UN SDG 3.1: International Partners and Ghana's Interventions on Maternal Healthcare

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Abstract:
The main aim of the study is to analyze the role of global partners and the government of Ghana's efforts toward achieving UN SDG 3.1. It specifically examines the effectiveness or otherwise of policy interventions of Ghana toward achieving SDG 3.1 by 2030. The health of mothers is crucial as states are taking appropriate measures and interventions to reduce maternal death to the barest minimum globally, in Africa, and Ghana. Maternal mortality is a global public health issue that has been at the center of global health. States' efforts toward achieving the target to reduce maternal mortality as part of the MDGs were not reached or achieved. Thus, the UN SDGs were adopted in 2015. SDGs particularly Goal 3.1 calls for interventions by governments to reduce maternal mortality globally. A qualitative design was used in this study in which data was obtained largely from in-depth interviews, a few FGDs and official document reviews. The researchers also utilized secondary data sources largely from books, journal articles, and internet sources. The data were analyzed through content analysis. The findings from Ghana revealed maternal mortality is largely due to obstetric causes, as such Ghana adopted rigorous interventions to address the problem. Some maternal health intervention gaps or some challenges were found which impeded the quality and access to maternal health services in Ghana. It recommends an improvement in mothers' access to emergency obstetric care and intensive education on maternal healthcare among others towards achieving SDG 3 by 2030.

Key words: UN SDG 3, maternal healthcare, international development partners, Ghana

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https://dx.doi.org/10.4314/ajmr.v31i1.3

Introduction

The study aims to analyze the role of global partners and the government of Ghana's efforts toward achieving UN SDG 3.1 (maternal mortality) by 2030. For this reason, it specifically examines the effectiveness or otherwise of Ghana's policy measures/strategies or interventions toward reducing maternal mortality by 2030. The study shared perspectives of healthcare workers (midwives/policy experts among others) on the efforts of international partners and Ghana toward the global agenda.

The World Health Organization (WHO) defines maternal health as "the health of women during pregnancy, at childbirth and the postnatal period" (WHO, 2021). Part of the human rights of women is the right to go through pregnancy and childbirth safely and this was first made clear in the Program Action of the United Nations International Conference on Population and Development in 1994 (Gruskin et al., 2008). Maternal health is regarded as a domestic issue however during the late 20th Century it was accepted globally as a public health issue (WHO, 1948, 2005). Maternal healthcare gained some international attention following the article "Where is the 'Maternal' in Maternal and Child Health". As it dealt with issues of the exclusion of women in maternal and child health programs. Over the years, the international community focused more on child healthcare than maternal healthcare (women). Global efforts to improve the health conditions of women and reduce maternal mortality brought about the Safe Motherhood Initiative following the International Conference on Safe Motherhood which took place in Nairobi in 1987. The conference called on the UN member states to improve the health conditions of women and particularly reduce maternal deaths (Gruskin et al., 2008). Also, the Safe Motherhood Initiative was adopted by various international agencies, governments and international non-governmental organizations (INGOs). This initiative highlights maternal health conditions and finding solutions to maternal mortality and morbidity by half by 2000. This was not achieved however it played a notable role in the introduction of policies regarding maternal health (Kyei-Nimakoh et al., 2016). In addition, the Safe Motherhood Initiative revealed the public health gap between rich and poor countries (Gruskin et al., 2008).

In 2000 the UN Millennium Summit led to the launch of the Millennium Development Goals (MDGs). The MDGs aim to address poverty, hunger, education, gender equality and diseases. The MDGs consisted of eight development goals to be attained by 2015 (UN, 2015). The Millennium Development Goal 5 focused on reducing the rate of maternal mortality by 75% and achieving universal access to reproductive health by 2015 (Kyei-Nimakoh et al., 2016). At the end of 2015, although there was significant progress towards achieving MDG 5, the progress was uneven, especially in Africa and other least-developed countries with the target of reducing maternal mortality (Moran et al., 2016). Maternal mortality remained high with about 303,000 maternal deaths annually with sub-Saharan Africa and Asia recording the highest (Moran et al., 2016).

