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Original Research Article

Access and Equity in Free Maternal Delivery Policy in the Brong Ahafo Region of Ghana: Voices of Women

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In 2005, Ghana instituted a free maternal delivery policy as a pro-poor strategy to enable all 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. It also aimed at increasing 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 analyze access and equity issues in free maternal delivery policy and to assess the level of awareness, concerns and perceptions of women on the policy. This study focused on the voices and concerns of women who are the direct beneficiaries of the policy. The study used a qualitative case study approach drawing on 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 many women are still excluded by reason of poverty. Irrespective of the policy, access to professional skilled birth attendant is still restrained by various indirect costs associated with hospital delivery. This made the policy inequitable to women and denied them their right to reproductive health. Women's concerns bordered very much on their right to dignity often denied them by health personnel in hospitals. Inclusion of women's voices is relevant to informing policy on free delivery policy that need to be addressed.

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

INTRODUCTION

The International Conference on Population and Development programme of action campaign on reducing maternal mortality is centred on the call for every woman to have access to quality maternal health services (Sivananthi and Sai, 2010). The action campaign includes the provision of antenatal care, professional skilled birth attendant; emergency obstetric care and postpartum (postnatal) care so that each woman can go safely through pregnancy and childbirth.

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 hundred; but where deliveries are handled by professionals in well equipped hospitals, the lowest mortality rates could be attained (WHO, 2002; Gerein and Green, 2006). Traditional Birth Attendants either trained or untrained are excluded from the category of skilled birth attendants (Chikanda, 2005). Worldwide, poor and rural women often do not have access to quality maternal delivery services for the mere fact that rural areas do not have hospitals [and well equipped clinics] and often rely on Traditional Birth Attendants. Most maternal deaths occur in developing nations where the majority of pregnant women deliver outside hospitals and are unable to avoid those deaths that would have been medically preventable (WHO, 2004c; UNFPA, 2004). The millennium Development Goal 5 seeks to provide at least 75 per cent 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).

Maternal Health Issues in Ghana

Ghana as a developing country, experiences high fertility rates especially in rural areas, yet one of the decisive indicators of lifetime risk of maternal death is related to the number of

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pregnancies a woman has in her lifetime. Fertility rate among Ghanaian women has only declined slightly since 1998 whereas contraceptive use is also generally low in Ghanaian families accounting for only 15 per cent (Ghana Statistical Survey, 2003a; Ghana Statistical Survey, 2000; Ghana Statistical Survey, 2003b**;** UNDP, 2007**).**

Antenatal care can help identify risk factors during pregnancy and postnatal care is very important since most maternal deaths occur within a few days after delivery. Though the Ghana Statistical Survey results show that the use of antenatal and postnatal care is very high with at least 92 per cent of pregnant women having access, yet in most instances more than half of those who attend antenatal have no access to supervised deliveries in hospitals by medically trained personnel. It has been identified that there has been a slight improvement in deliveries under skilled birth attendants from 52.4 in 2002 to 58.4 per cent in 2006.

Access to skilled birth attendant at delivery is very crucial for the health of the mother and to improve the chances of survival of the baby and mother**.** 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 by providing services in assisting pregnant women to deliver. Home deliveries still remain a prominent feature among pregnant women in Ghana and it is estimated that about 60% of maternal deliveries take place at the home. 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. 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. Maternal morbidity is high and accounts for the second major out-patient services after malaria (Ghana Statistical Survey, 2002; UNDP, 2007).

Though maternal deaths are said to be declining sharply worldwide, that of Ghana is said to be high and persistently remained at 214 in 100,000 live births for some time up to 2000. It reduced to 204 in 100,000 in 2002 and then to 187/100,000 in 2006 (UNDP, 2007). Under this situation Ghana will hardly be able to meet the MDG target of reducing maternal mortality by three quarters by 2015. The need for the free maternal delivery policy could not be overemphasized.

The Free Maternal Delivery Policy

The Safe Motherhood Programme was a prior initiative in Ghana to address the problem of maternal mortality, but the Safe Motherhood 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 (Ministry of Health, 2004; Ofori-Adjei, 2007).

