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Research Article

Women's Empowerment and the Integration of Traditional Maternal and Child Healthcare with National Health Systems in the Republic of Guinea.

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Abstract

Several studies show that policies to improve maternal and infant health must be contextualised within broader questions and commitments concerning women's empowerment. There are, however, two-way linkages between women's empowerment and reproductive services. Certain institutional approaches that support women's reproductive health can themselves be experienced as empowering whereas others, however well-meaning, can be experienced as disempowering, undermining health and broader goals. It is thus important to discern and support those elements of reproductive services that might have empowerment outcomes, and to avoid others that undermine them. This paper is premised on the hypothesis that approaches to reproductive health that are rooted in women's life worlds, that support women's social networks and which enhance women's confidence and control will have very different empowerment effect from those that subordinate women and their networks to external expertise and (often male) authority and undermine women's preferences or autonomy. We (a) conduct an audit of positive practices concerning maternal and child health and (b) examine how current support to maternal and infant health articulates with this. Analysis seeks to reposition indigenous knowledge, community wisdom and their secular practices in a way that promotes better health provision that is integrated with these existing practices and that is empowering.

Keywords:
Material and child health; Gender and Empowerment; Traditional practices; Health Systems

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Background

Whilst important in itself, women's empowerment plays an important role in wider development outcomes [1]. What women's empowerment means and how to measure it is much discussed [2], however all definitions extend beyond questions of economic empowerment, to engage with other dimensions of power, confidence and self-determination.

Many dimensions of women's empowerment have been discerned as important determinants for the use of maternal health care, including financial autonomy and household wealth, participation and influence in household and community decision-making, women's educational attainment, social status and freedom of movement [3]. These studies conclude that goals to improve the health, longevity, and mental and physical capacity of mothers and the well-being of children must therefore be contextualised within broader questions and commitments to women's empowerment [4].

There are, however, two-way linkages between women's empowerment and reproductive services. Certain institutional approaches that support women's reproductive health can themselves be experienced as empowering for women bringing wider advantages [5], whereas others, however well-meaning, can be experienced as disempowering, undermining health and broader goals [6]. Empowerment (and its wider health benefits) is not simply related to improved access to infant health care if these are perceived as disempowering. It is thus important to discern and support those elements of reproductive services that have empowerment outcomes, and to avoid others that undermine them. Approaches to reproductive health that are rooted in women's life worlds and that support social networks and which enhance women's confidence and control are very different from approaches that subordinate women and their networks to external expertise and (often male) authority and undermine women's preferences or autonomy. Those couched in world views that women share may have radically different effect to those couched in world views that are perceived as alien [7].

There are, however, complicating issues. In many social worlds, women's empowerment is gained from women's social support networks, many of which themselves focus on support to maternal and child health. Yet not all women's networks are so straightforwardly empowering, or where they are, are not necessarily supportive of reproductive health. The place of women's social and institutional networks in Female Genital Cutting and early marriage is particularly controversial in West Africa. Second, these issues are gendered, so whilst increasing women's status is an important strategy in reducing preventable maternal morbidity and mortality, male involvement is also important – which holds too, for domestic violence, women's sexual empowerment and control over family planning [4]. While efforts to both empower women and engage men in maternal health care-seeking can work synergistically, in practice they may result in opposing processes and outcomes [8]. For example, women's empowerment can be positively or negatively associated with male antenatal accompaniment.

It is thus important to discern the existing practices and support networks in the community that are empowering and bring health benefits whether directly or indirectly so that policies can be crafted to support them, and avoid undermining them [9].

Given systemic funding problems, there is also a need to ensure the most effective complementarity between traditional medicinal and care practices and the health system not only for reasons of efficacy, but also the efficiency, sustainability and resilience of health delivery. In Guinea, the importance of this became clear when Ebola Virus Disease (EVD) caused an almost instantaneous collapse of a formal health system already weakened by the lack of resources – undermining the availability and quality of health care services and thus their use. In neighbouring countries (Liberia, Sierra Leone, Cote d'Ivoire) unforeseen conflicts have had similar effects on formal health systems in past decades.