The sustainable development goals (SDGs) which are also known as the Global Goals were launched in September 2015 by United Nations member states to replace

the MDGs. The SDGs' are the global call for action geared towards the eradication of poverty and hunger, the protection of the planet and ensuring that all people (persons) enjoy peace and prosperity among others (United Nations, 2015). The SDGs consist of seventeen (17) goals which are to be realized by 2030. The SDGs also have 169 targets whose progress will be tracked with 232 indicators. The theme of the SDGs is ensuring that "no one is left behind." These goals and targets emerged from intergovernmental negotiations and proposals from the Sustainable Development Goals Open Working Group. This global agenda aims at building the MDGs and also completing what was not realized by the MDGs, especially, reaching the most vulnerable (United Nations, 2015). These global goals are to be implemented on national, regional and global levels taking into consideration the various capacities and levels of development of states as well as national policies (United Nations, 2015). With a vision of a world where "every pregnant woman and newborn receives quality care throughout pregnancy, childbirth and the postnatal period", WHO together with country stakeholders, United Nations (UN) agencies and other development partners came up with a global agenda to improve maternal health. This global agenda was focused on 'targets and strategies to end preventable maternal mortality' and was eventually incorporated into the SDGs (WHO, 2015b). The UN SDG 3 aims at ensuring that all persons of all ages enjoy good health. Within this goal is the target to "reduce the global MMR to less than 70 deaths per 100,000 live births by the year 2030" (WHO, 2015c).

International Development Partners support for Ghana toward achieving SDG 3.1

Maternal mortality is an issue of global concern and Ghana has made efforts to decrease maternal mortality. Ghana's health sector is supported by several international development partners like WHO, UNFPA, Japan International Cooperation Agency (JICA), USAID and the Korea International Cooperation Agency, Africa CDC and US CDS among others (MoH, 2020; Adams, Attuquayefio & Kipo-Sunyehzi, 2023). Support from these international health partners is mainly in the form of technical and financial assistance which helped Ghana efforts at maternal healthcare. The German government has provided substantial support for maternal child healthcare (MCH) in Africa and Asia through Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) toward reducing maternal and child mortalities, especially in improving quality of MCH in the two regions (Goyet, Broch-Alvarez & Becker, 2019). Also, Germany and some G8 countries as part of their support and commitment to countries where maternal and childcare mortalities are not reduced came up with the initiative termed "G8 Muskoka Initiative" with a $5 billion fund for 2010- 2015. The international fund established by the G8 countries was used to support maternal, newborn and child healthcare services across Africa and Asia, particularly the least-developed countries. At the bilateral level the bilateral cooperation agency, the United States of America (USA)'s Agency for International Development (USAID) has also established several bilateral relations with countries in Africa and other regions in the context of supporting material and childcare programs with

several countries in the global south (Dieleman et al, 2016; Goyet, Broch-Alvarez & Becker, 2019)

The government of Ghana supports the health Sector toward achieving SDG 3.1

On the national level, countries are to "reduce their maternal mortality ratio (MMR) by at least two-thirds from their 2010 baseline" and "no country's MMR should be higher than 140 deaths per 100,000 live births" (WHO, 2015c). Ghana like all other UN member countries have put in place strategies and efforts towards decreasing maternal mortality and increasing maternal healthcare support policies or programs to realize or achieve the SDGs. Also, following the implementation of the SDGs, Ghana has incorporated these goals into their various policies to see the realization of the SDGs. Maternal mortality accounts for the second leading cause of female mortalities in Ghana. Between 540 and 650 women per 100,000 live births were estimated to have died before the year 2000 (Adua et al., 2017). The antenatal care policy and the Safe Motherhood Initiative were among the policies put in place by the Ghana Health Service (GHS) to address the issue of high mortality ratio. These policies of Ghana are put in place toward the reduction of maternal mortality and improvement in maternal healthcare. However, it appears such policy interventions or programs have had little effect on the challenge of maternal mortality. Also, Ghana introduced a free maternal healthcare policy for pregnant women. The adoption of a fee exemption policy in September 2003 by the Ministry of Health (MOH) in Ghana to address the problem of financial constraints that inhibited access to skilled maternal services. This noble Ghana's health policy intended to increase child deliveries in health facilities (clinics/hospitals among others). Also, the health policy aims to ensure deliveries are attended by skilled attendants and ultimately to reduce maternal mortality in Ghana (Penfold et al., 2007;)Biritwum, 2006). Some studies in Ghana accessed the impact of the free maternal health policy (exemption policy). Penfold et al. (2007) in the Central and Volta Regions of Ghana showed there was a significant increase in facility-based deliveries. This was evident among less educated and poorer women. In July 2008 there was the introduction of the Free Maternal Healthcare Policy by the National Health Insurance Scheme (NHIS) of Ghana. The government of Ghana in both the design and the implementation of the (NHIS) in 2003 have some special provisions for pregnant women (Kipo-Sunyehzi, 2021; Kipo-Sunyehzi & Yakohene, 2023). Even before the introduction of the NHIS in Ghana, there was a policy introduced by the government of Ghana to exempt women in the Northern, Central, Upper East and Upper West Regions from delivery fees. These four regions were considered the poorest regions in Ghana (Singh et al., 2015). All these policies contributed to a decline in Ghana's maternal mortality and an improvement in access to maternal delivery services. Although maternal mortality remains high, Ghana has seen much progress in the area of maternal health as compared to other states in West Africa (Adua et al., 2017; Fenny et al, 2019).

