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BIRTH COMPANIONSHIP: PERCEPTIONS OF POSTNATAL MOTHERS IN TAMALE TEACHING HOSPITAL

BY

NABILA HAMIDU YAKUBU

(10294884)

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JULY, 2018.
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DECLARATION

I, Nabila Hamidu Yakubu hereby declare that this thesis, with the exception of references to literature which have been duly cited, is my own work produced from research undertaken for the award of degree of Master of Philosophy in Nursing at the School of Nursing and Midwifery of the University of Ghana, Legon. That, no part of this thesis has been presented for another degree in this University or elsewhere. That, this thesis was supervised by Dr. Florence Naab of the University of Ghana, Legon and Dr. Michael Wombeogo of the University for Development Studies, Tamale.

Nabila Hamidu Yakubu ............................ ............................
(Candidate)  Signature  Date

Dr. Florence Naab ............................ ............................
(Research Supervisor)  Signature  Date

Dr. Michael Wombeogo ............................ ............................
(Research Supervisor)  Signature  Date
ABSTRACT

Childbirth is a stressful and challenging experience in the life of reproductive women. Most women going through this process do that without companionship from family members despite the demands and challenges accompanying labour. Literature on companionship during labour is inadequate and the practice is rare in hospitals in Ghana. This study therefore explored the perceptions of postnatal mothers about companionship during labour. The study adopted a qualitative exploratory descriptive design with the social support conceptual model as a guide to the study. Using a semi-structured interview guide, data were collected through face-to-face in-depth interviews with fourteen purposively selected mothers who delivered at the Tamale Teaching Hospital. Interviews were audio-recorded and transcribed verbatim. After thematic content analysis of the transcribed data, five major themes were derived. These were; desire for companionship during labour, desired sources of companionship during labour, desired types of companionship during labour, perceived barriers to companionship and experiences of childbirth in a health facility. In conclusion, the findings suggest that there is an imminent need for companionship during labour. However, some institutional challenges inhibit the pursuit for companionship during labour. These findings have implications for policy formulations, future research and nursing practice.
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DEDICATION

This study is dedicated to my lovely family especially my parents (Mr. Iddrisu Yakubu and Mrs. Yakubu Balchisu) and my wife (Munaya Mashoud Idris).
ACKNOWLEDGEMENT

I am grateful to Allah for sustaining my life and granting me strength throughout the period of the study. I also acknowledge my phenomenal supervisors (Dr. Florence Naab and Dr. Michael Wombeogo) for their painstaking guidance and supervision of this research to the end. I am also appreciative of the hope and encouragement my family continuously instilled in me all these while. Thanks to my wife Munaya Mashoud Idris, for the patience, sacrifice and cooperation she exhibited during the period of my study. I remain indebted to my parents for the continuous financial and emotional support. Another profound gratitude goes to the management of Tamale Teaching Hospital and the staff of labour/postnatal wards for being supportive and cooperative during recruitment of respondents for this study. Likewise, I say thanks to all the postnatal mothers who consented to take part in this study. Thanks to the faculty members and other staff of the School of Nursing and Midwifery as well as the general University of Ghana staff for creating a conducive environment for the completion of this thesis. I also want to acknowledge the love and prayers that my colleague MPhil Nursing students shared with me all these while. All persons who have contributed in different ways to this study, I remain thankful.
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LIST OF ABBREVIATIONS

EMMa                           Enhanced Midwifery Maternity Care
FANC                            Focused Antenatal Care
FIGO                            International Federation of Gynaecology and obstetrics
GSS                             Ghana Statistical Service
ICM                             International Confederation of Midwives
MDGs                            Millennium Development Goals
NMIMR-IRB                       Noguchi Memorial Institute for Medical Research-Institutional Review Board
SGDs                            Sustainable Development Goals
TTH                             Tamale Teaching Hospital
UAE                             United Arab Emirates
UNICEF                          United Nations Children Fund
WHO                             World Health Organisation
CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Around the globe, and before the turn of the mid-20th century, women received support at home during the birthing process. They were assisted by family relatives and close friends during the birthing process. This idea of social support to women during birth has long been shown in the past decades’ (Bruggemann, Parpinelli, Osis, Cecatti, & Carvalhinho, 2007; Hofmeyr, Nikodem, Wolman, Chalmers, & Kramer, 1991) and current (Hodnett, Gates, Hofmeyr, & Sakala, 2013) findings of randomised control trials and systematic studies to be beneficial to the woman. The outcome of intervention from these support sources has been positively documented. Birth companionship reduces labour pain and lessens the need for neonatal intensive care (Hodnett, Gates, Hofmeyr, & Sakala, 2007; Mosallam, Rizk, Thomas, & Ezimokhai, 2004). Other benefits include; facilitation of the progress of labour, improves the woman’s confidence to breastfeed and makes her feel comfortable during the delivery process (de Lacerda, da Silva, & Davim, 2014; Hodnett et al., 2013; Ntombana, Sindiwe, & Ntombodidi, 2014) and increases the chances of a spontaneous vaginal delivery (Hodnett et al., 2007). The provision of social support reduces fear and panic, anxiety and makes the labouring woman feel accompanied (Ntombana et al., 2014).

In spite of these reported advantages of birth companionship, the practice has not been incorporated in many health facilities especially in Africa. The event of labour became medicalised and was dissociated from its medieval process known to be
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physically, emotionally and socially facilitated (Green & Hotelling, 2014; Kitzinger, 2012). The emphasis that supported the medicalisation of labour was that maternal and infant deaths were rising. After many years of advocacy by World Health Organisation [WHO], the International Confederation of Midwives [ICM] and the International Federation of Gynaecology and Obstetrics [FIGO] for measures to reduce maternal and infant mortality, it was pleasing to realise its inclusion in the Millennium Development Goals [MDG] (World Health Organisation, 2004) and now Sustainable Development Goals (SDGs). One way to improve maternal and infant health and development is the provision of skilled care during delivery (World Health Organization, 2004). According to WHO (2004, p.1) skilled care is defined as:

the care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/his disposal the necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care.

On the same trajectory of improving maternal health, in a Cochrane systematic review studies of 2007 and 2013, where sixteen trials of over 13,000 women and 22 trials involving more than 15,000 women respectively, the authors argued that women giving birth in facilities should be allowed to choose a companion of their preference to be present with them in the delivery room (Hodnett et al., 2007, 2013). The trials were among high, middle and low-income countries including Belgium, the United Kingdom, the United States, Canada, South Africa, Botswana, Guatemala and Mexico (Martis, 2007). The impact of these trials was reported significant when companionship was offered not only at an early stage of labour but also from non-professional sources.
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(Hodnett et al., 2007, 2013). Based on the trials, labour companionship is one key element in minimising maternal deaths and improving health and birth satisfaction.

Globally, maternal deaths reduced by 44% at the end of 2015 from the 1990 figures and therefore showed a failure to meet the desired targeted percentage of 75% by the end of 2015 (WHO & United Nations Children’s Fund [UNICEF], 2015). A total of 546 deaths per 100,000 live births were estimated in Sub-Saharan Africa in 2015 (WHO & UNICEF, 2015). In Ghana, maternal mortality slowly declined between 1990 and 2015 resulting in the failure of attaining the MDG target of 185 deaths per 100,000 live births (Ministry of Health, 2014; WHO & UNICEF, 2015). The inception of the SDGs seeks to advance the successes chalked-up in the MDGs. The SDG 3.1 aims at reducing a global maternal mortality ratio to less than 70 per 100,000 live births by year 2030 (United Nations, 2015). Labour companionship in the form of emotional, physical, comfort measures, advice and information, and advocacy is shown to improve the child birth experience and contribute in reducing maternal deaths (Hodnett et al., 2007, 2013).

Across the plethora of knowledge in the literature, the provision of companionship comes from different social support networks. Social support network has been referred to in the literature as social support structure and defined as the means through which social support functions are provided (Cohen, Underwood, & Gottlieb, 2000). The support structures are formal (by health professionals) and informal (family and friends or birth sisters). There are varying supportive functions provided through social relationships. The delineation of several supportive functions has been put forward as emotional support, physical or instrumental support, informational support (Cohen et al., 2000; Hodnett et al., 2007, 2013; House, 1981) comfort measures and advocacy
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(Hodnett et al., 2007, 2013) and appraisal (House, 1981). To be a companion means to be available to the woman, to listen, to understand and see a reflection of her situation in her body and to share the responsibility of childbirth (Lundgren & Dahlberg, 2002). It is argued that most women giving birth in the hospital preferred support from their partners whilst others regarded support from mothers, close friends or birth sisters (Hodnett et al., 2007, 2013). One study in Russia assessing the opinions of women on companionship during labour rather presented a sharp contrasting view about social support in labour. The conclusions of that study showed that childbirth is entirely a medical process requiring no social engagement (Bakhta & Lee, 2010). It is reflected in studies in most countries including Singapore, Brazil, and Norway that birth sisters, partners, female relatives and Nurses provide social supports in parturition (de Lacerda et al., 2014; Diniz et al., 2014; Fox et al., 2013).

The enormous benefits associated with the provision of social support in labour have caused countries like Singapore and Brazil to adopt public and social policies and programmes that ensured women delivering in the hospital received companionship from their relatives or friends (Diniz et al., 2014; Fox et al., 2013). For instance, Singapore has implemented in 2011 the Enhanced Midwifery Maternity Care (EMMa Care) programme in collaboration with one to one midwifery support to improve primary obstetric care (Fox et al., 2013). Brazil as well has since 2005 passed continuous support during childbirth into a law guaranteeing Brazilian women their right to a labour companion of their choice (Diniz et al., 2014). Furthermore, the Uruguay congress passed a law in 2001 affirming that all women should have companionship during labour (Hodnett et al., 2013).
In Malawi, companionship provided by non-professionals accrue desirable benefits to both the recipient of care and the health professionals and thus, companionship in labour has been accepted by women and health professionals in Malawi (Banda, Kafulafula, Nyirenda, Taulo, & Kalilani, 2010). In South Africa and Nigeria, parturient women were found to prefer emotional, psychosocial and physical support (Ntombana et al., 2014; Oyetunde & Ojerinde, 2013). South African parturient women attributed comfort, satisfaction and a shortened labour duration to the presence of a companion (Ntombana et al., 2014).

