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Pregnant women's perception and attitudes toward modern and traditional midwives and the perceptional impact on health seeking behaviour and status in rural Ghana

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ABSTRACT

This qualitative study was conducted in some selected rural communities within the Birim South District between March to June 2017 with the main aim of teasing out insights into Ghana's perspective of pregnant women's attitudes and perceptions about modern and traditional midwives and perceptional impact on health seeking behaviour and status. To the best of our knowledge, this is the first known study in Ghana that has provided empirical evidence on this subject. The study found that pregnant women have good attitudes and perceptions toward traditional midwives based on their personal experiences, beliefs and philosophies. Thus, pregnant women only see the need to seek the service of modern midwives when serious complications occur during childbirth and predominantly have their deliveries supervised by traditional midwives. These results call for, specifically two main policy interventions. First, behavioral change interventions through education, community sensitisation and awareness, is required. This should target family members, especially husbands and mothers in-law who are key household decision makers. This will radically help change the conservative attitudes and perceptions about modern midwives by pregnant women. Second, based on the support offered and willingness showed by the study participants, effective intercultural midwifery system will help maximise the utilisation of our midwifery and health delivery systems. Traditional and modern midwives need to work together to ensure safe birth. We consider collaboration among healthcare providers as critical, especially in the rural areas where the number of modern midwives are limited.

1. Introduction

Midwifery is the practice of assisting women through childbirth using natural procedures and was practiced primarily among traditional peoples with limited access to biomedicine (Torri, 2012). Historically, birthing was considered as a natural and social process where a pregnant woman was supported by neighbours at cross-roads between technical and familiar fields. The event of birth took place in a domestic and strictly feminine environment: female care providers guided women through their labour (Andrissi, Petraglia, Giuliani, Filiberto, et al., 2015). However, today, therapeutic pluralism has become common in many parts of the world where different approaches to care (traditional and modern) during childbirth exist side by side and are used simultaneously by women (Brown, 2008; Wiley, 2008). This can be understood as a coexistence within the same society or group of a number of health care alternatives with diverse origins and treatment hub representing different systems of medical practice and visions (Kempe, Theorell, Noor-AldinAlwazer, Kyllike, & Johansson, 2013; Pesek et al., 2009).

The World Health Organization (WHO) recognises that professional midwives can safely handle most pregnancies and have the skills to refer complex complications to a doctor and that well-trained professional midwives should continue to handle child bearing (Hazemba, 2003). On the other hand, the United Nations defines traditional midwife also known as traditional birth attendant (TBA) as a person who assists mothers during childbirth and acquired her skills by delivering babies herself or through apprenticeship to other TBAs (WHO, 1992).

Ghana has a long tradition of homebirth in rural and modern maternity centre birth in urban areas respectively while two systems of midwifery coexist. The Ministry of Health enlisted the assistance of traditional midwives to promote births as a medical event that should not be managed by specialists alone. In this arrangement, TBAs are allowed to handle "routine" birth while complicated pregnancies are referred to the district hospital or local clinics with the hope that it will

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assist in ensuring safe birth-giving (Olufunke & Akintujoye, 2012).

According to the Demographic and Health Survey data of Ghana, while deliveries with health professionals rose from 85% to 90% from 1993 to 2003 for the richest quintile, deliveries with health professionals for the poorest quintile dropped from 25% to 19%. Nationally, 45% of births were attended by a medical practitioner (79% in urban areas, 33% in rural areas); 31% by traditional birth attendants (TBAs) and 25% were unsupervised. There were also significant regional variations. The three northern regions have the highest levels of maternal mortality and the lowest levels of supervised deliveries (World Bank, 2009). Basic obstetric and antenatal care are provided by health centres, health posts, mission clinics and private midwifery homes. Each health centre or post serves a population of approximately 20,000. In the rural areas, TBAs continue to assist in child bearing; though they are trained to refer more complex cases (Witter, Arhinful, Kusi, & Zakariah-Akoto, 2007).

There are several studies that have been conducted on the use of services of modern and traditional midwives by pregnant women. These studies have primarily focused in the arena of determinants of traditional and modern midwifery use, socio-demographic and economic characteristics of pregnant women who use traditional and modern midwifery, barriers to modern midwifery use and integration of modern and traditional midwifery systems in Ghana (Witter et al., 2007), Africa (Adegooke, Ogundeji, Taiwo, Malcolm, & Ann, 2010; Ngoma & Himwiila, 2009) and beyond (Cuzzolin et al., 2010; Onta et al., 2014). However, an area of modern and traditional midwifery literature that seems to be not adequately explored, specifically in Ghana is the actual pregnant women's attitudes and perceptions of traditional and modern midwifery system and more importantly the impact of their perceptions on health seeking behaviour and status.