The Situation of Maternal Healthcare in Ghana

Maternal deaths occurring in developing

countries within Sub-Saharan Africa and South Asia was estimated at 99% in 2008. The MMR of Ghana was 451 per 100,000 live births in 2008. Although this was lower as compared to figures from neighboring countries, it was higher than the global estimation (Der et al., 2013). Studies show that Ghana saw a decrease in maternal mortality from 719 to 319 maternal deaths per 100,000 live births between 1990 and 2015 (Apanga & Awonoor- Williams, 2018). Although this was a significant improvement, the rate of maternal mortality was high thereby resulting in Ghana's inability to achieve the MDG 5A. (Adua et al., 2017). In addition, comparing the maternal mortality estimates of Ghana as of 2015 to those of developed countries such as the United Kingdom, the United States, and Germany which had maternal mortality rates of 9/100,000, 14/100,000 and 6/100,000 respectively (WHO, 2015c). Ghana in its quest to ensure the improvement of maternal health and a decline in maternal mortality has over the years adopted various strategies and policies. One key policy implemented by the government of Ghana was the Free Maternal Healthcare Policy under the NHIS in July 2008 (Dalinjong et al., 2018). This health policy was implemented by Ghana to achieve MDG 5. From 2015 onward, Ghana's focus has been more on achieving the UN SDG 3.1 which is reducing maternal deaths. Under this policy, pregnant women are allowed to register for the NHIS for free. This policy allows women to enjoy healthcare services during pregnancy, at delivery and then three months postnatal healthcare for free - without payment of cash across Ghana (Dalinjong et al., 2018). Also, the policy covers normal deliveries, caesarean section as well as complications associated with delivery (Singh et al, 2015;Adua et al., 2017 ;Wang, Temsah, & Mallick, 2017).

Despite these health policies and other interventions toward improving maternal healthcare services in Ghana or curbing the challenge of maternal mortality in Ghana, maternal mortality remains high. The maternal mortality estimate of Ghana was 308 maternal deaths per 100,000 live births in 2017 (WHO, 2019b). However, with 308 maternal deaths per 100,000 live births, the MMR of Ghana remains high in comparison with the country target for SDG 3.1 which indicates that the MMR of countries should be not higher than 140 maternal deaths per 100,000 live births and the global target of 70 maternal deaths per 100,000 live births by 2030 (WHO, 2015c). The information suggests Ghana's move toward achieving the global target looks quite far to achieve. Therefore, this research seeks to analyze the factors accounting for the high rate of maternal mortality in Ghana and various measures that have been put in place to achieve SDG 3.1 by 2030.

Methods and Materials

Research Design

A research design communicates a proposed type of research used, the mode of collecting data, the selection of participants and the methods or means of analyzing the data collected from the field, be it qualitatively (words/text) or quantitatively (figures/statistics) or mixed (Ranjit, 2011 ; Arghode, 2012; Kipo, 2014; Morgan, 2017). In this study, the researchers used a qualitative research design. The reasons include obtaining key information based on the shared views of participants, feelings, opinions and participants' experiences about the social phenomenon under investigation,

information obtained from participants' natural setting with an accurate 'measure' of reality (Cresswell, 1999; 2014; Arghode, 2012). Also, using qualitative research design enabled the researchers to collect, analyze, and report the findings along with the interview questions (Creswell, 1999). Moreover, the qualitative design allowed the researchers to obtain first-hand information from the life experiences of the study participants (Ranjit, 2011). Thus, it helped the researchers to understand the problems, opinions, and situations on the ground very well or better. Moreover, the qualitative research design enabled the researchers to collect data from multiple sources toward data triangulation through the use of in-depth interviews (face-to-face), documents and the use of direct observations instead of relying on a single source of data (Creswell, 2014).

