DonnishJournals 2041-3164

Donnish Journal of Nursing and Midwifery
Vol 1(1) pp. 001-004 March, 2015
http://www.donnishjournals.org/djnm

Original Research Article

Constraints Associated with Access to Free Maternal Delivery in the Brong Ahafo Region of Ghana

[1]Reuben K. Esena* and [2]Clara Ohenewa Benneh

[1]University of Ghana, School of Public Health, P. O. Box LG 13 Legon, Accra, Ghana.
[2]University of Ghana, Institute of Continuing and Distance Education, P. O. Box LG 31, Legon, Accra, Ghana.

Accepted 6th February, 2015.

The Ghanaian government instituted a nationwide free maternal delivery policy in 2005 as a pro-poor strategy to enable women have access to quality maternal health services. The aim was to meet the Millennium Development Goal 5 which seeks to reduce maternal mortality ratio by 75 percent between 1990 and 2015 and to increase the percentage of births attended by skilled professionals from 40 per cent in 2005 to 60 per cent by 2015. The purpose of the study was to identify challenges associated with access to free maternal delivery. This study highlights the concerns of women who are direct beneficiaries of the policy. The study adopted a qualitative case study using focus group interviews with women from three districts in the Brong Ahafo Region in Ghana. Results from the study were analyzed using the Constant Comparative approach of grounded theory. The findings showed that challenges to free maternal deliveries include: costs of transportation, distance from health facilities, denial of dignity by health personnel in hospitals and cultural issues. Availability of information on free maternal health services to these women, and the inclusion of their views are crucial to addressing these challenges.

Keywords: Free maternal delivery policy, access and equity, skilled birth attendant, women's voices, reproductive rights.

INTRODUCTION

Models of access to maternity services show that where non-professionals, usually traditional birth attendants carry out deliveries, maternal mortality rates are extremely high and never falls below a hundred; but where deliveries are handled by professionals in well-equipped hospitals, the lowest mortality rates of all could be attained (Gerein & Green, 2006; WHO, 2004). Traditional Birth Attendants either trained or untrained are excluded from the category of skilled birth attendants (Chicanda, 2006).

In developing countries, maternal deaths is normally among women who deliver outside hospitals and these would have been medically preventable (UNFPA, 2007; WHO, 2004). The millennium Development Goal 5 seeks to provide at least 75 percent of pregnant women access to professional delivery care and to reduce maternal mortality ratio by 75 per cent between 1990 and 2015 and development goals are looking forward to a time where the world would be free of maternal deaths (WHO, 2005).

The use of Traditional Birth Attendants (TBAs) both trained and untrained still remain the source of service to most pregnant and nursing mothers. TBAs often operate in localities or communities where there are no midwifery services and they [TBAs] provide services by assisting pregnant women to deliver (MOH, 2004). Home deliveries still remain a prominent

Corresponding Author: rkesena@hotmail.com

feature among pregnant women in Ghana and it is estimated that about 60% of maternal deliveries take place at the home (MOH, 2004). The distribution of health facilities in Ghana portrays inequity in access between rural and urban areas. Urban localities generally enjoy good access to health compared to rural areas. Urban areas tend to have a relatively better concentration of health facilities and better road networks as well as other factors that enhance access (MOH, 2004). Access to health facilities in the rural areas, therefore, becomes a major challenge for rural inhabitants. These circumstances have negative implications for maternal morbidity and mortality.

The objective of this study is to find out the constraints associated with access to free maternal delivery in the Brong-Ahafo Region of Ghana. Specifically it explores knowledge of these barriers to skilled birth attendants, knowledge on complications, cultural issues and costs involved [direct and indirect costs]. These information are needed to inform policy on the appropriate strategies to address the free maternal delivery issues.