In most geographical settings, it has been found that attitudes and perceptions of the quality of care by pregnant women and their families influence the utilisation of services (AbouZahr, 2003; Abrahams, Jewkes, & Mvo, 2001; Berry, 2008; Gill & Ahmed, 2004; Glei, Goldman, & Rodriguez, 2003; Griffiths & Stephenson, 2001; Stekelenburg, Kyanamina, Mukelabai, et al., 2004). Women's perceptions of the lack of interaction and listening skills of traditional and formally trained staff during childbirth have been also considered critical in health seeking behaviour of pregnant women (Kempe et al., 2013). Though perceptions of people are often relative, and sometimes overlooked, it goes a long way in sounding a warning and usually indicative of what is on ground.

The authors, therefore, argued that knowing and evaluating the attitudes and perceptions of the pregnant women in rural communities is crucial as it helps to identify factors that may affect their health seeking behaviour and status. Also, it could be important in the planning of future integration policies. Such in-depth knowledge and understanding is envisaging to directly inform the design of strategies and policies that bring together the two same but separated professions. Given the similar background of traditional midwives use dominance in Ghana, especially in rural areas, evidence ascertained from Ghana may provide a reference to other policy makers who are planning of tailoring traditional midwives into the mainstream midwifery policies to suit their local circumstances. Thus, this qualitative study, was, therefore, conducted in the Birim South District with the underpinning aim of exploring pregnant women's attitudes and perception of modern and traditional midwives and the perceptional impact on health seeking behaviour and status. With this aim, our research questions were framed as follow: What are the attitudes of pregnant women toward modern midwives? What are the attitudes of pregnant women towards traditional midwives? What are the pregnant women's perceptions of modern midwives? What are the pregnant women's perceptions of traditional midwives? And how do these attitudes and perceptions impact pregnant women and newborn health seeking behaviour and status in the study area?

2. Materials and methods

2.1. Study design and context

We conducted this case study with a purely qualitative strand of research from March to June 2017. This study adopted the interpretivist paradigm and subjectivist epistemology (Angen, 2000), where the original experiences and belief systems of respondents were granted prominence. This approach ensured adequate discourse between the researchers and the interviewees to generate a meaningful collaborative effect (Guba & Lincoln, 1994).

The Eastern Region is popularly known for healthcare and therapeutic pluralism where traditional and modern midwives operate side by side however, traditional midwives dominate. The decision for the selection of the specific communities (Akim-Achiase, Aperade and Asawase) within Birim South District was premised on two basic important reasons. First, these communities recently witnessed almost a complete abandonment of modern midwifery use by pregnant women which led to serious advocacy for the closure of traditional midwifery by health professionals in the district. For instance, the Ghana Health Service (GHS) Director of the district in 2016 reported of a decline in the use of modern midwives by 35% with an increase of unsupervised birth of 56% in the district (Ghana Health Service, 2016). Again, the district located within a semi-deciduous forest landscape which provides a wide variety of medicinal plant products for traditional and alternative healing purposes has promoted the thriving traditional midwifery. Hence, the district and communities were considered ideal location for a study that sought to explore pregnant women's attitudes and perceptions of traditional and modern midwives.

2.2. The sample and sampling procedure

In this study, we interviewed 30 purposively selected pregnant women who had previously given birth under the supervision of both modern and traditional midwives from April 10 to May 10, 2017. These women were purposively selected from three different rural communities notably known for abundance and predominant use of traditional midwifery service. The participants were recruited from among other pregnant women met by the researchers at their various homes, clinics/health centres and workplaces. Participants who satisfied the characteristic that was of particular interest to the study were determined by asking each pregnant woman met by the researchers the question: 'Have you given birth under the supervision of both traditional and modern midwives before?' which yielded a 'yes' or 'no' answer and those who responded 'yes' participated in the study. For the purpose of this study, a modern midwife is defined as a trained staff who assists pregnant women during and after childbirth while traditional midwives are considered as lay individuals with limited formal education and training who assist women during and after childbirth with the use of indigenous knowledge and medicinal plants and other forms of traditional medicine. The use of this criterion was influenced by the need to obtain detailed account from participants who had experiences from both traditional and modern midwifery as we also aimed to obtain high quality information on the complex normative standpoints regarding modern and traditional midwifery in Ghana. The purposive sampling method provided the needed flexibility to focus on participants who met the criteria for the study.

2.3. Data generation tool and procedure

The data for this study were collected by the use of face-to-face in-depth interview which provided enough communication space for both the interviewer and interviewee for a detailed information. The respondents were initially approached and informed of the key aim of the study and those who were interested in participating were given further details of the objectives of the study. With the use of interviews, rich

data, which can be used to describe and explain people's behaviour in relation to their social and cultural context were provided (Srivastava & Thomson, 2009). To ensure validity and quality control, the research instrument (Interview guide) was tested in one of the study communities with four pregnant women outside the larger study to find out the suitability of the questions. Experience and feedback from the pre-tests were used to improve the final study instrument by rephrasing questions, clarifying and using more appropriate concepts for easy understanding by the study participants. The interviews were supported with informal and personal conversations conducted with some of the participants after the interviews sessions by the second author who has in-depth knowledge on medical geography, health policy and health development. These conversations did not follow any structured questions but rather personal chats with the participants.