Sampling Method and Sample Size

The study setting was greater in Accra with the target population of health workers especially those who provide maternal healthcare services (clinicians) at the point of service delivery hospitals, and experts (health policy designers/makers) at the MoH, GHS. A sample of the population was used.

Practically, the entire population (health workers Greater Accra Area and Tema Metropolis) cannot be studied thus there is a need for a sample which is a subgroup of the population was chosen to represent the entire population (Banerjee & Chaudhury, 2010). The researchers used a non-probability sampling method (Acharya et al., 2013). The reasons for using a non-probability sampling technique are aimed at reaching out to some specific health workers based on the kind of healthcare services they provide in a particular healthcare facility (hospital). In this case, some medical doctors like gynecologists, as well as midwives, were purposively selected for interviews. Apart from the kind of services they provide at a healthcare facility, the researchers also considered expertise. This was based on knowledge a particular health worker possesses based on profession or as an expert in an area like health policy or based on experience (Etikan et al., 2016). For this reason, some experts were selected from the Ministry of Health and Ghana Health Service within the Greater Accra Area and Tema, all in and around the capital of Ghana (Accra). Also, some participants provided clues or directions or contacts for other participants. The snowball sampling technique was used to reach out to other relevant participants. Thus, the purposive and the snowball non-probability sampling methods were used (Lavrakas, 2008; Acharya et al., 2013).

The justification for the use of the purposive sampling method was to enable the researchers to select midwives who had been practicing for three years and above as an inclusion criterion because of their experiences in maternal health over the years. Medical doctors were purposefully selected as they also had an active role to play in maternal health interventions. Officials of the Ministry of Health (MoH) were selected because of their knowledge, experience and role in the implementation of health policies and programs. Also, the UNFPA staff were purposively selected because of their involvement in maternal healthcare in Ghana. The Korle-Bu Teaching Hospital was selected because it is a main referral hospital located in the Greater Accra Region (Greater Accra Area)

and the views of its officials are crucial. In Tema Metropolis, the Bethel Hospital was chosen. The reason that it is the main private health facility that offers maternal healthcare in Tema Metropolis.

On the rationale for the researchers' choice of snowball sampling method, the snowball sampling method was used because the information was obtained from other participants that the researcher in the field could not envisage but based on the recommendation of others such participants were eventually interviewed in the study.

The total sample size was 16 participants. The reason for this relatively small sample size was for effective management of the interviews and to be able to analyze the responses properly. The argument is that sample large qualitative sample size may be hard to manage well. As Boddy (2016) recommends that a sample size of over 30 in a qualitative is too difficult to handle and analyze. Not too small a sample and not too large the sample size (Onwuegbuzie & Collins, 2007). Thus, the reason why the researchers chose a qualitative manageable sample of 16 participants. The study sample size and the categories of participants that were interviewed are in Table 1.

Table 1, the justification for the large number of policy implementers (14) clinicians/street-level bureaucrats namely the midwives and the medical doctors at the two hospitals (Accra/Tema) against policy experts/makers (2) was based on the argument that in policy studies it is the frontline workers (bureaucrats) in the field who determines the success or the failure of a public policy including health policy. Also, it is argued that the frontline workers are the "actual policymakers" but not those in parliament or government offices (Lipsky, 1980; Kipo-Sunyehzi, 2020).

Data Sources

Data was collected from primary sources, namely interviews, documents, and direct observations. In-depth interviews were carried out with medical practitioners/clinicians like midwives and medical doctors from the Korle-Bu Teaching Hospital in Accra and Bethel Hospital in Tema, all in Ghana. Also, information from officials of the Ministry of Health (health policy expert/maker) and the United Nations Population Fund (expert) was useful to this study. The researchers used open-ended questions for the in-depth interviews and focus group discussions with midwives. The data collection instrument used was an interview guide in the form of open questions. This instrument helped the researchers to elicit meaningful information from the participants. Also, the researchers had the opportunity to probe the responses given by the participants (Stuckey, 2013).

The secondary data sources used include journal articles, books, and internet sources among others (Hox & Boeije, 2005). The researchers largely obtained secondary data from annual reports, policy documents and official documents from organizations like Ghana Health Service (GHS), Ministry of Health (MOH), World Health Organization (WHO) and other United Nations (UN) specialized agencies such as the United Nations Population Fund (UNFPA).

