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Ensuring quality obstetric care in rural Ghana: Shared experiences of obstetric care providers

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ABSTRACT

Purpose: To explore care provider lived experiences with obstetric care delivery in rural Ghana.
Methods: This interpretative phenomenological study utilised a semi-structured interview guide to collect data on care provider lived experiences with obstetric care delivery. Participants comprised purposively sampled obstetric care providers in selected health care facilities in the Northern Region of Ghana. Data processing and presentation followed interpretative phenomenological analysis procedure.
Results: Findings reveal four superordinate themes: being persuasive, striving to provide quality care, using evasive mechanisms and subtle preventive schemes. These specifically refer to the use of alternative care, soliciting partner involvement, voluntarily donating blood, stocking essential items and drugs, refusing care in some instances and performing unconsented interventions.
Conclusion: In their quest to provide quality care, obstetric care providers in some of Ghana's rural health facilities adopt a mix of altruistic, innovative, excessive and unethical approaches most of which are driven by systemic failures. A government-community collaboration and commitment to quality maternal health care delivery is essential to improving health outcomes of rural mothers.

1. Background

Prevention of maternal and neonatal mortality is an integral component of the Sustainable Development Goals (SDGs). SDG goal 3, mandates countries to reduce maternal mortality rate to less than 140 deaths per 100,000 live births and a neonatal mortality rate to less than 12 per 1,000 livebirths by the year 2030 (UNICEF, 2019). Quality obstetric care is critical to the realisation of this goal (Koblinsky et al., 2016). Roemer and Montoya-Aguilar (1988) conceptualised quality in health care as the degree to which the resources or services for health care agree with specified standards that will generally lead to desired outcomes. Standard clinical guidelines for obstetric care delivery include the Standards for Improving maternal and Newborn care and the Service Provision Assessment, (ICF, 2017; WHO, 2016).

In most developing countries, resources for quality obstetric care are inadequate and services are often sub-standard (Filby, McConville, & Portela, 2016). This culminates in adverse perinatal outcomes (Petrites, Mullan, Spangenberg, & Gold, 2016). More-so, scarcity of resources notably drugs, equipment and personnel coupled with clients' non-cooperation in service delivery activities (Ayawine & Atinga, 2022), have often subjected obstetric care providers in Ghana to significant practice constraints in the care delivery process. As a result, providers often adopt strategies such as self-motivation, maintaining peer support network and interacting with loved ones to mitigate the stress associated with care delivery (Ismaila, Bayes, & Geraghty, 2021; Petrites et al., 2016). However, studies reporting these findings are mostly conducted in southern Ghana which has different social orientations and demographic structures from Northern rural Ghana (GSS, 2015). Additionally, the lack of resources for effective care delivery may be direr in rural Ghana (Adatara et al., 2021) yet not much is known about care providers' coping experiences in this regard. The objective of the study is to explore providers' experiences in relation to quality obstetric care delivery in rural Ghana in order to contribute literature to fill this important gap.

2. Methods

2.1. Study design

The study adopted a qualitative study design using interpretive

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phenomenological approach to examine health providers' experiences in the provision of obstetric care delivery between May and August 2019. The approach allowed for the collection of detailed data on health providers' shared experiences on service delivering gaps and the coping methods adopted thereof (Starks & Trinidad, 2007). The interest of interpretive phenomenology is to unravel the subjective meanings that participants attach to their world and it is usually achieved using few homogeneous cases (Willig, 2008). An Interpretative Phenomenological Analysis (IPA) is often deployed for data analysis and the approach acknowledges the investigator as an integral part of the meaning making process (Smith, 1996).

2.2. Reflexivity

The researchers approached the study both as insiders and outsiders. As insiders, the researchers are familiar with the study context. Additionally, the researchers undertook training workshops and coaching in the field of phenomenological research. As outsiders, the researchers are academics and have no fore knowledge in obstetric care delivery. The researchers are, however, aware of inadequate health infrastructure in rural Ghana.

