



Is Maternal Healthcare Meeting Expectations in Agogo? A Critical Review of Service Satisfaction at Presbyterian Hospital, Akim North Municipality

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ABSTRACT

This study evaluates the quality of maternal healthcare services at Presbyterian Hospital, Agogo, following the implementation of quality improvement (QI) interventions. Using a mixed-methods approach, the research combines surveys of patients, review of patient records, and qualitative interviews and focus group discussions to assess satisfaction and clinical performance. The findings reveal high levels of patient satisfaction, with the majority rating their care positively and describing communication with providers as excellent. Clinical adherence to evidence-based practices was consistently strong, and most patients reported timely access to services. However, some inconsistencies remain, particularly related to delays, complications, and gaps in follow-up care. Despite these gains, infrastructural gaps, such as shortages in fetal monitoring equipment and sociocultural influences, continue to pose challenges. The study underscores that sustainable maternal health improvements require a holistic approach that addresses systemic resource shortages and sociocultural factors. Future strategies should combine infrastructural upgrades with culturally sensitive community engagement to foster trust and ensure long-term progress.

Keywords: Maternal healthcare, Quality improvement initiatives, Patient satisfaction, Healthcare providers

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Publication History

Received: 27th June, 2025

Accepted: 10th October, 2025

Published online:

11th December, 2025

To Cite this Article:

Appiah, Albert Junior Wilson, Felicia Hannah Nyame, Margaret Kessie & Angela Kwarteng.

“Is Maternal Healthcare Meeting Expectations in Agogo? A Critical Review of Service Satisfaction at Presbyterian Hospital, Akim North Municipality.” *E-Journal of Humanities, Arts and Social Sciences* 6, no. 14 (2025): 3519 - 3536, <https://doi.org/10.38159/ehass.20256141>.

INTRODUCTION

Maternal healthcare remains a vital component of global health priorities, especially in developing nations where maternal mortality rates are alarmingly high.¹ It refers to the comprehensive health and well-being of women throughout pregnancy, childbirth, and the postpartum period, encompassing services such as family planning, prenatal, and postnatal care. The quality of these services is crucial in reducing maternal morbidity and mortality, emphasizing the importance of continuous improvement in maternal health interventions.² Despite numerous international initiatives, including the Safe Motherhood program and

¹ World Health Organization, “Maternal Mortality,” 2016, <http://www.who.int/mediacentre/factsheets/fs348/en/>.

² WHO and UNICEF, “World Health Organization and UNICEF Countdown to 2015-Decade Report (2000–2010) Taking Stock of Maternal, Newborn and Child Survival (PDF)” (Geneva: WHO and UNICEF, 2010).

the launch of the Millennium Development Goals (MDGs), progress in maternal health outcomes has been gradual, with disparities persisting between developed and developing countries.³

Globally, maternal healthcare disparities are closely linked to various social determinants, with multiple studies highlighting how socioeconomic, geographical, and educational factors influence access and quality of maternal services in low- and middle-income countries.⁴ Evidence from Ethiopia, Mozambique, and Ghana reveals that maternal health literacy significantly affects service utilization by influencing women's awareness and understanding of available healthcare options and their benefits.⁵ Urban areas tend to report better maternal health outcomes owing to increased physical access and resource availability compared to rural settings, which face infrastructural and transportation challenges.⁶

Apart from infrastructural issues, social factors such as gender autonomy and familial support, as well as financial barriers, particularly out-of-pocket expenses, pose significant obstacles to accessing quality maternal care.⁷ The psychological and emotional aspects of maternal health, including feelings of depression, anxiety, and perceived support, further shape women's experiences and their satisfaction with care received.⁸ There is a growing consensus that healthcare quality must extend beyond clinical safety to encompass overall well-being, integrating physical, psychological, existential, and support domains.⁹

The global goal articulated by Sustainable Development Goal (SDG) 3.1 aims to reduce the maternal mortality ratio (MMR) to below 70 per 100,000 live births by 2030, recognizing that improved healthcare systems and equitable access are critical to this aim.¹⁰ Maternal mortality rate in Ghana remains a significant concern, especially within the Ashanti Region, where the rate was reported at 181 per 100,000 live births in 2022.¹¹ The complexity of maternal health challenges includes geographical barriers, socioeconomic disparities, and gaps in health literacy, all of which influence service utilization and health outcomes.¹² However, studies reveal that maternal health services' delivery varies widely across regions and facilities, often influenced by levels of resource allocation, training, and community engagement.¹³ Innovative quality improvement programs, including staff training, community outreach, and evidence-based practices (EBPs), have demonstrated potential in improving maternal health outcomes and satisfaction.¹⁴ The ongoing challenge remains in ensuring these initiatives are sustainable, accessible, and responsive to the unique needs of diverse populations within the healthcare system.

³ Jeremy Shiffman and Stephanie Smith, "Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality," *The Lancet* 370, no. 9595 (2007): 1370–79; World Health Organization, "Maternal Mortality."

⁴ Firew Tekle Bobo, Elias Ali Yesuf, and Mirkuzie Woldie, "Inequities in Utilization of Reproductive and Maternal Health Services in Ethiopia," *International Journal for Equity in Health* 16, no. 1 (December 19, 2017): 105, <https://doi.org/10.1186/s12939-017-0602-2>; Wondwosen Teklesilasie and Wakgari Deressa, "Barriers to Husbands' Involvement in Maternal Health Care in Sidama Zone, Southern Ethiopia: A Qualitative Study," *BMC Pregnancy and Childbirth* 20, no. 1 (2020): 21.

⁵ Leoba Nyathi et al., "Investigating the Accessibility Factors That Influence Antenatal Care Services Utilisation in Mangwe District, Zimbabwe," *African Journal of Primary Health Care & Family Medicine* 9, no. 1 (June 29, 2017), <https://doi.org/10.4102/phcfm.v9i1.1337>; Araya Abrha Medhanyie et al., "Barriers to the Uptake of Reproductive, Maternal and Neonatal Health Services among Women from the Pastoralist Communities of Afar, Ethiopia: A Qualitative Exploration," *The Ethiopian Journal of Health Development* 32, no. Special Is (2018).

⁶ Saifuddin Ahmed et al., "Economic Status, Education and Empowerment: Implications for Maternal Health Service Utilization in Developing Countries," *PLoS ONE* 5, no. 6 (June 23, 2010): e11190, <https://doi.org/10.1371/journal.pone.0011190>; Bobo, Yesuf, and Woldie, "Inequities in Utilization of Reproductive and Maternal Health Services in Ethiopia."