Table 1 Categories of Participants and the Sample Size

Categories of the Study Participants	**Number of Participants**
Midwives in the two hospitals (public and private)	12
Medical Doctors in the two hospitals (public and private)	2
Ministry of Ghana, Ghana Official (health policy expert)	1
United Nations Population Fund (UNPF) Official	1
Total	**16**

These multiple sources of data enabled the researchers to get relevant and adequate information to answer the research questions/ objectives which could not have been collected using only interviews (Creswell, 2014).

Data Collection

Interviews: Semi-structured interviews were used to collect data from medical doctors and officials from GHS and others from MoH and UNFPA. The interviews were conducted using an interview guide with open-ended questions and responses of participants were recorded with the help of an electronic device with permission from the participants. Those who declined interview recordings and handwritten notes were taken as part of the data collection strategies that were used in the study field. The answers of participants determined the direction of the interviews (Stuckey, 2013).
Focus Group Discussions (FGDs); The researcher who conducted the interviews (J. E.) organized focus group discussions in which the interviewer/researcher served as the moderator, and then asked participants specific questions about the phenomenon under investigation (maternal healthcare) The FGDs allowed for the members (group participants) who know a particular issue exchange ideas and opinions (Wong, 2008). Data was collected from midwives using FGDs, two FGDs were conducted with six participants in each group. The two FGs were held at the two hospital premises (Korle-Bu Teaching Hospital-public (Accra)/Bethel Hospital-private (Tema).

Data Analysis

Qualitative content analysis was used in analyzing the data gathered for the study. Content analysis is a way to make meaning from verbal, visual, or written data on a phenomenon (Bengtsson, 2016). This data analysis method classifies textual material into more relevant and manageable pieces of data (Weber, 1990). Data sources including written texts, audio and videos were used for content data analysis (Stemler, 2015). As part of the data analysis, the researchers represented the data in words and themes this helped to interpret the data- results (Bengtsson, 2016). For textual data, the researchers read and scrutinize the data gathered to identify patterns and concepts that are relevant to the phenomenon under investigation-maternal healthcare (White & Marsh, 2006). Recorded focus group discussions and the in-depth interviews were transcribed verbatim to allow for easy analysis. Data collected were thoroughly analyzed and were organized into themes (major and sub-themes based on the primary and secondary data sources.
of their corresponding manifest variables and uses them as perfect substitutes for the

manifest variables (Hair et al., 2012). Comparing PLS-SEM to CB-SEM, PLS-SEM works better with smaller samples- an average of 211.29 samples (Hair et al., 2012) and it achieves higher statistical power at all sample sizes (Hair, Matthews, Matthews and Sarstedt, 2017). PLS-SEM also produces higher composite reliability and convergent validity according to Hair, et al., (2017). Hair, et al. (2017) also explained that PLS-SEM is useful where theory is less developed in exploratory research and it can produce significant results in most instances.

Ethical Issues

The researchers recognize participants' rights to be protected. As such the researchers did their best to promote the integrity of their research (Creswell, 2014). Also, participants had the choice to either partake in or decline the interviews. Participation in the study was strictly voluntary. Also, the participants gave their informed consent which were obtained verbally, before interviews. Moreover, the researchers assured the participants of adhering to confidentiality and anonymity.

Findings

Two major themes merged from the data gathered namely the support of international partners to Ghana's health sector toward reducing maternal mortality and efforts of Ghana toward achieving the United Nations Sustainable Development Goal 3.1 (reducing maternal mortality) by 2030.

International Partners Support for Ghana Toward Achieving SDG 3.1

Two major international/development partners emerged from the several partners (WHO/UNFPA).

World Health Organization

In the area of maternal health, the WHO supported the Ministry of Health (MoH) and the Ghana Health Service (GHS) in technical assistance. Also, the international partners support the two lead institutions in Ghana (MoH and GHS) to plan, implement, monitor and evaluate reproductive, maternal, newborn, child and adolescent health programs. These programs are the means of minimizing maternal mortality and enhancing maternal healthcare in Ghana. The WHO also works toward improving the accessibility to quality health services by pregnant women in Ghana (WHO, 2020b). In addition, the MoH and GHS with technical and financial assistance from WHO conducted a reproductive, maternal, newborn, child and adolescent health program review with the WHO program review. This tool helped to identify the gaps and barriers in the area of reproductive, maternal, newborn, child and adolescent health (WHO, 2020b). The WHO provided technical and financial assistance for the maternal, child health and nutrition conference which was held in Ghana in 2019. To end avoidable maternal and child deaths and achieve maternal and newborn targets under SDG 3, Ghana has subscribed to the global network to boost the quality of maternal healthcare. Ghana with support from WHO has implemented the WHO standards for the quality of maternal and child healthcare through training in Ashanti, Brong-Ahafo and Western Regions of Ghana (WHO, 2020b). Besides WHO, UNFPA is a key international health partner that helped Ghana toward reducing maternal mortality.