Ghana's Free Maternal Delivery Policy

The Safe Motherhood Programme was a prior initiative in Ghana to address the problem of maternal mortality, these initiatives focused mainly on preventive health care. In pursuance of furthering the goal to reduce maternal mortality, the Government of Ghana introduced an exemption policy directed at making maternal delivery care free. It was initiated first, in four regions with the highest prevalence of maternal mortality in 2003. The policy was later extended to the remaining six regions in 2005. The primary objective was to facilitate access to free and quality maternal care for all mothers. The free maternal delivery policy also aimed at helping to reduce the number of women and babies who die from preventable pregnancy and labour related problems. The thrust of the universal free delivery policy is to improve access to delivery care in health facilities, to reduce financial barriers to using maternity services thereby improving access to skilled birth attendance and reducing maternal mortality (MOH, 2004).

The policy covered antenatal, postnatal as well as skilled delivery at healthcare facilities. Specifically, the policy allowed mothers to access services from six free antenatal services, covered caesarean deliveries, two ultrasound services, three postnatal services and free care for the first three months of the baby's life. Other services included medical and surgical complications arising out of deliveries, including the repair of vesico-vaginal and recto-vaginal fistulae. Mothers were not expected to pay anything including premiums for their registration with the National Health Insurance Scheme (Quarcoe-Duho, 2014). The policy covered delivery services in public, private and faith-based health facilities.

Before the free maternal delivery policy, delivery costs tend to be lumpy and sometimes go up as much as 8 times a household's monthly income (Asante, Chikwama, Daniels, & Armar-Klemesu, 2007)**.** There were instances where women who delivered were unable to pay for the fee charged and were detained together with their babies in various hospitals (Netright, 2009). **S**ome health facilities had no option than to chase some women who had delivered at the health facilities for payment and in most instances had to contain some proportion of defaulters (Witter & Adjei, 2007). The launch brought about an upsurge of many pregnant women registering with the National Health Insurance Scheme (NHIS) as a lead up to enjoying free service at the various hospitals (Netright, 2009).

Some researches on the free maternal delivery policy have focused on evaluating effectiveness, successes and pitfalls of the policy (Witter & Adjei, 2007) while others tested the perceptions of health personnels on the policy (Witter, Adjei, Armar-Klemesu, & Graham, 2009). Other studies used confidential enquiry in hospitals based clinical case notes as well as patients case records to extract and test causes of maternal death before and after the policy (Bosu et al, 2007). Researches conducted outside the health services focused on surveys on the cost of maternal health care within households (Asante et al., 2007)**.** Some conclusions on researches on the free maternal delivery are worthy of mention. Ofori Adjei (2007) recognized the effects of the free delivery policy on increased utilization of delivery services.

Major gaps identified with the policy pertain to inadequate and irregular flow of funding which at certain point in time forced some hospitals to reverse to the collection of user fees. The policy has also been noted to have been characterized by administrative blunders with regard to clear lines of responsibility among various government machineries involved in implementation. Financial barriers such as cost of transportation remains one of the most important factors or constraints to seeking skilled care during deliveries identified**.** Other barriers to skilled delivery care identified included, long distances to health facilities, cultural and social barriers and preference for services of Traditional Birth Attendant (Asante et al., 2007; Witter & Adjei, 2007; Witter et al., 2009; Witter, Arhinful, Kusi, & Zakariah-Akoto, 2007).

Conceptual Framework

This research positions itself in the feminist and human rights perspectives. Feminists research aims at making women's voices and experiences visible. It advocates for policies and strategies to be conscious of ideas and knowledge that are consistent with women's experiences (Watkins, 2000). It has been explained that women's voices represent what women really feel and know and not what they are supposed to know and feel (Zabu, 2007). The study employs the feminists' stance to re-emphasize the need for inclusion of women's perspectives in the free maternal delivery policies. Moreover, making motherhood safer is one of the major themes in reproductive rights (ICPD, 1994).

The study advocates for the right of access to quality maternal health care services by every woman as human rights principles also seek to promote equity and dignity for all people. It is a human right abuse for pregnant women to die or experience poor quality health as a result of complications of pregnancy and childbirth. The study is therefore premised on the view that lack of access to quality maternal delivery services violates women's right to safe delivery and the highest attainable standard of health and to life and therefore efforts should be geared towards promoting women's right to safe delivery (UNFPA, 2004; Human Rights Council Resolution, 2009).