⁷ Chioma Oduenyi et al., "Gender Discrimination as a Barrier to High-Quality Maternal and Newborn Health Care in Nigeria: Findings from a Cross-Sectional Quality of Care Assessment," *BMC Health Services Research* 21, no. 1 (2021): 198; Khátia Munguambe et al., "Barriers and Facilitators to Health Care Seeking Behaviours in Pregnancy in Rural Communities of Southern Mozambique," *Reproductive Health* 13, no. Suppl 1 (2016): 31; Judie Arnold et al., "Getting There: Overcoming Barriers to Reproductive and Maternal Health Services Access in Northern Togo-A Qualitative Study," *World Medical & Health Policy* 8, no. 3 (September 2016): 223–44, <https://doi.org/10.1002/wmh3.195>.

⁸ Shamsa Zafar et al., "Integrating Maternal Psychosocial Well-being into a Child-development Intervention: The Five-pillars Approach," *Annals of the New York Academy of Sciences* 1308, no. 1 (2014): 107–17.

⁹ S Robin Cohen et al., "Quality of Life in HIV Disease as Measured by the McGill Quality of Life Questionnaire," *Aids* 10, no. 12 (1996): 1421–27; Janet R McColl-Kennedy et al., "Health Care Customer Value Cocreation Practice Styles," *Journal of Service Research* 15, no. 4 (2012): 370–89.

¹⁰ World Health Organization, "Global Strategy on Human Resources for Health: Workforce 2030" (Geneva: WHO, 2020).

¹¹ Ghana Health Service, "Annual Health Report," 2022.

¹² Munguambe et al., "Barriers and Facilitators to Health Care Seeking Behaviours in Pregnancy in Rural Communities of Southern Mozambique"; Gladys Buruwaa Nuamah et al., "Access and Utilization of Maternal Healthcare in a Rural District in the Forest Belt of Ghana," *BMC Pregnancy and Childbirth* 19, no. 1 (December 7, 2019): 6, <https://doi.org/10.1186/s12884-018-2159-5>.

¹³ Nuamah et al., "Access and Utilization of Maternal Healthcare in a Rural District in the Forest Belt of Ghana."

¹⁴ Pascal Schmid, *Medicine, Faith and Politics in Agogo: A History of Health Care Delivery in Rural Ghana, Ca. 1925 to 1980*, vol. 13 (LIT Verlag Münster, 2018).

The Presbyterian Hospital in Agogo, established in 1931, holds a pivotal role within this context, serving as a pioneering mission hospital that provides both healthcare services and training for health professionals. Its evolution exemplifies resilience and adaptability in maternal health delivery, demonstrating a longstanding commitment to improving maternal outcomes.¹⁵ In recent years, targeted efforts at the hospital have focused on implementing QI initiatives aimed at reducing maternal morbidity and mortality. These initiatives have yielded notable achievements, such as a period in 2019 characterized by zero maternal mortality among delivering women, an important milestone indicative of progress.¹⁶ Building on these successes, it is essential to evaluate maternal healthcare satisfaction within the hospital's operational environment, not only to assess the current quality of care but also to understand how recent improvements have impacted patient perceptions and experience over the past years.

Understanding patient and provider perspectives, the effectiveness of ongoing programs, and the role of community engagement are critical for informing continuous QI efforts. This evaluation aims to identify the facilitators and barriers that influence satisfaction levels and service delivery, enabling the refinement of strategies to sustain and advance maternal health outcomes in Akim North Municipality. The broader significance of this inquiry underscores that healthcare remains a cornerstone of societal stability and development, underpinning societal progress.¹⁷ The study generates actionable insights and practical recommendations for sustaining and improving the quality of maternal healthcare services within the context of recent progress, particularly in resource-limited settings.

LITERATURE REVIEW

The quality of maternal healthcare extends beyond clinical safety, encompassing timely access to services, respectful and person-centered communication, emotional support, privacy, continuity of care, and the upholding of women's autonomy.¹⁸ Various frameworks highlight the importance of integrating psychological, physical, social, and existential aspects into maternal care experiences. Patient satisfaction in healthcare is widely acknowledged as a multidimensional concept. According to Andaleeb, satisfaction is shaped by expectations, the perceived technical competence of providers, interpersonal interactions, and systemic factors such as wait times and the healthcare environment.¹⁹ Within maternal care, satisfaction is strongly linked to women's perception of respect, the quality of communication, and the adequacy of information provided during pregnancy and after childbirth.²⁰

Service utilization in maternal health is influenced by factors such as socioeconomic status, geographic proximity, transportation access, and health literacy. Urban populations tend to report higher service utilization and satisfaction levels,²¹ although urban facilities often contend with overcrowding and resource limitations. In many low- and middle-income countries (LMICs), perceived high-quality and respectful care are key drivers of skilled birth attendance and overall satisfaction with maternal services.²² Persistent barriers include financial constraints, long waiting periods, staff attitudes, and a lack of privacy.²³

¹⁵ Schmid, *Medicine, Faith and Politics in Agogo: A History of Health Care Delivery in Rural Ghana, Ca. 1925 to 1980*.

¹⁶ DZIF- The German Center for Infection Research., "Zero Maternal Mortality-2023 Ghanaian Cooperation Hospital," 2024.

¹⁷ Wilson Albert Appiah, "Examining the Access to Healthcare among Inmates in Ghana since 1992: A Case Study on Manhyia Local Prison," *International Journal of Research and Innovation in Social Science* 8, no. 8 (2024): 2819–33.

¹⁸ Avedis Donabedian, "The Quality of Care: How Can It Be Assessed?," *Jama* 260, no. 12 (1988): 1743–48; World Health Organization, "Maternal Mortality."

¹⁹ Syed Saad Andaleeb, "Service Quality in Public and Private Hospitals in Urban Bangladesh: A Comparative Study," *Health Policy* 53, no. 1 (2000): 25–37.

²⁰ Medhanyie et al., "Barriers to the Uptake of Reproductive, Maternal and Neonatal Health Services among Women from the Pastoralist Communities of Afar, Ethiopia: A Qualitative Exploration."

²¹ Yubing Sui et al., "Household Socioeconomic Status and Antenatal Care Utilization among Women in the Reproductive-Age," *Frontiers in Public Health* 9 (2021): 724337.

²² G Justus Hofmeyr et al., "Obstetric Care in Low-Resource Settings: What, Who, and How to Overcome Challenges to Scale Up?," *International Journal of Gynecology & Obstetrics* 107 (2009): S21–45.

²³ Florence Gyembuzie Wongnaah et al., "Barriers to Healthcare Services Utilisation among Women in Ghana: Evidence from the 2022 Ghana Demographic and Health Survey," *BMC Health Services Research* 25, no. 1 (2025): 305; Daniel Adjei Amporfro et al., "Patients Satisfaction with Healthcare Delivery in Ghana," *BMC Health Services Research* 21, no. 1 (2021): 722.

