

Midwives' Perceived Social Pressures in Addressing Prenatal Maternal Mental Health: A Qualitative Study in the Ashanti Region of Ghana

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Wilhemina Dowuona Hammond¹ , Evelyn Asamoah Ampofo¹ , Adiza Atoko Mumuni¹ , and Mabel Suma-Amineng Faanye¹

Abstract

Introduction: Prenatal maternal mental health (PMMH) is a critical yet under-addressed aspect of antenatal care in Ghana. Midwives, as care providers, often face social and institutional pressures when navigating mental health concerns, especially in contexts where stigma, silence, and role ambiguity persist. **Objective:** Guided by the Theory of Planned Behaviour, this study explored the social pressures midwives experience and the motivations that shape their responses to PMMH, highlighting the emotional and relational tensions they encounter. **Methods:** Nineteen midwives working in diverse settings were engaged in semi-structured interviews from April 10 to April 22, 2025, which were analysed by thematic analysis. Results: Three major themes and one minor theme emerged: Perceived Pregnant Women's Expectations; Perceived Supervisors' and Institutional Expectations; Midwives' Responses to Expectations and Midwives as Cultural Gatekeepers. Findings highlight the complex circumstances midwives navigate to provide PMMH care. **Conclusion:** Midwives are influenced by a blend of relational sensitivity, contextual judgment, and personal ethics. Strengthening PMMH integration requires clear role definitions, audited screening metrics, stigma-free communication toolkits, facility-tiered support, and recognition of midwives' emotional contributions to PMMH care.

Keywords

prenatal maternal mental health, midwives, Ghana, antenatal care, qualitative research, emotional labour, role ambiguity, health systems, stigma, relational care

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Background

Maternal mental health (MMH) refers to the emotional and psychological well-being of a woman during pregnancy, labour, and up to one year postpartum (World Health Organization [WHO], 2024). Studies have underscored a strong link between stress during pregnancy and a heightened risk of psychological disorders, including depression and anxiety (Bandeira & Wagner, 2023; McNestry et al., 2023), highlighting the importance of addressing MMH during the prenatal period.

¹School of Nursing and Midwifery, Collage of Health Science, University of Ghana, Accra, Ghana

Corresponding author:

Evelyn Asamoah Ampofo, Department of Maternal and Child Health, School of Nursing and Midwifery, Collage of Health Science, University of Ghana, Legon, Accra PMB, Ghana.

Email: eaampofo@ug.edu.gh



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Driven by the clinical importance, prenatal maternal mental health (PMMH) is increasingly recognized as a critical component of maternal and neonatal outcomes. Yet in Ghana, PMMH remains under-addressed within routine antenatal care (WHO., 2024; Yevo et al., 2025). Midwives, as frontline providers, are uniquely positioned to identify and respond to PMMH concerns (Carroll et al., 2018). However, their capacity to do so is shaped not only by clinical training but also by complex social expectations and institutional norms (Lartey et al., 2020; Makarova et al., 2024).

Review of Literature

In Ghana's tiered healthcare system, the Community-based Health Planning and Services (CHPS) initiative provides close-to-client care, with midwives serving as lead clinicians (Adusei et al., 2024). Most midwives hold a three-year diploma or four-year degree, but their training focuses heavily on obstetrics and physical emergencies, leaving gaps in formal mental health knowledge (Agyekum, 2023). Although national policy mandates integrating mental health into primary care (Ministry of Health Ghana, 2020), implementation is inconsistent. In practice, mental health is often minimized as normal pregnancy stress, and women are rarely screened or asked about emotional wellbeing during routine antenatal visits (Agyekum, 2023).

This study was framed by the Theory of Planned Behaviour (TPB), which posit that intention to perform a specific behaviour is driven by attitude, subjective norms and perceived behavioural control (Ajzen, 1991). Existing research has extensively documented midwives' general attitude towards MMH and low perceived behavioural control due to systemic resource constraint (Adjorlolo et al., 2019; Higgins et al., 2018; Mellor et al., 2019). However, subjective norms and their role in shaping midwives' intentions and behaviour remains significantly under-explored. In this study, subjective norms, defined as perceived social pressures (expectations from significant others and motivation to comply) were essential as they shifted the focus from midwives' personal attitudes or perceived resources to the influence of society and how midwives negotiated these expectations when making clinical decisions. Though Previous studies had explored knowledge gaps and resource constraints and their influence on health workers' clinical choices in PMMH care (Adjorlolo et al., 2019; Higgins et al., 2018), limited attention has been given to the relational and institutional pressures midwives navigate in practice. This gap in existing research marks a fundamental contradiction where midwives are theoretically expected to provide comprehensive care, yet in Ghana, this mandate is rarely made explicit in formal protocols.