Here we report on research in the Republic of Guinea in West Africa that identifies the existing traditional health practices (and supporting knowledge, rationales, values) that are important for maternal and infant health given local conditions. The aim is first to identify systematically those that are directly positive (efficacious and safe), and those that are important indirectly in enhancing supportive social networks and empowerment (building social relations that are themselves 'good for health'). Second, we examine people's experience of the national reproductive health care system. Together this can provide a basis for innovation to improve sustainability in maternal and infant health.

Policy Context

This study derives from collaboration between Guinea's Ministry of Health (MoH) and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women). Since 2010, UN Women has been supporting efforts by the Government and civil society of Guinea, their technical and financial partners (UNFPA, WHO UNICEF), civil society, women's groups and the media to implement initiatives aimed at empowering women and reducing gender-based inequalities and violence support maternal health.

Guinea has formulated policy and programs that address health needs throughout the life cycle. The MoH has adopted standards and procedures to guide the organization and delivery of quality services throughout the health pyramid and supports the training, monitoring and evaluation, research, and health information in the field of reproductive health. A national roadmap (2005-2010) was developed to address maternal and infant mortality by improving the quality, efficiency and universal access to benefits. Yet despite this, national demographic / health indicators remained among the worst in the sub-region even prior to the Ebola epidemic of 2013-2016. Among Guinea's 11 million people, maternal and infant morbidity and mortality are extremely high. According to the [10], maternal mortality rate is 724 per 100 000 live births and infant and juvenile mortality is 122/1000 live births**.** These statistics certainly do not capture the full picture as many deaths go unrecorded. Moreover, since 2014, the Ebola epidemic, in conjunction with the challenges it posed to maternal and infant care, infant immunization services and to malaria, tuberculosis and HIV and AIDS has surely worsened this already precarious state of health. Traditional practices harmful to the health of mother and child also persist. In Guinea, 96% of women undergo female genital mutilation (FGM) that is conducted within women's social networks [10]. Table 1

Reproductive health care is integrated with primary health care in a package of essential activities, including (by level) CPN, CPC, birth attendants, PF, vaccination, post-natal consultation, STI / HIV / AIDS, IEC. Points benefits are: Community Based Services, Health Posts, Health Centres, Community Medical Centres, Prefectoral, Regional and National Hospitals. Laboratory services, medical imaging and blood transfusion support these as do Non-Government Organizations such as AGBEF. There are private practices and clinics, 'para-public' institutions and army medical health services.

The political will to improve the coverage, accessibility, equity and the quality of services is evident in the field of reproductive health in the creation of the Directorate for family health and nutrition; in legislation adopting reproductive health law (Law 010/2000/AN), and in the reproductive health policy and programme (2012). Family Planning and 'Adolescent and youth health and development plans' have been aligned strategically and implemented together. Specific programs have been launched such as the 'maternity program without risk' (MSR); the 'integrated management program for childhood

Table 1. Changes in key sociodemographic and health indicators in Guinea 2005-2012

Indicators	2005	2012
Crude Birth Rate (per 1000 per year)	38.4	34
Level of infant and juvenile mortality (deaths/1000 live births)	163	122
Maternal mortality ratio (deaths per 100,000 live births)	980	724
Synthetic fecundity index (number of children per woman).	5.7	5.1
neonatal mortality rate (deaths before 28 days per 1000 live births)	39	35
CPN cover	82%	85%
Level of assisted births	38%	46%
Level of modern contraceptive use.	6,8%	7%
Level of HIV seroprevalence	1.50%	1.70%

Source : DHS, 2005 and 2012

and newborn diseases (PECIMNE)'; an 'adolescent and youth health programme'; a product safety plan, and a 'plan for the development of human resources, standards and procedures,' alongside plans that address HIV and Malaria. Obstetric care, when available, is provided free. Socio-educational and communication programs and Youth listening, counseling and guidance center (CECOJE) have been implemented, and in the wake of the ICPD declaration a new population policy has been adopted.

Methods

The overall aims are (a) to draw up a directory of good practices drawn from tradition, custom and religion that promote maternal and infant health, whether directly or indirectly and gauge the views / opinions of the communities of the relevance of these practices and their feasibility, and (b) to discern how health delivery articulates with these practices.