Key determinants of service satisfaction in LMICs

Several factors consistently shape maternal service satisfaction in LMICs. Effective, respectful, and culturally attuned communication plays a critical role in fostering satisfaction and improving adherence to care.²⁴ Practices such as shared decision-making, clear explanations of procedures, and language compatibility are particularly influential.²⁵ Studies by Bowser & Hill and D-zomeku et al., reveal that experiences of disrespect and abuse discourage women from seeking care and reduce their satisfaction.²⁶ However, initiatives promoting respectful maternity care through provider training, policy reforms, and accountability systems have demonstrated potential in enhancing the care experience.²⁷ Additionally, long delays, weak referral systems, and fragmented care structures tend to undermine satisfaction. In contrast, continuity of care and integrated service delivery models, such as combining antenatal and delivery care in a single facility, have been associated with higher levels of patient satisfaction.²⁸

Health literacy also plays a pivotal role; women who are better informed about their pregnancy options are more likely to make empowered choices and express greater satisfaction with the care received.²⁹ Financial considerations, including out-of-pocket costs, indirect expenses, and the availability of insurance, also impact satisfaction by influencing perceptions of value and access to care.³⁰

Ghana-Specific Insights

Nuamah and colleagues reveal that maternal healthcare quality and service delivery vary significantly across regions and facilities, often due to disparities in resources, staff training, and management capacity.³¹ Although initiatives such as provider training, community outreach, and adherence to care guidelines have shown promise in improving service quality, maintaining these efforts remains a challenge.³² Research by Awoonor-Williams et al., Ameyaw, and Nuamah et al. highlights notable regional and institutional differences in maternal health service delivery, suggesting that patient satisfaction is highly context-dependent.³³

Maternal health literacy has also been identified as a key factor in shaping women's engagement with antenatal and postnatal care in Ghana. Greater understanding of health information leads to more positive perceptions of care and higher satisfaction.³⁴ Simplifying medical information and ensuring language alignment between providers and patients are effective strategies to enhance comprehension and satisfaction. Additionally, studies have documented both respectful and disrespectful treatment of women in healthcare settings, which significantly affects trust and ongoing service use.³⁵ Interventions that

²⁴ Veronica Millicent D-zomeku et al., "Exploring Midwives' Understanding of Respectful Maternal Care in Kumasi, Ghana: Qualitative Inquiry," *PLoS One* 15, no. 7 (2020): e0220538.

²⁵ Furaha August et al., "Community Health Workers Can Improve Male Involvement in Maternal Health: Evidence from Rural Tanzania," *Global Health Action* 9, no. 1 (2016): 30064.

²⁶ Diana Bowser and Kathleen Hill, "Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis," *USAID-Traction Project*, 2010; D-zomeku et al., "Exploring Midwives' Understanding of Respectful Maternal Care in Kumasi, Ghana: Qualitative Inquiry."

²⁷ Bowser and Hill, "Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis"; D-zomeku et al., "Exploring Midwives' Understanding of Respectful Maternal Care in Kumasi, Ghana: Qualitative Inquiry."

²⁸ Claire Jackson and Lauren Ball, "Continuity of Care: Vital, but How Do We Measure and Promote It?," *Aust J Gen Pract* 47, no. 10 (2018): 662–64; Vincent S. Fan et al., "Continuity of Care and Other Determinants of Patient Satisfaction with Primary Care," *Journal of General Internal Medicine* 20, no. 3 (2005): 226–33.

²⁹ Nyathi et al., "Investigating the Accessibility Factors That Influence Antenatal Care Services Utilisation in Mangwe District, Zimbabwe"; Medhanyie et al., "Barriers to the Uptake of Reproductive, Maternal and Neonatal Health Services among Women from the Pastoralist Communities of Afar, Ethiopia: A Qualitative Exploration."

³⁰ Arnold et al., "Getting There: Overcoming Barriers to Reproductive and Maternal Health Services Access in Northern Togo-A Qualitative Study." Jere R. Behrman et al., "How Financial Literacy Affects Household Wealth Accumulation," *American Economic Review* 102, no. 3 (2012): 300–304.

³¹ Nuamah et al., "Access and Utilization of Maternal Healthcare in a Rural District in the Forest Belt of Ghana."

³² Nuamah et al., "Access and Utilization of Maternal Healthcare in a Rural District in the Forest Belt of Ghana."

³³ John Koku Awoonor-Williams et al., "Using Health Systems and Policy Research to Achieve Universal Health Coverage in Ghana," *Global Health: Science and Practice* 10, no. Supplement 1 (2022); Edward Kwabena Ameyaw, *Maternal Referral Systems in the Northern Region of Ghana* (University of Technology Sydney (Australia), 2021); Nuamah et al., "Access and Utilization of Maternal Healthcare in a Rural District in the Forest Belt of Ghana."

³⁴ Nyathi et al., "Investigating the Accessibility Factors That Influence Antenatal Care Services Utilisation in Mangwe District, Zimbabwe"; Medhanyie et al., "Barriers to the Uptake of Reproductive, Maternal and Neonatal Health Services among Women from the Pastoralist Communities of Afar, Ethiopia: A Qualitative Exploration."

³⁵ D-zomeku et al., "Exploring Midwives' Understanding of Respectful Maternal Care in Kumasi, Ghana: Qualitative Inquiry"; Awoonor-Williams et al., "Using Health Systems and Policy Research to Achieve Universal Health Coverage in Ghana."

promote dignity and respectful communication are especially relevant in the Ghanaian context. Though sustainability and scaling are still crucial factors, Ghanaian healthcare facilities have tested QI approaches (including training, mentorship, and feedback loops) and seen encouraging gains in process indicators and user experiences.³⁶

THEORETICAL FRAMEWORK

This study employed the Donabedian Model, developed by Avedis Donabedian, as the foundational framework for examining the level of satisfaction in maternal healthcare at Presbyterian Hospital, Agogo. The model emphasizes that healthcare quality can be comprehensively assessed through three interconnected components: structure, process, and outcome, providing a holistic perspective on healthcare delivery.³⁷ The structure component pertains to the characteristics of the healthcare environment, including hospital resources, staffing levels, infrastructure, and availability of essential equipment. It encompasses factors such as staff qualifications, ongoing training, and the organization of the facility, all of which serve as the foundation for quality care.³⁸ The process component involves the actual activities involved in delivering maternal healthcare, including adherence to clinical protocols, diagnostic accuracy, treatment procedures, and interpersonal interactions between providers and patients. These processes directly influence the quality and safety of care, as well as patient engagement.³⁹ The outcome component measures the results of healthcare services, such as maternal morbidity and mortality, patient satisfaction, and other health indicators that reflect the effectiveness of care.⁴⁰

The relevance of the Donabedian Model in this context lies in its ability to evaluate maternal healthcare quality holistically by linking structural factors with procedural activities and health outcomes.⁴¹ It offers valuable insights into how improvements in facility resources, staff training, and clinical practices can positively influence maternal health outcomes and patient satisfaction. Although some critiques highlight the challenges in establishing direct causal relationships among the components,⁴² its flexibility and comprehensive nature make it an invaluable tool for guiding quality improvement efforts.⁴³ The suitability of this model for the current study is grounded in its capacity to identify specific areas for improvement within the hospital's maternal health services, thus informing targeted strategies that enhance care quality and patient satisfaction. Its extensive application in healthcare quality assessment underscores its robustness, especially in efforts aimed at improving maternal health outcomes through evidence-based interventions.⁴⁴ Fundamentally, the Donabedian Framework has provided a solid conceptual foundation for this research, enabling the synthesis of findings with existing literature and fostering actionable insights tailored to the context of Presbyterian Hospital, Agogo.