In many low and middle income countries in Africa like Tanzania, South Africa, and Zimbabwe, the Better Birth Initiative has recognised labour companionship as a major factor in improving maternal health. In spite of this initiative, many low-income countries do not allow women to have anyone with them during childbirth. Social support is proven to reduce anxiety and decrease pain (Hodnett et al., 2007, 2013) by suppressing an endogenous release of catecholamines in the body system thereby improving uterine contractility and facilitating delivery and equally lowering foetal distress (Rosen, 2004).

From past (Hofmeyr et al., 1991; Sosa, Kennell, Klaus, Robertson, & Urrutia, 1980) and current (Alexander et al., 2014; Hodnett et al., 2013) review about social support in labour, it is clear about the conclusions of social support researchers that social support provides a buffer between a person experiencing stress and the stressful event herein the woman and labour.

In Ghana, Focused Antenatal Care (FANC) was introduced since 2002 after its adoption from WHO, to amongst others, render continuous individualised care and birth preparedness to pregnant women (Baffour-Awuah, Mwini-Nyaledzigbor, & Richter,
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The programme is an initiative by the WHO in its attempt to reducing maternal mortality by providing skilled birth care to women especially in low resourced regions. However, the programme appears silent on the role of birth companionship in achieving the objective. Birth companionship does not exist in Ghana, and there is no such policy enjoining its mandatory practice in hospitals in Ghana. Midwives are limited by factors that may hamper their effectiveness. They are in charge of the health of women and their newborns, but are constantly found in a health care environment where the provision of social support is dominated by routine midwifery activities like documentations, checking of foetal heart sounds, cervical dilatation and the use of advanced technology. To understand the perceptions of postnatal mothers about birth companionship, this study was guided by the social support conceptual model.

1.2 Problem Statement

Childbirth is a momentous event in the life of every reproductive woman. The event has been described by women as challenging, painful, empowering and a period of transition to parenthood (Devereaux & Sullivan, 2013). Globally, the support of family and relatives in childbirth has played subtle when childbirth process took a paradigm shift from the social model to a biomedical model (Kitzinger, 2012; Maputle & Nolte, 2008). Most of the studies conducted globally around social support in labour were randomised control trials and descriptive quantitative studies while the qualitative studies delved into women’s birth experiences. In Ghana, childbirths have become more medicalised and are conducted by health care professionals. Research evidence on women’s experiences of childbirth revealed that medical and technological interventions increase chances of operative delivery (Indraccolo et al., 2010). This is suggested to
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result in a high probability of coping difficulties, delayed initiation of breastfeeding and
heightening chances of intensive neonatal care and unsatisfactory birth outcome (Hodnett
et al., 2013; Rosen, 2004).

Anecdotal evidence, researcher’s personal observation and experiences suggest
that deliveries occurring in public health facilities in Ghana are carried out without the
presence of a lay support person. This asserts that the woman is left in the unfamiliar
hospital environment with sophisticated machines and strange personnel around to labour
alone (Khresheh, 2010). In recent times, improving maternal health is one important
global agenda thus, has gained the focus of researchers.

In the provision of quality maternal health care encouraged by world health
bodies, it is important to consider the perspectives of women so that acceptable and
responsive care tailored towards their desires may be provided (Green, 2012). However,
in Ghana, literature on this area is rather sparse and it appears little is known about
women’s perceptions of birth companionship. The few qualitative studies conducted in
Ghana however, explored birth delivery location preference where homebirths were
regarded a norm (Cofie, Barrington, Singh, Sodzi-Tettey, & Akaligaung, 2015), factors
influencing location of delivery, women’s expectation and satisfaction of maternity care
(d'Ambruoso, Abbey, & Hussein, 2005). Moyer et al. (2014) studied the impact of social
factors on place of delivery and found its influence on women’s birth experience; the
study however lacked the views of women on birth companionship. One study in rural
central Ghana explored pregnant women’s attitudes towards the presence of an untrained
companion as a source of social support during labour and delivery (Alexander et al.,
2014). Suffice to say that the focus of that study was on pregnant women whom more
than half of the fifty respondents had never delivered in a health facility before. Besides, the attitudes of pregnant women towards the inclusion of support persons during labour and delivery may be different from women who have undergone hospital delivery. All these studies did not have the perceptions of postnatal mothers about birth companionship as the focus therefore leaving a narrow understanding of the choices women may make concerning companionship during labour. This study explored the perceptions about birth companionship among postnatal mothers at the Tamale Teaching Hospital using the social support conceptual framework as a guide to the study. This framework helped to understand the desires of postnatal mothers concerning birth companionship in a health facility.

1.3 Purpose of the Study

The purpose of this study was to explore the perceptions about birth companionship among postnatal mothers at Tamale Teaching Hospital.

1.4 Specific Research Objectives

The specific research objectives of the study were to:

1. Explain postnatal women’s desire for labour support (companionship) during facility delivery.
2. Describe postnatal women’s desired source of labour support (companionship) during facility delivery.
3. Explain postnatal women’s desired type of labour support (companionship) during facility delivery.
1.5 Research Questions

The researcher intended to find answers to the following research questions:

1. What is postnatal women’s desire for labour support (companionship) during health facility delivery?

2. What source of support (companionship) would postnatal women desire during a health facility delivery?

3. What type of labour support (companionship) would postnatal women desire during a health facility delivery?

1.6 Significance of the Study

The findings of this study may support other studies to provide workforce health planners and policy makers with useful information to improve the quality of service delivery to women during childbirth. The findings may be helpful to management of tertiary hospitals to consider companionship during facility births and may necessitate the development and organisation of programmes aimed at improving midwifery/nursing practice and care to mothers. Finally, the findings of this study would contribute to the corpus of knowledge on companionship in labour and the recommendations may guide future research.
1.7 Operational Definition of Terms

**Birth companionship:** Desired source of support present with the woman during labour and providing the desired type of support. In this study, companionship also means support and birth companionship is synonymous to companionship during labour.

**Desire for labour support:** Postnatal mother expressing the wish to have a family member, a relative or friend or a partner present during childbirth in a health facility.

**Support network (source):** Refers to the range of people available and accessible to the mothers. These people are to be desired or preferred by the mothers as companions during childbirth in the health facility. This however extends to include any other person that the labouring woman may desire support from.

**Type of Support:** Refers to various categories or sets of assistance or help that the mothers wish to have from the desired support networks.

**Postnatal mothers:** These are female individuals who are in their first six weeks after delivery at the Tamale Teaching Hospital.
CHAPTER TWO

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

The chapter directs attention to literature that delves into social support for women during childbirth in the healthcare facilities. It also considers the experiences of women during childbirth in the health facility. The chapter proceeds with the description of the social support conceptual framework and its suitability for this study and followed by a review of empirical literature on the phenomenon under study.

2.1 Conceptual Framework

In considering a framework for this study, the systems of support model by Rogers et al. (2011) was also reviewed. However, the model emphasises on social support networks (sources of support), it makes no provision for exploring the social support functions. The model was not considered appropriate to guide the current study. However, another model by Alexander and colleagues (2014) describes both the networks (sources of support) and functions (types of support) of social relationships. The model relates well with the phenomenon under study. The framework advances that the presence of a desired birth companion and the provision of the desired type of support (appraisal, emotional, informational and physical/instrumental) creates a buffer system that can diminish stressful experiences of the labouring woman (Alexander et al., 2014). Therefore the constructs of the social support conceptual framework by Alexander and colleagues (2014) were found appropriate and the framework was used to guide the study.
2.1.1 Conceptual Framework (Social Support Conceptual Framework)

The social support conceptual framework during delivery is credited to Alexander et al. (2014). The framework was derived from the concepts of social support. It has three main constructs; desire for labour support, desired source of support and desired type of support.

Desire for labour support: This describes a woman’s wish for support during labour. The woman may desire labour support to help her meet her needs. Individuals are not in social exclusion and are in one point in time seeking and offering help to one another based on prevailing situations. Therefore people would desire support from others depending on the circumstances calling for it. This desire for support may create a relationship process utilising the available resources (social networks and support types). Having the desired companionship may help alleviate the challenges of the stressful process of labour (Alexander et al., 2014). However, if the stressful event is not too demanding, the woman may not desire support.

Desired source of support: After the desire for support is expressed, the support sources emanate from one’s informal networks (family, friends) or formal network (health care professionals) (Heaney & Israel, 2008). It is proffered by other researchers that one’s network members may give varying extents and types of support (McLeroy, Gottlieb, & Heaney, 2001) with differing effectiveness based on the source of support (Agneessens, Waege, & Lievens, 2006). In this model, the social networks are categorised by sex; female sources include mothers, sisters, and mother in-laws and male sources include husband/partner, therefore the model emphasises the informal social networks (Alexander et al., 2014). These informal social networks are said to provide the
desired support which is likely appreciated by the recipient. Thoits (1995) orated that people who are similar in characteristics to the support recipient are more likely to provide effective supports alluding to the needs and values of the recipient.

Desired type of support: There are functional roles that these support persons are expected to engage in to establish that social relation with the labouring woman. The types of support are appraisal support, emotional support, informational support, and physical support (Alexander et al., 2014; House, 1981). Each type of support accomplishes a particular need desired by the woman during labour. Appraisal support encompasses the provision of useful information or advice that promotes self-evaluation (House, 1981) and includes acknowledging the efforts of the recipient (Alexander et al., 2014). Emotional support is about words of encouragement, love, trust, respect and affection. Informational support is prompted by suggestions, opinions, information, liaison between midwife and labouring woman sharing information and guidance (Alexander et al., 2014; House, 1981). Instrumental support encompasses tangible/physical or concrete assistance like massage, holding hands, financial help (Alexander et al., 2014; House, 1981) and other comfort measures that the labouring woman would desire (Wills, 1985). The provision of personal cleanliness, ambulation, positioning, application of warm or cold pads, providing foods and drinks are all examples of instrumental support (Bianchi & Adams, 2003). The framework is found in figure 2.1.
2.1.2 Application of the Conceptual Framework to the Study

Social support provides a buffer to a stressful situation. It is supposed to minimise the stress an individual goes through. Labour or childbirth is a stressful process for women that may require a woman to desire for support or not to desire for support. This stress is usually produced from the natural demands and challenges emanating from the physiological changes in the woman’s body. Besides, the labour ward environment remains quite strange and may be frightening to these women.