METHODS

The study was conducted in Akroforom in the Sene District and in the Dekyem in the Brong Ahafo Region. The districts and communities were randomly selected. The Brong Ahafo region was chosen because there are typical situations of chronic poverty in most parts of the Brong Ahafo Region of Ghana which has been ranked fifth in the hierarchy of the highest incidence of poverty after the three Northern regions and the Central Region (GSS, 2008).

A qualitative approach using in depth interviews was adopted to capture women's voices and viewpoint on the policy. The population for the study were the Techiman, Asunafo North and the Sene districts in the Brong Ahafo Region of Ghana. The study targeted and engaged women in focus group discussions in two communities from each of the three districts. The sampling technique was purposive, and focused on women who were in their reproductive age and have had deliveries when the policy was instituted. Seven members from each of the six study communities participated in Focus Group Discussions [FGDs].

Thus in all a sample of forty two [42] participated in the FGDs. The respondents were selected based on their willingness to participate. The interviews were tape recorded and transcribed. In the analysis, a qualitative approach associated with the constant comparative analysis which is used to sort, code and organize data according to key themes and emergent categories were used (Miles & Huberman, 1994). Keeping in mind the research questions, the raw data was read over a number of times to become thoroughly familiar with the key ideas emerging from the data. After key ideas were identified; the ones with higher frequencies were coded and organized into overarching themes. Themes are bulleted and supported with verbatim account by respondents. The discussion of the results involved descriptive and analytical discussions of the themes to arrive at interpretation of data and findings.

DISCUSSION OF RESULTS

The demographic profile of respondents presents the age, education and occupation of respondents. The profile is a useful way of identifying the background of respondents involved in the study. The age range for discussion was classified under human developmental categories of teenage, early adulthood and middle adulthood. Of the 42 women who took part in the focus group discussion, 29 were in their early adulthood and fell between the age range of 20-35 years. This age cohort is noted to be the best ages for childbirth and where fertility rates appear highest (GSS, 2008). Twelve [12] of the respondents were in middle adulthood, ages between 36-55, which falls within the reproductive age of women (GLSS, 2000).

Education is very critical to the improvement of livelihoods. The study showed that the educational levels of women in the study are low. In terms of educational attainments more than two thirds of (26) the respondents had, 5 had no education at all. 8 had education up to the secondary level and only three had tertiary education. Recent studies in Ghana demonstrate that education becomes beneficial only when a person can go beyond the basic level of education to complete senior secondary or have postsecondary education (Hashim 2007, Yeboah 2010). It could be inferred that the level of education of majority of the women would hardly serve them any useful purpose. The educational levels of women in the sample are consistent with the national statistics of lower female access to education or the higher drop out rate of females before and after the end of the basic level of education (UNDP, 2007).

Findings of the study indicate that only twelve [12] of the respondents were in formal sector employment, majority totalling thirty [30] were engaged in the informal sector, small scale trading enterprises and farming activities where they work to earn some sort of income. It has been argued that many women in Ghana are engaged in the informal sector because of lower educational background as the sector requires no formal education (Aduyame, 1999). Moreover, the results find support with surveys (GSS, 2008) which explained that informal sector, small scale enterprises and farming activities are dominated by Ghanaian women. In Ghana, the highest incidence of poverty is noted to be particularly evident among people involved in agricultural activities and micro and small scale enterprises which is characterized by low and irregular income. Majority of such people live below the poverty line and women are the worst affected (Wrigley-Asante, 2008).

