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Exploring the Lived Experiences of Healthcare Providers in Delivering Maternal Health Services in Underserved Districts of the Central Region, Ghana

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ABSTRACT

This article presents a comprehensive qualitative examination of the lived experiences of healthcare providers delivering maternal health services in three underserved districts of Ghana's Central Region: Gomoa West, Agona East, and Ekumfi. Drawing on in-depth interviews with midwives, nurses, and other maternal healthcare professionals, the study illuminates how systemic constraints, including infrastructural deficits, acute workforce shortages, resource limitations, and inadequate referral systems, profoundly shape provider experiences and, by extension, the quality and accessibility of maternal health services. The findings reveal a paradoxical environment wherein healthcare providers demonstrate remarkable resilience, professional commitment, and community engagement while simultaneously navigating conditions that systematically undermine their capacity to deliver optimal, respectful, and evidence-based care. This article contributes to the growing body of knowledge on maternal health workforce experiences in resource-constrained settings by foregrounding the structural determinants of provider experiences and their implications for maternal health outcomes. We offer actionable, evidence-informed recommendations for health system strengthening in underserved districts, emphasizing the need for integrated interventions that address both systemic constraints and provider well-being as essential components of maternal mortality reduction strategies.

INTRODUCTION

Ghana's maternal mortality ratio, currently estimated at 263 deaths per 100,000 live births, remains substantially elevated above the Sustainable Development Goal (SDG) target of 70 deaths per 100,000 live births (Ameyaw *et al.*, 2025). This persistent public health challenge reflects the complex interplay of systemic barriers that are particularly acute in rural, underserved districts across the country. Despite two decades of policy commitments, including the implementation of the National Health Insurance Scheme (NHIS), the Free Maternal Health Policy, and various community-based health interventions, the nation has yet to achieve the maternal health targets established under both the Millennium Development Goals and the subsequent SDG framework (Ameyaw *et al.*, 2025; JOICFP, 2024).

The Central Region of Ghana, encompassing districts such as Gomoa West, Agona East, and Ekumfi, exemplifies the disparities that characterize maternal health service delivery in resource-constrained settings. While national-level policies have expanded theoretical access to maternal healthcare, significant inequities persist between urban and rural areas, with rural populations facing substantially reduced access to skilled birth attendants, comprehensive emergency obstetric care, and quality antenatal services (Ghana Health Service, 2023). These disparities are not merely statistical abstractions but represent lived realities for thousands of pregnant women and the healthcare providers who serve them.

LITERATURE REVIEW

Ghana's journey towards improving maternal health has been marked by significant policy commitments, variable implementation, and persistent challenges. The introduction of the National Health Insurance Scheme (NHIS) in 2003, followed by the Free Maternal Health Policy in 2008, represented landmark policy initiatives designed to remove financial barriers to maternal healthcare. These policies have contributed to increases in antenatal care attendance and facility-based deliveries: the proportion of women making at least four antenatal care visits has increased steadily, although substantial regional disparities persist (Ghana Statistical Service, 2021; JOICFP, 2024).

However, as Ameyaw *et al.* (2025) observe, these policy gains have been insufficient to achieve Ghana's maternal health targets. The maternal mortality ratio, while reduced from its peak in the 1990s, remains substantially above the SDG target, and progress has been uneven across regions and districts. The three leading causes of maternal death in Ghana are hemorrhage, hypertensive disorders of pregnancy, and sepsis all conditions that are largely preventable with timely, high-quality emergency obstetric care (Ghana Health Service, 2023).

The gap between policy intentions and outcomes is particularly evident in rural districts, where health infrastructure is limited, skilled staff are in short supply, and geographic barriers impede access to emergency care. In the Central Region, districts such as Gomoa West,

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Agona East, and Ekumfi exemplify these challenges. Data from the Ghana Health Service reveals that the proportion of women making at least four antenatal care visits in Agona East increased modestly from 49.7 percent in 2012 to 55.7 percent in 2013, yet this remains substantially below national targets (Ghana Health Service, 2023).

