IARJSET ISSN (O) 2393-8021, ISSN (P) 2394-1588

International Advanced Research Journal in Science, Engineering and Technology

Impact Factor 8.311 ⁜ Peer-reviewed & Refereed journal ⁜ Vol. 12, Issue 11, November 2025

DOI: 10.17148/IARJSET.2025.121102

Socio-cultural barriers to midwifery services and Maternal Health care outcome in the Ashanti Region of Ghana.

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Abstract: Background: Despite significant national progress, Ghana continues to face disparities in maternal mortality, largely concentrated in rural areas. The Ashanti Region, a cultural and economic hub, exemplifies this paradox, with relatively strong health infrastructure yet persistent socio-cultural barriers to skilled midwifery care. Methods: This desk review synthesizes current data from the Ghana Demographic and Health Survey (2022), Ghana Health Service Annual Reports (2022-2023), and recent peer-reviewed literature to analyze the socio-cultural determinants influencing the utilization of midwifery services in rural Ashanti. Results: Key barriers identified include a strong cultural preference for Traditional Birth Attendants (TBAs) as spiritual and cultural custodians, matrilineal and gerontocratic decision-making structures that disempower pregnant women, spiritual interpretations of obstetric complications, and logistical challenges exacerbated by cultural norms of modesty. Ghana Health Service strategies, such as the revised CHPS model and TBA integration programs, show promise but require deeper cultural integration. Conclusion: The findings underscore that improving maternal health outcomes in such contexts requires moving beyond infrastructural investment to implement culturally intelligent policies that respectfully engage with traditional norms, leverage existing community structures, and redefine skilled birth attendance within a local socio-cultural framework.

Keywords: Maternal Health, Midwifery, Socio-Cultural Barriers, Traditional Birth Attendants, Ashanti Region, Ghana, Health Systems, CHPS

I. INTRODUCTION

Ghana's efforts to achieve Sustainable Development Goal 3.1, reducing the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births, are hampered by significant intra-national disparities (World Health Organization, 2023). The Ashanti Region presents a critical case study in this challenge. While it reported an MMR of 132 per 100,000 live births in 2022, significantly lower than the national average of 263, this figure obscures profound inequities between its urban capital, Kumasi, and its populous rural districts (Ghana Health Service, 2023).

Evidence consistently shows that skilled attendance at birth is the single most critical intervention for preventing maternal deaths (Say et al., 2023). However, in regions steeped in strong cultural traditions, the presence of midwifery services does not automatically equate to their utilization. This article argues that in rural Ashanti, socio-cultural factors constitute the primary barrier to the uptake of midwifery services, creating a gap between clinical availability and practical accessibility. This review synthesizes current data and literature to delineate these barriers and evaluate the policy responses aimed at mitigating them.

II. METHODS

This study employed a comprehensive desk review methodology. We analyzed secondary data from the 2022 Ghana Demographic and Health Survey (GDHS) and the Ghana Health Service's (GHS) 2022 and 2023 Annual Reports, with a specific focus on disaggregated data for the Ashanti Region. Furthermore, a systematic search of peer-reviewed literature published between 2018 and 2023 was conducted using databases including PubMed, Scopus, and Google Scholar. Search terms included: "maternal health Ghana," "socio-cultural barriers midwifery," "Traditional Birth Attendants Ghana," "Ashanti Region delivery care," and "CHPS Ghana." The synthesis aimed to identify recurrent themes and recent evidence on socio-cultural determinants of health-seeking behavior.