Women are mostly accompanied by their loved ones to the hospital during labour and delivery. In most instances, these accompanying persons have lived with the woman and assisted her in various ways during pregnancy at home. The establishment of this helping relationship would have resulted in some sort of a known acquaintance thus making companionship a healthy one. Thoits (1995) proffered that companionship is best appreciated and effective when it occurs between persons of similar characteristics. In this context of the social support model, the sources of support (husband, mother, mother-in-law, sister) reiterate the informal networks of the woman and justifying the contextual
similarity. Therefore, postnatal mothers’ desired sources of support were explored based on their informal support network system.

Based on the challenges and demands of childbirth, the experiencing woman may desire certain types of support from the support persons. According to the model these included appraisal, emotional, informational and physical/instrumental. Aside, cognisance is also given to other types like spiritual support which this model does not capture. This brings a wider variation to the desires of the labouring women. In this study, the social support conceptual framework is used to understand postnatal mothers’ perceptions about birth companionship.

2.2 Literature Review

Literature on women’s desire for social support in labour, women’s desired sources of labour support and their desired types of social support as well as women’s experiences of childbirth in a health facility were retrieved from online databases such as CINAHL complete, Medline, PubMed, EBSCOhost, Scopus, JSTOR and ScienceDirect. Google scholar as search engine was also used to facilitate the retrieval of related literature. Key terms like ‘birth companionship’, ‘perceptions’, ‘mothers’, ‘delivery’, ‘birth’, ‘labour support’ ‘experiences’ were applied to retrieve journal articles published in English between 2000 and 2018.

2.2.1 Women’s Desire for Labour Companionship

The increasing numbers of maternal deaths globally has attracted the attention of many researchers and international bodies to put in efforts to reduce these mortalities. Increase in the numbers of women giving birth at the facility call for an improvement in the quality of care and this is one critical measure of maximising maternal health (WHO,
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2016). The WHO (2015) quality of care vision holds that “every mother and newborn receive quality care throughout pregnancy, childbirth and postnatal period” (p.3).

There is strong research evidence that constantly indicate the profound need for companionship by women giving birth in hospitals. For instance, a study in three Arab nations; Lebanon, Syria and Egypt revealed that women greatly value and desire the presence of a trusted companion during labour and delivery in the clinical environment to provide varied supportive care (Kabakian-Khasholian, El-Nemer, & Bashour, 2015). Likewise in Greece, one study pointed to the effect that, women have a profound desire for companionship in labour and birthing process (Iliadou, 2012) and therefore proposed that health care institutions are reorganised to incorporate social support during facility delivery (Vaz & Fuhr, 2014). Brazilian women wished for a companion during childbirth (Vaz & Fuhr, 2014). This push for companionship is due to the existing law in Brazil supporting the creation of an environment apt enough to support the inclusion of a lay companion by choice during a facility-based delivery (Diniz et al., 2014). Much as research dominates, in view of improving the health of women during pregnancy and childbirth, the World Health Organisation equally supports with standards and guidelines based on research evidence. Therefore WHO finds it necessary synchronising social support into the components of quality of care to women giving birth in a health facility (WHO, 2015).

In Malawi and Nepal, companionship during labour and delivery was desired and, companions were regarded to have provided the needed assistance to women in labour and assisted health professionals as well (Banda et al., 2010; Sapkota, Sayami, & Manadhar, 2014). In Nepal, trust in the care providers (health professionals and relatives)
were core in making the women feel cared for in labour (Sapkota et al., 2014). A hospital-based cross-sectional study in Nigeria revealed that approximately 75% of respondents desired birth companions (Morhason-Bello et al., 2008). In the same way, Oyetunde and Ojerinde (2013) also found that 70% of newly delivered mothers preferred non-pharmacological support to relief labour pain. It is apparent that in Zambia, women have expressed worry about the absence of labour companionship in the healthcare facilities. Majority of Zambian women would have happiness and birth satisfaction if support persons were allowed in the delivery rooms to stay with them (Maimbolwa, Sikazwe, Yamba, Diwan, & Ransjö-Arvidson, 2001). Studies have demonstrated this desire vividly; however it is worthy to note sadly that, women chose not having a companion because there was nobody desirable. The companions’ activities interfered with care which became sources of stress (Maimbolwa et al., 2001).

Despite enormous indications that women wanted labour support perhaps because of its associated benefits, in the same way, some women thought contrary about the need for labour companion. In Saudi Arabia and Russia, a sharp differing perception was that a companion was not wanted in the labour and delivery room. For instance in Saudi Arabia, women fear exposure of their nudity to other persons who are not health professionals (Al-Mandeel et al., 2013). In Russia and Zambia, women believed that the activities of labour and birth are exclusively the responsibility of Midwives and lay persons have no role to play (Bakhta & Lee, 2010; Maimbolwa et al., 2001). It is not out of place to quickly show that few women (45%) prefer a companion during birth among Saudi women and approximately 14% ever experiencing birth companionship (Al-Mandeel et al., 2013). Another finding in a Kenyan study showed that mothers desired no labour
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support from lay companions because of fear of gossips or abuse (Afulani, Kusi, Kirumbi & Walker, 2018).

One of the differences between high-income countries and low resourced countries on maternal health is birth companionship. As indicated earlier, most women in high-income countries desired birth companionship and chose their desired companions to be with them during labour and delivery. However in Africa and in Nigeria, sociocultural and educational relations were noted setbacks for the presence of a companion during labour (Vehviläinen-Julkunen & Emelonye, 2014). Most women do not desire spousal presence because of Nigerian society frown on that and this makes women have a reduced desire for companionship especially from spouses (Vehviläinen-Julkunen & Emelonye, 2014). The low level of education influences the preference and attitudes of women towards choosing a companion for labour support (Vehviläinen-Julkunen & Emelonye, 2014). In Nigeria, acceptance of labour support is comparatively low. Researchers contended that a significant number of parturient women (40.6%) in Nigeria declined having a companion during labour even though slightly above half of the women desired a companion and most had an enhanced educational background (Aiken-Adenekan, 2009).

Alexander et al. (2014) in Ghana have painstakingly, in a mixed method approach, indicated how women differ in preference and attitudes to the inclusion of a labour support provider. Close to 60% of the women desired to have a close relative with them during birthing while about 40% think that labour and birthing process is the duty of Midwives and therefore require no lay person (Alexander et al., 2014). Alexander and colleagues’ findings appear congruent with the findings of Al-Mandeel and colleagues in
Saudi Arabia and Bakhta and Lee in Russian as well as Maimbolwa et al. of Zambia about the perception that labour and birth remain solely under the ambit of Nurses’ and Midwives’ responsibility (Al-Mandeel et al., 2013; Bakhta & Lee, 2010; Maimbolwa et al., 2001). In Ghana, numerous factors equally impede the utilisation of maternity services. There are complaints about poor health professionals’ attitudes and research suggests that women are more likely to change their place of birth if they are treated inhumanely (d’Ambruoso et al., 2005). Women therefore have high expectation of quality care from health professionals (d’Ambruoso et al., 2005). If quality of care is expected, then more women would desire to have a companion to assist in the provision of the needed quality care during childbirth.

The acceptance of support during childbirth is widely documented in the world of scientific studies and women across the global territory have somewhat showed passion and will to have a support person during labour and delivery. Now, the vexing question asked here is what would be the source of support women would desire during labour and delivery?

**2.2.2 Women’s Desired Sources of Labour Companionship**

The process of childbirth is pronounced a momentous and painful transition to parenthood. It is a time when the labouring woman would want maximum attention and care. The attention and care usually emanate from two distinct groups. Studies across the cosmos suggest that the source of labour support is either professional Nurses/Midwives (Bianchi & Adams, 2003; Sauls, 2004) or nonprofessionals (lay persons) (Bianchi & Adams, 2003). Lay persons represent those who have no specialised training in labour support and may include family members like mother, sister, mother-in-law,
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husband/partner (Alexander et al., 2014), friend or some other woman in the community who is experienced in birthing or has received recognition for providing labour companionship (Amram et al., 2014; Rosen, 2004). However, for the purposes of this study, nonprofessional sources are reviewed and categorised by sex (female and male) sources (Alexander et al., 2014).

Females support during labour is one major source in the literature. For instance in Brazil, qualitative descriptive findings showed that, puerperal women received support from their mothers, mother in-laws, sisters, and aunties and also from their brothers’ wives (Dayana et al., 2014). Another descriptive cross-sectional survey in Brazil supported that more than 50% of respondents received support from their mothers, daughters, sisters, mother in-laws and sister in-laws (de Oliveira et al., 2014). In Syria, support was desired from mothers, sisters, and aunties (Abushaikha & Massah, 2012). These sources provided various kinds of support to the labouring women resulting in varied levels of satisfaction and benefits to both the woman and baby. In a religious culture, in three governmental tertiary hospitals in Saudi Arabia, approximately 58% of 402 women prefer their mothers to provide labour support even though one-third of the women did not see the need for such companionship because of fear of being exposed to their companions (Al-Mandeel et al., 2013). These revelations were not influenced by educational level or prior antenatal attendance status (Al-Mandeel et al., 2013). It means that the choice to have a companion is independent of the educational status of the woman but to a large extent dependent on personal and perhaps religious reasons.

There were high dissatisfaction and negative feelings among women in a control group of a study determining women’s attitudes and preferences regarding psychosocial support
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during childbirth in United Arab Emirates (UAE) (Mosallam et al., 2004). A high satisfaction was obtained by women who were in the companionship of their mothers followed by the companionship of their sisters (Mosallam et al., 2004).

In Nigeria, Morhason-Bello et al. (2008) asserted in a cross-sectional study that 7% of 224 randomly selected antenatal women desired support from their mothers and 5% preferred their sisters’ support during delivery. Even though these percentages are small compared to other countries, there is generally a high affinity for mothers as birth companions. Perhaps mothers are perceived to have immense supportive care and experience and are more likely to bring it to bear during labour support to women.

Studies across the globe from Malawi (Banda et al., 2010), three Arab countries (Kabakian-Khasholian et al., 2015) and Thailand (Yuenyong, O'brien, & Jirapeet, 2012) supported the role that females play in the provision of labour support. In those studies, companionship was provided by females who have had child birth experience and findings showed that physical and psychological benefits resulted from the companionship. In Malawi, even though some women adored companionship, many others asserted that their companions (mothers) were not well trained to handle births thus would not offer anything good being present during labour (Kungwimba, Malata, Maluwa & Chirwa, 2013).