This model provides the theoretical foundation for the present study. Each of the four dimensions organizes a part of the analysis that follows: acceptability informs

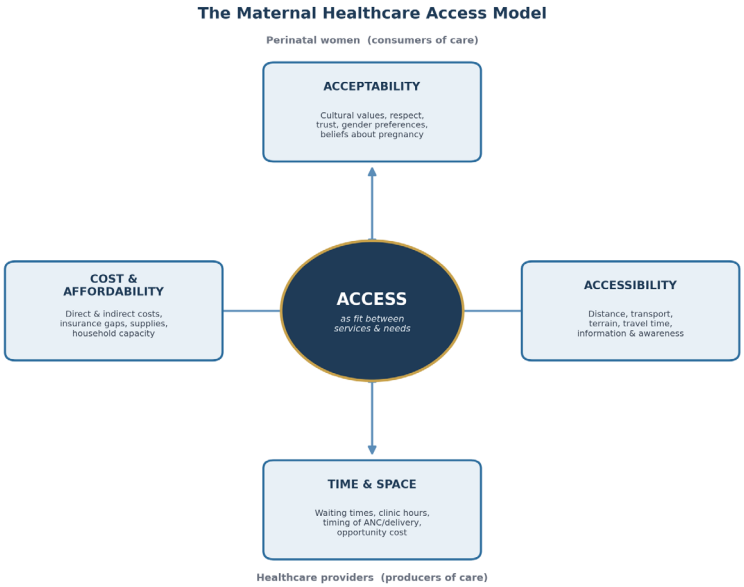

Figure 1: Maternal Healthcare Model
Source: Author, 2026

the interpretation of the interpersonal encounter and of cultural and spiritual influences on care-seeking. Accessibility frames the analysis of distance, terrain and transport and cost and affordability frames the analysis of the hidden costs of nominally free care. Time and space frame the analysis of waiting, timing and the opportunity costs of seeking care. By linking the discussion to this model throughout, the study reads the lived experiences of women and providers not as isolated complaints but as expressions of the degree of fit, or misfit, between services and needs along these four theoretically specified dimensions.

Lived Experiences of Healthcare Providers

Globally, healthcare providers' experiences in delivering maternal health services reflect a complex interplay of systemic, organizational, interpersonal and emotional challenges that directly influence both the quality of care and provider's wellbeing. Across low-, middle-, and high-income settings, maternal healthcare providers operate within health systems increasingly characterized by workforce shortages, resource constraints, performance pressures, and rising patient expectations (Kruk *et al.,* 2018).

Evidence suggests that chronic understaffing, high patient volumes and inadequate infrastructure significantly shape providers' daily work realities, often forcing them to prioritize urgent clinical tasks at the expense of relational and emotional aspects of care (Filby, McConville and Portela, 2016).

A systematic mapping of barriers to quality midwifery care across low- and middle-income countries found that insufficient human resources, limited access to essential medicines and equipment and weak institutional support systems constrain providers' ability to deliver safe, respectful and woman-centered care (Filby, McConville and Portela, 2016).

In such contexts, healthcare providers frequently experience role overload and professional strain, which may lead to emotional exhaustion and reduced job satisfaction. Research further indicates that exposure to high-risk obstetric emergencies, combined with limited resources to respond effectively, can produce moral distress among providers, particularly when they are unable to provide the standard of care, they believe is ethically appropriate (Bradley *et al.,* 2015).

Multi-country evidence also highlights the psychosocial burden associated with working in under-resourced maternal health settings. Providers report stress linked to fear of adverse outcomes, litigation concerns, community criticism and performance monitoring pressures (Kruk *et al.,* 2018).