METHODOLOGY

Study Design

This study employed a mixed-methods design, integrating both quantitative and qualitative data collection approaches to gain comprehensive insights into maternal healthcare satisfaction at Presbyterian Hospital, Agogo. This approach enhanced the validity of the findings through triangulation and cross-verification of information from multiple sources. Quantitative analysis involved the use of descriptive statistics to summarize satisfaction scores and QI initiatives in maternal care across various domains, helping to identify overall trends and variations among respondents. Qualitative data was analyzed through thematic coding of audio transcripts from interviews and focus group discussions, which facilitated the

³⁶ Nuamah et al., "Access and Utilization of Maternal Healthcare in a Rural District in the Forest Belt of Ghana"; Schmid, *Medicine, Faith and Politics in Agogo: A History of Health Care Delivery in Rural Ghana, Ca. 1925 to 1980*.

³⁷ Svetlana Begicheva, "Fuzzy Model for Evaluating the Quality of Medical Care," in *2019 IEEE 21st Conference on Business Informatics (CBI)*, vol. 2 (IEEE, 2019), 5–8.

³⁸ Begicheva, "Fuzzy Model for Evaluating the Quality of Medical Care."

³⁹ Hanae Ibn El Haj, Mohamed Lamrini, and Noureddine Rais, "Quality of Care between Donabedian Model and ISO9001V2008.," *International Journal for Quality Research* 7, no. 1 (2013).

⁴⁰ J K Opele and K O Adepoju, "Validation of the Donabedian Model of Health Service Quality in Selected States in Nigeria," *Nigerian Journal of Clinical Practice* 27, no. 2 (2024): 167–73.

⁴¹ Pamela Mitchell, *Core Principles & Values of Effective Team-Based Health Care*, 2012.

⁴² Begicheva, "Fuzzy Model for Evaluating the Quality of Medical Care."

⁴³ Opele and Adepoju, "Validation of the Donabedian Model of Health Service Quality in Selected States in Nigeria."

⁴⁴ Ibn El Haj, Lamrini, and Rais, "Quality of Care between Donabedian Model and ISO9001V2008."

identification of recurrent themes and patterns relating to perceived quality of maternal healthcare, challenges faced by patients and providers, and opportunities for service improvement.

Study Population

The study focused on three primary groups at Presbyterian Hospital, Agogo. The first group comprised patients who received maternal healthcare services at the facility. The second data were collected from patient record files, encompassing the period from 2021 to 2024. A total of 200 patient record files were randomly selected for review. The final group included healthcare providers involved in maternal healthcare delivery, such as nurses, midwives, and doctors working at the facility. Ninety patients participated in the survey, five healthcare providers were purposively sampled for interviews, and four midwives were recruited for a focus group discussion.

Data Collection Methods

Data was collected using a combination of instruments designed to capture both satisfaction levels and detailed personal experiences. Quantitative data were gathered through surveys that collected demographic information and assessed satisfaction across key domains such as quality of care, access, wait times, communication effectiveness, and overall experience. Qualitative data were obtained through interviews and focus group discussions with a purposively selected subset of healthcare providers, aiming to explore their perceptions, expectations, and suggestions for improving maternal healthcare services.

Study Site

This study was conducted in the Asante Akim North Municipality in Ghana, with Presbyterian Hospital, Agogo, serving as the primary site for participant recruitment. The facility is currently recognized as the second-largest hospital in the Ashanti Region of Ghana and functions as a referral center for numerous hospitals within the municipality and the broader region. In 2022, the hospital was upgraded to a Level 'A' health facility, which is equivalent to a regional hospital status. As of 2023, the hospital had a total bed capacity of 350. The municipality recorded a total population of 85,788 residents according to the 2021 population census, with females constituting 49% and males 51%. It is situated in the eastern part of the Ashanti Region, between latitudes 6°30' and 7°30' North, and longitudes 0°15' and 1°20' West. The district shares borders with Sekyere Kumawu District, Kwahu East, Asante Akim South District, and Sekyere East District. It covers a land area of 1,126 square kilometers, accounting for approximately 4.6% of the region's total land area of 24,389 square kilometers. Presbyterian Hospital, Agogo, was specifically selected for this study due to its wide range of healthcare services and its recent success in implementing quality improvement initiatives in maternal healthcare within the municipality.