Males as sources of support, especially husbands/partners involvement during labour, have been widely advocated in studies. For example, in Brazil, companionship in labour is a right by law to every woman attending maternity services. Approximately 56.3% of women, in a study investigating the contribution of the companion during labour and delivery, expressed satisfaction with husbands/partners’ support (Dayana et
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al., 2014). That study demonstrated that husbands/partners are sources that calmed labour pain and loneliness with their wives and made them feel safe and better (Dayana et al., 2014). This was alluding to the findings in Nigeria (Adeniran et al., 2015; Emelonye, Pitkäaho, Aregbesola, & Vehviläinen-Julkunen, 2017; Vehviläinen-Julkunen, & Emelonye, 2014). It is therefore acceptable when Backstrom and Wahn (2011) in Sweden, mentioned in their study that first-time fathers felt a part of their wives’ labour and birth process. The novice fathers had the opportunity to contribute to decision making concerning the care of their wives in labour (Backstrom & Wahn, 2011). What is more, a vast majority of about 62% of 105 Brazilian puerperal women reported receiving labour support from their husbands (Vaz & Fuhr, 2014) and de Lacerda et al. (2014) in a qualitative study.

Notwithstanding diverse global evidence of husbands as preferred choice for social support during labour and delivery, studies have not been resolute about it. There are conflicting viewpoints of husbands being companions during labour. Out of seventy women interviewed in Russia, about 69% indicated their unwillingness to choose their partners as birth companions owing to several reasons (Bakhta & Lee, 2010). It is stated that apart from husbands declining and personal feeling of embarrassment, some women were afraid that their sex life would be influenced by their husbands’ witnessing labour and delivery (Bakhta & Lee, 2010). In a qualitative study in Brazil to understand women’s perceptions of the inclusion of a companion during the labour process, Palinski, Souza, da Silveira, Salim, and Gualda (2012) reported four out of ten women choosing their husbands as birth companions. Thus 40% of the women who participated in that study prefer companionship from their husbands to guarantee security, peacefulness,
comfort and support (Palinski et al., 2012).

The idea of involving men in antenatal services is to increase social support to women during pregnancy (Agyare, Naab & Osei, 2018) and perhaps maintained after childbirth. Although men may feel involved in the antenatal services of their wives, a research finding in Japan however show a relatively poor percentage of Japanese men supporting their wives in postnatal periods although there was strong support during antenatal visits (Wai et al., 2016). Thus support in antenatal visits may not necessarily translate in support during labour and delivery. In patriarchal societies, male support is crucial in labour and delivery because most of the decisions are made by the husband or head of the household. Research strongly supported that husbands prepare for professional delivery and offer all the social support functions desirable when women choose them (husbands) (Story et al., 2012). In low and middle income countries, cultural definitions may frown on male inclusion in labour and delivery rooms for the purposes of providing companionship to their spouses. Africans appear to share similar cultural orientation, despite this, the phenomenon of birth companionship in Nigeria and Zambia present dissimilar indications. In a study, about 44% of the approximated 60% Nigerian women who preferred companionship desired their husbands as support persons (Aiken-Adenekan, 2009). Again, more than 80% of pregnant women attending antenatal clinics in Nigeria preferred their husbands as birth companions (Adeniran et al., 2015; Morhason-Bello et al., 2008) to see the pain of childbirth and accord women their deserved respect and value (Adeniran et al., 2015; Kabakian-Khasholian et al., 2015). In Zambia, husbands were the least preferred sources of social support by women in labour.
There is therefore a seemingly sceptical impression about males as sources of labour support in the African perspective.

### 2.2.3 Women’s Desired Type of Support during Labour

Majority of women giving birth in the United Arab Emirates (UAE) felt that psychosocial support is important in childbirth. Women expressed positive feelings and satisfaction with this type of labour support (Mosallam et al., 2004). Many researchers have identified that most women undergoing a facility-based delivery have reported preference for labour companionship. The various functions of labour support include emotional, physical, informational and appraisal (Adams & Bianchi, 2008; Bianchi & Adams, 2003; Dunne, Fraser, & Gardner, 2014; Sauls, 2004). Physical and emotional supports were tested in a randomised study in Thailand to evaluate the efficacy of a close female support during active labour and birth; indeed effective support from the females was reported (Yuenyong et al., 2012). The women in the experiment group expressed satisfaction with the support. Alexander et al. (2014) mixed method study among pregnant women, it was found that women desired to be told, as part of appraisal support, about the fact that they were doing things right with labour. Furthermore, in a quantitative descriptive study in Ireland that examined the relationships between social support, maternal parental self-efficacy and postnatal depression in primiparous, it was indicated that mothers received high levels of appraisal support (Leahy-Warren, McCarthy & Corcoran, 2011). This was reported to have a significant bearing on parental self-efficacy (Leahy-Warren et al., 2011).

Studies have pointed out that women derived much satisfaction and had a positive perception about the emotional support offered by companions. For instance, in
qualitative studies in Brazil, women expressed feelings of being cared for, secured, experience of calmness and confidence and a feeling of physical and emotional goodness and happiness (Dayana et al., 2014; Palinski et al., 2012). These were evident when a companion continuously stayed and offered words of encouragement, sang lullabies and held hands with the woman during labour (Abushaikha & Massah, 2012; Emelonye et al. 2017; de Lacerda et al., 2014). Some other studies indicated that women, in many cultures, experienced symptoms of depression and anxiety, (Giakoumaki, Vasilaki, Lili, Skouroliakou, & Liosis, 2009; Sapkota, Kobayashi, & Takase, 2013). It further showed that first-time mothers were more susceptible to developing such problems (Giakoumaki et al., 2009) and again reported that emotional support reduced these transient symptoms (Giakoumaki, et al., 2009; Sapkota, et al., 2013).

Despite the concerns about the impact of emotional support in labour, husbands whose wives delivered at home in Bangladesh relented in supporting their wives emotionally (Story et al., 2012). In most of the instances, husbands were absent during the period that their wives went into labour. However, delivery at the health facility rather brought husbands closer to their wives in the provision of emotional support in the form of prayers although this effort was not perceived by their wives as emotionally supportive (Story et al., 2012). Adams and Bianchi (2008) proffered that special knowledge and commitment is required to engage in and enhance social support for women in labour. This means that husbands will be more supportive during facility delivery than home delivery if they have knowledge on how to offer supportive care. If spouses communicate and stay more often together, it would perhaps increase their knowledge about what the woman would perceive as helpful during the labour process.
Previous studies in Syria, Ghana and Iran have suggested that women in labour emphasised the importance of receiving God’s blessings. The prayers by family members and affinal relations were noted to ensure safety, calmness and relaxation during the process of labour (Abushaikha & Massah, 2012; Fathi, Latifnejad, & Ebrahimipour, 2017) or have a reduced labour pain (Aziato, Odai, & Omenyo, 2016).

In Africa, cultural pluralism and poor understanding of labour and childbirth intricacies is something that seemingly establishes a barrier to the provision of social support in health facilities in Africa. This notwithstanding, social support and for that matter emotional support provides much relieves and comforts to women in labour. In Nigeria and Zambia, women experienced practical and emotional support (Emelonye et al., 2017; Maimbolwa et al., 2001) which created an atmosphere of cohesion and strength. Particularly, Emelonye et al. (2017) found that most women desired emotional or psychological support (71.8%) than physical support during childbirth. In their study that sampled 142 post-partum women by convenience in Nigeria, Emelonye and colleagues indicated that post-partum women were provided with emotional care in various forms like physical presence, encouragement, reassurances, inspirational words, and verbal interaction. These support strategies have a positive impact in reducing labour pain (Emelonye et al., 2017; Hodnett et al., 2013). More than 80% of 224 antenatal women receiving care in University College Hospital, Ibadan, Nigeria equally expressed desire for emotional support (Morhason-Bello et al., 2008).

Informational support has immense effect on pregnancy and labour outcome. Information is regarded relevant in labour if it has apparent benefits to the substantive reason for which it is received. In Sweden, first time expectant mothers’ experiences of
social support within the social network, it was opined that adequate information received from especially partners contributed to understanding of childbirth and strengthened bond between couples (Bäckström et al., 2017). Again in Iran, women desired to have information from health professionals about the progress of labour (Askari, Atarodi, Torabi & Moshki, 2014; Iravani, Zareen, Janghorbani & Bahrami, 2015). However it was sharply noted that conflicting information could result in a situation of confusion and despair (Bäckström et al., 2017) and also could lead to detachment of labouring women from such persons with discordant information (Regan, McElroy, & Moore, 2013). This therefore suggests that labour companions must be circumspect in the informational support they provide to women during labour and childbirth. Information creates an avenue for participation and cooperation, thus involvement in making decisions concerning the care of the woman in labour. In a study by Kungwimba et al. (2013) in Malawi, it was noted that birth companions and labouring women lacked knowledge on birth companionship resulting in reports of dissatisfaction of companionship. This was in resonance with the findings that about half of women had no concern for information about labour and birth companionship (Morhason-Bello et al., 2008; Ntombana et al., 2014). If women especially first-time mothers have no information and knowledge about what to expect during labour and childbirth, they are dissociated from decision making. Regan et al. (2013) asserted that women’s perception of involvement in decision making about birth is all about having information. Birth stories from family relatives, friends and other experienced persons, childbirth classes, care providers and written materials were major sources of receiving information (Regan et al., 2013). Kungwimba et al. (2013) asserted that women would feel empowered, have confidence and control over
their labour when they have knowledge and information about what to expect during labour and delivery. This suggests that, antenatal education should be geared towards the expectations ahead in labour and childbirth and women should be allowed to have their most preferred person as support provider. Since information is important in labour and delivery, women and especially primiparous, acquired such kinds of information from families and friends, what to do during uterine contractions (Bäckström et al., 2017; Kungwimba et al., 2013) and parenting which enhanced their understanding and strengthened them during labour (Bäckström et al., 2017).