All the interviews were conducted by the first author who is a native of the study District. The opening question asked participants to give account of their socio-economic backgrounds. Participants were also asked to provide details of their experiences with regards to the use of the services of modern and traditional midwives laying emphasis on their motivation for their choice of midwifery type – thus, why, how and when they use each type. This question generated further arguments and discussions which yielded in-depth data for study. The final question offered the participants the opportunity to describe how they perceive their health status and ascribe reasons for it. This was systematically done between a participant and an interviewer at the place where the participant was recruited. However, the researchers ensured that interviews were carried out at an enclosed site that was free from interference by any third party. To guarantee anonymity, no names were assigned to interviewees and no personal identifying details were recorded. Interviews were conducted in both Twi (the local dialect of the study area) and English language. This was done to serve the needs of the participants who had diverse socio-economic backgrounds and different literacy levels. Aside taking field notes, each interviewee was provided an informed consent for recording, and then the interview was audio recorded. This allowed the interviewer to capture the responses of the participants in their own words, which allowed for the examination of what was actually discussed. Each interview lasted for approximately 60 min.

2.4. Data analysis

Audio records were transcribed into both "Twi" dialect and English language of which those in "Twi" were later translated into English by all the authors individually. The transcripts were cross checked with the audio records and handwritten field notes to ensure validity, reliability and quality control. This was conducted immediately after the data collection process to prevent data loss. The study employed the *a posteriori* inductive reduction approach to develop consistent themes (Glaser & Strauss, 1967). The data were subjected to thematic and content analysis where coding and analysis is used to identify themes and subthemes. As a result, we classified and organised data according to key themes, concepts and emergent categories. To facilitate rigorous and transparent analysis, themes were compared with the responses to identify common trends, similarities and contrasts. Moreover, this data analysis approach offered the opportunity to identify, analyse and report patterns within the data and also helped to organise and describe the data in rich detail (Braun & Clark, 2006). The study results were presented under a number of themes and key subjective views of the participants were presented using quotations.

2.5. Trustworthiness

Trustworthiness in this study was ensured by emphasising strongly on credibility, transferability, confirmability and dependability through the use of purposive sampling, member checks whereby summaries of the study results were shared among those involved and the participants affirming that the findings reflect their expressed views, feelings and experiences; prolonged engagement with each interview session lasting for approximately an hour; external auditing and peer debriefing whereby an outsider researcher with experience in qualitative research examined the research process especially documents such as the transcripts, recorded interviews and handwritten notes and provided feedbacks to enhance accuracy and credibility; and thick description by giving a detailed and rich account of the participants feelings, actions, experiences and contexts (Creswell, 1998; Lincoln & Guba, 1985).

2.6. Ethical approval

Permission for this study was granted by the Department of Geography and Rural Development, Kwame Nkrumah University of Science and Technology. Informed consent was obtained from the participants by agreeing orally to participate in the study. To ensure the dignity, safety and wellbeing of the interviewees, participation in the study was strictly voluntary, and no identifying or sensitive information were recorded.

3. Results

The findings of the study constitute the analysis of accounts of the sample recruited for the study. The pregnant women's positive attitudes and perceptions toward traditional midwives and regular use of Traditional Birth Attendants (TBAs) were identified as a core theme. Also, eight interlinking sub-themes were identified, because they turned out to be important to many of the participants. These were previous experiences; interpersonal relationship; culturally-sensitive service/values and customs; holistic and natural treatment; availability, accessibility and affordability; autonomy/participation/family involvement; regular use of traditional midwives service; and support for intercultural midwifery.

3.1. Study participants characteristics

Overall, 30 pregnant women took part in the survey. The greatest proportion of study participants were in the age group 25–35 years (19), currently married (23), had schooling only up to the basic school level (22) and professed Christian faith (25). Most participants were self-employed (21) and were dealing in informal economic activities, including traditional peasant farming, artisanal works and petty trading which was reflected in the general relatively low income levels, with the majority receiving monthly income less than GH¢250 ($56.95). Interestingly, most of the participants were enrolled in the health insurance scheme (24) with household size of 4–6. Moreover, it was not surprising to discover that preponderance of the participants (20) constituted Akans of various sects including the Asantes, Fantes, Bonos, Akuapems, Akyems and Kwahus since the study region is predominantly dominated by the Akan ethnic group. Table 1 presents detailed characteristics of the study participants.

3.2. Previous unpleasant experiences

Most of the participants mentioned giving birth to their first child at modern maternity facilities under the supervision of modern midwives. However, dissatisfaction and unpleasant experiences with modern midwives have influenced their attitudes and perceptions. It was realised that participants' previous unfortunate experiences, particularly perceived insensitivity and impatience of modern midwives compared to the traditional midwives who were described as more sensitive and patient have influenced their health seeking behaviour and choice of midwifery type. Unlike the modern midwives, participants revealed that traditional midwives devote enough time to ensure that pregnant women and their babies are safe:

Table 1
Sample characteristics.