Research adopted a participatory approach to data collection at all stages of the process. To understand the gendered dimensions to these practices it was important not only to discuss with women, young and old, but also with men and with community and religious leaders (men and women). Given that the work of health-workers such as midwives and CSOs brings them into contact with everyday women's health practices, and with processes of empowerment and disempowerment, research extended to them. Research was thus focused on (a) women of childbearing age (young and old); (b) health personnel, involved in mother and infant care (including midwife elders); (c) young, adult and older men, and (d) community and religious leaders.

A multidisciplinary team conducted semi-structured interviews and focus groups with more than a thousand participants. Participants were stratified to embrace both rural and urban experience and the experience of Guinea's different regions. Accordingly research was conducted in 4 (of 33) Guinea's Prefectures and the Zone of Conakry, the Capital and in each (excepting Conakry) research focused on the chief town of the prefecture and on one rural commune. Further in-depth interviews were conducted with health workers and opinion leaders for which there was purposive sampling to capture the experience of providers within maternal health care structures (midwives, retired midwives, trained traditional birth attendants, and those working in community based services, family planning, maternity and child health and neonatal services (where they exist)). Civil society leaders were approached to facilitate the research and then interviewed by convenience.

Of participating women, 68% had no job beyond farm and household work, the others being students, traders, other workers (e.g. hairdressers) and civil servants. Most (54%) had no education although 19% had primary and secondary schooling and 8% tertiary education – more than national averages.

Just over half of those participating were married and 78% belonged to women's mutual health groups (Sèrè). The participating men were farmers, traders, builders, carpenters, artisans and students. 40% had no education, and those achieving primary and secondary, 18 and 15% respectively. 57% were married.

Of the local elected officials, community, traditional and religious leaders consulted, 69 live in rural areas, 102 in urban areas, and 31 in the special zone of Conakry. Most (52%) were 35-40, and those over 60, less than 10%. 77% were men and almost all, married. Some were farmers, ranchers and merchants, but others agronomists, civil administrators and notable or traditional practitioners. A third had no education, but 21% and 17% had attended primary and secondary school, respectively.

Beyond the authors, research was conducted by 12 experienced fieldworkers each with a local guide, overseen by four supervisors. Fieldworkers were trained in the aims of the study and read an analytical review of documentation. They were trained, too, in modes of conduct to assure confidentiality and anonymity, and to ensure that participation was voluntary on the basis of prior oral consent. Field-workers conducted semi-structured interviews drawing on a common questionnaire, and conducted focus groups according to a prepared guide, all of which were field tested, ensuring too, the ability of investigators to understand and communicate the content of the tools. Quantitative data were entered and analysed through appropriate software (Epi-data / SPSS and Excel). For qualitative data, a semantic analysis was performed to identify a transcript and listed key messages.

Results

Pregnancy, Birth and Neonatal Care

By positive traditional practices, both women and men understood an assemblage of social practices and values as well as the specific resources and practices that help women through pregnancy and childbirth. The most fundamental traditional practice articulated by women is the social "Solidarity" of family and community translated generously in pregnancy, birth, and in the succeeding days and weeks. These are periods of vulnerability and risk, and birth of a baby is a joyful event that is shared by couples, extended family and the community. Social assistance is manifest in visits and in gifts of foods, soap, clothing, advice and actual care of the newborn. Such social assistance strengthens social ties and community – and is couched, too, in religious practices whether Islamic, Christian and traditional religious practice according to region and community. A second element to social assistance is the mutual associations that the majority of women join and that provide a platform for economic activity, be it working, saving or sharing. These help women directly around childbirth and the social networks and economic support provide women some autonomy (empowerment).