In Obuasi East District of Ghana, anecdotal evidence suggests that midwives assume maternal mental healthcare provision as the responsibility of psychiatry nurses. In the absence of explicit guidelines, midwives navigate a variety of unwritten and often conflicting expectations from significant others such as pregnant women, families, supervisors, and the broader health system. These pressures often conflict with midwives' professional judgment and emotional labour (Lartey et al., 2020; Makarova et al., 2024), warranting urgent exploration. Relational and institutional pressures do not only constrain midwives' ability to respond to PMMH, but also reveal deeper tensions between professional judgment, emotional labour, and systemic expectations. These pressures shape how care is delivered, withheld, or emotionally negotiated often in ways that remain invisible within policy and practice.

Purpose of the Study

This study explored the social pressures midwives experience and the motivations that shape their responses in addressing PMMH. It highlights the emotional and relational tensions midwives face when their efforts to support PMMH are met with silence, resistance, or misalignment from significant others who held different views.

Methodology

Study Design

This study adopted a generic qualitative design with interpretive thematic analysis guided by the TPB. This approach enabled both descriptive reporting of midwives' accounts and their interpretive insights (Braun et al., 2022; Kahlke & Hon, 2014; Thorne, 2025).

To carry out this design, individual, face-to-face, semi-structured interviews were conducted privately within the health facilities by the lead author (Master of Philosophy student). Only the participants were present during interviews to ensure privacy. To minimize emotional risk, no follow-up interviews were undertaken.

The interview guide was developed using insights from the literature review and research question, linked to the subjective norm construct of the TPB. The tool was structured into distinct components; Section A captured the background information

of the participant. Section B captured perceived social pressures: midwives' perceived expectations of significant others and their motivation to comply (e.g., "What are the views of people you deem important on addressing PMMH").

During the interviews, open-ended prompts were explicitly used as follow-ups on what participants shared organically to elicit richer, more nuanced reflections. The full interview guide is referenced in [Appendix A \(Table 1\)](#).

To ensure clarity and contextual relevance, the interview guide was piloted with midwives in a neighbouring district, which prompted a revised and simplified version to enhance participant understanding. Interviews were conducted in English, lasted 40-60 minutes, and with consent, audio-recorded on two devices for backup. Field notes were used to capture non-verbal cues during interviews. Data collection spanned a 13-day period from April 10 to April 22, 2025.

Research Questions

To address the invisible relational, cultural, and institutional dynamics within antenatal care, this study was guided by the central research question: "What social expectations and motivations shape how midwives respond to PMMH concerns? Framed by the TPB, this inquiry specifically explored how midwives navigate the relational expectations of pregnant women, community and healthcare institutions, alongside the underlying factors driving their clinical choices.

Sample

The study population comprised midwives currently practicing in the Obuasi East District of Ghana. A purposive sampling strategy was employed to recruit nineteen (19) midwives from a range of facility types including hospitals, Community-Level Facilities (CLF) (health centres, and CHPS compounds) across both urban and rural settings. No approached participant refused nor dropped out. Recruitment ceased at 19 participants based on the principle of saturation. Code saturation was reached by participant 14, when no new codes emerged. Meaning saturation was reached by participant 17, when subsequent interviews yielded no new insights into existing codes. Saturation grid ([Appendix A, Table 2](#)) was maintained to document this process.

Inclusion/Exclusion Criteria

To ensure a cohort with relevant and current clinical insights, specific criteria were applied:

Inclusion Criteria: Participants were required to have at least six months of experience providing direct antenatal care within the districts healthcare tier system. This ensured sufficient exposure to local institutional norms and established client relationships. All participants provided written informed consent.

Exclusion Criteria: Midwives who were not exclusively assigned to antenatal units, and those immediately returning from extended leave were excluded to prevent recall bias. This ensured reflections matched current systemic pressures.

Institutional Review Board Approval, Informed Consent, and Animal/Human Subjects' Rights Required

Ethical approval was obtained from the Ghana Health Service Ethics Review Committee and permission was sought from all participating healthcare facilities. Participants' rights were strictly protected following the core bioethical principles of autonomy, beneficence, non-maleficence, and justice [Varkey's \(2021\)](#). Every participant provided written informed consent prior to data collection.

Voluntary participation and confidentiality were guaranteed, with pseudonyms assigned to protect participant identities. Interviews were conducted privately with extreme sensitivity, and support mechanisms were in place if distress occurred. All digital data are stored securely with restricted access and will be retained for a mandated five-year period before destruction.