Variable		N (30)
Age	18–24	7
	25–35	19
	36–45	4
Education	None	3
	Basic	22
	Secondary	3
	Vocational	2
Marital status	Single	2
	Married	23
	Divorced	3
	Widow	2
Employment status	Institutionally employed	2
	Self employed	21
	Unemployed	7
Household size	1–3	2
	4–6	17
	> 6	11
Health insurance status	Yes	24
	No	6
Average monthly income (GH¢)	< 250	15
	250–350	9
	> 350	6
Religious affiliation	Christianity	25
	Islam	5
Ethnicity	Akan	20
	Others	10

Pregnant woman seven: *I remember clearly when I went to deliver my first born at the hospital where the modern midwife who was supposed to assist me was rather on social media "whatsapping and facebooking". I was in serious pain and suffering and calling the midwife. She boldly told me to keep quiet and suffer because no one forced me to get pregnant as a young girl and that she was busy on social media. But, the last time I delivered at traditional birth attendant home, in fact, the person was really good. She showed great care, concern and commitment. The traditional people understand the pain and suffering during childbirth so they pamper, encourage and assist very well to ensure that mothers and their newly born babies are safe. So, my next birth which will be in the next two months, I have told my husband that it will be under the supervision of a traditional midwife.*

3.3. Interpersonal relationship

Most of the participants emphasised on interpersonal relationship and elaborated that traditional midwives are friendlier, cordial and respectful as compared to their modern counterparts. Interestingly, participants revealed the secret underpinning the good interpersonal relationship and ethics of traditional midwives to be the fear of losing customers, livelihood and reputation. As a result, traditional midwives treat their clients as good as possible so as to attract recommendations for more clients and avoid humiliations for causing birth complications:

Pregnant woman three: *Traditional midwives treat pregnant women with utmost care and respect which I think is due to the fact that they do not want to destroy their good will, reputation and livelihoods. In this village, if you are a traditional midwife and someone's child dies in your hands, I can say, that particular midwife will be humiliated, victimised and no one would prefer to give birth at her place again. So, to ensure that they get more clients, they really respect us, play with us and give us all the needed care and attention. They motivate and encourage us during the painful moment of childbirth. We hardly find these with modern midwives.*

However, despite recognising the knowledge and skills of modern midwives, the opposite of the preceding account was mentioned about modern midwives which accounted for the participants' attitudes and perceptions toward them. They perceived modern midwives to be unfriendly, hostile and disrespectful. The participants specifically mentioned that pregnant women who are young, especially those below 20 years, non-regular prenatal care attendant and women who cohabit mostly receive insults and reproach from modern midwives. Participants argued that modern midwives are not reprimanded or sacked for their lack of respect and poor attitudes toward clients even when complains are lodged and hence do not treat their clients with utmost respect and care. Considering this, most of the study participants expressed strong willingness of giving birth under the supervision of a traditional midwife who will respect and give them maximum care and attention:

Pregnant woman one: *Admittedly, modern midwives have knowledge and skill for assisting women during childbirth. However, their attitudes and behaviours make us use the service of traditional midwives in this community. I remember having serious encounter with the modern midwife who assisted me with my first born. My brother, let me tell you this, giving birth is not easy. It is very painful and needs someone who will give you maximum care, attention and pamper. However, the modern midwife insulted and reproached me while I was in severe pain. From there, I have not delivered at hospital again. To me, the modern midwives are arrogant and insensitive to the pains of women giving birth. Even, almost all the young ladies who are pregnant and not married have chosen not to give birth at the clinic all because of insults and unnecessary reproach. I think they are encouraged to portray such attitude and behaviour because they are not reprimanded.*

3.4. Culturally-sensitive service/values and customs

Almost all the participants explained that traditional midwife services are culturally accepted, as they speak the same local language and use natural herbal medicines for treatment. It emerged from the interview that traditional midwives were people who reside in the same areas with pregnant women and understand the cultural setting. On the other hand, it was revealed that the modern midwives in the study area were not natives of the area, not fluent in the local dialect and used conventional medicines which the participants perceived as alien to their culture as well as ineffective. Aside the cultural sensitivity, certain traditions, values and customs regarding pregnancy and birth-giving were observed to have influenced pregnant women's attitudes and perceptions toward both modern and traditional midwives. These beliefs have not just influenced pregnant women's attitudes and perceptions but also their decisions concerning the type of midwife service to use:

Pregnant woman five: *One thing is that, traditional midwives have been with us for a very long period even in the days of our forefathers. They stay with us, and understand our tradition, culture and beliefs. One important thing about them is that they speak our local dialect unlike the modern midwives who mostly speak the English language and do not understand our local dialect which makes communication difficult. I can tell you with conviction that the herbs that traditional midwives give to us are also part of our culture and effective unlike the conventional medicines which are alien and ineffective. At least, we should have some form of knowledge about the therapy before using it. But here is the case that we do not have any knowledge about most of the conventional medicines.*
Pregnant woman 23: *I see both the traditional and modern midwives to be knowledgeable and qualified for their professions. However, the difference between the two are that, I see the traditional midwives to be part of our culture, they know us, we know them as well, we understand them while they also understand us and we are able to communicate with them effectively without fear and panic.*