Structures of education that prepare a girl for married and reproductive life extend into the wider community [11]. Such education covers, for example, the rights, responsibilities and propriety of a responsible mother; the cleaning, feeding, parenting skills; the responsible behaviors in adulthood including endurance and perseverance in work and honesty; the moral education promoting modesty and dignity. It covers, too, the pitfalls of improper moral and sexual conduct and how these are thought to be associated with complications in pregnancy and birth and with the wider community. This moral and institutional order curbs prostitution, rape, sexual and domestic violence and other forms of violence against women, particularly those who are pregnant or breastfeeding. It also gives attention to the quality of drinking water; to hygiene and basic sanitation-hygiene rules (including hand washing before eating and after defecation) and careful hygiene around menstruation [12]. It includes a zero tolerance of psychoactive substances such as tobacco, alcohol and drug consumption by girls and women. For Muslims, Koranic instruction for women includes learning virtuous verses, providing psychological support, and fasting restrictions associated with Ramadan are lifted in pregnancy and for new mothers. This education is acquired in the course of everyday life, but is given especially by those involved in events surrounding women's initiation that involves female genital cutting – FGC [13].

A second arena of practices concerns dietary enhancements during pregnancy, for birth and during breastfeeding. According to region, women consume special foodstuffs and recipes, using herbs such as kinkélibala (*Combretum micranthum)*, pellitoro (*Hymenocardiaacida spp*.), guile (*Solanum verbas-cifolium*), Siminyi **[***Grewia malacocarpa*], suukoran (medicinal plant used by mothers), Shea Butter (*Vitellaria paradoxa*), chicken, honey, lemon and other fruits and vegetables. These are taken to prevent

or treat particular complications of pregnancy, childbirth or related diseases (malaria, parasitizes, diarrhea) that themselves would complicate pregnancy. New mothers are offered enriched porridge. Elder women suggest foods that stimulate and enhance lactation (including peanuts, porridges) as well as herbal medicines. Such consumption in some regions extends to geophagy: the eating of earth, usually of termite mounds or the nests of mud daubing wasps that are rich in the minerals for which many women in these regions are otherwise critically deficient [14].

A third area of practices concerns birth spacing. Both women and men describe the ideal age for marriage and first pregnancy to be after first menstruation, rather than by age per se, though suggest this is usually between 15 and 17. Health professionals considered 18 as the ideal. For men interviewed, it is inconceivable to talk about ideal age of pregnancy outside questions of marriage. Women, on average, expressed a preference for a spacing of two years between births (or miscarriage) and to breastfeed for about a year. Ideally family size would be 2 sons and 2 daughters. Men, however, expressed ideals for more children (average 2.7 sons and 2.3 daughters) but recognise too the practical challenges to provide for their food, education and health. Men articulated a preference for a slightly shorter birth spacing of 18 months after a birth, and a much shorter one of only a few months after miscarriage.

The most cited practices to the enabling the birth spacing that guards women's health is the 'maternal holiday' in which women are able to abstain from sex for extended periods. In certain regions young mothers separate from their husbands and return to their parental home for some or much of this time. This period is usually associated also with the period of breastfeeding, which also suppresses fertility. Indeed several studies indicate that women may abstain from sex whilst breastfeeding as it is considered to endanger the health of the newborn [15]. The amulets that women wear 'to avoid pregnancy' also suggest sexual inactivity. These practices are decided by the couple and their families along with the easing of domestic responsibilities and greater attention to the newborn and nursing mother. Of those interviewed, 58% of women reported using some assistance in birth spacing, with this higher in town, yet these local methods were considered to fail frequently by 51% of those reporting their use, and to be only weakly or moderately effective by a further 22%. Induced, 'underground' abortions are unacceptable socially. Table 2, Table 3.

Women did not report any adverse effects of traditional practices on maternal and infant health - nor any perceived disadvantages that would impede the use of them. Very few men, too, said that they had ever been present at discussions concerning adverse effects of traditional practices on maternal health. Men agree that the ease of access, low cost, negotiable payment terms, and selfless social assistance in the neighbourhood support the use of traditional practices [16]. They do not imagine that zero risk is possible, but understand that these positive practices reduce it. Indeed, for some, these practices have been used for a long time by ancestors in the past who had fewer health problems (in extent and gravity) than current generations [17].