Data Analysis

This study utilized the six-phase reflexive thematic analysis framework by [Braun et al. \(2022\)](#). Data was analysed manually in Microsoft Word to systematically identify and report patterns. Transcripts were produced verbatim and anonymized by the lead author. Analysis involved comprehensive data familiarization, followed by a combination of deductive coding (linked to TPB constructs) and inductive coding (capturing organic participant meanings, such as "taboo-talk"). Preliminary codes were clustered into candidate subthemes and major themes.

To ensure analytical rigor and consistency, two members of the four-female research team (consisting of two clinical midwives and two lecturers) engaged in peer debriefing. Coding conflicts were resolved through collaborative re-examination of raw transcript segments to reach a consensus rather than relying on a rigid statistical inter-coder agreement

score. The final coding tree synthesized raw data into 16 codes which was regrouped into 9 subthemes under 4 major themes. Findings were transparently reported using the COREQ guidelines, which can be found in full in [Appendix A \(Table 4\)](#).

Methodological rigour and trustworthiness was evaluated using [Lincoln & Guba's \(1986\)](#) criteria, supported by peer debriefing, rich description of the study context, participant profile, data collection process and member checking (where participants validated preliminary findings and corrected minor grammatical errors) and an audit trail. A daily reflexive journaling was done by the lead author to address potential bias stemming from her insider status as a former practitioner within the district. Participants were informed that the lead author was a student and interested in improving maternal health outcomes. This iterative reflexive process enhanced transparency, minimized bias, and deepened the interpretive quality of the findings.

Results

Demographic Profile of Participants

The study included nineteen (19) midwives, ranging in age from 26 to 43 years. Most participants (12) held diploma qualifications in midwifery, while seven (7) had obtained bachelor's degrees. The majority (13) had five or more years of professional experience, with six (6) classified as early-career midwives. Christianity was the predominant religious affiliation, with one participant identifying as Muslim. In terms of facility type, most midwives (13) worked in hospitals, while three (3) each were employed in CLF. The full demographic profile of participants is presented in [Appendix A \(Table 3\)](#).

Main Findings

Three key themes emerged from the data: (1) perceived pregnant women's expectations, (2) perceived supervisors' and institutional expectations, and (3) midwives' responses to these expectations. Additionally, one emergent theme: Midwives as cultural gatekeepers was identified which captured how healthcare was adapted to align with cultural norms. Collectively, these themes reveal how midwives navigate relational ambiguity, institutional silence, and emotional labour in their efforts to address PMMH. The findings underscore the complex interplay between social expectations, professional judgment, and systemic constraints that shape midwifery practice. A summary of these themes and their corresponding subthemes is presented in [Table 1](#).

Table 1. Summary of Main Findings

Theme	Subtheme	Codes	Total no. of pat.
Perceived pregnant women's expectation	• Uncertainty about mental health inquiry	• Expect physical care	• 15
	• Emotional disclosure as a request for support	• Clinical confusion	• 7
Perceived Supervisors' and Institutional expectations	• Uncertainty about PMMH roles	• Disclosure	• 6
	• Expectations shaped by facility context	• Relational Trust	• 4
Midwives' Responses to Expectations	• Conditional Responsiveness based on situation	• Role confusion	• 11
	• Unconditional responsiveness rooted in personal values	• Institutional silence	• 13
Midwives as Cultural Gatekeepers	• Hiding the Mental Health Label	• Structural cues	• 4
	• Fear of Offending Pregnant Women	• CHPS default	• 3
	• Mixing Medical and Spiritual Beliefs	• Reactive care	• 9
		• Resource linked care	• 9
		• Intrinsic motivation	• 13
		• Professional identity	• 10
		• Hiding labels	• 14
		• Taboo-talk	• 12
		• Fear of offense	• 5
		• Spiritual mixing	• 7

Note. This table illustrates the themes and subthemes that emerged from the data.

Perceived Pregnant Women's Expectations

Midwives' engagement with PMMH was shaped by their interpretations of women's often subtle and emotionally charged expectations. These were rarely expressed directly but inferred through facial expressions, disclosures, education, and cultural context. Some women showed discomfort when mental health was raised, while others shared personal struggles that midwives read as implicit requests for support. This theme highlights how midwives navigated emotional ambiguity, responding to silent invitations, hesitant signals, or clear expectations for intervention.

Uncertainty About Mental Health Inquiry

Midwives frequently encountered hesitation, confusion, or discomfort when they introduced mental health topics during antenatal care. These reactions led many to question whether pregnant women expected or even welcomed such inquiries. The uncertainty was not just clinical; it was also relational. Midwives had to read facial expressions, body language, and tone to gauge whether their questions were perceived as helpful, intrusive, or irrelevant.