2.3. Study area

Northern region is the second largest of Ghana's 16 regions in terms of land size. It is located at the North of the country and has about 16 districts which are largely rural (Sasu, 2023). The region was purposively selected for the study based on several considerations. Fertility rate at the time of research was 6.6, higher than the national average of 3.82 (GSS & GHS, 2017). This corresponds to a higher risk of pregnancy complications leading to poor maternal outcomes on some occasions (GSS, GHS, ICF, & MoH, 2018). The region is one of the bottom poorest in the country where health, economic and social problems severely constrain development (Cooke, Hague, & McKay, 2016). Most of the inhabitants are Muslims and polygamy is a common practice. About 70% of the population work in the informal sector, especially subsistence farming comprising cereals and grains cultivation (Amanor-Boadu et al., 2015). Agro-processing (shea butter extraction), meat production and petty trading are growing occupations in the region. Health care challenges in the region include inadequate skilled care providers and poor infrastructure (Centre for Health Information Management, 2017). Nonetheless, essential obstetric staff with varied years of experience (e.g beginning as a staff midwife and transitioning through the ranks to principal midwifery officer after 12 years of undisrupted service) strive to provide care in these challenging circumstances (Ameyaw, Amoah, Njue, Tran, & Dawson, 2020). It is prudent to investigate the experiences of these providers in rural facilities to aid in quality improvement efforts.

2.4. Sampling

Four community-based health centres and a hospital in the region were sampled purposively. A total of nine midwives and an Obstetrician Gynaecologist were further sampled from these facilities by means of convenience sampling. All four midwives managing selected health centres in communities were recruited into the study while the only specialist and five midwives were also sampled from the hospital.

2.5. Inclusion criteria

Obstetric care providers who had practiced for at least 3 years at the time of the study.

2.6. Exclusion criteria

Obstetric care providers who were on clinical rotation and those who had practiced for less than 3 years.

2.7. Data collection

A semi-structured interview guide (Smith, 1996) was used to gather data. Items on the interview guide included: Can you please tell me about your experience with obstetric care delivery in this facility? Do you have challenges with regards to quality care delivery? What are they, if any? How are you able to cope with these challenges? Do you think your clients are pleased with the quality of care provided? The guide was earlier piloted in related facilities and corrections made before final administration. Interviews were conducted in English and took place after close of work and at places of convenience to participants. The lead author conducted interviews largely employing prompts and probes to elicit detailed narratives from participants. Interviews lasted an average of 42 min and were tape recorded with consent from participants. Data saturation occurred when information provided became repetitive (Mason, 2010). Five persons who were earlier enrolled into the study, later declined participation for undisclosed reasons.

2.8. Rigour

Guba and Lincoln (1994), criteria for establishing rigour were ensued to enhance the trustworthiness of the study. These comprised credibility, transferability, dependability and confirmability. An adoption of member checking technique, where processed data were sent back to participants to ascertain if they were representative of their accounts ensured that feedback from participants was incorporated into study findings to promote the credibility of the study. An analytic framework was adopted to present thick descriptions and concrete details of events illustrative of provider experiences in the context in which they occurred. This was an attempt to ensure transferability of findings. Dependability and confirmability were achieved using an audit trail to enlist the steps involved in data analysis and the generation of themes in order to reduce researcher bias.

2.9. Ethical approval

Ethical approval for the study was obtained from the Ghana Health Service (GHS-ERC004/04/19) and the University of Cape Coast [UCC] Ethical Review Board (UCCIRB/CES/2019/03). Informed consent was received from participants to illustrate willful participation. Participants were further assured of confidentiality and anonymity of information through the use of pseudonyms.

2.10. Data analysis

Data analysis followed IPA (Smith & Osborn, 2007). First, the interview data were transcribed verbatim edited and checked for completeness. The lead author conducted the analysis which was thoroughly reviewed by the second author. Analysis was done in two phases: within and across cases. Within case analysis centered on analysing data on respective transcripts. The first author began the process by conducting thorough reading and thinking through the transcripts. This initial process allowed the researcher to familiarise with the data by jotting down comments and synopses evolving thereof on the left margins of all transcripts. These initial notes became the basis upon which conceptual themes were identified. Such themes were written on the right margins. Thereafter, themes were checked against the original data to derive sub-teams that shared a common idea with each major theme identified. Lastly, a summary table that primarily reflects health providers' lived experiences with care delivery was composed for each participant. This comprised major theme, sub-theme and illustrative quotes. In the cross analysis stage, each analysed transcript was checked against the other to identify common themes and any developing

themes. This was an iterative process that involved a back and forth movement across scripts to identify superordinate themes highlighting key shared experiences in obstetric care delivery. In all, four superordinate themes described the experiences of midwives in the delivery of quality obstetric care. Table 2 presents superordinate themes and subthemes derived from the coding process. Participants' names are replaced with pseudonyms in the presentation of results.