3.5. Holistic and natural treatment

Most of the study participants perceived the assistance and treatment given by traditional midwives during pregnancy and after birth to be holistic, safe and natural compared to the services of their modern counterparts. The holistic treatment and assistance mentioned by the participants were underpinned with the beliefs that diseases in pregnancy and complications during childbirth have strong spiritual connections of which modern midwives and conventional medicines cannot prevent or cure except for some specific traditional midwives and herbs. Pregnant women strongly argued that using the services of traditional midwives from the onset of pregnancy prevent unforeseen spiritually-driven diseases and complications during birth giving:

Pregnant woman 16: *I have six children of which I delivered only one at hospital ward under the supervision of a modern midwife. All the remaining five happened at home with the assistance of traditional midwives and nothing happened to them. I must say giving birth with the supervision of traditional midwives is really safe and their herbal medicines are also effective and natural. Let me tell you one secret, the traditional midwives know us very well, especially our health status than their modern counterparts at hospitals. The reason is that, for instance, all my five previous child births were assisted by the same person. So, the person had a great deal of knowledge about my birth history and health status. When I go to her in the coming three months I think, she will have no difficulty in assisting me since she has been my midwife for a long period of time. However, it is unlikely to meet the same midwife who assisted you let say about three to five years at the hospital ward, you are likely to meet a different person who has no knowledge about your birth history*.

Pregnant woman 19: *Especially in this community, when you are pregnant several eyes are watching you and not all these eyes are good, some of the eyes watch you with bad intentions to destroy you the parent or the unborn child. To prevent this, we use the services of traditional midwives who have the ability to prevent such spiritual diseases. Also, during birth-giving, major complications which have spiritual connections are mostly prevented when the process is supervised by a traditional midwife. The modern midwives only deal with physical illness and complications and even most of their drugs are ineffective and have harmful side effects*.

3.6. Availability, accessibility and affordability

The availability, easy accessibility and low cost of traditional midwives' services were found to be one main factor influencing pregnant women's attitudes and perceptions toward traditional and modern midwives. The traditional midwives were mentioned by the study participants to be always available, easily found and reached with little or no amount of money compared to their modern counterparts who are limited, mostly unavailable and unreachable. Modern midwives often reside in the district capital and other big towns within the district which make accessibility by rural people much difficult. For instance, it emerged during the interview that some traditional midwives in the study prefecture are mobile, that is, able to move from their residence to the residence of the pregnant women when called upon regardless of time, night or dawn, since they live in the same neighborhood as the pregnant women. They further argued the service of modern midwives is expensive especially when the user has no insurance coverage and when complications occur:

Pregnant woman 10: *To me the modern midwives are very difficult to be found to assist pregnant women during pregnancy period and childbirth, especially for us who are in the rural areas. This is because most of these modern midwives reside at the district and big clinics. Looking at the transportation and the cost involved, I see the traditional midwives to be easily accessible since we live in this community with them all the time. They assist us whenever and wherever we need them. The same thing cannot be said about the modern midwives. Also, the cost involved in using the service of modern midwives is too high compared to the traditional ones*.

3.7. Autonomy/participation/family involvement

The desire to participate, have some sort of control and responsibility over the birth giving process was observed to be one factor influencing expectant mothers' choice of delivery. Unlike the modern midwives who take absolute control over the birthing process, dictating and instructing, traditional midwives offer families of expectant mothers a degree of control over the birth giving process and this motivates, empowers and enhance their confidence to birth their babies in their own abilities:

Pregnant woman twenty: *I cannot allow maybe someone who has not yet given birth to take absolute control over me when giving birth. I remember the last time I birthed at the clinic, the modern midwife who assisted me was yet to give birth and she was dictating, instructing and controlling me and was not even willing to give me a bit of freedom to control or lead the process. Upon all the instructions and control, I encountered serious complications. However, the traditional midwives allow us to lead the process while playing the supporting role*.

Aside the control, the detachment of family members from the birthing process was also echoed by the participants as an influencing factor. It was revealed that traditional midwives allow the families of the pregnant women especially their mothers to be along with them during labour. However, the participants explained that this hardly happens at the formal maternity wards:

Pregnant woman three: *The traditional midwives allow your family members, at least your mother and mother- in- law to be around during childbirth. However, the modern midwives do not allow anyone to follow you to the ward which I think is very bad. This is because, family members when they are around, give you encouragement and motivation*.

3.8. Regular use of traditional midwives service

It was observed that the perceptions and attitudes held by the participants have impacted their choice of medical care. Most of the participants are said to have abandoned the modern midwives for the service of traditional midwives, only seeking treatment from modern midwives upon the recommendations from the former, especially when serious complications occur. Consequently, traditional midwives serve as the first port of call for most of the participants. On health status impact, a significant number of the participants were convinced that they and their newborn babies were of good health and attributed it to the service of traditional midwives:

Pregnant woman 9: *Because they [modern midwives] do not respect and treat us anyhow, I have stopped giving birth at the hospital. The traditional midwives get time for us and treat us with utmost respect and care. Should there be no serious complications, I will never go to the hospital to give birth*.