Some midwives described visible shifts in clients' demeanour when mental health was mentioned. Participant 16 recalled:

"Their face change when you ask if any member of their family has any mental issues... maybe because they were not expecting such question from me." (P16)

Participant 1 described how some women equated mental illness with visible dysfunction, making mental health inquiry seem unnecessary or offensive:

"I think the question someone asked me was, can't you see I'm normal. If I was mad, wouldn't you have seen it... So we shouldn't ask them such questions." (P1)

This discomfort was often rooted in limited awareness of mental health as part of maternal care. Several midwives noted that clients viewed antenatal visits as strictly physical focused on the baby, not the mother's emotional wellbeing. Participant 19 explained:

"They think that they are coming here for their babies... just for us to take care of their pregnancy." (P19)

Participant 7 emphasized how lack of awareness shaped expectations:

"The awareness is the problem. If you don't know about mental health, how would you expect a person to provide it for you?" (P7)

Midwives also described how cultural norms and stigma influenced this uncertainty. This made midwives cautious, often waiting for cues before initiating PMMH conversations. Participant 10 reflected on this hesitation:

"You can't just ask about mental health. You have to be sure the person will not feel offended. Some people think it means you are saying they are mad." (P10)

Emotional Disclosure as a Request for Support

Midwives often viewed women's emotional openness such as sharing personal struggles, family tensions, or distress as a quiet but clear request for support. These disclosures typically arose in everyday conversation rather than as formal complaints or mental health concerns. For midwives, such sharing signalled trust, vulnerability, and an implicit relational invitation to respond. Participant 7 captured this dynamic clearly:

"They know you can help them. That is why they've been telling us some of their problems... If they do know we are to provide mental healthcare, I think they will expect it from us" (P7)

Midwives interpreted emotional disclosures as both awareness and subtle expectations for care. Even without explicit requests, they felt morally and relationally obliged to respond. Listening itself became an intervention, while remaining silent was perceived as abandonment.

Participant 13 added that educated women especially those exposed to media and public health messaging were more likely to expect support and to disclose emotional concerns:

“Educated client’s expect mental health care. Mental health is all over the news, social media, so they expect that when I’m in the facility, they get the support from the nurses or the midwives. But sorry to say, those who are not educated, they don’t know whatever we do for them. maybe they don’t expect mental health support from us” (P13)

In some cases, emotional disclosure was accompanied by a desire for immediate help, even when referral was the standard protocol. Participant 6 described how women’s sharing often came with an expectation for direct action:

“They come here with such situations, and we refer... they feel, ‘No, madam, you should do something for us here.” (P6)

Perceived Supervisors’ and Institutional Expectations

Midwives’ involvement in PMMH was influenced not only by client interactions but also by how they interpreted institutional and supervisory expectations. These were seldom communicated directly, but inferred from training availability, policy guidance, facility structures, and leadership behaviour. A lack of formal instruction often signalled that PMMH was not prioritized, while delegation practices shaped perceptions of responsibility. This theme highlights how midwives read institutional silence and structural cues to define their professional boundaries and obligations in PMMH care.

Uncertainty About PMMH Roles

Midwives often described a lack of clarity around their professional role in addressing PMMH. This uncertainty was not due to personal reluctance, but rather to the absence of formal training, institutional guidance, and supervisory communication. Without explicit instruction or reinforcement, many midwives interpreted PMMH as outside their scope of practice.

Participant 11 articulated this clearly:

“We have never for once been in an in-service training about mental health of a pregnant woman... so it means that it is not expected of us.” (P11)

Midwives saw the lack of structured training not only as a knowledge gap but as evidence that PMMH was not a priority for institutions. They believed that if mental health care were truly expected of them, it would be reflected in ongoing education and clear policy guidance. Participant 12 described the disconnect between perceived expectations and actual support:

“They expect you to do it, but they don’t even give you the tools to do it.” (P12)

Supervisory behaviour also contributed to this uncertainty. In some cases, mental health education was delegated to other professionals, reinforcing the idea that it was not a core midwifery responsibility. Participant 4 noted:

“They (superiors) will prefer maybe a nurse from the psychiatry will come one day and give a general health talk.” (P4)

Expectations Shaped by Facility Context

Midwives’ views on their PMMH role were strongly influenced by facility structures and resources. In larger hospitals with psychiatric units, they often assumed mental health care was outside their scope, seeing it as the responsibility of specialized staff. The presence of such units signalled clear boundaries, reinforcing the perception that mental health belonged to other professionals. Participant 13 described how this structural cue shaped her assumptions:

“If you don’t have the units here, then it will be part of our duties. But so far as we have the unit here... all issues concerning mental health is pushed to them.” (P13)