3. Results

Care providers' experiences and copings reflected 4 thematic areas notably the deployment of persuasive, conforming, evasive and preventive approaches. Table 1 contains characteristics of study participants while Table 2 is a summary of study findings.

3.1. Characteristics of study participants

Nine midwives and an Obstetrician Gynaecologist participated in the study. These were drawn out of a total of 25 midwives, two house officers and a Specialist who made up the target population at the study facilities. All the midwives held diploma in midwifery certificates from accredited institutions in the country and had practiced for an average of 6 years.

3.2. Being persuasive

3.2.1. Using alternative care

The findings suggest that, most pregnant women in the study area suffered low haemoglobin levels. This was attributed to poor feeding due to their low economic status. According to *Zuwera,* some clients also failed to take iron supplements given at ante natal clinic (ANC) to boost blood production. They claimed the medication had negative effect on them and their unborn babies:

> "…Some of the women are poor and don't feed well yet they don't take the ANC drugs we give them. One woman had all the drugs in her bags when she came to deliver…"

Care providers revealed that due to the uncompromising behaviour of clients, coupled with socio-cultural restrictions on feeding, during pregnancy, there were common events of pale and fragile looking mothers or newly delivered mothers being carted to the referral hospital, together with their low weight babies for medical intervention. Such women were immediately transfused putting lots of strain on the already insufficient blood bank. Care providers had to adopt another strategy to win the confidence of clients. A blood supplement in the form of ampoules was instead prescribed and this improved the health of mothers:

> "…Anaemia in pregnancy is endemic in the Northern Region and most babies are born with record low birth weight. We give them medications and they won't take so at some point I brought the Tothema (blood tonic) for them to take. They see it as tea; they don't see it as medicine so they take it…" (Abdallah).
>
> "…You know their culture too is a challenge to us. They place a lot of prohibitions on the pregnant woman in terms of feeding and these compound their health issues…" (Mina)

3.2.2. Seeking partner support

Care providers further disclosed that they encouraged pregnant women to visit the clinic with their partners in some instances to promote adherence to ANC counselling. Since most women suffered anaemia due to poor feeding, involvement of the partners got their attention not only to reinforce their wives' adherence to ante natal counselling on good feeding, but to provide the resources required for this to happen. *Abiba* intimated that some women could not relay messages to their partners as a result of cultural restrictions, hence midwives carried the additional responsibility of having to convince clients' partners to the hospital in a bid to solicit their co-operation:

> *"..When we realise that the lady is not receiving support from the partner, we ask them to come with the partner but they are unable to do this for fear of being rebuked. So we have to call the partner and convince them to the hospital then we educate the partner and some of them change after that…"*

3.2.3. Following up on complicated deliveries

Participants disclosed they sometimes followed up to the homes of women, who experienced complicated deliveries but failed to turn up for reviews, to see their state of health. They seized such opportunities to educate women nearby on the need to utilise skilled delivery and on time to prevent complications during delivery:

Table 1
Caption.

Characteristic	No.	%
Female	9	90.0
Male	1	10.0
Age		
20–29	4	40.0
30–39	3	30.0
40–49	2	20.0
50 and above	1	10.0
Rank		
Staff midwife	3	30.0
Senior staff midwife	3	30.0
Senior midwifery officer	3	30.0
Obstetrics and gynaecology specialist	1	10.0
Years in practice		
01-Oct	6	60.0
Nov-20	3	30.0
21–30	0	0.0
31–40	1	10.0
Female	9	90
Male	1	10
Age		
20–29	4	40
30–39	3	30
40–49	2	20
50 and above	1	10
Rank		
Staff midwife	3	30
Senior staff midwife	3	30
Senior midwifery officer	3	30
Obstetrics and gynaecology specialist	1	10
Years in practice		
01-Oct	6	60
Nov-20	3	30
21–30	0	0
31–40	1	10

Table 2
Summary of study findings.