Constraints in access to skilled birth attendants during delivery

The study did find out from respondents what could serve as a barrier for them for not having access to skilled birth attendants at the hospitals or delivering at the hospital. In the first instance, the responses by many of the respondents seem to give the inclination those women felt it was only critical to seek skilled birth attendant when one is having a first delivery and also when during pregnancies, women experience frequent illness. From the analysis of the responses, it was noted that most of the women ensured that at all cost their first time pregnancies are delivered at the hospital and more so when they experience critical illnesses during pregnancy. Most of the women seemed not to have the knowledge that complications could set in at any time during pregnancy, whether one is healthy or not and that the supervision of a skilled professional for every single delivery if highly necessary. Women being aware of such important information can also be a step in fighting maternal mortality.

Constraints and barriers identified in access to skilled birth attendants were mentioned as non availability of transportation, especially when labour sets in at night time and sometimes financial constraints with reference to the inability to afford the transportation cost to the health facilities. Again, emphasis was laid on not having money for the demands for some items made at the hospital from pregnant women during delivery. Women also mentioned short labour where childbirth occurs far earlier than anticipated. It has been recommended there is the need for provision of maternal waiting wards attached to all hospitals where women about to deliver are treated as in-patients and prepared for delivery to pre-empt any other problem that may restrain access (Stokoe, 1991; van Lonkhuijzen, Stekelenburg, & van Roosmalen, 2009).

Again respondents observed that up that most often the decision of not giving birth at the hospital was not by their choice but decided by other people and some women claimed they had very short labour. Examples of women's comments were:

- Indirect costs associated with hospital deliveries are barrier for pregnant women

> *People living in villages don't have access to hospitals and it is difficult to get transport especially during the night, even transport cost is a problem to many women.*
>
> *Women use traditional birth attendants as when they are constrained; sometimes they do not have the money for transport and are forced to use traditional birth attendants*
>
> *A pregnant woman may simply not deliver at the hospital just because she cannot afford the items she is supposed to bring along for delivery*

The women observed that they had great difficulty getting transport to hospitals during the night whenever they were in labour. Many researches accessed factors that served as constraints talked about geographical distance, but in this research the message was clear that women did not see distance as a barrier. In the interviews, none of them said the hospital was far from them, their emphasis was on availability of transport, especially during the night whenever labour set in. Therefore, in this case study, availability of transport in the night was identified as a strong determinant that restrained access to the of use of skilled birth attendants.

Financial constraints bordered on, the cost of transportation and the money to purchase items demanded by health personnel for delivery at the hospital. Women observed that even in urban communities transportation cost to hospitals still serve as constraints in access to skilled care during delivery. Access to delivery at hospitals related to items prescribed by nurses for pregnant women to carry along when they go for delivery. From their perspectives, many women cannot afford these items and as such decide not to deliver at the hospital. Investigations on the cost of hiring a taxi from the community to the hospital showed that costs could sometimes amount up to a maximum of $US 10.00 and the total cost of items such as sanitary and toiletries (soap, detergents, disinfectants, sanitary pad) demanded for delivery at the hospital could amount to a total cost of at least $USD 15.00. Looking at the background of respondents such costs would be very difficult to afford. It has to be noted that the free maternal delivery policy does not include non- facility costs (Mills, Williams, Adjuik, & Hodgson, 2008).

Their studies both concluded that in spite of the provision of the free maternal delivery other unofficial costs or indirect costs associated with delivering at the hospital pose major barriers to access to skilled birth attendance. Therefore, the Universal Free Delivery Policy was aimed at reducing financial barriers to maternity services to improve access to skilled birth attendance and reducing maternal mortality, indirect cost served as important sources for exclusion though institutional cost is free. The finding is confirmed by some studies (Witter & Adjei, 2007; Witter et al., 2009) that indirect cost as one of the most important factors or constraints to seeking skilled care during deliveries even with the implementation of the free maternal delivery policy.

CONCLUSION

- Women's views are important contribution to policy on free maternal delivery.
- Integrating women's perspectives in the free maternal delivery policy could be an effective strategy in increasing effectiveness and access to skilled birth attendance for accelerating efforts in achieving the targets set by the Millennium Development Goals on maternal mortality.
- Biometric registration under the National Health Insurance Scheme [NHIS] could facilitate instant registration to enable expectant mothers without NHIS benefit from the Free Maternal Health Policy.