Such stressors are associated with burnout, characterized by emotional exhaustion, depersonalization and diminished professional accomplishment (Maslach & Leiter, 2016). Burnout not only affects provider well-being but has also been linked to reduced empathy, compromised respectful maternity care practices, and lower patient satisfaction (Bohren *et al.,* 2015; Afulani *et al.,* 2018). In addition to structural constraints, global literature highlights the emotional labour inherent in maternal healthcare delivery. Providers are expected to

maintain compassion, reassurance, and professionalism even under stressful and resource-limited conditions.

When healthcare providers operate in settings lacking essential supplies, referral systems, and functional infrastructure, their capacity to deliver timely and respectful care is compromised. These systemic weaknesses create a cycle in which provider stress and system inefficiencies reinforce each other, ultimately affecting maternal health outcomes.

Despite these extensive global insights, much of the literature remains outcome-focused, prioritizing indicators such as maternal mortality rates, service utilisation, and patient satisfaction. There is comparatively limited attention to the lived, subjective experiences of healthcare providers, particularly how they interpret, negotiate, and make meaning of systemic pressures, emotional strain and relational challenges in their everyday practice.

Despite this recognition, much of the literature tends to focus on outcomes or organizational metrics, rather than the lived, subjective experiences of healthcare providers, revealing a gap in understanding how providers interpret and navigate the emotional, ethical, and relational dimensions of maternal healthcare delivery.

In Sub-Saharan Africa, the lived experiences of perinatal women during pregnancy, childbirth, and the postpartum period are shaped by interactions with health systems, socio-cultural norms, and emotional as well as physical challenges. These experiences often reveal how systemic constraints intersect with personal realities and influence women's perceptions of care quality and maternal health outcomes.

These narratives highlight how surviving a life-threatening obstetric event extends beyond clinical survival to encompass emotional trauma, social stigma, and disrupted daily life, revealing the profound personal impact of severe maternal morbidity. Another Tanzanian study examining women's childbirth experiences found that women frequently encountered variations in communication with providers, inconsistent respect and dignity during care, and mixed support during labour.

Some women appreciated emotional encouragement from staff, while others reported verbal mistreatment, threatening language and inadequate interpersonal support, contributing to feelings of vulnerability during childbirth (Metta *et al.,* 2024).

In southwestern Uganda, Atuhaire *et al.* (2021) conducted a phenomenological study on women who had recovered from postpartum depression. These women described a range of somatic and emotional experiences such as insomnia, fatigue, negative emotions (e.g., anger, loneliness, self-blame), strained family relationships and social isolation that persisted long after birth. Some described suicidals or self-harm thoughts, illustrating how perinatal mental health challenges can dramatically affect women's wellbeing and family dynamics (Atuhaire *et al.,* 2021).

Other qualitative studies in Uganda, such as research on respectful maternity care in Busia District, indicate that women's perceptions of treatment play a key role in shaping their experiences. Women reported incidents of disrespect and abuse, lack of privacy, negative attitudes from providers and exclusion from decision-making, which discouraged facility utilisation and affected maternal health outcomes (Nankabirwa, 2025).

Semasaka *et al.* (2019) explored the experiences of Rwandan women who had faced pregnancy-related complications such as postpartum hemorrhage, pre-eclampsia, fistula, or dystocia. Many participants reported they were unaware of the complications they experienced, felt they received insufficient explanation from healthcare providers and perceived that inadequate care contributed to persistent health problems and economic hardship.

Women described strategies for coping with long-term consequences such as reliance on family support and adjustments to daily life routines which reflect how serious maternal events continue to shape women's lives long after hospital discharge (Semasaka *et al.,* 2019).

Further, broader evidence from Eastern Rwanda suggests that women's perceptions of respectful maternity care greatly influence their experiences and satisfaction with services. Women who felt treated with dignity, informed consent and respectful communication were more likely to express positive care experiences, while others reported neglect, mistreatment, and lack of privacy (Muhayimana *et al.,* 2025).