Superordinate theme	Sub theme
Being Persuasive	– Using alternative care – Seeking partner support – Following up on complicated deliveries
Striving to Provide Quality Care	– Saving lives through blood donation – Being in it together – Stocking essential items – Stocking essential drugs – Improvisation of care – Practicing spirituality
Using Evasive Mechanisms	– Referral of critical cases – Switching career to avoid stress – Extending leave days
Adopting Preventive Schemes	– Unconsented interventions – Concerning high risk women

" …We personally go to some of the women who will not come for review to see their state of health and to educate those around on the need to come to the hospital to deliver to avoid complications…" (Bintu)

4. Striving to provide quality care

4.0.1. Saving lives through blood donation

The preservation of life also appeared very important to care providers. They employed all possible means to make this happen including blood donation in some threatening cases. They disclosed that though they educate their clients on birth preparedness and complication readiness, they (clients) most often failed to comply. As such, providers had to donate blood in some emergency situations when blood was required, yet there was none in the blood bank and relatives were reluctant to donate. *Asana* said the risk of losing a client at such moments made them to voluntarily donate blood to resuscitate women:

"There are times we donate blood ourselves to support women survival here because their relatives are either not at the hospital at the time or they are not ready to donate. Last year, a colleague donated for three different women, the fourth one, our boss stopped her. It was too much for her health…"

4.0.2. Being in it together

Providers also shared in the plight of women who came to deliver at the facilities. *Memuna* disclosed that they equate their challenges in the hospital to the long journey endured by some clients to the facilities to be delivered. Apparently, some women in labour dodged to the facilities because family members preferred home delivery. Such clients came to facilities without birthing items nor relatives. Also, some less privileged women came to deliver without the basic items. The feeling of *being in it together* made providers assume responsibility for such persons by feeding them, providing dresses for the newly born and taking over their hospital bills on some occasions:

"…Some of our clients dodge from their homes to the hospital to deliver because family members want them to deliver at home. Some are also poor. They arrive here looking very exhausted and with nothing. We contribute money from our meagre salaries and benevolent people around to prepare hot tea to assist them. We also pick dresses from other clients in the ward to support them and even pay their bills afterwards…"

In some other instances, clients who delivered at the hospital and were abandoned due to sex of baby or apparent misunderstanding with partner / family were taken home upon discharge to stay with a concerned midwife who continued to provide her health needs till the family was ready to receive them. According to them, their actions are borne out of solidarity with fellow women and to ensure a pleasant birthing experience. *Kate* shared her experience:

"…Once a lady delivered her forth baby girl and the husband abandoned her here. He said he preferred a male child. I took the lady home and continued to provide her with needed health care for two months before the husband came for her.…"

4.0.3. Stocking essential items

Although the National Health Insurance Scheme (NHIS) in the country provided for logistics and supplies, drugs and equipment, to facilitate care delivery, care providers indicated the Scheme did not ensure regular supply of these relevant resources and materials. For example, the beds lacked disposable mackintosh and midwives found the use of 'parazone' to clean beds for the next client, unhygienic. The use of cotton, as provided by the NHIS was also not suitable for estimating amount of blood loss during deliveries to determine blood transfusion. Also, they found the use of rags provided by clients for delivery related activities very unsuitable as it led to infections in most cases:

"…Instead of pad, some women bring rags. This time the infection is even better, somebody can bring rags and while tearing it you will be sneezing. Even one came with rags and when we removed it cockroaches were coming out of it…" (Zuwera).

Another provider justified their actions:

"…We no more get Tetanus these days because we use pad. We can easily estimate the blood lost from the pad but if you bring a rag or even a clean cloth, you can't estimate how much blood is lost and it makes the work very difficult for us…" (Bintu)

Due to the lack of essential supplies in health facilities, care providers devised means of accessing needed items by personally buying, keeping and using them, especially during emergency to arrest obstetric complications since a little more delay could lead to loss of life. Though clients were required to pay for or replace the items used on them, this appeared secondary. Some providers claimed, they were stuck to providing suitable care barring clients' ability to pay for the cost of items:

"… I personally had to pick some pads and a new cloth I bought while here, tear it and use on a client because she was bleeding and had no cloth and no one came with her. We want quality care…." (Samira)

This stance differed among participants. *Fati* indicated such an approach was unsustainable. She maintained that clients, who could afford, were required to pay or replace items used on them to keep stock running:

"…To be honest, we can't help all clients. Some will have to pay something or buy and replace so that it will be available for the next emergency…."