In contrast, midwives working in smaller or more remote facilities such as CHPS compounds felt that they were the default providers of all aspects of care, including mental health due to the absence of other professionals. Participant 14, working in a CHPS compound, explained:

“As a CHPs compound... you being a midwife, you’ll be taking care of her till she delivers... So they will be expecting that as the midwife here you do everything for them.” (P14)

She further emphasized the impracticality of referral in such contexts:

"You don't expect to take care of the baby or the mother during pregnancy and then expect her to go to another facility to go and see a mental health nurse or something." (P14)

Midwives' Responses to Expectations

Midwives' responses to expectations around PMMH reflected a spectrum of motivation shaped by context, capacity, and personal values. While some offered support only when emotional needs were visible or intervention felt feasible, others demonstrated consistent engagement driven by empathy, experience, and a sense of moral duty. These patterns revealed two distinct orientations: conditional responsiveness, shaped by situational cues, and unconditional responsiveness, rooted in intrinsic motivation.

Conditional Responsiveness Based on Situation

Midwives' motivation to engage with PMMH was situational, activated only under certain conditions. Their responsiveness depended on visible distress, perceived ability to help, or opportunities to encourage facility-based care. This reflects a pragmatic, reactive approach, where intervention occurred when emotional needs were clear and manageable. Participant 8 explained how her motivation was shaped by perceived capacity and emotional cues:

"No, they've not given us any protocol... so when the person comes and I see that she's now getting emotional stress, I intervene and support this person. I think that one, it was simple and it was within my capacity." (P8)

Participant 14 linked her motivation to the broader goal of encouraging facility attendance, suggesting that emotional support could build trust and continuity of care:

"...the way this community is, some love giving birth at home. So the way you treat her, makes her feel so comfortable. It will always make her come to the facility... to talk to you about any issues... either her mental issues or any other thing." (P14)

Unconditional Responsiveness Rooted in Personal Values

Many midwives described a form of motivation that was self-driven, consistent, and rooted in personal values, empathy, and lived experience. Unlike conditional responsiveness, this orientation was not dependent on visible distress or institutional support. Instead, midwives acted because they felt emotionally connected to their clients, ethically compelled to help, or personally fulfilled by the process of supporting maternal mental health. Participant 11 reflected on how her own experiences shaped her motivation:

"Maybe I can say it's my experience that has been motivating me... I think it is my experience that is motivating me to meet expectations." (P11)

Participant 5 described the emotional reward of seeing clients recover:

"When they come out from the problem... it gives me a motivation, oh, then I think I'm doing something better." (P5)

Participant 13 expressed a deeply empathetic stance, rooted in identification and moral responsibility:

"We call ourselves midwives, we should do the best for clients... assuming we are them. I see myself there." (P13)

Participant 16 added a quiet but powerful sense of purpose:

"Nothing motivates me, I think I just want every pregnant woman to go through pregnancy smoothly... So, I try to come in a little to see if I can be of support." (P16)

Participant 9 also spoke to the emotional bond and sense of fulfilment that comes from meeting expectations:

"Yes, with the confidence the pregnant women build in me... I have that feeling that I should be part of their daily living... It motivates me to do it (meet patient's expectations), and when successful, I feel that I have done something." (P9)

Participant 6 described a personal drive to improve and avoid disappointing those who seek her help:

"I will feel disappointed if I'm not able to help the woman... Someone may come to me for information, I will not be able to provide, and I may feel ashamed and disappointed... so I will try my best." (P6)

Midwives as Cultural Gatekeepers

Midwives were found to act as "cultural gatekeepers," mediating between medical standards and community taboos. Because local stigma often equated mental health with "madness," they prioritized protecting patients' social safety over clinical clarity. This involved three strategies: using safer, non-clinical language, avoiding direct questioning to prevent offense, and integrating spiritual perspectives into advice. In doing so, midwives guarded patients' reputations to keep them engaged with the healthcare system.

Hiding the Mental Health Label

Midwives used a strategy of avoiding clinical mental health terms, since words like "mental," "depression," or "anxiety" were often equated with "madness" in the local context. To reduce stigma and defensive reactions, they employed linguistic shielding; disguising clinical screening as casual conversation. This allowed them to assess women's well-being without triggering resistance linked to psychiatric labels.