United Nations Population Fund (UNFPA)

UNFPA has assisted Ghana in terms of maternal health over the years through its

partnership with the MoH and GHS. The UNFPA targeted addressing adolescent pregnancy, which is a major cause of death among female adolescents in Ghana, Also, the complications that come with adolescent pregnancy work to ensure the prevention of adolescent pregnancy. UNFPA emphasize preventive maternal healthcare issues of female adolescents. The institution works with the government and civil society organizations to provide education on sexual and reproductive health and counselling to young people, especially female adolescents. The UNFPA also works with other international partners to prevent child marriages within communities as a strategy to end adolescent pregnancies in Ghana (UNFPA, 2017). UNFPA worked closely with the Ghana government on maternal issues.

In the area of midwifery, an official of UNFPA indicated that:

The UNFPA supports the MOH and midwifery training center to ensure that birth attendants at health facilities are well-trained and skilled to perform deliveries. It also performs a regulatory role by ensuring that midwifery services are of good quality and meet international standards.

The official of the UNFPA further mentioned that:

The UNFPA also provides technical support in the form of coordination to the maternal death audit system introduced by GHS which is a strategy adopted to reduce the rate of maternal mortality in Ghana. It is also supported by the emergency obstetric and newborn assessments conducted by the GHS.

Ghana's Maternal Healthcare Policy Interventions Toward Achieving SDG 3.1

These are some of the policy interventions of Ghana toward achieving SDG 3.1 by 2030

The introduction of the Free Maternal Healthcare Policy

One major intervention to address this global problem of maternal mortality in Ghana was the introduction of the Free Maternal Healthcare Policy by the government of Ghana. The policy was in line with the fee exemption policies adopted by various African countries to reduce the financial barrier of seeking medical care. This resulted in a user-fee-exempt policy which was adopted in 2008 under the National Health Insurance Scheme (NHIS) (National Health Insurance Authority, 2014). The free maternal health policy aims at increasing access to maternal healthcare services and skilled delivery by addressing financial barriers to utilization of medical facilities by pregnant women in Ghana. This policy was one of Ghana's main policy interventions to achieve SDG 3.1. The free policy allows all pregnant women to register for the NHIS for free (Dixon et al., 2014).

In addition, the free maternal healthcare policy covers antenatal services rendered to pregnant women, normal and assisted deliveries and the three-month post-partum (Dalinjong et al., 2018). Beneficiaries of the policy have to be verified by a registered nurse, doctor or midwife and enrolled on the NHIS to enjoy the free services offered under the policy (Azaare et al., 2020; Kipo-Sunyehzi, 2021). Although the free maternal health policy is one of the best maternal healthcare strategies, participants

expressed that the policy was not entirely free as it did not cover all maternal healthcare services in Ghana. Also, it was found in the field that pregnant woman made payments for scans, drugs which not covered by the health policy (NHIS) and some payments at caesarean sections.
This was what a midwife said during a focus group discussion:

The free maternal health policy is not so totally free, but pregnant women enjoy subsidized consultation fees and pharmacy charges at the referral center (Midwife 2)

Ghana's Universal Health Coverage Roadmap

As part of Ghana's commitment to achieving the SDGs and other international agreements, Ghana developed a ten-year strategic plan for the health sector termed "Ghana's Roadmap for Attaining UHC" in the year 2020 with the vision that all persons should have access to quality healthcare services by 2030 (Ministry of Health, 2020). The Universal Health Coverage roadmap is aligned with the SDGs and other international commitments like the Global Action Plan for Healthy Lives and Well Being, Universal Health Coverage (UHC) 2030 Compact and the Declaration on Primary Healthcare in Astana 2018 (Ministry of Health, 2020). It also emphasizes "health-in-all" policies as proposed by the WHO. The policy emphasizes primary healthcare of which maternal and child nutrition services form the majority of it. This policy highlights reducing maternal deaths and providing access to essential healthcare services as part of its objectives.
This was how an official of Ghana's Ministry of Health (MoH) a health policy expert explained:

Although the policy does not specifically address the challenge of maternal mortality, its universal nature and approach allow it to cover the issue of maternal mortality.