Pregnant woman 1: *I will never give birth at the hospital again, not even when I am dying during childbirth when been assisted by a traditional midwife. This is because the modern midwives do not respect; even, modern midwifery is not part of our culture. I even made a mistake by giving birth under the hand of a modern midwife some years back. Why should I continue to allow someone I do not know anything about me to assist during childbirth? In fact, I will never do that again*.

3.9. Support for intercultural midwifery

All the participants showed strong support for and believe in intercultural midwifery and expressed their readiness and expectation to receiving assistance and prenatal and postnatal traditional medical care from a primary care environment and the health facilities. They maintained that these would encourage pregnant women to give birth at hospitals since they are likely to find traditional midwives at formal hospital facilities. However, participants bemoaned certain challenges that were acting against successful implementation of intercultural midwifery. Poor implementation mechanisms, weak institutional support, and lack of political will were highlighted by the participants as key institutional setbacks for actualising an intercultural midwifery system. Also, one critical issue that was trumpeted throughout the discussions was that most modern midwives perceived the traditional midwives with disdain, regarding them as 'unscientific and primitive' and therefore, having the potential to bring chaos and danger into medical practices. In all, our study participants strongly called for the integration.

Pregnant woman 15: *To me the integration would be a good news since it can encourage us to give birth at the hospital. So I wholeheartedly support it and hope to see it done, it will help all of us.*

Pregnant woman 4: *Bringing the two midwives together to work at the same place to me is a good thing if only it will work. When it happens like that, we would have alternatives when giving birth at the hospital. It is a very good idea, and we all support it.*

4. Discussion

The present study adopted purely qualitative research approach to explore Ghana's perspective of pregnant women attitudes and perceptions about modern and traditional midwives. Also, perceptional influence on health seeking behaviour and status has been explored. To the best of our knowledge, this is the first known study that provides evidence in this important area of inquiry but a neglected topic in the health care literature in Ghana. Positive perceptions and attitudes toward traditional midwives were demonstrated by the participants in the present study. However, their perceptions and attitudes reflected their personal experiences and stemmed from their perceived previous unpleasant experiences with modern midwives, good interpersonal relationship, culturally-sensitive service, holistic and natural treatment, availability, accessibility and affordability as well as autonomy granted by traditional midwives. The interplay of these beliefs have resulted in the regular use of traditional midwives service by the pregnant women. Nevertheless, the participants expressed a strong willingness and readiness to support future intercultural midwifery in Ghana. The conservative attitudes and perceptions about modern midwives must be radically changed through education, community sensitisation and awareness and behavioral change interventions. Such interventions, according to Onta et al. (2014), should specifically target family members, especially husbands and mothers' in-law who often take key decisions concerning choice of birth.

The need for indigenous persons who had previously supervised ones' childbirth was a concern as pregnant women perceived modern midwives to be non-natives and always changing their stations of work. The belief that newly-met midwife may not have the requisite knowledge about previous birth experiences influenced their decisions to visit traditional midwives whom they perceived as personal childbirth assistants. This evidence suggests a possible review of the current modern midwifery system which does not allow trained midwives who are posted to rural areas to stay for a longer period of time before they are transferred to different areas. Similar findings was observed by Hildingsson, Waldenström, and Rådestad (2003) that women may also choose a birth centre because they value continuity of care and want to have a known midwife present at the birth.

In support of other previous studies (Kline, Willness, & Ghali, 2008; Rodriguez, Rodday, Marshall, et al., 2008; Siyambalapitiya et al., 2007; Taraska, 1994), our study shows that the attitudes and perceptions of most expectant mothers originated from interpersonal relationship of care. Our findings indicate that majority of pregnant women expected respect, cordial communication and tolerance from both modern and traditional midwives however, they mostly get these treatments from traditional midwives other than their modern counterparts. Pregnant women who experienced negative attitudes by modern midwives, especially during their first childbirth thereby tend to use the services of traditional midwives who they perceive to have good and positive attitudes towards their clients. This result affirms the evidence by Sjöblom, Idvall, and Lindgren (2012) that women who reported experiencing negativity from hospital staff in response decided to birth at home.

The experience of owning authority and control during childbirth was also highlighted significantly among pregnant women. Maintaining authority during childbirth is achieved through the show of strength and active encouragement by traditional midwives and female birth participants (Kempe et al., 2013). The current study participants considered this to be associated with traditional midwives than their modern counterparts influencing pregnant women to visit them during childbirth. Previous work by Kempe, Noor-Aldin Alwazer, and Theorell (2011), Kempe et al. (2013) in Yemen showed that women who experienced an institutional childbirth were less willing to give birth in the same location next time than women who gave birth at home. Thus, previous experiences and encounters were seen as factors influencing attitudes and perception about traditional and modern midwives.