Participant 10 emphasized that for a midwife to be successful, she must effectively hide the clinical nature of the conversation to ensure the woman does not feel accused of being "mad":

"Some people think it means you are saying they are mad... so you don't even mention the word 'mental'. You just ask how they are sleeping or if they are happy." (P10)

While midwives are performing a version of mental health assessment, the lack of explicit labelling makes the care invisible. Participant 17 further supported this by noting that they focus on the physical signs of distress rather than naming the condition, as the latter often leads to the woman fearing the service:

"If you say Mental Health, she will think she is sick in the head. So we hide it and ask about her heart, emotions and her sleep... that way she will talk to you." (P17)

Fear of Offending the Patient

This addresses the psychological and social risk midwives associate with PMMH inquiries. Beyond the difficulty of the terminology itself, midwives expressed a deep-seated concern that probing into a woman's emotional state would be interpreted as an act of ridicule or a personal attack on her character.

Participant 6 described this tension, noting that the patient's immediate reaction is often to question the midwife's perceived judgment:

"If you ask it wrongly, it is like you are ridiculing her... they will say, 'Why are you asking me that?'" (P6)

This fear of offending creates a silence that is not caused by a lack of knowledge, but by a desire to be seen as a supportive ally rather than a clinical judge. Participant 13 described the "risk" involved asking about mental health:

"You must be careful... if she thinks you are saying she is 'not correct' (mentally unstable), she will not come back to you. So, you just do the physical check and let her go." (P13)

Some midwives also avoid mental health inquiry all together to prevent damaging the midwife-patient relationship especially when there is no accountability:

"When you look at the appearance of your client, nothing shows they're mentally not okay, so if you ask, they become offended inside. Sometimes for me, I don't ask. I just look at you and assume you're okay." (P17)

"Sometimes, I skip that question (mental health inquiry), Because if I don't ask her, no one is there to hold me responsible" (P16)

Mixing Medical and Spiritual Beliefs

Midwives addressed mental distress by blending clinical advice with spiritual or religious language. Since communities often attributed psychological issues to causes like "spiritual attacks," purely medical explanations were frequently rejected. To

make care culturally acceptable and reduce resistance, midwives integrated spiritual perspectives into their guidance, aligning support with patients' worldviews.

Midwives do not necessarily abandon their medical training, but rather "re-package" it. Participant 11 explained that this cultural alignment is a way to protect the woman's feelings and ensure she feels understood:

"In our culture, when you talk about the mind, they think it is spiritual... so sometimes we have to talk to them in that way, so they don't feel bad." (P11)

This mixing acts as a bridge between two different systems of belief. Participant 18 noted that using spiritual metaphors can increase a woman's understanding about mental well-being as something that can be protected through both prayer and clinical care:

"You tell her to pray, but you also tell her the 'heavy mind' (mental instability) can affect the baby, so she must rest and talk to us. If you only speak 'hospital language,' she will think you don't understand the real spiritual problem." (P18)

Discussion

This study explored how midwives working in diverse settings in Ghana perceived and responded to expectations surrounding PMMH. The findings reveal that midwives operate within a complex web of inferred expectations, institutional ambiguity, and personal motivation. Through the lens of the TPB, these findings suggest that midwives perceived social pressure from significant others are fragmented, leaving midwives to navigate their roles individually. In the absence of formal guidance or structured protocols, midwives relied on relational cues, emotional disclosures, and contextual signals to determine when and how to engage with PMMH concerns. Their responses were shaped by both perceived social and institutional expectations, as well as by their own values, experiences, and sense of professional responsibility. Furthermore, a responds strategy (Midwives as Cultural Gate keepers), emerged from fragmented expectations in addition to the negative perception of mental health. This led midwives to adapt their care, making care professionally and culturally acceptable. These insights highlight the interplay between structural constraints and individual agency in shaping midwives' roles in maternal mental healthcare.

The broader societal discomfort with mental health discourse act as an effective negative subjective norm. This structural aversion means midwives operate within a climate of social pressure that actively discourages psychological inquiry. This dynamic creates a distinct professional dissonance: the absence of positive social and institutional mandates reinforces a perceived expectation of silence, which effectively suppresses the midwife's behavioural intention to initiate care. Many midwives consequently described relational uncertainty, choosing to cautiously navigate this negative subjective norm by relying on implicit, non-verbal cues (such as facial expressions or silence) to gauge whether an inquiry was safe. This defensive behavioural strategy aligns with [Mellor et al. \(2019\)](#), who observed that midwives proceed with extreme caution when mental health is stigmatized. Furthermore, because some women equated mental illness with visible dysfunction, an explicit inquiry was often anticipated to cause offense. Hence, the midwife's behavioural choice to remain silent is not a passive omission, but a calculated response to a hostile subjective norm, reinforcing findings by [Sheikh and Gele \(2023\)](#) and [WHO \(2024\)](#) regarding the deep separation of emotional well-being from routine antenatal care.