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 were lumpy and sometimes rose as much as 8 times a household's monthly income (Asante et al, 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). Some 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 (Wittie and Adjei, 2007).

The launch of this brought about an upsurge of many pregnant women registering with the National Health Insurance Scheme (NHIS) to enjoy 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 while others tested the perceptions of health personnel on the policy (IMMPACT, 2005; Wittie et al, 2007,2009; Wittie and Adjei 2007; Ammar-Klemansu et al, 2006). 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).

Research conducted outside the health services focused on surveys on the cost of maternal health care within households (Asante et al, 2007**).** Conclusions on researches on the free maternal delivery are worthy of mention. Ofori (2007) recognized the effects of the free delivery policy on increased utilization of delivery services. A significant reduction of maternal mortality rates in some regions in Ghana has been cited (UNDP, 2007). The policy's positive economic impact on the reduction of household poverty has also been noted (Asante et al, 2007; Witter et al, 2009). Contrarily, Bosu et al (2007) noted that there were no policy impacts on the quality of care given to pregnant women.

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 be 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 (IMMPACT, 2005; Ofori-Adjei, 2007; Bosu et al, 2007; Tornui et. al; 2007; Asante et al, 2007; Wittie and Adjei, 2007 ; Wittie et al, 2007, 2009).

Conceptual Framework

This research adopts the feminist and human rights perspectives. Feminist's 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). Zabu (2007) explains that women's voices represent what women really feel and know and not what they are supposed to know and feel. The study supports the feminists' stance to emphasize the need to include women's perspectives in the free maternal delivery policies. Moreover, making motherhood safer is one of the major themes in reproductive rights (Sivananti and Sai, 2010).

The study supports 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 rights 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).

METHODS

The study was conducted in six [6] communities in three districts randomly selected in the Brong Ahafo Region in Ghana. The districts were: Techiman, Asunafo North and Sene. The Brong Ahafo region was chosen because of its poverty status and it ranks fifth in the poverty hierarchy just below three Northern regions and the Central Region Central Region (Ghana Statistical Survey, 2007).

A qualitative approach using in depth interviews was adopted to analyze women's views on free maternal care policy. 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 and Huberman, 1994). Keeping in mind the research questions, the raw data was read over a number of times to become 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 discussions of results involved descriptive and analytical discussions of the themes to arrive at interpretation of data and findings.

DISCUSSION OF RESULTS

Awareness and Perception of the Free Maternal Delivery Policy

Maternal health is very crucial to women because of their vulnerability to biological health risks associated with their reproductive functions. The multitude of risks associated with pregnancy and childbirth results in maternal morbidity and mortality. Awareness and access of free maternal delivery policy, particularly to women can prevent exclusion from access to skilled birth delivery and vulnerability to maternal illnesses and deaths. The discussion on respondent's awareness of free maternal delivery policy was inspired by a prior experience of Ghana's health sector exemptiom policy covering certain categories of people introduced by the Ghana government, in 1995.

Survey results from the country showed that many of the supposed beneficiaries were not aware and in two districts where the initiative was rolled out, 88 per cent of community members interviewed were not aware of this exemption policy. As a result many of the intended beneficiaries did not utilize available services when they were ill (Ministry of Health, 2001). As a fallout from the findings of the prior research on exemption policies, this study tested the awareness level of respondents on the policy to ascertain their level of awareness and their perceptions about the policy in general. Discussions focused on whether women were aware of the free maternal delivery policy and the extent of their access to it. Discussions on the policy by women's interviewees were very positive. Thus Focus group discussions [FGDs] showed that women's awareness of the free maternal delivery policy was very high; 39 out of the 42 respondents were aware of the policy and perceived it as very good and complies with earlier research findings (Witter, et. al; 2009).