Physical supports and comfort measures facilitate labour progress and increase the satisfaction of birth experience (Adams & Bianchi, 2008). Prior study showed that breathing techniques, relaxation, and massage were effective physical support and comfort measures that helped relief pain during labour (Brown, Douglas, & Flood, 2001). Getting into the desirable positions, receiving sacral massages and warm baths were highly solicited by primiparous women as mechanisms of physical support (Kungwimba et al., 2013). Other helpful activities primiparous women desired included provision of clean clothes and assisting in wrapping baby after birth (Kungwimba et al., 2013). The absence of a support person during labour made some labouring women experience poor physiological care (Iravani et al., 2015). Women desired nutritional care (foods and drinks), assisting to ambulate around the ward without any restriction to bed and changing positions on bed, hygienic needs and environmental comforts including noise and odour control (Iravani et al., 2015). It was reported that restricting water or foods could bring about reduced energy which may not be healthy to both mother and foetus during childbirth and require replenishing the source of energy (Chalmers, Mangiaterra &
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Porter, 2001). In Kenya, women wished their family members were present to assist them to the washrooms, to purchase medications and other items required by the health staff and doing referral arrangements (Afulani et al., 2018). The presence of support persons have also been reported to facilitate the initiation of breastfeeding post-delivery (Morhason-Bello et al., 2008). Support persons would perhaps encourage such mothers and support them to begin early breastfeeding more importantly when mothers have had a caesarean delivery. The provision of physical support in labour has wider benefits including emotional effects. About 94.5% of 200 women attending antenatal and infant welfare clinics in Nigeria reported that they enjoyed emotional security when their physical (instrumental) desires were met (Sokoya, Farotimi, & Ojewole, 2014).

2.2.4 Barriers to Companionship

There are numerous factors that militate against the implementation of birth companionship in hospitals. Majority of these are health institutional related factors which include the absence of an institutional policy to support the inclusion of lay support persons during labour and delivery (Maimbolwa et al., 2001; Senanayake et al., 2017). In Brazil where there is a law enjoining health staff to allow support persons during labour, it was reported in a study that health professionals and the institution did not adhere to the companion’s Law (Brüggemann, Ebsen, de Oliveira, Gorayeb & Ebele, 2014). Other factors noted included the poor infrastructure or inadequate resources both human and material (Brüggemann et al.,2014; Kabakian-khasholian et al., 2015; Senanayake et al., 2017). The low resource state of health care institutions pose a great amount of work on the few professionals in the wards and this reported a reason for disallowing a companion (Senanayake et al., 2017). Elsewhere in Norway, a study
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revealed that Midwives were faced with a huge amount of work which constrained them from rendering continuous support to women in labour (Aune, Amundsen, & Skaget Aas, 2014). In a study from three Arab countries, Zambia and Sri-Lanka, companions were reported to interfere in the activities of Midwives (Kabakian-Khasholian, & Portela, 2017; Maimbolwa et al., 2001; Senanayake et. al, 2017). This was noted to have a possible marginalisation of health professionals’ duties (Kabakian-khasholian et al., 2015; Maimbolwa et al., 2001; Senanayake et al., 2017). In Kabakian-khasholian et al. (2015) study, health professionals indicated that, the absence of prenatal education, certain social values and practices were part of barriers to implementing best practices in hospitals. In a mixed method study in Kenya among postnatal women, it was revealed that the presence of males during labour was not preferred because of the cultural belief that labour is delayed with their presence (Afulani et al., 2018).

Studies from Senegal and Zambia pointed that distance to hospital (Faye, Niane, Ba, 2011; Gabrysch, Cousens, Cox, Campbell, 2011) and quality of care rendered during labour in the health facility are some factors that prevent mothers from health facility deliveries (Faye et al., 2011). Health care cost also remains an issue for most mothers delivering in the hospitals more especially when such mothers do not have health insurance cover. It was reported in Kenya and Nigeria that most women were unable to settle health bills after they were discharged which led to a detention in the wards (Abuya et al., 2015; Okafor, Ugwu & Obi, 2015). It means that mothers may remain at home and deliver under unskilled care (Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei & Adongo, 2008).
2.2.5 Women’s Experiences of Childbirth in a Health Facility

Childbirth process is a transition stage to parenthood for every reproductive woman. The experience of this process comes with mixed feelings. There is strong evidence that childbirth is clouded with negative and positive experiences both of which have their respective impact on the health of the woman and baby. For instance, women have expressed worries about how the medicalised process of labour and delivery has led to disregard their social needs and feelings (Askari et al., 2014). In one study in Nigeria, it was shown of how pregnant mothers were welcomed by Midwives into the labour ward with physical (slapping) and verbal (insults) abuses (Bohren et al., 2017). Mothers who reported late for labour or came without the labour items were usually scorned and threatened of poor labour outcome (Bohren et al., 2017). Again, older or younger mothers in South Africa were more likely to be disrespected during care by Midwives (Oosthuizen, Bergh, Pattinson & Grimbeek, 2017).

Women experienced difficulties adjusting to their new roles such as breastfeeding and baby care in parenthood and have appraised the need for companionship in mitigating such difficulties in motherhood (Coates, Ayers, & de Visser, 2014). In Iran, mothers were discomforted and anxious by the frequency of routine interventions such as frequent vaginal examination, abstaining from foods and drinks, early amniotomy, accessing a vein that took place even before a normal delivery (Askari et al., 2014; Bohren et al., 2015; Hatamleh, Shaban & Homer, 2013a; Hatamleh, Sinclair, Kernohan & Bunting, 2013b; Hussein, Dahlen, Ogunsiji & Schmied, 2018; Pazandeh, Potrata, Huss, Hirst & House, 2017) and some women would wish for a caesarean delivery instead (Pazandeh et al., 2017). Seemingly, there is an inverse connection between hospital
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delivery and provision of social support; hospital delivery has resulted in the increase in medical interventions in labour, and the loss in social connection with the labouring woman. Women have reported labouring in noisy wards (Askari et al., 2014; Iravani et al., 2015) and unhygienic environments (Iravani et al., 2015; Sapkota et al., 2014) and in India, have experienced poor personal hygiene (Missiriya, 2016). This influenced their satisfaction and anxiety but this was linked to the idea that health professionals were always busy with other things (Iravani et al., 2015). Conversely, Nepal women experienced a feeling of equal treatment and a sense of not being alone when they found themselves cared for in the same room, see each other and hear screams of labour pain (Sapkota et al., 2014). Therefore, noise resulting from screams of labour pain in that study was rather an experience of not being alone and a preparation for mothers yet to experience onset of labour/delivery. In other studies in Brazil (Jamas, Hoga & Tanaka, 2011) and Ghana (Mensah, Mogale & Richter, 2014), mothers reported giving birth in a clean, calm and organised environments. In another systematic qualitative review of studies published between 1996 and January, 2018, it was reported that women expected giving birth to a live healthy baby in a safe clinical environment (Downe, Finlayson, Oladapo, Bonet & Gülmezoglu, 2018). Environmental conditions therefore remain an issue that mothers are concerned with during childbirth in the hospital.

Other studies have also found that mothers have varied expectations when giving birth at the hospital. They expect to meet caring staff with specialised knowledge to provide quality care during hospital delivery without compromising on their privacy (Cipolletta & Sperotto, 2012; Jenkins, Ford, Morris & Roberts, 2014; Rabor, Taghipour & Najmabadi, 2015). Mothers also expect that health professionals exhibit competence in
the discharge of clinical care; they expect kindness and reassurance from healthcare
providers during the provision of care (Downe et al., 2018).

Decision making and participation are important concepts in health care delivery
more especially during labour and delivery when most women would want to be actively
involved throughout the process. Unfortunately, there are expressions of shock and
feelings of neglect when health professionals do not involve women in decision making
about care in the labour process (Coates et al., 2014; Jamas et al., 2011). Globally, poor
communication and interaction between women and health professionals (Bohren et al.,
2017; Bradley, McCourt, Rayment & Parmar, 2016; Coates et al., 2014; Floyd, Coulter,
Asamoah, and Agyare-Asante (2014; Hussein et al., 2018; Jamas et al., 2011; Sengane,
2013) have been reported enormously to be worrying. Women have associated the poor
interaction with inadequate number of Midwives/Nurses in the ward (Coates et al., 2014).
Iravani et al. (2015) have reported contrarily that Midwives communication with mothers
was satisfactory. Whereas lack of shared information relaxed other women’s autonomy
and ability to make informed choices, some women were comfortable with that,
entrusting absolute responsibility in the hands of caring Midwives (Maputle & Nolte,
2008). This may therefore indicate that many women may not be aware of their rights and
responsibilities during childbirth or they want to adhere to only the directives from the
health professionals as they are perceived to have the technical know-how. Aside these,
there are reports of lack of privacy and disrespect for human dignity, overcrowding in the
labour rooms to an extent of making women in first stage labour sit on chairs hoping for a
bed to become free (Jamas et al., 2011). These daunting experiences form part of the
reasons why some women would choose to deliver at home or at birth centres despite the
associated potential risks (Jamas et al., 2011).

Mothers have equally felt satisfied with care during birth in the health facility. There are research findings indicating that women enjoyed physical and emotional support from their relatives during the first stages of labour (Sapkota et al., 2014). Even though such companions were not chosen by the labouring women, there was trust established and the companions represented the women, relating with the Midwives in most decisions taken concerning the women’s care (Sapkota et al., 2014). That study was silent on the presence of a companion during the second stage of labour and whether the women would have desired for their presence in the second stage.

In other studies, socio-cultural norms like the male dominance and supremacy over women took away decision making power from the woman thus, restricted the woman’s desire for health facility delivery (Sialubanje, Massar, Hamer & Ruiter, 2015). Nonetheless, women had greater birth satisfaction at home as reported by a woman in Zambia that her mother in-law gave her comforts and assisted her calmly to undergo a successful labour process (Kwaleyela & Greatrex-White, 2015). That woman expressed fears of being scolded by Midwives had her delivery taken place in the hospital (Kwaleyela & Greatrex-White, 2015). There are expectations of midwifery care held by women giving birth at the hospital. Although Midwives provide information (Askari et al., 2014; Nikula, Laukkala, & Pölkki, 2015) about the progress of labour and physical measures to relief pain and generate confidence (Askari et al., 2014), some mothers experienced Midwives inability to give adequate and factual information about labour (Maputle & Nolte, 2008). This inability of Midwives’ information sharing to mothers may have resulted in feelings of anger, disappointment, fears, discouragement especially
for first time mothers (Cappelletti, Nespoli, Fumagalli & Borrelli, 2016).

Fears of developing childbirth complications; either for the baby or the mother or not surviving the process of labour and delivery was reported in studies in Switzerland and Northern Ireland among pregnant women (Geissbuehler & Eberhard, 2002; Greer, Lazenbatt, & Dunne, 2014). Furthermore, the expression of fear for labour was more among first time mothers than experienced mothers (Dahlen, Barclay & Homer, 2010).