While broader cultural stigma creates a default social pressure for silence, individual clients' interactions can dynamically alter the immediate subjective norm. For instance, midwives interpreted emotional disclosures such as sharing personal struggles or distress as subtle but clear requests for support. Though rarely framed as formal complaints, these moments carried moral and relational weight, compelling midwives to respond. Listening itself became an intervention, while silence was experienced as abandonment. Educated clients, especially those exposed to media and public health messaging, were more likely to expect mental health support, reinforcing midwives' sense of responsibility ([Dubreucq et al., 2024](#); [Yevoo et al., 2025](#)). Midwives interpreted women's emotional openness as micro-level subjective norms that created immediate expectations for support, especially among educated clients. These localized cues often overrode broader societal pressures to remain silent. However, when referral was the only option, some clients felt disappointed, expecting direct action from the midwife. Emotional openness hence functioned as a relational signal for sign of trust and a test of attentiveness which midwives navigated even without formal training or institutional backing.

Midwives' perceptions of their professional role were strongly shaped by institutional silence, lack of training, and structural omission. Within the TPB framework, this silence acted as a systemic feedback mechanism, shaping beliefs about what authorities valued. The absence of in-service training, supervisory guidance, and clinical protocols signalled that PMMH was not part of their accountability, leading many to conclude that PMMH lay outside their mandated scope of practice ([Coates & Foureur, 2019](#); [Dubreucq et al., 2024](#)). This mechanism of behavioural retreat is further reinforced by

superficial supervisory delegations, such as inviting psychiatric nurses to lead mental health talks during antenatal clinics. This invitation serves as a visual and systemic cue that validates the perception that PMMH is strictly the domain of external specialists (Dm et al., 2021; Tallam & Mash, 2022). Consequently, without an external, institutionalized mandate to drive compliance, PMMH care becomes an entirely individualized, informal relational commitment guided purely by personal values (Mellor et al., 2019).

Facility structure also played a decisive role in shaping midwives' behavioural intentions by altering the source and intensity of their perceived expectations. In larger hospitals with dedicated psychiatric units, the immediate presence of specialized personnel created a distinct social and professional hierarchy. In this environment, the prevailing subjective norm among midwives was one of peer deference. Midwives perceived those institutional authorities, and specialized colleagues expected them to hand over all mental healthcare services. This led to a diffusion of responsibility where mental health was strictly treated as the domain of specialists. Conversely, in smaller or rural facilities such as CHPS compounds, the social landscape changes entirely. In the absence of specialized personnel in these under-resourced settings, the midwife is exposed to a direct, unmediated and an unwritten social expectation from the community to provide an all-inclusive care. As observed by Sheikh and Gele (2023) and Yevo et al. (2025), midwives in rural Ghana often assume broader roles because the immediate social pressure to intervene in a crisis is much higher. Hence, the facility context does not just change workload; it completely shifts the reference group dictating the expectation. This forces the midwife to constantly negotiate her behavioural responses between distant institutional silences and immediate, pressing community expectations.

Midwives showed two motivational orientations toward PMMH: conditional responsiveness, shaped by situational cues, and unconditional responsiveness, grounded in personal values. Those responding conditionally described their engagement as reactive, triggered by visible emotional distress, their perceived capacity to help, or opportunities to build trust and encourage facility-based care. This pragmatic approach aligns with findings from Tallam and Mash (2022) and Dm et al. (2021), which observed that midwives in low-resource settings often intervene when mental health needs are overt and manageable. This study suggests that conditional responders are highly influenced by immediate social expectations where they act when distress was visible enough to create a clear expectation of care. This demonstrates a mechanism where PMMH care was not routine but entirely dependent on the social pressure from pregnant women.

In contrast, midwives who demonstrated unconditional responsiveness described a consistent, self-directed commitment to PMMH, driven by empathy, lived experience, and a sense of moral responsibility. Their motivation was intrinsic, sustained even in the absence of formal training or institutional support. This echoes Mellor et al. (2019) and Sheikh and Gele (2023), who highlight the role of personal conviction and emotional labour in sustaining maternal mental health care. Midwives in this group viewed emotional support as integral to their role, often drawing on relational bonds and ethical commitment to guide their actions. This demonstrates that, in under-resourced and structurally ambiguous settings, PMMH care is often upheld by midwives' internal values rather than external mandates, a pattern also noted by Yevo et al. (2025) in rural Ghana. Additionally, the relational bond between midwives and pregnant women served as a medium that empowers midwives to routinely provide PMMH care even in the absence of explicit directives or request by pregnant women.