The respondents rated maternal delivery policy as very good because respondents felt that it would relieve them of financial burden which could have been used in paying for antenatal services and the upkeep of the babies. Awareness of the policy was therefore very high and respondents observed that it could greatly relieve them of some financial burden. This finding was consistent with the research findings of Witter et. al; (2009) who confirmed that awareness of maternal delivery policy was high and consistent with the outcome of research on the perceptions of the policy (IMMPACT, 2005; Witter et. al; 2009).

Sources of Information on the Free maternal Delivery Policy

The high level of awareness made it important to explore the sources of information on maternal delivery by respondents. Knowledge of the sources of information about the free maternal delivery policy can provide avenues of getting critical information and education to reach pregnant women. The results showed that twenty one [21] of the respondents got information on the free maternal delivery policy from the media specifically from local FM stations. Fifteen [15] also received the information from the ante-natal services.

The remaining eight [8] received the information either through a friend, the national health insurance scheme and others when they were not asked to pay anything after delivering at the hospital. The study showed that the two most important sources for disseminating information on maternal health and other important information to women especially rural women FM stations and Ante-natal services.

Perceptions on Places of Deliveries

The study explored the perceptions on places of deliveries to explore issues on access and usage. Respondents identified four main places that provide services for childbirth and they were hospitals, Clinics or midwives, the home and Traditional Birth Attendants (TBAs). Almost all respondents mentioned that hospital deliveries are the safest and expressed preference for it as a place for delivery. Common themes drawn from the reasons why they perceived that hospital deliveries are best centred on the following:

- the expertise of doctors
- availability of trained health personnel
- availability of drugs' and
- access to important health information and education at hospitals on pregnancy and childbirth'.

Excerpts from verbatim accounts are as follows:

The hospital is the best place for delivery due to the availability of doctors with expertise for dealing with complications, Hospitals have the drugs, Hospitals also have the equipment and trained health personnel. At the hospital you are also taught what to do

The findings indicated respondents were aware of the avoidance of danger and risks in using hospitals. If women have such information one would wonder what impediments could restrain them from seeking skilled care during delivery. Respondents were asked to share their perceptions and some of their experiences on the four places of delivery identified. Though women in this study did not directly state these as factors that limited their access to the free maternal delivery policy question posed by the researcher for respondents to share on some of the experiences with hospital deliveries brought to the fore serious concerns that they have been harbouring all along**.** Much of their concerns centred on the unwelcoming attitude of some nurses, respondents complained about the attitude of nurses towards them whenever they go for maternal health services. The theme derived from discussions on their concerns with some of the comments were:

'Some nurses don't have patience for sick people' 'some nurses are rude to pregnant women' 'some nurses like shouting on us for unnecessary reasons' 'some nurses are rude when they see you are poor'

Women talked about the impatient attitude of nurses and how nurses shouted at pregnant women whenever they were at their service. To most of the women, nurses were simply rude to patients, especially when they estimate that one is poor many of women perceived they received such undignified treatment from nurses just because they were poor.

One other concern expressed by women in relation to hospital deliveries that was a surprise during discussion was the perception of a fear of episiotomy and many alleging that sometimes women could have their wombs removed without their knowledge and consent. The authenticity of this issue could not be ascertained because none of the women admitted to have been a victim, but any women will be very reluctant to admit such incidence in public. For a traditional society that places a high premium on childbirth, removing someone's womb, which is perceived as a symbol of women could be interpreted as a taboo and therefore a tragedy. However, for the fact that it came up during two of focus group discussions showed that it was a concern and a claim that could be true, as having happened if not at all once at some place and their voices served as a protest.

Even though respondents overwhelmingly accepted the importance of hospital deliveries they were not hesitant in acknowledging reasons why women find home deliveries more honourable and comfortable. Respondents were, however, aware of the risk that could be associated with home deliveries yet they declared that the ultimate attention, warmth, dignity, care and support normally accorded pregnant women during home delivery, often denied or abused by some nurses at the hospital where skilled birth maternal care is accessible. In fact, eleven of the respondents preferred having their deliveries at home with the support of their family members. It is no surprise Ghana Statistical Survey (2006) indicated that home deliveries ranked second to hospital deliveries and forms about 60 per cent of all deliveries in Ghana.