Qualitative research in rural KwaZulu-Natal shows that many women's experiences of labour care are characterized by poor communication, lack of privacy, disrespectful treatment, and inadequate emotional support, which contribute to ongoing distress and potentially discourage future facility use. Some women described experiences of verbal abuse, denial of birth companions, and invasive procedures without consent, illustrating how interpersonal dynamics within care settings shape women lived experiences (Luthuli *et al.,* 2025).

Similarly, Nkoane and Makhubela-Nkondo (2024) documented perinatal women's experiences in public hospitals in Gauteng Province, highlighting themes such as provider attitudes, communication gaps, delays in care and poor complaint mechanisms that affected maternal healthcare experiences. These findings point to how system shortcomings and provider patient interactions influence women's perceptions of maternity care quality (Nkoane and Makhubela-Nkondo, 2024)

Interpersonal and cultural factors also feature prominently in regional studies. Providers frequently navigate language barriers, cultural beliefs, and patients' low health literacy, which complicate the communication of maternal health information (Banda *et al.,* 2018). While these studies document systemic and interpersonal challenges, few explore the subjective meanings and emotional experiences of providers or how they interpret and reconcile the pressures of delivering maternal care in resource-limited environments. This gap suggests the need for qualitative, phenomenological approaches to

better understand the lived realities of providers in Sub-Saharan Africa.

Maternal healthcare provision in underserved districts of Ghana presents multifaceted challenges shaped by systemic, contextual and relational factors. Evidence from the Northern, Upper East, and Central regions indicates that healthcare providers operate in environments characterized by high patient loads, limited staffing, shortages of essential drugs and supplies and weak referral systems, all of which constrain their ability to deliver timely and quality maternal care

(Ganley *et al.,* 2015; Adatara *et al.,* 2021; Dahab & Sakellariou, 2020). Despite policy interventions such as the Free Maternal Health Policy under the National Health Insurance Scheme, structural deficiencies persist, resulting in operational strain and emotional burden for frontline providers.

Ganle *et al.* (2015) highlight that inequities in service distribution, long travel distances for women, and insufficient staffing are not only patient-level issues but systemic barriers that shape provider experiences. Adatara *et al.* (2021) similarly reports that rural healthcare professionals manage multiple responsibilities simultaneously, including clinical care, administrative duties, and community outreach, which intensify stress and risk of burnout.

Dahab and Sakellariou (2020) further illustrate that inadequate resources, delayed referrals, and poor infrastructure compel providers to make ethically complex decisions during obstetric emergencies, often leading to emotional distress when outcomes are adverse.

The emotional and relational dimensions of maternal healthcare are also significant. Afulani *et al.* (2019) reveal that providers in Ghana experience moral distress and fatigue stemming from high workloads, institutional pressures, and challenging patient interactions. These conditions influence interpersonal behaviour during childbirth, shaping the quality of care and the provider patient relationship.

Dzomeku *et al.* (2017) extend this understanding by showing how midwives navigate the emotional labour of childbirth care, balancing compassion for women with professional duties under constrained conditions. Providers reported adopting coping strategies such as peer support, improvisation of care practices and prioritization of emergencies to manage the stress of service delivery. Workforce motivation and burnout are critical aspects of providers lived experiences. Agyepong *et al.* (2016) highlight that inadequate recognition, limited career progression and suboptimal management practices contribute to low morale and diminished job satisfaction among healthcare workers in Ghana, further affecting their engagement in maternal care.

Hill *et al.* (2014) emphasizes the role of culturally sensitive communication and respectful maternity care, noting that providers often face challenges when conveying health information due to low literacy levels, language differences and entrenched cultural beliefs.

Including the review, it is imperative providers adapt communication strategies to ensure comprehension and compliance, often investing additional emotional and cognitive effort to maintain effective patient interactions.