Lariba supported *Fati*'s stance:

"You see, those days that we recorded very high maternal deaths are gone. This time we are determined because when we record a maternal death and they come to audit, it appears as if we don't know our work. We appear stupid so we won't allow that to continue. If we need something and it is not there, client must support because we don't manufacture those things.

4.0.4. Stocking essential drugs

Health providers further kept to quality standards through the use of more efficacious drugs. They admitted that though oxytocin was the official drug for the treatment of Post-Partum Haemorrhage (PPH), which was the commonest obstetric complication in the region, they carried misoprostol with them because they claimed it was more efficacious than oxytocin. They administered it alongside oxytocin in extreme cases, to achieve best results after which client either paid for the cost of drugs or replaced it:

"…Both oxytocin and misoprostol are uterotonics but in extreme cases where the client is bleeding so much we give misoprostol. it will look like you use plenty meat to prepare soup, it doesn't spoil the soup. It is in extreme cases…" (Lariba).

4.0.5. Improvisation of care

Though providers committed to quality care, they sometimes had to improvise due to lack of essential equipment. For instance, the forceps was a rare equipment in the hospital. In emergency, episiotomy was

given instead:

"You use what you have to do the work because the real thing is not there…." (Asana)

Another form of improvisation was where providers tried to hasten care delivery using symbolic language instead of a telecommunication system. In the event of an obstetric emergency, a "pink" paper was attached to the concerned folder to signify emergency. According to *Zuwera,* this approach ensured that the folder received urgent attention at which ever unit within the facility to facilitate timely and effective care:

"…We attach a small pink sheet to the folder so that whoever sees this will know that this folder must be attended to urgently. Whether at the dispensary, OPD Lab everywhere you see it the folder should be treated with urgency…"

Moreover, in the event of an emergency, clients were carried in a pick-up car and supported on oxygen cylinder held by a midwife to the referral facility due to lack of fuel in ambulance and in most cases, the non-existence of ambulance in such facilities. Equipment were also sterilised through boiling instead of using an autoclave:

"…There are times we have to carry oxygen cylinders to support our clients in our Boss' pick-up because the ambulance is either broken down or there is no fuel in it…" (Abiba)
"…We don't have an autoclave so we boil our equipment instead…."(Mina)

4.0.6. Practicing spirituality

Participants further alluded that due to their low numbers, it was not possible to have two midwives on duty as recommended by standard practice. One midwife was on duty at a time and inexperienced midwives were charged to always call for help in times of obstetric emergency. This approach was effective only when midwives were within reach. In several instances where the few experienced midwives were not readily available, midwife on duty sought solace in God:

"…Sometimes you call and call, they will never pick up. When things become so difficult, we turn to God…" (Samira)

For *Bintu*, she prayed everyday against maternal death in her shift because of the trauma of losing a client and the stress of being subjected to an audit. She tried to give the best possible care amidst prayers, irrespective of the challenges and these experiences subjected her to extreme anxiety, nonetheless, the feeling of God's presence gave her hope:

"…For me, I am always praying that a woman doesn't die in my hands so I am extremely careful and God helps me…"

4.1. Using evasive mechanisms

Referral of critical cases

Participants also revealed referral of cases as a coping strategy. According to them, some parturients arrived at the hospital in a bad state. Accepting such cases, especially when the Specialist was unavailable, and not being able to succeed in care delivery, might end up with a maternal death that may further damage their reputation. Such cases were denied admission and relatives had to try the next facility by which time, it might be too late. This was contained in *Samira's* submission:

"…When we peep in the truck and the woman still has life, we try to help but if it will be a difficult one, judging from our circumstances here, we don't admit, unfortunately. We ask them to try the next facility…"

Their stance is backed by what they perceived as irresponsible acts from colleagues in neighbouring districts:

"…All our maternal deaths this year have been referral cases. The midwives at the other end are always referring bad cases to us under the pretext that doctor is not around and they come to soil our records here…." (Zuwera).