Table 2. Frequency and method of family planning (reported by women)

Method	Frequency	(%)
Maternal 'holiday' (involving sexual abstinence and residence with parents)	8	44
Maternal breastfeeding	10	56
Cervical mucous	0	0
Amulets	14	78
Upended calabash	3	17
Coitus interruptus	2	11
Abstinence	7	39
Other	4	22

Table 3. Positive practices for maternal and neonatal health and their reported frequency (n=329)

Practices	Frequency	%
Breastfeeding (as opposed to formula milk)	318	97
Traditional or natural birth spacing	120	36
Special pregnancy / maternal diets (chicken broth enriched porridge, food stimulating lactation)	110	33
Parental or 'community education' (moral education and promotion of values of dignity and honour inspired by tales, legends, proverbs and stories)	58	18
Limiting the number of live births per woman and a husband's number of wives	21	6
Therapeutic properties of some traditional medical recipes (preventative and curitative)	222	67
Social solidarity / humanitarian assistance and pooling of resources (community health mutual)	124	38
Deferring marriage to 18 (in contrast to early / forced marriage)	111	34
Advice on danger signs in pregnancy	125	38
Orientation of pregnant women and children to public or private health facilities	98	30
Social mobilization (by SMNI) in hygiene including hand washing, the maintenance of drinking water sources; the rights of women and children, and predispositions to work with health services for the continuum of care and the use of the telephone and ambulance motorcycle	101	31
Restrictions increasingly raised on practices harmful to maternal health (excision, domestic violence, early marriage, burden of domestic responsibilities, lack of dialogue with future spouses, prostitution, divorce, empowerment of women through AGR....)	77	23
Jobs associated with training of girls in French and local language literacy and 'blossoming', (proud, educated, informed, successful, fulfilled)	45	14
Initiation education for girls into values and standards on morality, and into avoiding forms of harmful (immoral) practices that affect a woman's health and well-being	69	2
Speech/comportment and marital / social relations based on cordiality and mutual trust	44	14

Informants suggested that pregnant women and young mothers who seek care whether for themselves or their children are always welcomed by traditional care providers. A few quotations can provide a sense of this:

My child lost weight following a fever associated with diarrhoea, I took her to an elder woman ('grandmother') who gave me a root decoction. She told me to boil them and have the child drink the decoction and wash with it morning and evening. Three days later, the child returned to suckle the breast and laugh."

"When I delivered my baby, he was small and weak, and the midwife helped me with food"

"Ahh! it is a feeling of joy and satisfaction after using traditional recipes."

For men as for women, the traditional practice promoting maternal and infant health include the set of values and resources used to prevent or restore the deteriorating health of the mother and child. This included support to breastfeeding, recipes based on medicinal plants and, indeed, recommendations to use health services. Again some quotations are indicative:

"We know the interest of positive traditional practices especially breastfeeding, complementary feeding and body and food hygiene for the health of children." (men, Soyah, Mamou)

"We are told by the elders of the importance of breastfeeding for the health and growth of children." (men, Kissdidougou)

"Of course, we always talked about the importance of breastfeeding and human warmth / kindness of the mother towards the child / maternal care and cleanliness; it is for the health and rapid growth of the child." (men, Baténafadji, Kankan)

"We are told by the elders of the importance of the use of Shea butter after bathing newborns for them to grow up healthy." (men, Kissdidougou)

Community leaders, too, highlighted the concept of ancestrally proven values in the preservation of women's health during maternity. Positive practices, in their telling, range from forms of sexual abstinence, to the Muslim faith and to traditional herbal and dietary recipes. They emphasized how traditional practices are couched within their community's socio-cultural values, are easily accessible (available day and night), and have benevolent payment terms [18]. Such psychosocial determinants and empathy have heightened significance given difficulties of affordability in the context of growing poverty.

Issues of cost and availability came over strongly in the focus groups.

"Concerning the cost of traditional practices, sometimes we offer products for free or with payment terms easier: in kind, delayed, moderate prices". In comparison, the prices of medicines are high in pharmacies or the market." (woman, Urban Commune of Mamou)

"Traditional products are either free or very affordable." (woman, Sangardo, Kissidougou)

"There are traditional products everywhere next to our homes and it costs nothing." (woman, Soyah, Mamou)

"There is always someone around capable of dealing women's and children's health issues." (woman, Kissidougou)

"There is always someone to go to who can distribute a traditional product and give practical advice, whether in the family, among immediate neighbours or in the surrounding villages." (woman, Soyah, Mamou).