Issues of availability and accessibility were crucial to the study participants as they perceived modern midwives to be mostly unavailable and inaccessible. The unavailability and inaccessibility of modern midwives could be attributed to the rural transport nature and limited number of modern midwives in the study area and most areas in Ghana. This finding concurs with the results by (Kabakyenga, Ostergren, Turyakira, & Pettersson, 2012; Kitui, Lewis, & Davey, 2013; Titaley, Hunter, Dibley, & Heywood, 2010) in Indonesia, Uganda, and Kenya where transport facilities and irregularities among health care providers are the main causes of unavailability and poor utilisation of modern midwives services. This finding calls for critical look at the transportation network and other social facilities that will ensure modern midwives availability, accessibility and utilisation at remote areas.

More importantly, the issue of cultural sensitivity services was echoed by the study participants. The present study revealed that pregnant women's preference for traditional midwives is associated with familiarity with local culture. Pregnant women perceived traditional midwives as their own and modern midwives as aliens who do not understand the local cultural values and beliefs with regard to childbearing and midwifery. Again, the socio-cultural belief that complications during pregnancy are caused by spirits or witchcraft influences the women's preference for traditional midwives services. This suggests that in the modern midwifery system which is strictly scientific and devoid of "religiousity, culturallity" and spirituality, pregnant women who are attached to cultural values are more likely to have negative attitudes and perceptions about it. Interestingly, past studies in other rural communities in Ghana and beyond confirm women's positive perception about and preference for traditional midwives due to their provision of psychosocial support and culturally sensitive services (Dako-Gyeke, Aikins, Aryeetey, Mccough, & Adongo, 2013; Griffiths & Stephenson, 2001; Maimbolwa, Yamba, Diwan, et al., 2003; Pfeiffer & Rosemarie, 2013; Shiferaw, Spigt, Godefrooij, Melkamu, & Tekie, 2013). These experiences are different from participants' accounts of modern midwives' who provided culturally insensitive services, which discourages use of public maternity (Paula & Rob, 2001; Simkhada, Teijlingen, Porter, & Simkhada, 2008). For instance, in Northern part of Ghana, Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei, and

Adongo (2008) found a high cultural value attached to home births, which is in sharp contrast with negative perceptions that equated skilled birth attendance. In rural Zimbabwe, Mathole, Lindmark, Majoko, and Ahlberg (2004) discovered that a local belief about increased vulnerability to witchcraft during early pregnancy period resulted in avoidance of health facilities, as against increased use of alternative forms of care. Likewise, in Tanzania, women are known to hold the belief that long labour may be caused by extramarital affairs during pregnancy, therefore, some avoid birth giving at the health facility due to fear of being exposed (Mrisho et al., 2009).

Birth support by other family members constituted a strong aspect of pregnant women's good attitudes and perception about traditional midwives. It has been reported in other settings that women who give birth at home have been found to value the ability to select their own team of support people and the degree to which their chosen support network is involved in the birth experience (Boucher, Bennett, McFarlin, et al., 2009; Hildingsson et al., 2003; Murray-Davis, McNiven, McDonald, et al., 2012). Such birth support allowed by traditional midwives where family members can take part in the process to serve as a source of motivation, solidarity and encouragement for positive outcome. Kempe et al. (2013) emphasised that the element of birth support is one of the most frequently addressed in research and intervention studies. The importance of birth support for a positive birth giving outcome and birth experience is well documented in regional and international studies (Pascali-Bonaro & Kroeger, 2004; Scott, Klaus, & Klaus, 1999). For instance, a recent review of 16 trials with more than 13,000 women in low, middle and high-income countries reported that continuous labour support reduces Caesarian section rates, decreases need for analgesia, increases maternal satisfaction, and improves breastfeeding success (Sibley et al., 2007).

The observations from our study participants that modern midwives did not allow family support during childbirth deviates from WHO's Better Birth Initiative. The World Health Organization's initiative specifically stipulates continuous companionship during labour as a key evidence-based component of improving quality of care in low and middle-income countries (WHO, 2002). The isolation of pregnant women at maternity wards by modern midwives as reported by the study participants therefore in a way violates women's right as outlined by WHO (d'Oliveira, Diniz, & Schraiber, 2002).

The decision to birth at home remains highly contentious and is viewed by some as highly serious to mothers and babies. Evidence from this study shows health-seeking behaviour of pregnant women is largely influenced by the interplay of attitudes and perceptions that shape individual's decision to attend a particular health facility. Our study showed that, the perception about and attitudes toward modern and traditional midwives have influenced the decision, preference and health-seeking behaviour of pregnant women during childbirth. We found that pregnant women's perceptions have caused them delays in seeking assistance from modern midwives during and after childbirth. Participants in our study only saw the need for modern midwives when severe complications which are beyond the ability and control of traditional midwives occur. This finding certainly agrees with the observation by Onta et al. (2014) and Titaley et al. (2010) in Indonesia that women use health services during birth giving mainly due to childbirth complications. Moreover, Morrison et al. (2014) who conducted a qualitative study among rural women in central Nepal found similar results.