Switching career to avoid stress

The difficulties surrounding care provision made care providers to seek an escape route. *Memuna* mentioned that most of her colleagues left to school to acquire additional degrees that qualified them to teach in the health training colleges or even travel abroad to practice. This behaviour has often led to scarcity of obstetric staff in most health facilities in Northern Ghana:

"…For those of us in the North, the stress is unbearable so most of us ran back to school so that they can teach afterwards or be posted elsewhere. At the end, they enjoy their night sleep while we are here suffering to deliver women.

Extending leave days

The desire to provide good quality obstetric care and the lack of essentials to make this happen also compelled some midwives to take extended days off work. Some admitted they deliberately overstayed their leave with petty excuses and only returned to the workplace when the risk of losing the job was imminent:

"…Working here is so difficult. When I'm on leave I go to my parents in the South and I feel so happy but really sad when I have to resume work…' (Kate)

Abiba shared similar sentiments:

"…Working here is really hell. Everyone is always looking up to their leave period and some don't even come back till they are threatened…

4.2. Adopting preventive schemes

Unconsented care

Participants lamented that women in the study area generally did not use modern contraceptives for fear of losing their fertility. Accordingly, some women who presented at the hospital with life threatening complications and who survived Caesarean Section were sometimes provided with an additional Bilateral Tubal Litigation (BTL) service as a preventive measure. They were, however, informed only after the procedure had taken place. This is contained in *Mina's* quote:

"…We delivered a lady here and that was her 12th child. In fact, she nearly died through bleeding. So sometimes we just force to do BTL for our great grand multips to stop them…"

Unconsented care was also applied especially during emergency. In the event that emergency Caesarean Section was extremely necessary to protect life, this was done irrespective of clients' consent as health providers maintained their delay in granting consent compromised the life chances of the client and foetus. Seemingly, some clients and relatives resisted such interventions by refusing to grant consent which providers largely attributed to ignorance:

"…When we ask them to sign consent form for a Caesarean section, for instance, some refuse perhaps because they don't know the implication but we go ahead because the client may be in a critical situation and we wouldn't want to lose her nor the baby…" (Abdallah)

Concerning high risk women

It further emerged that due to the high fertility rate in the study area, providers tended to concentrate on high-risk women. Women regarded as great grand multiparous and those with histories of hypertension and post-partum haemorrhage usually received greater attention during labour and delivery at the expense of less threatening cases. Care providers seemed to lose sight of the unpredictable nature of obstetric emergency, by this approach, leading to some bad cases:

"…We tend to concentrate on high risk women such that we sadly lost a young lady here because we didn't realise she had obstructed labour and she died after surgery together with her baby.…" (Lariba)

5. Discussion

Obstetric care providers in rural Ghana face heinous challenges in the discharge of their duties (Adatara et al., 2021). The study sought to relay their experiences and the coping mechanisms employed to ensure quality obstetric care. The results reveal a mixed bag of strategies adopted by participants. They comprised the use of persuasion to promote adherence to treatment, an attempt to conform to best clinical practice and deployment of evasive tendencies to cope with the shortcoming of the health care system.

Participants in this study resorted to the use of persuasion as a strategic tool for ensuring compliance to care due to the perculiarity of the socio-cultural environment. In general, rural Northern women carry many more pregnancies than the average woman in urban Ghana yet they lack the resources required for a heathy pregnancy and a successful delivery (Cooke et al., 2016). They are also surrounded by unhealthy cultures and poverty that compromise positive maternal outcomes (Ganle, Dery, Manu, & Obeng, 2016). They thus carry a higher risk of maternal morbidity and mortality (GSS et al., 2018) yet they are less willing to adhere to clinical counselling on healthy motherhood. The deployment of alternative care, partner involvement and following up on complicated deliveries as coping activities undertaken by participants in this study suggest the ingenuity of health providers to influence circumstances outside the ward. This finding may be perculiar to this study as similar studies often report on coping strategies that relate to provider resiliency with regards to challenges in the work environment (Ismaila et al., 2021; Stabnick et al., 2022). The efforts displayed by participants reveal the extent to which providers in rural facilities commit to promoting maternal health. This is further reflected in the empathic nature of care provided. They exhibited empathy by providing free clinical and material supports to some less privileged women. This finding supports Aziato et al. (2017) and departs from the others that have cited health worker behaviour, especially towards the poor, as discriminatory (Bogren et al., 2020; Kanengoni, Andajani-sutjahjo, & Holroyd, 2019). Perhaps, the difference might be due to the fact that other studies captured events solely at the intrapartum period which might be a single phase of the entire childbirth experience. Empathic care has the tendency of attracting women to facilities to deliver (Vogel et al., 2015). While incentives may increase the spirit of commitment among care providers, the need for communal support in maternal and child health initiatives is critical in promoting the reproductive health of rural women.