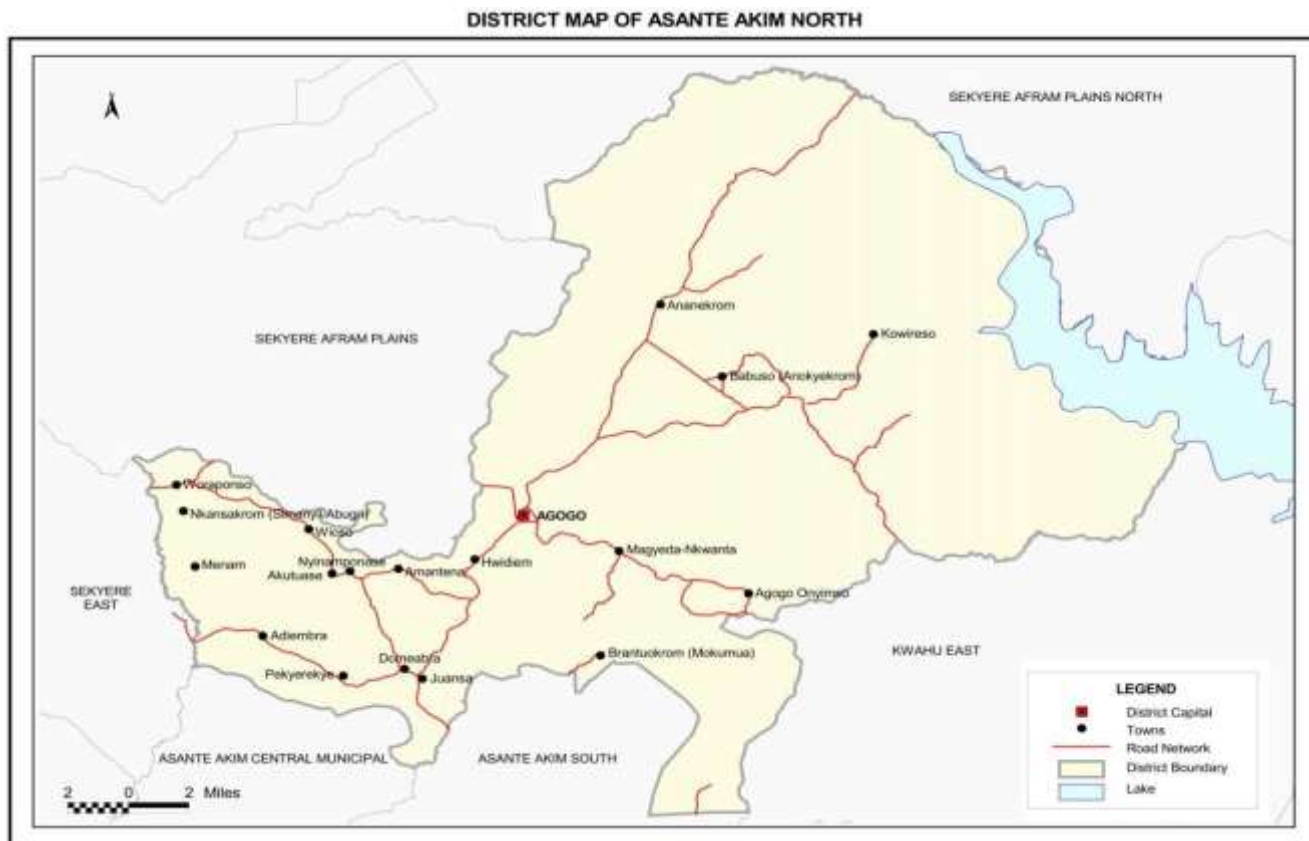


Fig. 1: The Map of Asante Akim North Municipality locating the capital (Agogo) where the Presbyterian Hospital is located. Source: Ghana Statistical Service (2014).

Ethical Considerations

Before the fieldwork commenced, the study received approval from the administration of the Presbyterian Hospital in Agogo. In addition, all participants were provided with a consent letter, which they signed prior to their involvement. This process was designed to uphold their rights and safeguard their privacy. For confidentiality and anonymity purposes, participants were informed that they had the right to withdraw from the study at any time, and that any information they provided could be retracted without consequence. The researchers were committed to maintaining these ethical standards throughout the study.

PRESENTATION OF FINDINGS

A total number of (n=90) patients/clients responded to the quantitative survey, with the majority aged between 20 and 35 years—36.7% were aged 20–27 years and another 36.7% were aged 28–35 years. The remaining participants were aged 36–43 years (18.9%) and 44–51 years (7.8%). Regarding education, 36.7% had completed senior high school, 23.3% had junior high school, 23.3% had tertiary education, 10.0% had never attended school, and 6.7% had only primary education. Over half of the respondents (51.1%) were married, while 25.6% were not married, and 23.3% were cohabiting. In terms of occupation, 61.1% were engaged in trading, 21.1% in farming, 6.7% in teaching, and 11.1% identified as healthcare providers.

Table 1. Percentage Distribution of Patients' Responses to Maternal Healthcare Services

Themes	Category	Percentage %
Quality of Care		
Quality of care during the recent visit	Excellent	59.6
	Good	29.8

	Poor	10.6
Delays in treatment	Frequent	4.3
	Sometimes	53.2
	Never	42.5
Staff-client Communication	Excellent	74.5
	Good	14.9
	Bad	10.6
Healthcare Accessibility		
Easy accessibility to maternal services	Very easy	87.3
	Neutral	11.3
	Challenging	0
Promptness of treatment	Rare	6.4
	Sometimes	12.8
	Regular	80.8

The responses of patients to maternal healthcare services showed generally high satisfaction levels. Majority rated the quality of care during their last visit as excellent (59.6%) or good (29.8%), with only 10.6% rating it as poor. Regarding delays, 4.3% experienced delays always, 53.2% sometimes, while 42.5% reported no delays. Communication between staff and clients was predominantly positive, with 74.5% describing it as excellent and 14.9% as good. Access to maternal health services was largely easy, with 87.3%, while 11.3% were neutral, and none found it difficult. Lastly, the majority of patients felt their treatment was prompt, with 80.8% reporting frequent promptness, 12.8% occasional, and only 6.4% experiencing it rarely.

Table 2. Statistical Distribution of Patient Record Files

Demographics / Variables	Distribution / Description	Percentage / Central Tendency	Variability / Notes (Std Dev)
Demographic Variables			
Antenatal care recipients	pregnant mothers reviewed (78)	39 of 200 patients	—
Delivery patients	mothers who delivered (92)	46 of 200 patients	—
Postnatal care	lactating mothers (30)	15 of 200 patients	—
Clinical And Quality Data			
Patients correctly diagnosed	(Yes)95.5, (No) 4.5	Mean: 4.89 out of 5; 95.5 correct diagnosis	Low variability (0.32)
Adhered to evidence-based practices	(Yes) 100, (No) 0	Mean: 5.00 (full adherence); 100 compliances	No variability (0.00)
Complications encountered during the patient’s visit	(Yes) 24, (No) 76	Mean: 2.13 out of 5; 24 experienced complications	Higher variability (0.83)
Patient seen within the guideline-prescribed timeframe	(Yes)100, (No) 0	Mean: 5.00; 100 within recommended time	Fully consistent (0.00)
Lab results/imaging communicated promptly	(Yes)74, (No) 26	Mean: 4.07; 74 timely reports	More fluctuation (0.83)
QI initiative followed	(Yes)100, (No) 0	Mean: 5.00; 100 adherences	Consistent compliance (0.00)

A total of (n=200) patient files were reviewed to assess various demographic and clinical variables. Among these, 78 pregnant mothers (39% of the total) were receiving antenatal care, 92 mothers who had recently delivered accounted for 46%, and 30 lactating mothers represented 15% of the sample. In terms of clinical and quality data, the diagnosis accuracy was very high, with 95.5% of patients correctly diagnosed, reflecting a mean score of 4.89 out of 5 and low variability (standard deviation of 0.32). All healthcare providers adhered to evidence-based practices, achieving full compliance with a mean score of 5.00 and no variability. About 24% of patients experienced complications during their visit, with a mean score of 2.13 out of 5 and higher variability (standard deviation of 0.83), indicating some inconsistencies. All patients (100%) were seen within the recommended timeframe, demonstrating full consistency (mean score of 5.00, no variability). Timely reporting of lab results and imaging reports was achieved for 74% of patients, with a mean score of 4.07 and more fluctuation in adherence (standard deviation of 0.83). Lastly, adherence to quality improvement initiatives was universal, with all facilities fully compliant, reflected in a mean score of 5.00 and no variability.

