very helpful. There have been massive turnover in respect to clients patronage. The only thing is because f our weak staff strength we sometimes get so much exhausted. Another thing is with my health center we do not have security person. And hence we are sometimes gripped with fear. We have confronted our heads about it on several occasions. We hope with your help they will respond to our plea.''(Midwife IDI)*

On the contrary a few pregnant women said the approach was not so effective because on several occasions anytime they came for medical care the evenings, some medical practioners were not around especially with the gynecologist. And hence they are asked to report the following day, or they will sometimes be admitted without any medical attention.

4.4.5 Involvement of community Nurses Services

Three midwives and reproductive health nurse spoke about the involvement of the community health nurses as a strategy to enhance reduce maternal mortality in the district. According to the midwives these nurses are assigned to specific catchment area. They major responsibility is to follow up on clients who came for antenatal in the district. The midwives affirmed that the strategy has been very helpful. The communities' nurses report the conditions of each client to the head of reproductive health and they further communicate to the midwives. Similarly they

visit TBA's to assistant with necessary skills and also they advocate for collaborating with the midwives at the various health centres.

> *There has been massive turnout in antenatal health care since the last year. The involvement of community health nurses has been very rewarding. Sometimes they are able to give first aids at during their visitations. The pregnant women have been very happy about this strategy. they always plead that we continue our good works.(reproductive health nurse IDI)*

This is in consonance in a practice in Yemen that aided in the reduction of maternal mortality. Over three- quarters of deliveries are outside the health facility by skilled birth attendants and community nurses. UNICEF hence intervenes in offering training for community nurses and midwives especially in the rural areas, and also partners with religious leaders and local authorities in making such initiatives very sustainable (MDG report, 2013).

4.5 Conclusion

Presentations of findings were presented in this chapter. The findings of the study generally indicate that, though the district is employing strategies to curb the challenge of maternal mortality it faces a lot of challenges. Despite several efforts to curb this trend the number of women who die from childbirth is still high. There are a number of medical and non-medical, direct and indirect causes that account for the maternal deaths in the region. Most of these deaths are preventable or in the least can be better managed. The medical and socio-cultural causes must be viewed side by side because they are significantly related. A critical issue that must be given significant attention is the mix of medical and non-medical causes. Further studies should be carried out to determine the exact relationship between the two and how they play out in the maternal mortality situation in the country.

The responses pertaining to the challenges that hindered the achievement of MDG goal 5 by participants in indepth interview were not different from that of the focus group discussion. Financial constraints, weak staff strength, illiteracy, religious fictions and effect from TBA'S were cited as the main problems that hindered the achievement of MDG Goal 5 In addition Inadequate logistics, poor attitude of midwives were however stated as challenges. For instance pregnant women who are engrained in their religious or cultural beliefs prefer to resort to the services of traditional birth attendants. Sometimes their services do not match the clinical standard which further complicates their situation.

It was also revealed in the study that the trend of maternal death in the district per the MMR is not a true reflection of the total number of deaths, since some labour cases that were complicated and were referred beyond the district facilities were not followed up to know their results. The study also unveiled some strategies employed by the district to curb the challenge of maternal mortality. Some factors stated include pregnancy school, involvement of community nurses, 24hour services and Focus antenatal. The respondents affirmed that these approaches have been helpful. For instance one respondent stated that the pregnancy school had given her much insight on how to manage her pregnancy. Interestingly she further stated that she is able to know the stages of her babies development on a weekly basis due to the images that were shown during the educative sessions. Also with the focus antenatal midwives are assigned a specific number of clients to follow up and monitor them during their pregnancy period. These approaches as mentioned by both medical personnel and pregnant women in the district have been helpful in curbing maternal mortality ratios in the District

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATION

5.0 Introduction

This chapter presents a summary of the key findings. It also provides useful recommendations. The implication of the study for health policy makers and academic research are highlighted.

5.1 Summary of key findings

The study sought to assess the challenges that hindered the achievement of MDG goal 5 in Ga focusing on South district. The study had the following objectives: assessing the trends and causes of maternal deaths in Ga South district factors that hindered the achievement of MDG Goal 5; and, identified some interventions or measures being employed to improve maternal health in the district.

The study employed a case study design with the use of qualitative methods. The use of indepth interviews and FGD were the primary data collection techniques used. The key informants interviewed included the deputy district director, facility heads and midwives from Ga South district. The review of maternal health archives in the district and MDGs report were the secondary sources of data used.

5.1.1 Trend of maternal deaths in GA South District

The study did a trend analysis from 2012 to 2017. The causes of maternal deaths in the district include illegal abortions normally associated with teenagers, pregnancy induced hypertension (eclapsia and pre eclapsia). There is an increasing trend of maternal deaths in the district. In the year 2012 and 2013 there were no maternal deaths recorded in the district. In the year 2014 two deaths were recorded whiles in 2016 the number shot up to three. Already by the first quarter in

the year 2017, one death has been recorded. This shows that for the past five years the trend of maternal deaths has been increasing within the district which contradicts the MDG goal 5 goals targeting the reduction of maternal deaths by 75%.