"Families can find someone in the village at any time to discuss questions about nutrition and feeding of newborns and children."

The low costs with payment often deferred, waived or in kind; the ease of access to traditional practices; their easily understandable use; the ability to converse easily in commonly understood idioms and conceptual framings; the empathy about them, all rooted in widely shared values are all strong reasons why traditional practices remain so popular.

Yet women themselves also emphasize the importance of both the formal healthcare institutions alongside their traditional practices, and many engage with both. Indeed, both women and men are very aware that pregnancy monitoring and antenatal care is provided by both public and private health facilities as well as the community level, but only 21% of women surveyed reported using both. More women reported that delivery itself was in health facilities (whether public or private), but this was still less than half (49%). More men (57%) reported that births were in health facilities, and 77% of providers reported this, seemingly revealing interpretative bias among providers for their own significance. There is, thus, a very low use of antenatal care services and a low use of assisted delivery.

Qualitative evidence reveals that the majority tend to visit the formal clinics when faced by problems – for curative rather than for monitoring and prevention. "For me, simple cases are treated well by the wise women, but if the case is serious about the child becoming thin, smooth, with brown hair and bloated stomach, you have to visit hospital." (women, Baténafadji, Kankan).

"As our grandparents' products and incantations are available in our community, older women and other healers take care of the health problems of children and women, or if they cannot, they ask us to go to the health center or to the hospital." (men, Soyah, Mamou).

"In most cases (we frequent clinics when), it is malaria / fever, diarrhoea, vomiting, weight loss or lack of vitamins, or birth." (Men, Ratoma, Conakry).

Those who do not visit reproductive health services describe how they are not adapted to their needs. For women, specific problems included difficulties with opening times (44%); cost (62%), the derogatory attitudes of health workers and their poor welcome and communication (indiscretion and lack of confidentiality by 'indelicate personnel'); (59%); distance (15%), beliefs and prejudices (11%). These issues emerged to be of wider significance than the lack of support by husbands (12%) and by family (13%), or the low availability of user-friendly services (10%). Concerns extend to the quality of service, for example:

"I found that traditional services are more satisfactory than the performance of health centers where medicines and vitamins are almost non-existent." (Urban Commune of Kindia). Men, too, expressed various reasons for avoiding modern maternal health services, reiterating the significance of the poor quality and range of their services; opening times, and the difficult access that formal healthcare has to health products (drugs etc.). Like women many men highlight the poor welcome, the indiscretion, and the lack of effective and sympathetic communication between those attending and the health professionals.

Women suggested that efforts to improve comprehensive sexual and reproductive health should focus on improving the quality of services and the conditions that promote information sharing. In interviews, their answers extended to the Ebola epidemic – and concerns with hygiene in the use of health services. Men too made connections between the Ebola epidemic and the increased use of traditional / customary practices given concerns with hygiene during the epidemic and speculation about the epidemic's origins.

Providers recognize the existence of traditional family planning, breastfeeding, modified diets, herbal remedies that prevent complications, and local care in pregnancy and birth - and admit that these are more accessible and affordable [19]. They also did not list any factors impeding the use of traditional practices, as their opinion is generally favorable towards them. Their benefits are comparable to modern therapies, even though there are concerns that traditional practices may expose women to more or less severe health risks. And yet those working in the health centers (and higher level structures) were unequivocal that pregnancy care is ensured formally through the antenatal care in government health and private structures and only marginally at the community level through the use of positive traditional practices [20].

Significantly, no health workers interviewed had encouraged the use of positive traditional practices for monitoring pregnancy. Community based workers, by contrast (traditional birth attendants, community health workers) did advise on the use of proven positive practices.

Health workers suggest that among the reasons why their services are poorly frequented are the low availability and quality of services (opening times); their poor stocks of health products; the costs ; the poor reception visitors receive, the communication gap and lack of privacy. Awareness, too, that they are silent on traditional practices and do pay little attention to 'beliefs' and customs. The Ebola epidemic had had a negative impact throughout the health system, and the increased use of traditional practices.