MATERIALS AND METHODS

This article draws on a qualitative study conducted in the Gomoa West, Agona East, and Ekumfi districts of Ghana's Central Region between July 2023 and January 2024. The study employed an exploratory descriptive qualitative design, which enabled a comprehensive understanding of participants' experiences in their real-world context (Sandelowski, 2000; Kim *et al.,* 2017). The data was analyzed qualitatively based on the themes derived from the response recorded from interview with the respondents from the study areas.

Data Analysis

Staff Shortages and Increased Workload

Healthcare providers described staff shortages and increased workload as one of the most significant challenges affecting the delivery of maternal health services in the underserved districts. Participants explained that the number of healthcare providers available in many facilities was often inadequate compared to the number of women seeking maternal healthcare services. As a result, healthcare providers were frequently required to attend to large numbers of patients, work extended hours and perform multiple responsibilities simultaneously.

One midwife explained

"*Most of the time we are very few on duty. You may find one midwife attending to antenatal mothers, women in labour and postnatal mothers at the same time. It becomes very difficult to give each woman the attention she deserves."*

(HP-EK -02)

Similarly, another healthcare provider stated

"*Sometimes the workload is too much. We can have many women waiting to be seen and only a few staff available. By the end of the day, you are physically and mentally exhausted."*

(HP-GW-01)

Resource and Infrastructure Constraints

Healthcare providers described inadequate resources and poor infrastructure as persistent challenges in maternal healthcare delivery. Participants reported shortages of essential medicines, equipment, supplies and space required for effective maternal healthcare provision. These shortages often affected the quality and efficiency of care provided to women.

One healthcare provider explained

"*There are times when we do not have all the equipment we need. You must improvise or find alternative ways of helping the patient because the resources are limited.*"

(HP-AE-03,)

Another participant stated

"*The maternity ward is sometimes overcrowded and space becomes a challenge. We do our best, but the infrastructure does not always match the number of women requiring services."*
(HP-GW-04)

Another healthcare provider highlighted shortages of essential supplies that affected routine maternal healthcare delivery

"*Sometimes we run short of basic materials that we use every day. You may know exactly what a woman needs, but because the supplies are limited you must find another way of managing the situation.*"
(HP-EK-06)

A participant from Agona East similarly explained

"*The challenge is that the demand for services keeps increasing but the resources do not increase at the same pace. There are days when equipment is shared between units and this can delay the care we provide.*"
(HP-AE-05,)

Another healthcare provider stated

"*We sometimes receive emergency cases that require immediate intervention, but the facility may not have all the equipment needed. In those situations, you feel frustrated because you want to provide the best care possible.*"
(HP-GW-03)

One participant further explained

"*The working environment can be difficult. We may not have enough beds, enough space or enough supplies for the number of women who come for services. Despite that, we still must make sure every woman receives care.*"
(HP-EK-02)

Managing Maternal Emergencies and Referrals

Healthcare providers described managing maternal emergencies and coordinating referrals as particularly challenging aspects of maternal healthcare delivery. Participants explained that many women arrived at healthcare facilities with complications that required urgent intervention. Delays in referral systems, transportation challenges and limited emergency resources often complicated the management of such cases.

One participant narrated

"*Some women arrive when their condition has already deteriorated. At that point you have to act very quickly, but sometimes the resources needed for emergency management are not readily available.*"
(HP-EK-05)

Similarly, another healthcare provider stated

"*The referral process can be difficult. Even when you identify that a woman needs higher-level care, transportation may not be immediately available, and this creates anxiety for both staff and patients.*"
(HP-AE-01)

The experiences of healthcare providers revealed that managing emergencies require rapid decision-making and constant coordination under challenging circumstances. Another professional in Ekumfi confirmed this picture from their side of the encounter.

"*The distance is our biggest enemy here. By the time some of them arrive, the situation has already become an emergency, when it could have been managed simply if they had come early. But I do not blame the women. I blame the road. If you had to travel that road in labour, you too would hesitate.*"
(HP. EK-03)

RESULTS AND DISCUSSION

Participants' accounts reveal that challenges such as infrastructural deficits, workforce shortages, resource limitations, and inadequate referral systems are not merely contextual factors but are actively experienced, embodied, and navigated by providers in their daily work. These systemic constraints affect every dimension of professional experience: the physical comfort and safety of the work environment, the emotional well-being of providers, the clinical quality of care that can be delivered, and relationships with patients and communities.