Furthermore, it could be noticed among the Akan ethnic group where data was collected, and also among traditional societies where a premium is placed on childbirth, traditional tenets uphold that the dignity of women is during pregnancy and childbirth. Among the Akans, it is a taboo to hit or even push women when she is pregnant or for a pregnant woman even to be divorced. Pregnancy and child delivery is one of the rare moments that women enjoy a right to protection from violence and indignity in relationships of trust. The nature of warmth and dignity accorded pregnant women in traditional societies is a true reflection the assertion by of Tamale (2008) that there are some of the instances where cultural norms and values are rights-supportive and promote women's rights to dignity. In government clinics, women complained of inadequate and poor state of facilities.

On examining the perception and concerns about delivery manned by midwives, respondents commented that midwives have some experience but they were quick to add that they lack the equipment for dealing with complications. Attitude of private midwives was noted to be better than nurses in government hospitals and clinics.

The results of this finding comply with an observation of institutional data from the Ghana Health Service indicating that there have not been much improvement in deliveries supervised by skilled birth attendants, and that the national statistics stood slightly above average at 58.4 percent in 2006 (GSS, 2006).

The results demonstrated that Traditional Birth Attendants (TBAs) both trained and untrained may provide maternal services especially for rural women during delivery. Respondents actually made a differentiation between giving birth in the home and delivering at TBAs. The study exploration of respondents' perceptions, experiences and concerns about TBAs was actually to identify if women really have a preference from for traditional birth attendants.

According to women interviewees, giving birth at TBAs it attracts some delivery fees ranging from about $US 3.00 in addition to fewer sanitary and toiletry items as compared to the demands for confinement at the hospital during delivery. Moreover, TBAs may further demand fowls and eggs in addition. However, TBAs may not demand out of pocket payments and therefore clients can make payments latter and at their convenience, payments could be made in a form of cash or kind.

Analysis of their responses indicated that respondents were not really enthusiastic about having deliveries at TBA and would avoid them if they had the choice. Women were therefore highly apprehensive of traditional birth attendants and complained about the poor environment to which TBAs

made women deliver. Respondents lamented about pregnant women being mishandled and being made to deliver on spread mats placed on the floor by TBAs. They showed concern about the nature of the rooms which were often far below standards as the rooms are often used for other purposes. Women noted that services rendered to pregnant women are of low inferior quality. Women were highly aware of the risks in using TBAs. Extracts from some of their short responses were:

'The well being of the mother is not guaranteed.'
'One can contact HIV from them.'
'Some are unable to help but waste time until complications set in.'
'They are very dangerous and can cause maternal deaths.'
'Some do not cut the umbilical cord well and sometimes the baby can bleed to death.'
'Some of them have bad spirit and can transfer them to the baby'

However, many women coped with the inability to afford the indirect cost associated with delivery at the hospital in terms of the items demanded at the hospital of meeting transport cost. In most instances women who have immediate and extended family members who could aid them in their deliveries prefer using them than TBAs. The outcome of the study does not concur with a prior findings of Jokhio et al (2005) and Ofori Adjei (2007) where women actually preferred to use TBAs. The findings indicate that they use TBAs as a last resort. The comments from respondents raises eyebrow on issues of training and supervision of TBAs by health services.

Past studies have emphasized the limited training and supervision of TBA and to even where there has been some form of training to have had limited impact on maternal outcomes. World Health Organization (WHO) has recently commented on uncertainties about the type of training that could be deemed proper for TBAs (Stokoe,1991, Goodburn et al, 2000; WHO, 2005b).Some studies on TBAs have even advocated that to achieve any improvement in maternal mortality in developing world it may be necessary to ban traditional birth attendants (Davies et. al; 2007; Parchurst and Rahmann, 2007). Others like (Jokhio et. al; 2005) feel that they can be useful for linking pregnant women to the appropriate health service providers. The findings from this study prognosticate that TBAs will in no time outlive their usefulness, they may not be banned but women will avoid them.