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III. FINDINGS: THE SOCIO-CULTURAL LANDSCAPE OF BIRTH IN ASHANTI

3.1 The Primacy of Tradition and the TBA The influence of Aporo (custom) in Ashanti society cannot be overstated. The Traditional Birth Attendant (TBA) is embedded within this cultural fabric as a custodian of ritual and spiritual practice, not merely a birth helper. The TBA performs ceremonies such as herbal baths (ahobrobo) and the ritual burial of the placenta, acts that are perceived as essential for the child's successful integration into the clan (Addai et al., 2023). This cultural legitimacy often supersedes the technical expertise of professionally trained midwives, who are frequently viewed as outsiders offering a sterile, impersonal alternative. Despite 86% of births occurring in facilities at the regional level, reliance on TBAs remains a default for a significant minority in rural pockets, often until complications arise (GSS, GHS, and ICF, 2023).

3.2 Decision-Making in a Matrilineal Society Ashanti's matrilineal system uniquely shapes health choices. While empowering in lineage matters, it can disempower the individual pregnant woman. Decision-making authorities are often gerontocratic, resting with maternal elders, particularly the woman's mother and the family's queen mother (Ohemaa) (Ahinkorah et al., 2021). These elders, guided by their own historical experiences, may veto a daughter's preference for a health birth facility, advocating instead for the known quantity of the TBA. This transfers the critical decision of birthplace away from the mother, introducing dangerous delays in emergencies.

3.3 Spiritual Etiologies of Illness A profound barrier is the spiritual interpretation of obstetric complications. Conditions like postpartum hemorrhage or eclampsia may be diagnosed as sunsum yare (spiritual illness), attributed to curses, broken taboos, or supernatural forces (Moyer et al., 2022). The first line of treatment for such an ailment is not a midwife but a traditional healer (odunsini) or spiritualist. This fundamental clash of health belief systems, biomedical versus spiritual, leads to critical delays in seeking emergency obstetric care, turning preventable conditions into fatal ones.

3.4 Logistical Barriers Amplified by Culture While infrastructure in Ashanti is comparatively developed, logistical issues persist in remote districts and are magnified by cultural norms.
Transportation: The financial and physical difficulty of travel (okotofa) is compounded by cultural concerns about the dignity and modesty of a woman in advanced labour undertaking a arduous journey (GHS-Ashanti, 2022).
Provider Gender: Cultural values surrounding modesty make the presence of male midwives a significant deterrent to service utilization for many women, who would rather deliver at home with a female TBA (Aliyu et al., 2021).

IV. DISCUSSION: POLICY RESPONSES AND THE PATH FORWARD

The Ghana Health Service has recognized that technical solutions alone are insufficient. Its strategies in the Ashanti Region reflect an attempt to work within the cultural context:

1. The CHPS+ Initiative: Deploying resident midwives in community-based compounds (CHPS zones) aims to reduce physical and social distance, transforming midwives from outsiders to trusted neighbors (GHS, 2023).

2. TBA Integration: Training TBAs as "Maternal Health Champions" for referral leverages their cultural authority for positive health outcomes, a strategy more effective than their marginalization (Ashanti Regional Health Directorate, 2022).

3. Culturally Targeted Communication: Health education campaigns delivered in Twi via local radio and endorsed by chiefs and queen mothers aim to reframe skilled attendance as a modern, responsible choice aligned with Ashanti values of protection and family (GHS Health Promotion Division, 2023).

However, challenges remain. Programs must be consistently funded and evaluated. The deep-seated nature of spiritual beliefs requires ongoing, sensitive engagement rather than one-off campaigns. Furthermore, empowering individual women within a collectivist and gerontocratic decision-making structure remains a complex, long-term endeavor.

V. CONCLUSION

The case of the Ashanti Region illuminates a central truth for global maternal health: the barriers to care are often less about a lack of clinics and more about a clash of worldviews. The region's progress is contingent upon its ability to harmonize evidence-based midwifery with the deep-seated cultural practices that give birth to its social meaning. This necessitates a continuous, respectful dialogue with community structures chiefs, queen mothers, TBAs, and families to co-design solutions that are both medically sound and culturally coherent. For Ghana to fully realize its gains in maternal health, its policy must be as culturally competent as its midwives are clinically proficient.

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