Beyond clinical and social expectations, this study identified cultural gatekeepers as a role played by midwives to ease the tension between bio-medical frameworks and traditional belief systems by hiding the mental health label to avoid offending clients. This strategy of using milder expressions to bypass the deep-seated stigma of "madness" represents a form of cultural negotiation aimed at maintaining the therapeutic relationship. According to Kwasi and Patheja (2026), such negotiation is vital in the Ghanaian context, where over 77% of the population attributes mental illness to spiritual or supernatural forces, and 59% associate these conditions with profound family shame. Avoiding stigmatized clinical labels ensures that midwives prevent the "family shame" that often leads patients to abandon formal psychiatric care in favour of traditional interventions.

Furthermore, midwives often blended spiritual and clinical beliefs when addressing distress. They acknowledged spiritual causes, such as "spiritual attacks," while still offering medical support. This shows they acted as negotiators, reshaping mental health definitions to make care culturally acceptable. The approach reflects the "Sankofa principle" by Adomako et al. (2016), which emphasizes integrating indigenous cultural values and social networks into mental health provision. By informally combining spiritual and clinical frameworks, midwives created culturally competent interventions that bridged Western psychology with local worldviews, ensuring care remained accessible in high-stigma environment.

Strength and Limitations

This study explored midwives' perceptions of PMMH in Ghana, highlighting several methodological strengths. In-depth interviews provided rich, context-sensitive insights into relational, institutional, and motivational experiences. Including participants from hospitals, health centres, and CHPS compounds enhanced transferability across diverse settings. Although geographically limited, purposive sampling across facility levels captured varied perspectives. To reduce social desirability bias, interviews were conducted privately with confidentiality emphasized. While the design did not capture changes over

time, iterative coding and peer debriefing strengthened credibility. Despite limitations, the study offers valuable evidence to inform policy, training, and support systems for midwives in low-resource maternal health contexts.

Implication for Practise

To strengthen PMMH practice in Ghana, the study recommends moving beyond generic training and formally embedding the informal strategies midwives already use. The Ministry of Health should integrate mandatory PMMH screening metrics into maternal health records to shift accountability norms. Maternal health divisions should co-design a “Stigma-Free Prenatal Communication Toolkit” that legitimizes euphemisms and incorporates the “Sankofa” principle by blending spiritual and biomedical perspectives. Interventions must also be tailored to facility contexts: urban hospitals need clear boundaries to reduce over-reliance on psychiatric units, whereas rural CHPS facilities require telehealth linkages to support midwives facing heavy community expectations. Together, these measures would structurally validate midwives’ role and ensure culturally competent, context-sensitive PMMH care.

Conclusion

This study highlights the complex and often unspoken expectations midwives navigate in addressing PMMH within Ghanaian antenatal care. In the absence of formal training, clear protocols, and institutional support, midwives relied on relational cues, emotional disclosures, and personal conviction to guide their engagement. Their responses ranged from conditional, context-driven support to value-based care rooted in empathy and lived experience. These findings underscore the need for policy and practice reforms that clarify midwives’ roles, reduce stigma, and provide culturally adaptable tool, training and supervision. Recognizing and supporting midwives’ emotional labour is essential to strengthening PMMH integration in low-resource settings and ensuring holistic maternal care.

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ORCID iDs

Wilhemina Dowuona Hammond  <https://orcid.org/0009-0001-5950-5068>

Evelyn Asamoah Ampofo  <https://orcid.org/0000-0002-6135-5388>

Adiza Atoko Mumuni  <https://orcid.org/0009-0003-6117-782X>

Ethical Considerations

Ethical approval for this study was obtained from the Ghana Health Service Ethics Review Committee (Ref: GHS-ERC 012/2025) on 17th 2025. Additional permissions were granted by the Obuasi East District Health Directorate and participating health facilities.

Consent to Participate

Written informed consent was obtained from all participants prior to data collection, with assurances of confidentiality, voluntary participation, and the right to withdraw at any time without consequence.

Author Contribution

WDH conceptualized the study, led data collection, analysis and drafted the manuscript. EAA and AAM contributed to study design, supervised analysis, and provided critical revisions. MSF contributed to data analysis and drafting of manuscript All authors read and approved the final manuscript.

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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.

Data Availability Statement

The datasets generated and analysed during this study are not publicly available due to participant confidentiality but are available from the corresponding author on reasonable request.

Supplemental Material

Supplemental Material for this article is available online.

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Appendix

Abbreviations

PMMH	Prenatal Maternal Mental Health
CHPS	Community-based Health Planning and Services
GHS	Ghana Health Service
TPB	Theory of Planned Behaviour
CLF	Community-Level Facility
BSc	Bachelor of Science
WHO	World Health Organization
MH	Mental Health
ANC	Antenatal Care.