5.1.2 Achievement of MDG Goal 5 at Ga South district

The study also probed further to explore the factors that hindered the achievement of MDG goal 5 in the district. The findings reveal that one major hindrance in achieving goal 5 of the MDGs was financial constraint which affected the ability of the pregnant women to patronize some relevant drugs, go for scans as well as laboratory test. Some also stated transportation cost as a major setback and hence their ability to report for antenatal healthcare was highly dependent on their financial strength. Nurses similarly stated that some women due to their finances are unable to take nutritious meals to aid in the development of their babies as well as their own health management.

Adding to that nurses stated that illiteracy has been a major setback in reducing maternal health care in the district. Most of the women in the district did not know the essence of antenatal health care; they will wait till the final trimester before they report to the health facility which could lead to complications. Also women sometimes patronize wrong drugs and will not follow prescriptions given to them by the midwives or the doctors. Adding to that, some clients could not speak and understand the English language, hence midwives sometimes employ translators to assist them.

Weak staff strengthin the health facilities was one problematic area almost all respondents affirmed. The midwives especially complained about how they were pressurized, they combined both antenatal and labour roles due to their limited number.

A major finding was inadequate infrastructure and logistics in most health centres. Delivery rooms were very small and heads of some facilities complained of lack of delivery beds. Consequently most pregnant women complained about the absence of laboratory facilities in almost all the health centres. They had to travel a few miles for scans and laboratory test which complained as being hectic. Most of these laboratory centres were private owned and attracted higher fees than the government owned ones.

Energy crises in the past years similarly hindered the achievement of MDG goal 5 in the district. Most midwives complained bitterly about how the power fluctuations affected their service delivery. Especially at night when women were in labour they had to resort to substitutes such as lamps and torchlights. Sometimes when clients were supposed to go for scans there were delays due to the absence of power. It also affected the preservation of some of the essential drugs in the health facilities. Some health facilities had a generator fuelling it becomes a problem.

5.1.3 Mainstreaming SDG 3-Target 1 at the Ga South District

The study showed that despite the challenges encountered in the district in respect of maternal health , structures have been put in place to rectify the challenges to achieve the SDGs by 2030. Some of these interventions include employing 24-hour service which meant that women could seek for medical care anytime of the day. Some of the health facilities in the district had also introduced pregnancy school which aids in educating pregnant women about how to manage their pregnancies.

Midwives were assigned specific clients to attend to and follow up on their wellbeing. The clients were at liberty to call their respective midwives anytime they needed medical attention. Involvement of community nurses has been a tremendous remedy in curbing maternal mortality

in the district. The community health nurses follow up on women in their respective homes. Each community nurse was assigned a catchment area for which they attend to the clients and also offer first aids to them when needed. Community nurses collaborate with traditional birth attendants in terms of educating them on appropriate health measures.

5.2 Conclusions

From the research it could be inferred that Ga South District is faced with enormous challenges in the quest to improve maternal healthcare. Some of these challenges were associated with the clients while others were assosciated with the health facilities.

The issue of financial constraints has been a major hindrance in the quest to reduce maternal mortality in Ga South District. Health insurance has been helpful to pregnant women but it does not cover all health expenses such as laboratory test scans.There is a challenge of inadequate infrastructure and logistics that affected service delivery.

The environmental conditions under which most health facilities operate are not favorable. Poor ventilation accompanied with poor infrastructure and other supporting equipment have affected the quality of maternal health care. The absence of adequate infrastructure affects the delivery of quality products for the clients. Without adequate infrastructure, it will be difficult to practice policies and programs skewed towards the reduction of maternal mortality.

5.3 Recommendation

To improve maternal healt care, there is the need for skilled delivery,motivating health personnel, and increasing the coverage of health insurance.The study therefore recommends the following.

- Executing programmes and policies must include a strong human resource base. Health facilities should frequently provide training for midwives designed to enhance the full scope of maternal healthcare before implementation proceeds.
- Infrastructure and logistics must be improved to reduce maternal mortality. Government should skew resources to enhance health service delivery. Similarly there should be consistent monitoring and evaluations at the health centres.
- To ensure commitment is built in the respective health centres, team work must me encouraged. If midwives are treated as colleagues and not subordinates they will gather more confidence which will boost their self-esteem. Consequently it will enable them bring execute their best which will in the long run improve service delivery.
- Accommodation should be provided for health personnel such as midwives nurses, and laboratory technologists to help retain them in the district. Rewarding schemes for dedicated and hardworking staff should be instituted to encourage them put in their best.
- There must be outreach programmes in various communities within the district aiming at educating pregnant women on the need to resort to antenatal services, and also encouraging members of the community to resort to health facilities on time.

5.4 Implications of the Study for the SDGs and further Research

The study revealed some critical impediments to maternal health in the context of a developing country. The findings of the study has notable implications for policy existing literature further research.