2.2.6 Summary of Literature Review

It was realised that women constantly desired to have a birth companion usually of their choice. However, institutional, health professional, financial, socio-cultural, distance and personal factors prevented women from sourcing this support. Even though some countries have policies and programmes endorsing social support in labour and empowering women to choose their preferred birth companion, there remains a great deal of effort to truly find its absolute operation.

Globally, women have varying sources of social support; from family relatives, husbands/partners, friends, health professionals or from birth sisters. The literature indicated how women, in relation to their birth experience, benefited or would benefit from their desired source of support. Further, the literature across the globe revealed mixed preferences for the sources of social support.

Emotional, informational, physical were the main support types desired by women who gave birth in the hospital. Most of the women did not have their needs met and those fortunate to receive them were happy about the emotional and informational support through which confidence and personal control were found.
The reviewed literature also covered women’s experiences of childbirth during in a health facility. The literature exposed both the experience of satisfactory and unsatisfactory care. Women have reported their sad moments giving birth in hospitals where they acted passively in their own care. The majority of the findings harmonised the enormous dissatisfaction in Midwifery care and what women expected from Midwives. The care experienced during childbirth in the health facility were tainted with discouragements, anxiety, anger, fear, noise, inadequate privacy, disrespect for human dignity and needs, and poor communication between women and Midwives. Despite these daunting events of childbirth experiences, some women found the process an entirely medical process and regarded the Midwives’ actions and inactions as appropriate and satisfactory.

Majority of the studies were randomised controls and descriptive quantitative studies with few qualitative reports on labour experiences. Most studies were on pregnant women’s perceptions which, after delivery (postnatal) may differ or change thus the question; what are the perceptions of postnatal mothers about birth companionship in a tertiary level hospital?
CHAPTER THREE

METHODOLOGY

This chapter presents a description of the methods employed. It covers the study design, study setting, target population, inclusion and exclusion criteria, sampling technique and sample size, tool for data collection and data collection procedure, rigour, data management and analysis and ethical consideration.

3.1 Study Design

A research design indicates the basic strategies adopted by a researcher to answer the research questions and/or test hypotheses (Polit & Beck, 2010). It is the conceptual structure within which research is conducted and constitutes the blueprint for the collection, measurement and analysis of data (Kothari, 2004).

The researcher adopted a qualitative research methodology employing an exploratory descriptive design. According to Creswell (2007), qualitative method allows the researcher to obtain insight, meaning and understanding of a phenomenon from the perspectives of respondents. Merriam (2002) further emphasises that qualitative methods are used when little is known about a phenomenon. A qualitative method was used in this study because the research purpose sought to explore in-depth and obtain an understanding of the perceptions of postnatal mothers about companionship during labour.

Exploratory descriptive designs require that the researcher engages respondents with interviews of flexible questions in order to obtain an understanding of a phenomenon from the respondents’ viewpoint (Wood & Ross-Kerr, 2011). The
researcher used an exploratory descriptive design because the topic under study, based upon review of literature, revealed little knowledge in Ghana of the perceptions of postnatal mothers about companionship during labour. Wood and Ross-Kerr (2011) support the use of this design especially when much is not known about the concept or situation.

3.2 Study Setting

Tamale, one of the fast developing cities, is the capital of the Northern region of Ghana. Northern region has a population of 2,479,461 out of which the Tamale metropolis is occupied by 371,351 people with a sex differentiation of male (185,995) and female (185,356) (Ghana Statistical Service [GSS], 2012). Tamale metropolis has a total land surface area of 750 km² and a population density of about 480.77/km². The inhabitants predominantly engage in trading, craft works and farming (GSS, 2012). The predominant local dialect spoken in Tamale is Dagbani and its inhabitants are largely Muslims (GSS, 2012).

The Tamale Teaching Hospital (TTH) occupies about 490,000 square meters in the eastern part of the metropolis. In 1974, the hospital was commissioned by the then head of state Lt. Col. I. K. Acheampong as a regional hospital until 2005 when it was upgraded to a teaching hospital. It is currently the only tertiary level hospital serving as a major centre for referred cases from lower health facilities in the Northern, Upper West, Upper East and some parts of Brong Ahafo regions. The hospital equally serves other nearby countries like the Ivory Coast, Togo and Burkina Faso. The hospital also serves as a teaching facility for the School of Medicine and Health Sciences (SMHS) of the University for Development Studies (UDS), Tamale. It provides clinical teaching for
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Nursing and Midwifery Training Colleges both within and beyond the metropolis.

The hospital has a bed capacity of about four hundred (400) and offers specialist services in the following areas: Obstetrics and Gynaecology, Surgery, Orthopaedics and Trauma, Internal Medicine, Child Health, Pathology, Ear Nose & Throat, Eye Unit, Endoscopy, Neurosurgery, Anaesthesia & Intensive Care Unit, Psychiatry, Dentistry, Pharmacy, Laboratory, Out-Patient Unit etc. The Obstetrics and Gynaecology department has a total of 94 Midwives and 120 Nurses as at the end of the year 2016 with a total bed complement of 122. However, labour, prenatal and postnatal wards together have a 60 bed capacity.

3.3 Target Population

The target population included all postnatal mothers who gave birth at the TTH in the Northern region of Ghana.

3.3.1 Inclusion Criteria

Postnatal mothers who were 18 years and older, consented to the study, understood and spoke Dagbani or English language, had laboured and delivered per vagina or laboured and subsequently had emergency caesarean delivery were included in the study.

3.3.2 Exclusion Criterion

Postnatal mothers who were emotionally unstable were excluded from the study.

3.4 Sampling Technique and Sample Size

Purposive sampling was used to obtain a sample for the current study because this technique allowed the inquirer select respondents of homogeneity in character that had rich information concerning the purpose statement of the study.
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Creswell (2007, p. 125) proffered that purposive sampling “means that the inquirer selects individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study”. Polit and Beck (2010) and Kothari (2004) further posited that with purposive sampling, the inquirer deliberately and intentionally chooses individuals who can best contribute to the information needs of a study. The stage when additional data collected showed no new emerging theme was the point of data satiety (Lacey, 2015). Therefore, by the fourteenth respondent, data saturation was reached thus amounting to a sample size of fourteen (14) postnatal mothers.

3.5 Data Collection Tool

Semi-structured interview guide (appendix F) was used for data collection. Semi-structured interview guide is a tool with open-ended questions (Tod, 2015). Tod further states that semi-structured interview guide allows flexibility, control and direction of the interview process. Its flexibility allows follow up questions to explore new and interesting responses. The semi-structured interview guide had two sections. One part elicited respondents’ demographic data and the second part, with guiding open-ended questions and some probes, elicited detailed data on the problem under study. The questions were developed upon extensive literature review on the phenomenon under study and the questions were categorised based on the objectives of this study. The tool was pre-tested with two postnatal mothers at the Tamale Central Hospital to rectify any irrelevance and ambiguities of questions.
3.6 Procedure for Data Collection

This study explored the perceptions of postnatal mothers about companionship during labour through qualitative face-to-face in-depth interviews. Through face-to-face interviews, non-verbal expressions are noted and further probes done to elicit relevant information (Tod, 2015). The developed semi-structured interview guide was pre-tested and ensured that more clarity was brought to the guiding questions to answer the research questions of the study.

Ethical clearance (appendix A) from the Noguchi Memorial Institute for Medical Research Institutional Review Board (NMIMR-IRB) of the University of Ghana and an introductory letter (appendix B) from the School of Nursing and Midwifery of the University of Ghana were taken to the TTH management and sought authorisation (appendix C) from the management of the hospital for the usage of the labour/postnatal ward as site for recruitment of respondents for the study. The researcher then contacted the Nurse Manager of the Obstetrics and Gynaecology department with the authority letter permitting the usage of the facility and explained the purpose of the study. The head of the unit then granted final permission to access the labour/postnatal ward. In the ward, the researcher greeted the Midwives/Nurses, established rapport with them, explained the purpose of the study and gained their interest and cooperation because they (Midwives/Nurses) were vital to the relationship between the researcher and the respondents. The researcher then engaged the Midwives/Nurses in a discussion about the inclusion and exclusion criteria and together with the Midwives/Nurses, such mothers who met the inclusion criteria were identified. The researcher then gave an introduction and established rapport with the mothers and explained to them the purpose and other
information about the research. The mothers’ phone numbers and home addresses were taken with their permission and a follow up to their homes was done after one week following discharge from the hospital. The face-to-face interviews were conducted after seven days of delivery, at the homes of respondents and at their convenient time and without the presence of unapproved persons. Consent information (appendix D) including the risks and benefits of taking part in the study were explained to the understanding of mothers. They were requested to sign or thumb-print a volunteer agreement (appendix E) that signified their consent for participation before the interviews commenced. Each interview session spanned between 30 and 45 minutes. Interviews were conducted in either English language or Dagbani (local dialect) because these were fluently spoken and understood by the researcher. Besides Dagbani (local dialect) is dominantly spoken in Tamale (the setting for the study). Interviews were audio-recorded with the permission of respondents after explanation of the need to capture the entire conversation which may not be possible without audio-recording. Field notes were written about the interviews; the non-verbal cues of respondents, the interview environment as well as dates and time of interviews.

3.7 Data Management and Analysis

Data collected from respondents were manually and electronically managed. Each respondent was represented with a pseudonym as a unique identification corresponding to their transcripts in order to facilitate easy veracity of information. Field notes of relevant points made by respondents during the interviews, the non-verbal cues of respondents, dates, time and place of interview sessions were preserved. Furthermore, demographic information of respondents did not bear their actual names to ensure confidentiality of
Qualitative data analysis is defined by Morse and Field cited in Polit and Beck (2010, p. 464) as “process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents. It is a process of conjecture and verification, of correction and modification, of suggestion and defence”. Thematic content analysis was employed in the analysis of data collected. The strategy involved the reduction of data, display of data, conclusion drawing and verification (Miles & Huberman, 1994). Thematic content analysis also involves identifying, analysing and reporting patterns (themes) within data allowing the researcher to minimally organise and describe data set in rich detail (Braun & Clarke, 2006) by examining who says what, to whom, and with what effect (Bloor & Wood, 2006). This strategy was suitable for data analysis in this study because of the exploratory and textual nature of the data that were collected on a phenomenon where little was known. Green and Thorogood (2004) posited that thematic content analysis is useful in exploring an area where not much is known and report common issues mentioned in the data.