Access to Antenatal and Postpartum Care

Access to antenatal and post natal care was very high. The findings of this study confirmed an earlier Report that access to ante-natal and post natal services were about 96 per cent in the country (UNDP, 2007). Ante natal and post natal cares were available in clinics within communities and women also attested to visits by health personnel to deprived communities to provide those services. However the results also showed evidence that women are still engaged in use herbal treatment and seeking for prayers and protection from pastors during pregnancy and after birth all showing the persistence of cultural beliefs among pregnant women.

What can we learn from these experiences, perceptions and concerns? Throughout the discussion women seldom made reference to the common themes that other research have pointed out as barriers in access to skilled birth attendants. These were such as distance to hospitals, inadequate doctors, doctor nurse ratio increased utilization of health facilities macroeconomic issues like poverty reduction. This find support with the findings that birth rates were still high as the preferred number of children among many was a minimum of three or four and also that most childbirth was also not planned. From the voices of the respondents, factors that constrained access to skilled birth attendants bother not so much on geographical distance but strongly on the availability of transport during the night. The non-facility user financial constraints bordered on transport cost to the hospital and sanitary and toiletries demanded from pregnant for delivery at the hospital.

Decision making processes about place of delivery also played a role in the access to skilled birth delivery as many such decisions were taken other household members during the critical periods during labour, the persistence of the unwelcome attitudes of nurses and health workers testifies that unless these voices of women are factored into the policy, Ghana will face strenuous challenges in increasing access to skilled birth attendant and in meeting the Millennium Development Goals.The constraints so far identified in access to skilled birth attendants confirms Graham (2004) prognosis that increase of access to skilled attendant in Ghana will remain one of the main challenges in free maternal delivery policy, noting that the rates of access skilled attendance would either be stagnant or decline for poorer women.

The challenges and concerns raise worries about of access, equity and human rights. Despite the fact that the policy was introduced to ease financial access and address iniquity some women's access to skilled birth, the findings show that some women are excluded from enjoying the free maternal delivery policy by reason of financial constraints induced by poverty. Due to other unconventional expenses and indirect costs associated with delivery the policy still favors the rich and serves as a barrier for many poor women. In such circumstance those who cannot afford forfeit their right to reproductive health specifically to skilled birth attendants. Yet, every woman has a right of access to affordable and the highest attainable standard of reproductive health services [UN Women, 2009]. Witter et al (2009) and Ofori-Adjei (2007) have commented on equity issues arguing that the universal exemption still favors the rich.

It could be argued that the policy did not only promise to take a dynamic step forward in fighting maternal mortality in Ghana but to combat disparities in access maternal health outcomes. To ensure equitable access to quality health care**,**consideration of indirect financial costs and other constraints are necessary to address the lack of parity between the rich and the poor as well as rural and urbancontexts.Human rights principles strive for equity and social justice for every single woman who goes through pregnancy and childbirth.Women have a right not to die from childbirth but every minute somewhere in the world, a woman dies from complications of pregnancy and childbirth. The United Nations is calling on every country to uphold every mother's right to a safe and healthy childbirth, often cost prevents women from accessing life-saving care. Currently, the maternal mortality rates has increased to 350 in 100,000 births

Free Maternal Delivery policy seemed to have been gradually even though slowly moved towards lowering maternal deaths (UNDP, 2001). It estimated a decline from 214 in 1998 to 187 in 2007 in every 100,000 births. However, the policy seems to be losing its momentum with the change of government. In May 2014 it was reported the Daily Graphic newspaper that in spite of the free maternal health policy, twelve nursing mothers were detained at the Korle-Bu Teaching Hospital, the leading hospital in Ghana, for their inability to settle their medical bills after they have given birth. The total amount to be paid was $US 4,141.00, but pregnant

are supposed to receive free maternal care. But the women in question were accused for not to have signed into the NHIS and therefore had to pay for their deliveries. However, most of the women were rushed to the hospital in critical conditions and therefore they were unable to register with health insurance scheme before accessing services. This brings to question whether or not, only women who have registered with the NHIS could enjoy the policy or every woman for that matter require maternal care during delivery. It is therefore expected that government fashion out more effective ways of getting expectant mothers, whether they have registered with NHIS or not to enjoy the free Maternal Health policy run by the ministry. Following a directive from the Minister of Health forced the health institution to discharge the nursing mothers free of charge (Quarcoe-Duho, 2014).