Blood Donation

There has been the introduction of blood donation exercises across Ghana as a measure to reduce the rate of maternal deaths. Studies on maternal mortality have outlined haemorrhage as the leading cause of maternal deaths in Ghana and to address this major problem, blood donations at health facilities (hospitals) have been adopted. There was also the issue of mandatory donation of blood before delivery. This medical demand seems to be in line with the recommendation proposed by Asamoah et al. (2011) that health interventions to reduce maternal mortality should be aimed at haemorrhage, which has been identified as a main cause of maternal deaths. Thus, pregnant women in Ghana are required to bring people to health facilities to donate two pints of blood at the health facility prior to delivery. This intervention is aimed at ensuring that there is constant availability of blood, and the practice helps for easy access to blood in case of emergencies (during deliveries).
On the practice blood donation, this was what a medical officer said this:

Pregnant women are made to donate blood at the health facility before delivery. (Medical doctor 2)

Midwives during the study mentioned that blood donated on behalf of a particular pregnant woman did not necessarily have to be used for that pregnant woman. However, the blood donated was to ensure that blood is readily available at the facility for use at any point in time when it is

needed. This was how a midwife commented on blood donation:

Pregnant women do not always use the blood donated by their relatives. The blood is stored and used at another time for someone who may be in need of blood. (Midwife 8)

Participants of the study mentioned that the blood donation exercises have been effective over the years because most people complied with the directive. However, midwives during the focus group discussions added that there were still some people who refused to donate blood.
This was what a midwife said:

Some people refuse to comply when they are asked to donate blood in advance. (Midwife 11)

Education of Pregnant women

The education of pregnant women has also been a strategy to address the issue of maternal mortality. Pregnant women are educated on different subject areas related to pregnancy. During antenatal clinics, the midwives dedicate time to educating expectant mothers on the various issues concerning maternal health like the importance of attending antenatal clinics, skilled delivery and maternal nutrition. Pregnant women are also taken through pregnancy complications and the need to seek medical help when such complications arise. Such education within the two health facilities between the midwives and the pregnant women was directly observed at the two hospitals (Accra and Tema). This direct observation was made at health facilities by the researcher during the study. Moreover, as part of education on maternal health, pregnant women are expected to be enrolled in a pregnancy school. The pregnant women attend the pregnancy school, held at the health facilities till delivery takes place. The pregnancy school at the health facility during the fieldwork period was observed to take place on the second and fourth Saturdays of each month.
A midwife revealed that:

Women are well educated on the need to take drugs administered to them, the importance of ultrasound scans and other matters of importance to pregnancy. They are also taken to the various maternity and labor wards as a form of orientation before admission. (Midwife 11)

The only means of publicity for this program was that women were informed of the program during their antenatal clinics. Concerning funding of the pregnancy school, another midwife mentioned that:
The facility sometimes receives funds from external institutions as sponsorship for the program. (Midwife 2)
Some midwives interviewed for the study attested to the pregnancy school being effective as it was well participated in by expectant mothers. The pregnancy school is an innovative means of educating pregnant women on maternal healthcare issues and creates awareness of complications that could arise from pregnancy.
This was how another midwife commented:

The pregnancy school has been beneficial and we have many pregnant women who participate in it. (Midwife 11)

Education of Midwives

Besides the educational programs organized for pregnant women, some

trainings are organized for midwives with the various departments at health facilities either weekly or biweekly.
One midwife said this:

We have internal workshops on maternal healthcare organized for us at our facility. (Midwife 8)

Another participant added that:
We hold mortality meetings every fortnight and it is mandatory for all of us. (Midwife 3)

The study also revealed that individual health personnel improved their knowledge of maternal health by partaking in maternal health training programs that are held either in person or virtually.

I personally pay to participate in some maternal health training programs when I hear of them. (Midwife1)

In addition, health personnel have adopted technological means of sharing knowledge on various maternal health issues through online platforms. Midwives confirmed that the training programs and workshops are beneficial because they keep them well-informed about maternal health issues. Also, the midwives' direct involvement in maternal health makes it imperative for them to acquire the necessary skills and training to increase their skills in the areas of delivery and management of pregnancy-related complications.
This was how a midwife commented on maternal healthcare training programs:

The training programs are very helpful because we need to increase our knowledge of maternal health and also improve our skills as health workers (Midwife 8).