RECOMMENDATION

There is the need to improve the skills of birth attendants and emergency obstetric care and made available to all women. In this respect, it is important to address issues that inhibit equal access on indirect costs and the attitude of health personnel concurs on equity, dignity and human rights issues.

REFERENCES

Aduyame, B. E. (1999). *Gendering Work and the Economy Domestic Work*. Paper presented at the 7th International Interdisciplinary Congress on Women at Tromso, Norway.

Asante, F., Chikwama, C., Daniels, A., & Armar-Klemesu, M. (2007). Evaluating the economic outcomes of the policy of fee exemption for maternal delivery care in Ghana. *Ghana Medical Journal, 41*, 110-107.

Chicanda, A. (2006). Medical leave: The exodus of health professionals from Zimbabwe. cited in: G. G. Grown, G. Caren, E. Braustein and Malhotra, A. (2006). Trading women's health and reproductive health in developing economies. London: Zed Books.

Gerein, N., & Green, E. (2006). *Midwifery and nursing migration: Implications of trade liberalization for maternal health in low income countries* [Eds. Braunstein, E. and Malhotra, A]. Trading women's health and reproductive rights? Trade liberalization and reproductive health in developing economies. London: Zed Books.

GSS. (2008). *Ghana living standard survey: Report of the Forth and fifth Round* Accra: Ghana.: Ghana Statistical Service.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source-book*. Thousand Oaks, CA: SAGE.

Mills, S., Williams, J. E., Adjuik, M., & Hodgson, A. (2008). Use of health professionals for delivery following the availability of free obstetric care in Northern Ghana. *Maternal and Child Health Journal, 112*(4), 509-518.

MOH. (2004). *Guidelines for implementing the exemption policy on maternal deliveries*. Accra: Ghana: MOH/PPME-59.

Netright. (2009). *Compilation of a yearly review on the status of women in Ghana*. Accra North.

Quarcoe-Duho, R. (2014, Thursday, May 22, 2014). Korle-Bu detains 12 nursing mothers, despite free maternal care policy: Minister intervenes, p. 45.

Stokoe, U. (1991). Determinants of maternal mortality in the developing world. . *Aust. New Zealand Jounal of Obstetrics and Gynaecology, 31*(1), 8-17.

UNDP. (2007). *The Ghana human development report. Ghana Offic*. Accra: Ghana: Combert Impressions.

UNFPA. (2007). The Ghana human development report. Ghana Office

van Lonkhuijzen, L., Stekelenburg, J., & van Roosmalen, J. (2009). *Maternity waiting facilities for improving maternal and neonatal outcome in low-resource countries*. Groningen, Netherlands, 9700 RB.

Watkins, G. (2000). *Feminist theory and practice: From margin to centre*. Cambridge.

WHO. (2004). *Maternal mortality in 2000: Estimates developed by WHO, UNICEF, UNFPA* Geneva.

WHO. (2005). *World Health Report. Making every mother count.* .

Witter, S., & Adjei, S. (2007). Start-stop funding, its causes and consequences: A case study of the delivery exemptions policy in Ghana. *International Journal of Health Planning and Managemen, 22*, 133-143.

Witter, S., Adjei, S., Armar-Klemesu, M., & Graham, W. (2009). *Providing free maternal health care: Ten lessons from an evaluation of the national delivery exemption policy in Ghana*.

Witter, S., Arhinful, D. K., Kusi, A., & Zakariah-Akoto, S. (2007). The experience of Ghana in Implementing a User Fee Exemption Policy to Provide Free Delivery Care *Reproductive Health Matters, 15*(30), 61-71.

Wrigley-Asante, C. (2008). Men are poor but women are poorer: Gendered poverty and survival strategies in the Dangme West District of Ghana. *Norwegian Journal of Geography, 62*, 161-170.

Zabu, C. (2007). *Between rites and tights: Excisions in women's experiential texts and human context*. Stanford University Press.