Interviews

Table 3. Emergent Themes from the Qualitative Interview

Major Themes	Emergent Issues / Sub-Themes
Capacity Building and Training	Annual training for midwives and nurses Weekly maternal health audits Use of Laboratory and Health Information Management System (LHIMS) and Focused Antenatal Care
Health Education and Community Engagement	Health education during antenatal visits Home visits by Obstetrician-Gynecologist Specialist (OGS) Protocol notes/posters at wards
Clinical Management and Protocol Utilization	Use of Cardiotocographs (CTG) during labor and antenatal care Improved client follow-up at ANC
Strategic And Systemic Improvements	Future planning and maternity complex Strengthening public health units Accessibility of gynecologists (night shifts) Celebrating lifesaving successes
Focus On Prevention, Staff Well-Being, And Quality	Preventing complications Boosting staff morale Dedicated obstetricians
Training & Evidence-Based Practices	Internally-led training on protocols, resuscitation, referrals, and partograph monitoring Continuous evaluation of practices
Resource Allocation and Support	Management support Institutional and municipal collaborations
Challenges Of Qi Initiatives	Internal Recognizing danger signs Workforce stability & skills Equipment availability Decision-making efficiency Staff motivation/response responsiveness External Cultural beliefs and myths

	Financial barriers Referral delays and community-level delays
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Synthesized Themes from Participant Responses

Participants emphasized ongoing efforts to improve maternal health through education, training, and monitoring. For example, staff reported that antenatal health education is key to increasing awareness, with midwives providing crucial information on pregnancy, delivery, and postnatal care. The hospital has also implemented annual training programs for midwives and nurses, involving partnerships with nearby facilities. Since starting these trainings in 2022, staff have noted a significant reduction in maternal mortality, with some reporting zero maternal deaths in 2023. Weekly maternal audits were cited as instrumental in reviewing cases, enabling continuous improvement, while follow-up systems, including home visits and patient tracking, helped ensure timely care.

Participants highlighted the importance of future planning to sustain maternal health improvements. One respondent stressed the need for strategic assessments to anticipate challenges and strengthen systems. They suggested making gynecologists more accessible, especially at night, through accommodations, to ensure ongoing care. Building a comprehensive maternity complex was also proposed to improve service integration and community outreach. Respondents underscored the importance of dedicated obstetricians and acknowledged past successes in saving lives, emphasizing that committed staff are vital to achieving zero maternal mortality.

The hospital’s internal training initiatives, led by specialists, were recognized as impactful. Staff pointed out that regular workshops and conferences, held twice monthly, keep midwives updated on best practices and protocols. These training sessions, along with continuous monitoring of practices such as partograph use and referral processes, have resulted in improved outcomes. For example, preparation for incoming referrals, including prompt assessment and intervention, has helped save neonatal lives and reduce complications. Also, participants expressed that management strongly supports staff training and development. Collaboration with the Ghana Health Service and regional partners enhances resource sharing and expertise, improving service quality. For instance, partnerships with research institutions and neighboring hospitals strengthen referral networks and resource pools.

Despite progress, several barriers remain. Community beliefs and myths often delay care-seeking, as women fail to recognize danger signs or avoid hospital visits due to cultural or financial reasons. One respondent recounted a maternal death caused by delayed recognition of hypertensive complications, emphasizing the community’s role in timely intervention. Additionally, staffing challenges, inexperience, and resource limitations hinder progress. Continuous training and community engagement, the respondents agreed, are essential to overcoming these obstacles and improving maternal outcomes.

Focus Group Discussions

Table 4: Emergent Themes from the Focus Group Discussion

Topics Discussed in Focus Group	Key Sub-Themes
Resource availability and infrastructure	Insufficient equipment (e.g., CTG, pinards) Infrastructure challenges and motivation Resource management and support Need for innovative resources and ongoing training
Community engagement and access to care	Outreach programs and community involvement Financial barriers delaying care Referral and response delays Emergency preparedness and response plans
Staffing, guidelines, and education	Accessibility of clinical guidelines Fetal monitoring practices and education Staffing shortages and workload issues

Responses from Focus Group Discussions

On issues of resource availability and infrastructure, participants highlighted that inadequate equipment, such as only two CTGs and a single Pinard stethoscope, hampers effective fetal monitoring. One respondent noted, “The limited availability of essential equipment like CTGs affects our ability to monitor fetal health properly”. Call for infrastructural enhancement was also emphasized. Respondents noted that renovating and establishing a mini-theater to enhance maternal care will ease the burden on the existing ones. Staff expressed motivation to improve skills through workshops, aiming for greater access to diagnostic tools like ultrasound.

“Participating in workshops helps us gain skills and access to ultrasound machines for better care.” Positive impacts were observed when resources like protocol posters and the LHIMS were introduced, improving record-keeping and reducing maternal mortality. Training programs, such as shoulder dystocia and partograph workshops, significantly enhanced clinical skills. One midwife shared, “The shoulder dystocia workshop taught me how to manage difficult deliveries, which I previously didn’t know”.

Effective community engagement through home visits by the OGS department educated pregnant women on ANC importance and danger signs. One participant stated, “home visits have helped us inform women about labor signs, encouraging them to deliver at the hospital.”

However, financial barriers were a major concern, with delays caused by patients’ inability to afford care on time, sometimes worsening health outcomes. Referral delays were a major concern among all the participating midwives in this study. Late referrals from surrounding clinics often arrive when patients are already critically ill, and sometimes, staff experienced reluctance among some doctors to review cases promptly.

Having accessible protocols and guidelines was deemed crucial for quality care. Staff shared that posters and LHIMS have improved clinical decision-making and record accuracy. One respondent said, “Protocols and notes help us make informed decisions and have reduced maternal mortality”. Training in fetal monitoring and emergency management improved staff competence, with workshops on partograph use and shoulder dystocia noted as particularly helpful. Participants explained, “The partograph is mandatory now; it helps us monitor labor and identify when to intervene”. However, staffing shortages and high workload remain significant barriers. A participant recounted this;

“..... You see, sending a patient to the theatre is the decision of the doctors. Sometimes, theatre referrals often get delayed whenever we tell the doctor, this patient needs to go to the theatre. I remember when Maa Mary [respondent’s in-charge] was here, there was a case that we had to run to the theatre. But the doctor said he has not ordered us to bring the patient to the theatre, so we should send the patient back to the ward. This wasn’t easy at all. I was a junior staff member then. My in-charge still insisted that I send the patient to the theater. These cases happen often here, and it seems no one is concerned about it. Even though I’m no longer a junior staff member, I have seen a couple of cases like this recently and sometimes by the time a decision is made, the condition of the patient has worsened.”