All interviews conducted in English language were transcribed verbatim whiles interviews in the local language (Dagbani) were also transcribed into English language by the researcher after each interview session. Transcripts were read through severally by the researcher to gain insight into the data. Then significant statements and related concepts were identified and assigned codes (appendix G) based on the objectives of the
study and this was concurrently done with data collection. The simultaneous nature of data collection and analysis helped determine when no new data were forthcoming; a stage referred to as data saturation (Lathlean, 2015). Assigning codes is described as giving key words to significant statements and concepts in the raw data which become signposts to emerging themes (Bloor & Wood, 2006). These identified statements and concepts were then extracted from the transcripts onto new word documents to represent statements for the preconceived themes from the constructs of the framework and objectives of the study. These extracted concepts and statements from the raw data together developed what Polit and Beck (2010, p.465) called ‘category scheme’ which facilitated the coding process. Each category scheme was further read through and codes assigned to similar statements and finally regrouped accordingly to create sub-themes under an overarching major theme. The emerging themes and sub-themes were concurrently revised in the analysis process as supervisors of the study reviewed them. This was to ensure that data had been categorised to fit in the right themes and sub-themes. Field notes were analysed to support the information from interviews and verbatim quotes of respondents were used in backing major themes and sub-themes which were organised under the three main constructs of the conceptual framework and objectives of this study. However, content analysis of the remaining textual data was conducted and two other major themes emerged.

3.8 Rigour

Creswell (2007) explains rigour to mean validating the accuracy of a research using one or more of validation strategies. The quality of the process and product of research are evaluated using the concepts underpinning each research paradigm.
Qualitative methodology has its unique criteria of establishing trustworthiness in a research process and product to meet the mark of quality in the world of research. The researcher ensured trustworthiness by following Lincoln and Guba (1985) criteria (credibility, transferability, dependability and confirmability) of evaluating a research study.

Credibility refers to confidence in the truth of the data and interpretations of them (Lincoln & Guba, 1985; Polit & Beck, 2010). Credibility was ensured by prolonged engagement in the field (three months) during data collection. Interviews lasted between 30 and 45 minutes with the mothers. Prolonged engagement with respondents helped the researcher establish rapport and gain respondents’ trust which was critical in increasing the chances of eliciting useful, accurate and rich data from the respondents. The researcher clearly audiotaped and transcribed verbatim fourteen interviews that were conducted. The transcripts were severally read through and a deeper contact was established with the data for analysis. Audit trail of events of the research process were kept to help in arriving at a conclusion about the study. The researcher allowed member checking by returning transcripts to some of the respondents to validate the precision of transcripts and emerging interpretations from the interviews.

Transferability refers to the extent to which findings have applicability in other settings (Lincoln & Guba, 1985; Polit & Beck, 2010). Study applicability is built around collection and description of thick and contextualised information (Clark, Reed, & Keyes, 2015). The researcher presented a vivid account of descriptions of the research process. These descriptions covered the research context, the methodology, the respondents’ demographic characteristics and perceptions of phenomenon studied. Creswell asserts
that rich and thick descriptions allow readers make decisions regarding whether or to what extent the findings are transferable based on shared characteristics. This means that the findings and conclusions may not be entirely applicable to other similar settings.

Dependability indicates the consistency and reliability of the study findings over time by other researchers (Lincoln & Guba, 1985; Polit & Beck, 2010). The researcher developed a semi-structured interview guide based on the objectives of the study and upon extensive literature review on the phenomenon. The tool was subjected to supervisor’s scrutiny and pre-tested to establish its relevance in achieving the study objectives. The process of data analysis was systematic with continuous engagement with supervisors to ensure that data are coded well and findings appropriately articulated. Furthermore, the researcher has provided detailed description of the phenomenon under study as well as the social context where the problem exist. Member checking and keeping of audit trail of the research process helped in establishing dependability of the study.

Confirmability of a study is the ability of the findings to remain impartial but reflecting in accuracy, relevance and meaning of what respondents say (Lincoln & Guba, 1985; Polit & Beck, 2010). This was ensured by returning the analysed data to respondents who clarified and validated the meaning the researcher ascribed to what respondents said.

3.9 Ethical Considerations

Ethical clearance (appendix A) was issued by the NMIMR-IRB of the University of Ghana, Legon. An introductory letter (appendix B) from the School of Nursing and Midwifery of the University of Ghana was sent to the authorities of the TTH and sought
permission and approval of use of the facility as site for recruitment of respondents. The purpose of the study which was to explore postnatal mothers’ perceptions about companionship during labour was explained to respondents. The respondents were informed about the audio-recording of the interviews and consent was granted. Respondents were informed of their right to refuse participation or withdraw from the study at any time even after consenting, or choose not to answer a particular question without suffering any consequence as a result. The benefits/risks associated with taking part of the study were explained to the mothers before they were requested to sign or thumb-print two volunteer agreement forms (appendix E) which signified an understanding and agreement in taking part in this study before interviews were conducted. Each signed agreement form was kept by the researcher and the respondent.

For purposes of confidentiality, respondents were informed that the study was for research purposes only and information gathered from them were not used for any other purposes without their informed consent. Transcripts, audio-tapes, demographic data and field notes were secured in files under lock and key in the investigator’s office and passed word protected on the investigator’s personal computer. The information was accessible to only the researcher and supervisors and data will be destroyed after five years of collection.

Privacy was ensured by maintaining anonymity of the mothers. Their actual names were replaced with pseudonyms. Interview transcripts, demographic information and field notes were identified by each respondent’s pseudonym. All interview sessions were conducted at the homes of the mothers, at their convenient time and without the presence of unapproved persons.
In summary, this study utilised a qualitative exploratory descriptive design and explored the perceptions of fourteen purposively selected postnatal mothers about companionship during labour at the Tamale Teaching Hospital. Data collection and analysis started at the latter part of December, 2017 up to March, 2018. Out of the fourteen in-depth interviews conducted, eight were in the English language and six were in Dagbani (local dialect).
CHAPTER FOUR

FINDINGS OF THE STUDY

This chapter reports on the findings of the study. Five themes and twenty-two sub-themes were generated from the analysis. These themes and sub-themes are presented and backed with verbatim quotes from respondents whose actual names have been replaced with pseudonyms for purposes of privacy and confidentiality. The findings are presented according to the objectives of the study. The demographic characteristics of the respondents are presented first.

4.1 Demographic Characteristics

All the fourteen respondents were women. Their ages ranged from twenty-seven to forty years. All the respondents were Ghanaians and married. Eight respondents attained tertiary level education; out of this number, one had her master’s degree and two attained their first degrees whilst the remaining attained either a diploma or advanced certificate. The rest of the respondents either attained a senior high education, junior high education or no formal education at all. Among the respondents, eight were Dagombas and two were Ewes whilst the rest of the four belonged to the Builsa, Gonja, Kotokolis and Moshi tribes. Only one of the respondents was a student and one was unemployed. The rest were either civil servants, private employees or self-engaged in various kinds of trades and businesses. Eleven of the respondents were Moslems and three were Christians. It was shown that three respondents had each experienced three pregnancies but one had a history of ectopic in her second pregnancy, the other two had all pregnancies successfully. Again, two respondents had each experienced five pregnancies
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and deliveries but one lost her first baby three days after birth and the other had all five currently living. Two of the fourteen respondents had four pregnancies and deliveries all currently alive and four respondents had their second pregnancy and delivery and all children presently living. Three of the respondents were first time mothers who were all delivered by caesarean section and the rest of the eleven respondents experienced vaginal births. The demographic characteristics of respondents can be found in table 4.1.

Table 4.1
Demographic Characteristics of Respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category</th>
<th>Frequency (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>26-30</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>31-35</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>36-40</td>
<td>4</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Dagomba</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Gonja</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Ewe</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Kotokoli</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Moshi</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Builsa</td>
<td>1</td>
</tr>
<tr>
<td>Level of education</td>
<td>Tertiary</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>SHS</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>JHS</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No formal education</td>
<td>2</td>
</tr>
<tr>
<td>Employment status</td>
<td>Employed by government</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Employed by private sector</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Self-employed</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Unemployed</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td>1</td>
</tr>
<tr>
<td>Number of children living</td>
<td>One</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Two</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Three and above</td>
<td>6</td>
</tr>
<tr>
<td>Birth mode</td>
<td>Caesarean section</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Vaginal birth</td>
<td>11</td>
</tr>
</tbody>
</table>

4.2 Organisation of Major themes and Sub-themes

Five major themes and twenty-two sub-themes were derived from the data after thematic content analysis of fourteen interview transcripts. Three of the major themes were in line with the objectives of the study and the constructs of the social support conceptual framework. Four of the sub-themes were directly based on the framework. However, two other major themes; perceived barriers to companionship and experiences of childbirth in the health facility as well as eighteen sub-themes emerged after content analysis on the remaining textual data. Details of the major themes and sub-themes are presented in tables 4.2 and 4.3.

Table 4.2

Major themes and Sub-themes

<table>
<thead>
<tr>
<th>Major theme</th>
<th>Sub-theme</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b. No need for support.</td>
<td></td>
</tr>
<tr>
<td>2. Desired sources of companionship during labour</td>
<td>a. Spousal support.</td>
<td>SSupport</td>
</tr>
<tr>
<td></td>
<td>b. Extended family support.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Support from affinal relations.</td>
<td></td>
</tr>
<tr>
<td>3. Desired types of companionship during labour</td>
<td>a. Appraisal.</td>
<td>Typesup</td>
</tr>
<tr>
<td></td>
<td>b. Emotional.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Informational.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Physical (instrumental).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Spiritual.</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.3

Major themes and Sub-themes

<table>
<thead>
<tr>
<th>Major themes</th>
<th>Sub-themes</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Perceived barriers to companionship</td>
<td>a. Unfriendly hospital rules and regulations</td>
<td>Bar4</td>
</tr>
<tr>
<td></td>
<td>b. Lack of space and physical structure</td>
<td>sup</td>
</tr>
<tr>
<td></td>
<td>c. Taboos as barriers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Interference with care during labour</td>
<td></td>
</tr>
<tr>
<td>5. Experiences of childbirth in a health facility</td>
<td>a. Reception and admission</td>
<td>Exp</td>
</tr>
<tr>
<td></td>
<td>b. Clinical care and clinical environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Personal hygiene</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Interaction with healthcare providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Enduring labour pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. Fear of survival</td>
<td></td>
</tr>
<tr>
<td></td>
<td>g. Expectations in the hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>h. Delays in the health facility</td>
<td></td>
</tr>
</tbody>
</table>


4.3 Desire for Companionship during Labour

This is the expression of a need to have a lay support person during labour and delivery in the hospital. This theme has two sub-themes; expression of desire and no need for support.
4.3.1 Acceptability/Expression of Desire

Generally, women wished to have family members or husbands with them during labour in the hospital. The desire was based on the support they will derive from them. Talata expressed her desire for support during childbirth acknowledging the difficulties associated with pregnancy and labour. She puts it in this manner;

*You know pregnancy is not easy you need care and other things and every woman who has passed through understands better than those who have not. So it is important people are always around you to help you or to assist you during labour* (Talata).