This finding aligns with the growing body of research on healthcare provider experiences in low-resource settings. Studies have documented how "barriers such as professional silos, traditional discipline-specific training systems, inadequate infrastructure, and cultural attitudes undermine the effectiveness of [interprofessional care] in Ghana" (Dzomeku *et al.,* 2025, p. 4). The current study extends this understanding by showing how these systemic challenges translate into individual provider experiences of physical discomfort, emotional distress, professional frustration, and ethical dilemmas. Moreover, the study demonstrates how these experiences are not separate but are interwoven and mutually reinforcing, creating conditions of chronic stress and moral distress.

The study also highlights the paradox of provider experiences in underserved settings. Despite facing formidable challenges, such as chronic understaffing, inadequate infrastructure, resource scarcity, professional isolation, and moral distress, participants demonstrated remarkable resilience, commitment, and resourcefulness. This resilience was manifested in various ways: professional commitment and sense of purpose, innovative practices and resourcefulness, social support and community relationships, and spiritual and religious coping. The study also highlights the paradox of provider experiences in underserved settings.

Recommendations

Invest in health infrastructure: Addressing infrastructural deficits, including improvements to sanitation, equipment, and space for privacy, would not only improve the quality of care but also reduce provider stress and frustration (Dzomeku *et al.,* 2025).

Ensure reliable equipment and supplies: Health systems

should ensure that facilities have the equipment and supplies necessary for routine and emergency obstetric care. This includes not only equipment for deliveries but also for emergency procedures, as well as essential medications and consumables.

Expand the health workforce: Recruitment and retention of health professionals in underserved districts requires targeted interventions, including: financial incentives (e.g., hardship allowances, loan forgiveness programmes, stipends for rural postings); professional development opportunities (e.g., continuing education, mentorship, career advancement pathways); and improved working conditions (e.g., adequate housing, safe working environments, reasonable workload).

Strengthen inter professional team-based care: Team-based approaches can help address workforce shortages while improving the quality of care. However, as Dzomeku *et al.* (2025) note, this requires "clear role definitions, transparent communication, personal empathy and professional competence" (p. 8). Investing in inter professional education and training, as well as creating structures for effective team-based care, is essential.

Strengthen referral systems: Effective referral systems require clear protocols, reliable communication, and appropriate transport. Investments in ambulance services, telemedicine, and coordination between facilities could significantly improve maternal health outcomes. Additionally, strengthening the capacity of primary-level facilities to manage obstetric emergencies within their scope of practice could reduce the frequency and urgency of referrals.

CONCLUSION

This study has explored the lived experiences of healthcare providers delivering maternal health services in the underserved districts of Gomoa West, Agona East, and Ekumfi in Ghana's Central Region. The findings reveal that providers navigate a complex and challenging landscape of systemic constraints, including infrastructural deficits, acute workforce shortages, resource limitations, and inadequate referral systems. These constraints fundamentally shape provider experiences, affecting their physical comfort, emotional wellbeing, clinical practice, and professional identity.

Despite these formidable challenges, providers demonstrate remarkable resilience and commitment to their communities. This resilience is manifested through professional commitment and sense of purpose, innovative practices and resourcefulness, social support and community relationships, and spiritual and religious coping. However, the reliance on individual provider resilience without addressing systemic constraints is unsustainable and potentially exploitative.

Addressing the challenges documented in this study requires a comprehensive, multi-level approach that recognizes the interconnection between provider experiences and maternal health outcomes. Investments in infrastructure, workforce expansion, technology and innovation, and governance and leadership are not merely matters of provider welfare but are essential for improving the quality and accessibility of maternal health services.

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