DISCUSSION

The findings reveal high levels of satisfaction with maternal healthcare services. Most women rated the quality of care during their last visit as excellent (59.6%) or good (29.8%), with only a modest proportion (10.6%) describing it as poor. Additionally, 87.3% reported that accessing maternal health services was easy, and 100% of patients perceived their treatment to be prompt, with the majority experiencing frequent promptness (80.8%). These findings align with the broader literature, which establishes a positive correlation between structured QI strategies and improved patient satisfaction.⁴⁵ High patient satisfaction levels are a key indicator of the success of quality initiatives. Research suggests that patient perceptions are strongly linked to the quality of communication, respect, and timely care. For example, studies by Sirera et al., have demonstrated that when health facilities implement structured patient-centered

⁴⁵ Ashley K Hagaman et al., “The Impacts of Quality Improvement on Maternal and Newborn Health: Preliminary Findings from a Health System Integrated Intervention in Four Ethiopian Regions,” *BMC Health Services Research* 20, no. 1 (2020): 522.

approaches, such as standardized communication protocols and reducing waiting times, patient satisfaction significantly increases.⁴⁶

The fact that 74.5% of respondents rated staff communication as excellent echoes such findings, indicating that efforts to improve provider-patient interactions at Presbyterian Hospital Agogo are yielding positive outcomes. Furthermore, delays in treatment, a common challenge in resource-constrained settings, were experienced “sometimes” by the majority (53.2%) of women, with only 4.3% reporting consistent delays. This relatively low occurrence of persistent delays suggests that targeted interventions such as process streamlining and staff training have had some effect in improving timeliness, consistent with studies like those by Holtz et al., which highlight that process improvement strategies can significantly reduce wait times even in low-resource settings.⁴⁷

Clinical record review reinforces the positive feedback from patients, with 95.5% of diagnoses being accurate, reflected in a mean score of 4.89 out of 5 and low variability (standard deviation Std Dev: 0.32). This high diagnostic accuracy indicates that clinical protocols and diagnostic procedures are largely being followed, consistent with prior research emphasizing the importance of adherence to evidence-based protocols in improving maternal outcomes.⁴⁸ Additionally, all healthcare providers adhered fully to evidence-based practices, achieving a mean adherence score of 5.00, with no variability, showcasing the effective dissemination and institutionalization of clinical guidelines at the hospital. These findings provide empirical support for the proposition that continuous medical education (CME), regular audits, and feedback mechanisms, core components of QI initiatives, are instrumental in fostering compliance and clinical excellence. Komolafe and colleagues hypothesize that institutional capacity-building programs that emphasize adherence to current standards of maternal care are fundamental in reducing preventable maternal morbidity and mortality, especially in settings where resource limitations are persistent.⁴⁹

Despite these positive indicators, approximately 24% of patients experienced complications during their visits, with a mean complication severity score of 2.13 out of 5 and higher variability (Std Dev: 0.83), suggesting inconsistencies in clinical management. This evidence points to gaps in resource availability and clinical oversight, corroborating prior findings that infrastructural deficiencies, such as shortages of essential monitoring equipment, hamper the quality of care.⁵⁰ Indeed, commodities like CTGs and Dopplers, which are critical for fetal monitoring, are often in limited supply, forcing reliance on less effective tools like Pinard stethoscopes. Such infrastructural gaps can directly impact clinical accuracy, as highlighted by Goldenberg et al., who demonstrated that equipment shortages are a significant barrier to optimal obstetric care in many low-resource settings.⁵¹ Also, though all patients were seen within the recommended timeframe, the timely reporting of lab results was achieved for 74% of cases, with more fluctuation and variability (Std Dev = 0.83). This emphasizes logistical bottlenecks that often impede prompt diagnosis and treatment, a problem well-documented in similar settings where delays in laboratory reporting compromise maternal safety.⁵² Effective resource management, including timely procurement and maintenance of laboratory and imaging equipment, remains critical to sustain and expand improvements in clinical care.

Enhancing provider capacity through CPD and adherence to EBPs remains at the core of ongoing maternal healthcare transformation at Presbyterian Hospital Agogo. Training programs that focus on fetal monitoring, emergency obstetric response, and management of complex deliveries such as shoulder

⁴⁶ Betty Sirera et al., “Impact of Patient-Centered Communication on Patient Satisfaction Scores in Patients with Chronic Life-Limiting Illnesses: An Experience from Kenya,” *Frontiers in Medicine* 11 (2024): 1290907.

⁴⁷ Sara A Holtz et al., “A Systematic Review of Interventions to Reduce Maternal Mortality among HIV-Infected Pregnant and Postpartum Women,” *International Journal of MCH and AIDS* 4, no. 2 (2015): 11.

⁴⁸ World Health Organization, “Maternal Mortality.”

⁴⁹ Abiola Olubusola Komolafe et al., “Adherence to Practice Guidelines in the Implementation of Emergency Obstetric and Newborn Care in Referral Hospitals in Osun State, Nigeria,” *SAGE Open Nursing* 10 (2024): 23779608231226064.

⁵⁰ Joseph Adu and Mark Fordjour Owusu, “How Do We Improve Maternal and Child Health Outcomes in Ghana?,” *The International Journal of Health Planning and Management* 38, no. 4 (2023): 898–903.

⁵¹ Robert L Goldenberg et al., “Maternal near Miss in Low-resource Areas,” *International Journal of Gynecology & Obstetrics* 138, no. 3 (2017): 347–55.

⁵² Shahin Sayed et al., “Improving Pathology and Laboratory Medicine in Low-Income and Middle-Income Countries: Roadmap to Solutions,” *The Lancet* 391, no. 10133 (2018): 1939–52.

dystocia have bolstered provider confidence and procedural competence. These developments are consistent with best practices outlined by the Global

Maternal and Child Health Initiative, which advocates regular skill-enhancement workshops, simulation exercises, and mentoring.⁵³ However, integrating new EBPs into daily routines faces obstacles, including resource constraints, cultural resistance, and traditional beliefs embedded within some communities. For instance, resistance to hospital-based care and women's preference for traditional birth attendants (TBAs) are common issues, as reported in similar studies by Dako-Gyeke et al.⁵⁴ Developing culturally sensitive training curricula and engaging community leaders can facilitate greater acceptance and adherence to recommended protocols. Such strategies have proven effective in enhancing behavioral change and promoting sustainable health practices.⁵⁵ Staffing shortages and high workloads further threaten the consistency of the EBP application. Literature indicates that staff burnout, limited training opportunities, and high turnover impede the institutionalization of quality protocols.⁵⁶ Addressing these systemic challenges requires a multi-sectoral approach involving government support, increased funding, and policy reforms aimed at workforce strengthening.