Community leaders were also concerned by the lack of attention paid by the formal health structures to positive traditional practices – and in the lack of qualified and motivated providers; opening schedules; distance; costs (direct and indirect); attitudes of health workers towards patients, and lack of empathy and lack of communication between caregiver and treated, vocalizing concerns, even, with the disrespect and prejudice that women in labor perceived during childbirth [21].

Engagement with Family Planning Services

Whilst similar issues emerged in people's engagement with formal family planning facilities, lack of engagement with them concerned more their social acceptability. The reasons women gave about the low rate of use of modern family planning (averaging about 7% nationally) relate to fear of disapproval from their husband (41%) and from in-laws (33%), and from speculation about the hidden intent of family planning (45%). Only 14% of women suggested a lack of a perceived need (14%). They expressed reasons why their choice was focused on traditional methods of birth spacing and other traditional practices lay in (a) lack of access to family planning facilities (in terms of cost and time)

and (b) the lack of confidence they placed in the facilities for their discretion and (c) concerns with the efficacy of the method recommended.

Men had slightly differing views. The proportion of men who supported their wives to delay pregnancy or avoid pregnancy is relatively low (19%). Yet those expressing a lack of need felt by women was negligible (1%). Most men suggested that it was the unfavourable opinion of husbands (34%), fear of in-laws (21%), fear and prejudicial rumours about modern family planning (24%) that reduced its use. They also outlined, however, how women's access is limited by opening hours and distance; by costs (direct and indirect); by the attitudes of health staff. Services were not considered 'user friendly' for young people's health needs, and operated poorly as centers for listening and advice [22]. Leaders especially expressed a lack of user-friendly services tailored to the specific needs of adolescents that make them more vulnerable concerning, in particular sexual immaturity, unwanted pregnancies, socio-economic dependence, risk of STDs, HIV & AIDS.

Health care workers, by contrast, suggest that low levels of family planning are attributed to the lack of need felt by women, as well as their husbands' opposition, and rumours about family planning. Questions concerning welcome and discretion were not articulated. Health workers said that few women of childbearing age confide in them about the effectiveness of natural or traditional methods of child spacing. Those who do speak about are concerned that their methods are ineffective because the failure rate is high [23]. Women find information on family planning options through traditional birth attendants, older women, community health workers and health staff. Men tended to know of natural or traditional practices through their partner in nearly half the cases, and many quietly expressed a need for sex education [24].

Traditional support structures coexist with national maternal and child health services. Evidence provided here shows that women who use the latter integrate these in practice with their traditional maternal support. Conversely, however, whilst we find that those working in those structures appreciate the significance of traditional systems, there is neither policy nor practice that acknowledges and builds on the potential benefits of such integration [25]**.** Health services and wider administrative forums debate the high levels of mortality of mothers and newborns, but there is no evidence that providers have been approached to dialogue on traditional practices on maternal and newborn health.

We have provided information on the underlying reasons behind the continued use of traditional and religious practices despite some "accessibility" to modern health services. It is not the case that the modern system is displacing traditional practices, but the specifics of their encounter help maintain both, as socially separate. To the extent that the separation is maintained by the national structures, these structures do not become 'part of the community'. This is a missed opportunity for a variety of reasons, whether relating to efficacy, efficiency, sustainability or resilience [26]. Whilst this paper renders visible these missed opportunities, our focus has been on an associated problem: by ignoring existing social support, knowledge, practices and ethics supporting maternal and child health, the formal medical structures can contribute to processes of disempowerment that undermine both their own goals concerning maternal and infant health, as well as broader development goals.