Aside the underpinning objectives and questions of the present study which have been sufficiently analysed and discussed, two main themes/findings surfaced which are worth mentioning and discussing: First, the demographic characteristics of pregnant women who visit traditional midwives during childbirth. From the background information in Table 1, analysis suggests that pregnant women having positive attitudes and perceptions toward traditional midwives were young and married with low level of formal education and self-employed in the informal sector with low level of income. With this, it can be argued that socio-demographic/economic factors may also have a role to play in shaping pregnant women's attitudes and perceptions toward modern and traditional midwives.

Second, our study provides evidence to suggest that pregnant women were ready and willing to provide support for intercultural midwifery system where the two main midwifery systems (traditional and modern) come under a single umbrella of midwifery system in Ghana. Globally, supporters of traditional midwives' integration into the formal health system have argued that midwives serve as a key link between pregnant women and increasing accessibility to maternity services while reducing mortality rate (Mathole et al., 2004). The need for integration of local perspectives into the systems of care advocated by the internationally defined Safe Motherhood Initiative has been recognised (Kwast, 1998; Pittrof, Campbell, & Filippi, 2002), and the importance of learning from local communities and traditional care has been highlighted (Dietsch & Mulimbalimba-Masururu, 2011; Gabrysch, Lema, Bedrinana, et al., 2009; Van Roosmalen, Walraven, Stekelenburg, & Massawe, 2005). Interestingly, some countries have successfully been able to integrate local concepts and practices into the modern system of care, and indigenous women with little formal education have been shown to use birth giving services with high levels of satisfaction when their needs are met (Gabrysch et al., 2009).

Over the decades, Ghana has attempted to integrate traditional and modern healthcare systems however, any significant incorporation of the traditional systems of medicine into the mainstream health care system has not been achieved yet (Gyasi et al., 2017) considering the current challenges. Effective intercultural midwifery should start from the grass root level, involving training of physicians and practitioners to ensure mutual understanding and direct communication between them. The traditional and modern midwives should not be seen as battling for supremacy, each of the two midwifery systems has its own value; certainly, they would mutually benefit from each other's strength. With conscious policy decisions, the two midwifery systems can successfully be merged together within the framework of the culturally acceptable midwifery system in Ghana. The study results support the need for improved political commitment for effective education and training and enforcement of regulatory measures. Integrative midwifery ought to be addressed within the context of the individual practitioner, family, and the community levels (Gyasi et al., 2017).

This study has some strengths that need to be remarked. First, to the best of our knowledge, this is the first known study that teased out insights into pregnant women's attitudes and perceptions about modern and traditional midwives and perceptional influence on health-seeking behaviour and status in Ghana. Second, one major strength of the study was its ability to include participants who had used both the services of modern and traditional midwives from diverse geographic and sociocultural contexts. Thus, the interpolation of data and incorporation of viewpoints, putting into perspective the attitudes and experiences from the actual people who are directly involved in, and purported to be benefited from the services of modern and traditional midwives make the study unique. The current study, therefore, demonstrates a depth of understanding from the views of a multicultural and multiethnic population. The present study proffers an important contribution to address the existing gap in knowledge and also probes Ghana's health policy framework on a potential regulation of midwifery system. Our findings in this study serve as a baseline for the government health sector in formulating its future policies towards the eventual goal of intercultural midwifery system.

While our study has many advantages, we acknowledge a number of limitations. The study limitations are basically premised on its methods; hence reading, interpreting and using findings from this study must be undertaken with caution. Owing to the use of non-probability sampling techniques including purposive sampling, our results should not be regarded as representative of the general population in Ghana. However, this study consciously prioritised the depth of participants' experiences, rather than merely the breadth. Furthermore, the measures

were derived from self-reports of participants, thereby exposing the findings to potential response bias and social desirability bias. Finally, the study's findings were based on a survey data from three rural communities. Thus, other settings outside the communities may have different contexts. Also, the study did not include detailed analysis of efficacy of modern and traditional midwives medicines and this calls for further studies to ascertain evidence in these areas.

5. Conclusion

The present study explores pregnant women's attitudes and perceptions about modern and traditional midwives and perceptional influence on health-seeking behaviour and status in rural Ghana. To emphasise the take-home point from this paper: The study provided empirical evidence to prove that pregnant women have good attitudes and perceptions toward traditional midwives in rural Ghana reflecting their personal experiences and beliefs. Thus, pregnant women only see the need to use the service of modern midwives when serious complications occur during childbirth and predominantly have their deliveries supervised by traditional midwives. These results call for, specifically two main policy interventions. First, behavioral change interventions through education, community sensitisation and awareness that will radically help change the conservative attitudes and perceptions of pregnant women about modern midwives. Such interventions specifically target family members, especially husbands and mothers in-law who are key household decision makers. Lastly, based on the support offered and willingness showed by the study participants, effective intercultural midwifery system should be undertaken to help maximise the utility of our midwifery and health delivery systems. Traditional and modern midwives need to work together to ensure safe birth. While education of important persons is important, collaboration among healthcare providers is critical, especially in the rural areas where modern midwives are limited.

Conflict of interest

The authors declare no conflict of interest.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.ijans.2018.03.003.

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