Supporting Peripheral Health Facilities

An intervention adopted to reduce maternal deaths resulting from late referrals from peripherals has been addressed by assigning specialists to such peripheral health facilities. This measure was influenced by the lack of specialists at peripherals to manage pregnancy complications. Specialists from referral facilities visit peripherals on specific days to attend to pregnant women thereby making it easier to detect and treat pregnancy complications, which are contributing factors to maternal morbidity and mortality in Ghana.
A midwife commented on the relevance of specialists to peripheral health facilities:

Specialists being sent to the peripheral facilities weekly is one of the ways we are trying to reduce maternal mortality because of late referrals. (Midwife 2)

The initiative is aimed at reducing the problem of transferring women with serious complications to referral facilities and increasing access to emergency care by women with complications. It is also aimed at preventing the progress of pregnancy-related complications and abnormalities since they will be detected early.

Assigning specialists to the peripherals helps to detect and treat complications that could lead to maternal mortality. (Midwife 2)

The midwives that were interviewed confirmed that this strategy has been effective and has given support to peripherals health facilities in the management of pregnancy-related complications.

Discussion

The midwives who were interviewed for the study acknowledged that despite some of the setbacks of the NHIS and the Free Maternal Healthcare Policy, the policy interventions have been of great benefit because over the years the policies have improved access to maternal healthcare services positively. This assertion is in agreement with the findings of Bonfrer et al.(2016). Also, the increase in attendance to four or more antenatal visits between 2011 and 2012 increased from 71.3% to 72.3%. Such an increase was attributed to the fee exemption policy on maternal health services where pregnant women's fees for maternal healthcare services were waived or offered free (National Health Insurance Authority, 2014).

The target group for free maternal healthcare in Ghana is the poor and the vulnerable particularly children, adolescents, women and the aged (Kipo-Sunyehzi, 2021). The elimination of both financial and physical obstacles to access primary healthcare services and building sustainable partnerships between the government, the private sector, non-state actors as well as international development partners all form part of the guiding principles outlined for the free policy. The policy seeks to improve basic essential services, by ensuring that maternal healthcare services as well as child health services are made universally available at all the various levels of service deliveries in Ghana (Ministry of Health, 2020). Interventions under this policy include managing clinical and public health emergencies, improving efficiency in human resource performance, as well as enhancing quality of care and information management. In addition, some institutional reforms aimed at strengthening health policy and financing systems. The measurement of the policy progress is supposed to be based on the various national and global platforms for measurement (Ministry of Health, 2020). This road map is projected to improve access and quality of maternal services in Ghana. This is a positive move as it aims at reducing Ghana's MMR by two-thirds of its 2017 figures and consequently contributing to the global target of SDG 3.1 by 2030 (WHO, 2015). Ghana's maternal health policy intervention is similar to the strategy proposed by Filippi et al. (2006) to decrease maternal complications and mortality.

Health workers particularly, midwives are educated on maternal health through various training programs. Findings from the study revealed that there were several workshops held within a year for midwives to educate them on maternal healthcare issues and keep them updated on the current maternal health protocols. This study's findings however differ from the findings of Banchani and Tenkorang (2014) in that there were inadequate in-service training programs for midwives as it usually took more than a year to be organized. It was found that midwives sent representatives from their various health facilities to participate in maternal healthcare training since not all midwives can partake in such training programs. It was also found that those midwives who received such training/workshops/in-service training on maternal healthcare go back to share with their colleagues at their facilities and or educate their colleagues after the workshops. Thus, this study's findings are inconsistent with Banchani and Tenkorang (2014).

Conclusion

The study concludes that both the government of Ghana and the international development partners in health work hand in hand in their efforts toward achieving the United National Sustainable Development Goal 3.1 on maternal healthcare with fewer conflicts of interest and less distrust.

Recommendations

The study recommends more financial resource mobilization and empowerment of the NHIS to make the free maternal healthcare policy cover most of the essential maternal healthcare services in Ghana. This will go a long way to reduce or end co-payments (petty cash) at health facilities.

Also, the study recommends more collaboration and coordination between the government of Ghana and the various international partners in the health sector to attract more support from the global partners. Such a move would possibly accelerate Ghana's move toward achieving the global agenda (UN SDG 3.1 reducing maternal mortality drastically) by 2030.

One key limitation of this study is the adequate number of health policy experts. Future studies on maternal healthcare services in Ghana should include more health policy experts (policymakers).

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