Findings further depict that care providers engaged in several activities purported to decrease the risk of adverse maternal and neonatal outcomes. Such altruistic acts of voluntarily donating blood and the stocking of essential items and drugs were attempts by care providers to adhere to standard practice and to intervene timeously to forestall unpleasant outcomes. Similar preparatory measures were put up by midwives in another study to enable them cope with any adversity (Schack, Elyas, Brew, & Pettersson, 2014). Though the intent by participants in this study is good, the inability of some women to pay or replace used items may also serve as a disincentive for future patronage of care. (Dalinjong, Wang, & Homer, 2018). They may resort to alternative sources of care that may increase the risk of unpleasant consequences thereby defeating the purpose of the quality measures enforced in health facilities. It is suggested that health providers contextualise maternity care to commensurate with the economic ability of rural communities by adhering to the principle of efficiency. Using less expensive substitutes to achieve intended effect may promote financial access to quality obstetric care among rural women. Ironically, care providers failed to accept cases they felt were bad on arrival in order to dissociate themselves from imminent death. This contrasts with Nyande et al. (2021) finding where midwives only transferred less serious cases due to lack of space. The action of participants in this study may sound inappropriate since providers are required to provide best possible nursing care till the end of life (Petrites et al., 2016). Ignoring such a responsibility at a critical time makes one wonder about the place of nursing in midwifery. Conversely, their resolve might be due to the punitive nature of clinical audits following adverse outcomes (Cetin, Worku, Demtse, Melberg, & Miljeteig, 2022). It is imperative that clinical audits are conducted in a non-threatening manner to relieve health providers of the stress it conveys and to motivate them to provide best possible care in all circumstances.

Findings also show the use of unsolicited interventions as a preventive strategy to protect life. This conforms to earlier studies (Bohren et al., 2019; Vogel et al., 2015). Such a strategy may not only sound unethical, it defies the client's right to dignified and consensual care. Health providers may need to be guided by the principle of cause no harm and avoid obstetric violence by respecting the rights of clients during care delivery (United Nations General Assembly, 1948). Related themes on pursuit of further studies and extension of leave days appeared as escape mechanisms through which providers sought to exit from their challenging circumstances. This revelation is similar to Coldridge et al. (2017) finding among young midwives in England. Such actions place rural areas at a greater disadvantage as providers are less likely to return to such areas upon completion (Prytherch et al., 2013). It is essential for government and health authorities to ensure regular supply of needed items in rural facilities to facilitate service delivery and to retain essential staff.

6. Conclusion

Obstetric care providers in rural facilities face serious challenges providing quality care. They thus adopt a mixture of altruistic, innovative, excessive and unethical approaches in a bid to provide quality care. These actions have consequences on the health of rural women and the attainment of the SDGs on maternal health. A government-community collaboration and commitment in maternal health care are essential to improving health outcomes among rural mothers.

7. Implications for practice

Improving rural health infrastructure is very essential to reducing maternal and neonatal morbidity and mortality. It is critical that the government of Ghana pays attention to the health sector to reduce the burden of challenges experienced by care providers in rural areas to promote positive maternal outcomes. Care providers may be mindful of their call to service and the need to engage in appropriate conduct irrespective of challenges in the work environment. Community involvement in maternal and child health is equally desired to relieve mothers of the cultural restrictions that compromise their reproductive health.

8. Strengths and limitations

The use of a semi-structured interview guide enabled collection of wide ranging data that sufficiently represented providers' care delivery experiences, hence a major strength of the study. Nonetheless, the study drew evidence from experiences of care providers in rural Ghana. Though the findings may be similar in related settings, they may not be generalisable. The study was further limited to health staff within a particular time frame. It is possible that some information, including the views of clients, might be lost due to this restriction.

Author contribution

Alice Ayawine conceived of the idea, did the data collection and

analysis and wrote the initial draft of the paper. Roger A. Atinga reviewed the data analysis and contributed to the intellectual content of the paper. Both authors approve of the final draft.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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