The challenges faced by Presbyterian Hospital Agogo are emblematic of broader systemic issues common in many low-resource settings. Limited financial resources, delayed procurement processes, and infrastructural deficits often restrict the scope of QI initiatives. These issues are compounded by socio-cultural factors that influence health-seeking behaviors and acceptance of new clinical protocols. Resistance from healthcare providers, due to fears of conflicting with traditional practices or lack of capacity, hinders the dissemination and widespread adoption of EBPs. As highlighted in studies by Kudiabor, addressing these barriers necessitates community engagement, health education campaigns, and culturally sensitive policy interventions.⁵⁷ Sustainable improvements require systemic changes, including increased government investment and multi-sectoral collaborations. Evidence from Iyer et al., accentuates that policy frameworks supporting health system strengthening, such as increased budget allocations, infrastructural upgrades, and workforce capacity-building are pivotal to scaling up successful QI efforts.⁵⁸

This study reinforces the literature proposition that maternal satisfaction is influenced as much by provider communication and interpersonal engagement as by technical competence, since most respondents rated communication quality very highly. The findings therefore support previous arguments that respectful treatment and the preservation of patient autonomy are essential drivers of maternal service satisfaction.⁵⁹ At the same time, they provide an important corrective to the Ghanaian literature, which often emphasizes chronic delays as the principal barrier to satisfaction.⁶⁰ In contrast, women in this study generally reported timely services, echoing Nuamah et al.'s claim that institutionalized quality improvement mechanisms can yield measurable and sustained progress even in resource-constrained facilities.⁶¹ Yet the persistence of complications among nearly a quarter of patients complicates this optimistic narrative. Although diagnostic accuracy and adherence to evidence-based guidelines were exceptionally strong, variability in complication severity suggests that infrastructural constraints and gaps in clinical oversight continue to undermine outcomes. This inconsistency indicates that improved technical compliance alone does not guarantee uniformly safe maternal experiences, thereby suggesting that strengthening facility-based care directly translates into higher service utilization. The results both affirm and extend the broader literature by demonstrating that while QI strategies, respectful

⁵³ World Health Organization, "Everybody's Business--Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action," 2007.

⁵⁴ Phyllis Dako-Gyeke et al., "The Influence of Socio-Cultural Interpretations of Pregnancy Threats on Health-Seeking Behavior among Pregnant Women in Urban Accra, Ghana," *BMC Pregnancy and Childbirth* 13, no. 1 (2013): 211.

⁵⁵ Sula Hood, Brittany Campbell, and Katie Baker, "Culturally Informed Community Engagement: Implications for Inclusive Science and Health Equity," 2023.

⁵⁶ Carolyn Brown-Kaiser and Amita Vyas, "Subjective Well-Being and Burnout Among the Maternal and Child Health Workforce," *Journal of Primary Care & Community Health* 15 (2024): 21501319241263444.

⁵⁷ Amanda Seyram Adjoa Kudiabor, "Gestational Hypertension and Birth Outcomes at Shai-Osudoku District Hospital in The Greater Accra Region of Ghana" (Ensign Global College, 2024).

⁵⁸ Hari S Iyer et al., "A Comparison of Health Achievements in Rwanda and Burundi," *Health and Human Rights* 20, no. 1 (2018): 199.

⁵⁹ Bowser and Hill, "Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis"; Dzomeku et al., "Exploring Midwives' Understanding of Respectful Maternal Care in Kumasi, Ghana: Qualitative Inquiry."

⁶⁰ Wongnaah et al., "Barriers to Healthcare Services Utilisation among Women in Ghana: Evidence from the 2022 Ghana Demographic and Health Survey"; Amporfro et al., "Patients Satisfaction with Healthcare Delivery in Ghana."

⁶¹ Nuamah et al., "Access and Utilization of Maternal Healthcare in a Rural District in the Forest Belt of Ghana."

communication, and adherence to clinical protocols are vital to raising satisfaction, their long-term effectiveness in Ghana requires concurrent investment in infrastructure, resource reliability, and culturally responsive engagement with communities.

Policy Implications and Future Recommendations

Findings from this study highlight the urgent need for policy reforms that can sustainably transform maternal healthcare in Ghana by addressing financing, supply chain inefficiencies, professional accountability, and community participation. These results have particular significance for the Akim North Municipality, where the predominantly rural population depends on the Presbyterian Hospital in Agogo as the only referral facility in the area. In this context, a critical priority for the government is to safeguard maternal health budgets through protected allocations for infrastructure, emergency obstetric care, and essential commodities, insulating them from the volatility of short-term donor funding. At the same time, the Ghana Health Service must strengthen procurement and distribution systems by adopting digital monitoring platforms to prevent stockouts, ensure equitable access, and improve accountability across districts. Equally important is the mandate for the Nursing and Midwifery Council, working with training institutions, to institutionalize continuous professional development as a licensing requirement, expanding beyond technical skills to include trauma-informed, culturally sensitive training programs and respectful maternity care, thereby addressing long-standing gaps in provider–patient relations.

At the local governance level, embedding maternal health indicators within District Planning Coordinating Units would ensure that service delivery gaps identified in communities feed directly into development agendas, reframing maternal health as a shared governance priority. Developing institutional feedback mechanisms involving both patients and staff is equally vital, as such systems will support ongoing quality refinement, promote accountability, and align maternal healthcare services more closely with local needs and expectations. These implications also extend to development partners and civil society, who should align their interventions with nationally defined strategies by supporting government-led monitoring and evaluation systems rather than creating fragmented programs. Civil society organizations and women’s advocacy groups, when strengthened through legislative reform, can play a watchdog role in amplifying patient voices and ensuring responsiveness. Taken together, these results suggest that coordinated but differentiated policy actions across national, professional, and community structures are essential to shift maternal healthcare in Ghana from episodic gains toward systemic, resilient, and enduring improvements.

CONCLUSION

The experience at Presbyterian Hospital Agogo illustrates that in resource-constrained health systems, meaningful gains in maternal care are possible when structured quality improvement strategies are applied. Yet, the notion that technical protocols alone can resolve maternal health challenges has proven insufficient: systemic barriers such as medicine shortages, inadequate diagnostics, and workforce gaps persist as defining obstacles. At the same time, maternal healthcare cannot be divorced from the lived realities of patients whose health-seeking choices remain shaped by cultural norms and gendered expectations, underscoring the need for trust-building beyond the clinic. The modest improvements achieved through training and adherence to evidence-based guidelines symbolize both the promise and fragility of reform in such contexts, hopeful signs of progress that remain vulnerable to broader socio-political and infrastructural constraints. What this experience ultimately demonstrates is that sustainable maternal health outcomes demand more than clinical fixes: they require accountability in resource allocation, policy commitment to equity, and continuous engagement with communities whose lives are most affected. In this sense, the case of Agogo affirms both the possibilities of resilient local health innovations and the urgent necessity of embedding them within enduring, system-wide reforms.

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Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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