On the issue, the Director of Family health at the Ghana Health Service emphasized that Ghana's policy on Free Maternal Health, introduced in 2005, was still in force and therefore called on expectant mothers to take advantage of it. In spite of this directive, again in May 2014 some women marched through their respective districts to demand improved medical services in hospitals complaining about payments made by expectant mothers at health facilities, even with the implementation of the free maternal health care policy and the unhealthy attitude of nurses towards pregnant women. Inscriptions on placards read 'no maternal deaths, we need our babies alive' young nurses have mercy on us 'improve maternal health care (Agbey, 2014). The reportage affirms the major reasons to have discouraged women from seeking maternal care services from skilled birth attendants.

MAIN FINDINGS

The study assessed the awareness and perceptions of rural women on the free maternal delivery policy and their experiences, challenges and concerns; the main findings of the study are as follows:

- The women were classified [using human and income poverty indicators] as poor.
- The sources for disseminating information to pregnant women were local FM stations and antenatal clinics.
- Respondents showed high awareness of the safety of hospitals deliveries with skilled birth attendants.
- Hospital deliveries were not comfortable as compared to home deliveries because the support and dignity offered by family members in home delivery were unavailable to them at the hospitals.
- The unhealthy attitude of nurses towards pregnant women and the fear of a potential episiotomy were some of the concerns of women in terms of hospital deliveries.
- Some of the key factors preventing access to skilled birth attendant were indirect costs associated with deliveries at hospitals.
- Perceptions about TBAs was negative among women and the women were apprehensive about TBAs and used them [TBAs] as a last resort.
- The study showed that pregnant women believed that it is only critical to seek skilled birth attendant during the first delivery or when they experienced ill health.
- The preferred number of children among respondents was four [4] children followed by three [3] children, none of the women wished to have a lone [1] child.
- Access to ante-natal and post natal cares was high; and access to skilled birth attendance was faced with challenges.

Policy Implications: Integrating Women's Voices

The Findings call for integrating the following issues within the framework of the policy:

- The Government should increase budgetary allocation to the Ghana Health Services so that the service would be in a position to roll out programmes that would help improve maternal health care, especially in deprived communities across the country.
- The Ghana Health service has the prime responsibility of ensuring the strengthening of free maternal health care initiative to provide delivery care whether women have registered for NHIS or not.
- The Ghana Health service should embark on sensitization of health personnel on attitudinal change towards pregnant women at the health facilities.
- The Ghana Health Service must Educate of pregnant women through ante natal clinics and local radio stations on the need to make advance preparation towards delivery and inform household members of their choice of place of delivery.
- Education should involve traditional medical practitioners and religious leaders on the need for pregnant women to seek hospitals care as well.
- The Government should improve road networks from rural communities to district hospitals to improve accessibility.
- There is the need for the provision of ambulances for maternal delivery at the community level to ease the problem of transport fares or unavailability of transport during the night.
- Provision of sanitary and toiletries needed by pregnant women are relevant for delivery at the hospitals could be integrated in the policy.
- The Ghana Health services should consider the provision of maternal waiting wards to all hospitals.
- Living expenses of pregnant women in maternal waiting wards should be integrated in the policy.
- The use of 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.

CONCLUSION

- Policies often ignored women's views, their experiences and concerns.
- Women's views were important in addressing the challenges associated with access and equity on the free maternal delivery policy
- Integrating women's perspectives in the free maternal delivery policy could be an effective strategy in increasing effectiveness and access to skilled birth attendance.

RECOMMENDATION

There is the need to improve access to skilled birth attendant and emergency obstetric care and make it readily available to all women. In this respect, issues that inhibit equal access on indirect costs and negative attitudes of health personnel, dignity and human rights issues needs to be considered and addressed.

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