5.4.1 Implications of the Study for existing literature on maternal mortality.

There have been numerous studies on issues relating to maternal mortality especially in the developing country. Most of such studies explored issues hindering the quality of maternal healthcare and the attainment of MDG goal 5 in developing countries. Challenges such as inadequate financing, human resource gaps and unfavorable policy enviroment were identified (Addai et al, 2006; Aseweh Abor et al, 2011; Fehling, 2013).

The renewed efforts in combating the problem of maternal mortality in the SDGs was recognized and in the context of Ga South district.

The failure of leaders to attain target like MDG 5 which has resulted in the stipulation of SDG 3-Target 1, which is to "reduce the global maternal mortality ratio to less than 70 per 100 000 live births" in 2030.

5.5.2 Theoretical Implications of the Study

The incrementalism theory is an acclaimed school of thought in the field of Public Adminstration. Incrementalism is adopted by scholars mostly to explain the origins of policy. This study employed the incrementalism theory to explain the formation of the SDGs as incremental policy based on the MDGs. This affirms the view of Loewe (2012) on the SDGs. Loewe (2012) cautioned that SDGs is likely to fail in achieving its target because it share substantial affinity with MDGs and the fear is that methods which failed to address the MDGs would be used for the SDGs.

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APPENDICES

APPENDIX 1

FOCUS GROUP DISCUSSION FOR PREGNANT WOMEN

I am an MPhil student from the University of Ghana Business School, and I am undertaken a research on ***from MDGs to SDGs and assessment of Maternal Health In Ghana A case Of Ga South District****. Informations to be provided will be considered as confidential and private. The study would not include your name. Taking part of this study has no risk involved. I will be very grateful in your answer these questions as objective as possible*

Position of Officer(s)…….....

Sex…….. Years of Experience……..

1. What is the essence of antenatal health care in the life of a pregnant woman?

2. Is the proximity of health centre conducive for pregnant women?

3. How do you access the health facility?

4. What is the motivation behind choosing this particular facility?

5. How does long distance travel hinder pregnant women from accessing health care during antenatal and labour?

6. How is the attitude of midwives towards pregnant women?

7. How does poverty or lack of financial assess hinder ones antenatal care, labour and postnatal in the life time of a woman in this district?

8. How do cultural and religious beliefs influence maternal deaths?

9. How do you describe the issue of maternal death in the Ga South District?

10.in your opinoion what do you think causes maternal deaths in the district?

APPENDIX 2

INTERVIEW GUIDE FOR THE HEAD MIDWIVES /NURSES

1. To what extent do the human resources for health and logistics in your facility complement your skills as a Midwife/ Nurse in the care of expectant mothers?

2. How does the lack of availability of care in health facilities contribute to the death of pregnant mothers?

3. What contribute to the delay of pregnant mothers in attending clinic during labour in your facility?

4. What are the main causes of maternal death in this facility/district?

5. What medical conditions do pregnant women report within your facility and what are you doing to remedy the situation?

6. What do you think can be done to improve the usage of antenatal care by pregnant women in your facility?

7. What do you expect the district health directorate to do to enhance maternal care in this facility?

8. In your own opinion how can the maternal health care services be improved in your facility?

APPENDIX 3

INTERVIEW GUIDE FOR THE DISTRICT DIRECTOR OF HEALTH SERVICES, DISTRICT PUBLIC HEALTH NURSE AND A PUBLIC HEALTH NURSE AT GA SOUTH DISTRICT.

1. How would you describe the issue maternal death situation in the Ga South District?

2. How resourced is Ga South district resourced with facilities to bring health care to the door steps of its people especially maternal health?

3. In your opinion how rich would you describe the human resource base in the district.

4. In your own opinion, how efficient is the national health insurance scheme in offering the financial access to all expectants mothers in the GA South district?

5. What would you describe as the main causes of maternal deaths in the district?

6. What are the challenges that hindered the achievement of MDG 5 in the district.

7. What strategies has the district health directorate put in place to improve upon maternal health in the district?

8. What cultural factors in your own view hinder the district in its quest to achieve the MDG 5?

9. In your own opinion, do you what do you think hindered the district in achieving MDG goal 5

10. What is the way forward in addressing the issue of maternal health in the district?

APPENDIX 4

INTERVIEW GUIDE FOR FACILITY HEADS IN GA SOUTH DISTRICT

1. How would you describe the issue maternal death situation in the facility?

2. How resourced is the facility in bringing health care to the door steps of its people especially maternal health?

3. In your opinion how rich would you describe the human resource base within the facility?

4. How would you describe the attitude of midwives?

5. How would you describe the workload on midwives?

6. How efficient is the facility in terms of availability of logistics

4. In your own opinion, how efficient is the national health insurance scheme in offering the financial access to all expectants mothers in the GA South district?

5. What would you describe as the main causes of maternal deaths in the district?

6. What are the challenges that hindered the achievement of MDG 5 in the district?

7. What strategies has the district health directorate put in place to improve upon maternal health in the district?

8. What cultural factors in your own view hinder the district in its quest to achieve the MDG 5?

9. In your own opinion, do you what do you think hindered the district in achieving MDG goal 5

10. What is the way forward in addressing the issue of maternal health in the district?