Without community involvement, it is illusory to think that the health service can improve mother and child health. Such a commitment necessarily entails the recognition and promotion of popular knowledge and positive traditional practices in preserving maternal and newborn health [27]. The experience of disempowerment relates not to these experience of maternal health facilities (as demeaning in welcome and unsupportive in communication) but more broadly, to the lack of appreciation of what women and the wider social world are already doing in supporting maternal health [28]. The latter is rendered all the more complex where these traditional support networks that are in some ways empowering, are associated too with social networks which also support more negative aspects – most significantly Female Genital Cutting – legislated against nationally and internationally as a human rights violation [29]. Women's poor experience of modern health systems and their dependency on community social networks thus creates a dependency, too, on the structures supporting FGC. The customs, worldview and values of a community shape behavior. FGC exemplifies how the inherited dispositions and acquired habits (that sociologist Bourdieu calls habitus) that are important in delivering health also involve the structure and identity of a community, and are thus resilient to change. Identity and identity politics

are thus closely integrated with health practices. A first step to address FGC must be to empower and integrate women within modern maternal health structures.

The system of sharing information about these practices is currently disorganized, informal and poorly explored [30]. Access to information on positive traditional practices is also hampered by taboos, prejudice and the lack of communication between all stakeholders. There are, however, precedents in the sub-region and elsewhere to create maternal health structures that are empowering [31] and for a more systematic integration. Work in Benin [32] has exemplified, for example, the potential for integrating positive traditional practices, and highlights the significance of community-based services (with their experience and knowledge of communities) as a key point of communication between citizens, health providers and policy makers [33]. Study have found that those who perceive the formal structures as disempowering (as unwelcoming, with opening time not attuned to women's lives, as demeaning and difficult to communicate with) tend to use them only in times of desperation – in antenatal care after complications have arisen for curative reasons, rather than as part of the support system that assists all mothers, prevents problems or identifies them earlier.

Modern health planning is increasingly focused on health performance and reducing maternal and infant mortality is a central agenda [34].

Conclusion

We have documented an assemblage of traditional practices which support maternal and infant health and that include not only specific dietary and medicinal practices but extend to moral and social practices and community values. These bring multiple personal and public benefits to maternal and infant health, although further precision is needed on their nature and extent. Whilst it would be wrong to assume romantically that these practices are equally supportive to all, as Guinea's communities are differentiated and people can find themselves more or less marginalized for a wide variety of social and financial reasons, these practices are clearly of central significance to women's lives and Guinean society.

There are many factors already contributing to women's disempowerment, including the combined effects of several often interrelated factors including low levels of women's education, the young age of marriage, sex, pregnancy and parenthood, and male dominance in decisions over sexual and reproductive health and the number of children. This intersects with poverty and limited purchasing power, with access to resources often controlled by husbands. It is problematic if maternal services simply add to this disempowering experience.

In Guinean society tradition and modernity coexist, but as we have seen they interact in specific ways for different social groups. Elites and educators lean towards modern methods of family planning and attach confidence in state and private modern health care facilities. For others, whilst there is a high level of poverty there is also a growing social demand for quality social and health services – albeit undermined by the loss of trust in recent Ebola epidemic that caused an almost instantaneous collapse of the health system already weakened by lack of resources [35].

Despite subsidies, costs (direct and indirect) deter a significant segment of the population. Experience here supports [36] who argues that poverty reduction and economic empowerment of rural women are prerequisites for any tangible improvement in the utilisation of antenatal care and obstetric delivery services. However, whilst necessary, our findings suggest that this may be insufficient. When spouses discuss informally issues of maternal and newborn health, they lament poor access to services, quality and high costs. Responsibility need not be attributed to those working in the formal system, as they face structural constraints – lack of staff; of supplies; of appropriate materials and medication given current funding practices, and of motivation given challenges to pay and morale in community health delivery.

Methods that integrate such work more firmly at the intersection of existing practices (traditional and modern) can be envisaged that are continually evaluated and improved on, with a system of monitoring and evaluation mechanisms for the implementation of best traditional practices. Whilst it will be important to recognize the central importance of existing practices, health professionals and leaders have lingering concerns about potential for dosage poisoning, profiteering and poor hygiene in traditional practices too [38]. Supporting and extending the use of traditional practices will thus require further

studies evidence-based efficacy and safety. This can be couched within a wider strategy that develops communication around the importance of existing practices. Mobilization around such a program would require strong leadership of the health authorities and local governance.

Competing Interests

The authors have declared that no competing interests exist.

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