Some respondents asserted that Nurses may be busy attending to other women and so may be unable to meet everything that they may require during labour and so they would prefer the presence of somebody during labour to support them. Sana and Larihi shared their views;

*Actually I would prefer that I have somebody with me so that the person will do things I want for me; things that the Nurses would not do or when they are not around* (Sana).

*I would prefer that someone is with me during my labour. If you are in need of something and someone is with you the person could do that for you quickly. But if there is no one with you, the Nurses are also busy caring for others and because of the pains, you are unable to call out loudly for any assistance you may need, its worrying* (Lahiri).

4.3.2 No Need for Support

Some respondents did not see the need to have a relative during labour because they perceive that relatives will have no role to play inside the labour and delivery rooms. They also expressed fears about the ability of such persons to be secretive and confidential about what women do or say during childbirth process. Thus some women will not desire the presence of their relatives with them during health facility births.

*I personally wouldn’t feel to have a relative in there with me. The presence of the Nurses and Midwives in there [labour and delivery room]*
is better because that will carry some level of secrecy and privacy than having a relative in there. Because whatever happens inside there or whatever actions I put up in there is between me and the Nurses who are only doing their work and may not even recognise me when they see me someday let alone say anything about me to others. But if my relative is in with me, as human beings, you may fault one day (Dangana).

Fuseina also reported that relatives can do nothing about her labour pain and that the work during labour is for Nurses.

...as I am in labour I don’t want to see anybody near me even my husband I don’t want to see him near me. So it is good me and the Nurses should be there. Maybe those who brought me can be outside but not inside. Because, when they [relatives] are there they can’t reduce the pain.... if they are there, what would they do? They don’t have anything to do but the Nurses they know what to do and the baby will come out... (Fuseina).

Some respondents further articulated reasons for not desiring the support of other relatives. For instance reasons were given as to why they would not want their husbands or friends support (companionship) during childbirth.

Ashetu made it clear that though her husband was supportive throughout her pregnancy period, he may not be the right person to help inside the labour and delivery rooms because his gender identity disqualifies him of knowing what support to give and may lead to a quarrel between them. This was the way she put it;

For a man, you have to tell him; I want this or do this or do that, may be he doesn’t know where to start or what to do. At the end of it, if he is not having patience or you are not having patience, you will even fight at the hospital before you are discharged (Ashetu).

Sana pointed out that if it’s the husband present, a woman in labour may end up abusing the husband unintentionally due to the labour pain she is experiencing.

When a woman is in a labour, she may feel holding on to something. She may even bite her husband if he is closer to her but that is not intentional [laughing] because if you look at it...It isn’t your intention (Sana).
Lariba also stated that some husbands may not be able to withstand seeing a woman in the delivery stage of a baby. She added that some husbands may collapse on witnessing childbirth. Lariba used this to justify her reason for not desiring her husband’s presence during labour and delivery more especially inside the delivery room.

...because in the delivery room and for some men, the first day they may see you in that action (baby coming out) can make them faint [laughing… heheheheh!] (Lariba).

She quickly noted that her husband’s presence may on one hand relief her but may also cause her anger on seeing him.

Even though on one hand, the sight of him [husband] may bring some sort of relief to me; on the other hand his presence could make me angry (Lariba).

Lariba will not prefer her friend’s support because of issues bothering on trust and possible bridge of confidentiality when a quarrel sets in between the two one day. She indicated that;

For friends, not all are to be trusted because once you are both females and she has seen you in your labour situation, when you two have a little disagreement, she could insult you with what she has seen you do. But if it is your husband, it’s him and if it’s your mother in-law, it’s her (Lariba).

4.4 Desired Sources of Companionship during Labour

This theme has three sub-themes; spousal support, extended family support and support from affinal relation. The postnatal mothers desired these various sources for the provision of companionship during labour.

4.4.1 Spousal Support

Spousal support was one major source that respondents desired to have during labour in the hospital. Their choice for this source were based on reasons like; spouse’s ability to provide desired support, has the right to see the nakedness, to give respect to the woman,
to appreciate the struggles in childbirth and have compassion for the woman, to support for safe delivery and to consider reducing family size.

Talata desired her husband’s support apart from her mother because she knew her husband can give her motivating words to have her labour go well.

*The person I can think about apart from my mother is may be my husband, if my husband will be around that one too will help because I know if he is around, his words can motivate me, can help me, can ginger me to give birth well* *(Talata).*

Most of the women wanted their spouse’s presence and support because their spouses are regarded to have the right to see their nudity. Tani indicated that she will feel proud and appreciate the presence and support of her husband during labour.

*I want my husband because I can expose myself at any time but since he is my husband, there is no problem but other person, except the health provider; the other person doesn’t need to see my nakedness and other things....I will feel proud my husband is by me [she laughs… hahahaha!] that’s all and I will appreciate because he will also feel the pain I am going through so he will have respect for me because labour is not easy that’s all* *(Tani).*

Lahiri wanted to have her spouse because he will realise the pains of labour that women go through and begin to have compassion for her as a wife.

*I will prefer my husband... (She sighs...Hmm!) he [husband] will witness the kind of things I go through and this can let him have compassion for me as his wife. I know that my husband will not become fed-up with me because the children are for the two of us* *(Lahiri).*

Miriam emphasised that when husbands witness labour and delivery, perhaps there may be reasons for them (husbands) to reconsider decisions or plans of having many children. Besides, husbands support would contribute to a safe delivery. She indicated as follows;

*Preferably the baby’s father should be around me to see how the baby comes out. Husbands, if they are part of giving birth process they will see how women go through and maybe, probably it will even make them change some of their decisions because you will hear husbands say I want*
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to give birth to twenty or fourteen but if they are part of it, at least if they are not the people to labour they will also sweat a little because whoever is in the labour ward at least for the first time will sweat if that is not your work. So it is important and they will also support the women to at least deliver safely (Miriam).

The mothers have diverse reasons for desiring spousal presence during labour. The reasons touched on privacy, compassion, respect and family planning.

4.4.2 Extended Family Support

Desire for mother’s support was reported by Talata. She would want to have her mother with her during childbirth because of her mother’s experience with births. A person with such experience understands and knows what is good in childbirth. Talata says it as follows;

_I would prefer my mother because I need somebody who has given birth, somebody who has an experience when it comes to giving birth. Because she has passed through that, she understands you and knows how to manage you within that period of time [period of labour and delivery]. My mother will give me all the support I want_ (Talata).

It was acknowledged by Atipe that her husband could not do everything for her so, she would desire her mother’s presence to help with those things.

_I prefer my mum to be with me because it’s not everything that my husband can do for me_ (Atipe).

Some respondents desired to have their sisters’ support because they believed their sisters could render the support they would require in labour.

Sana desired her sister’s support because of the bond by blood between them and therefore Sana will be more opened and free with her sister’s presence than any other persons. She shares her view;

_I will prefer my sister because she is my blood sister and so I will feel so free to ask her to do anything for me than if it is any other person_ (Sana).
Similarly, Ashetu desired her sister’s support because she was sure her sister being a lady, knew what to do in supporting her.

_I will rather prefer...let me say my sister to be with me. A sister because she is also a lady or a woman she knows what she is supposed to do for me (Ashetu)_.

Lamisi was accompanied by her Aunty to deliver in the hospital and thus Lamisi found her Aunty to be the best person to give her labour support but that desire was not met.

_I went with my Aunty (my father’s sister) and I needed her presence during my childbirth times. I thought my aunty was going to be there until I give birth but she wasn’t there, so after I delivered, they went outside to look for her (Lamisi)_.

4.4.3 Support from Affinal Relations

Mother in-laws were desired sources of labour support because they are seen as people who have the time for their daughter in-laws during childbirth. Lariba stated as follows;

_I want my mother in-law to be present with me. I chose my mother in-law because she has the time for me and she is stable, my husband travels frequently; he does not stay home for longer than four days. It is my mother in-law who has the time (Lariba)_.

Bodua, who had her mother in-law moved in to stay with them in the house four days before delivery, wanted her companionship.

_I like my mother in-law to be with me in the hospital. Because of work my husband can’t be there until the time that they will discharge me that’s why our mother has come, my in-law has come. So she is the one there for me (Bodua)_.

4.5 Desired Types of Companionship during Labour

This theme presents respondents’ desired types of companionship during labour and has five sub-themes. Postnatal mothers desired appraisal, emotional, informational,
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physical (instrumental) and spiritual supports from their various support networks available. They expressed various reasons for being desirous of the type of support.

4.5.1 Appraisal Support

This type of support refers to statements or words that give self-evaluation and acknowledgment of efforts. Such statements empower the women to strive to do well in labour or delivery.

Lahiri and Talata desired to receive appraisal support from their husbands as this support would bring a peaceful mind, a feeling of being loved and cared for and feeling enabled to give birth.

Lahiri shared her desires;

My husband would be encouraging me small, small or consoling me, giving me courage and telling me I am strong I have delivered before and I can make it again, that I can face what I am about to face. Because he will see my situation in childbirth, his presence and with these statements will give me peace of mind to go through it [labour and delivery] (Lahiri).

Talata noted that when labour and delivery is becoming difficult and a feeling of giving up is mounting, appraisal support will be very important to her. She believed that if her husband is present during labour, she would desire appraisal support from him so to keep her encouraged and feel enabled to give birth. She indicated that;

...and even sometimes if you are giving up in the delivery room, and your husband is there, some of these things he can encourage you that ooh! Sweetheart or darling, you can make it, you can do this! You just do it for me, do it for our child. My husband playing that role will be ok for me and will motivate me that; oh! I also have somebody who is caring and loving, somebody who will always be ready to stand by me (Talata).

The pain associated with labour and delivery usually makes women behave in a bizarre way, however, the ability to self-control and self-comport during labour is important for
the endurance. Talata revealed that she received advice from her mother earlier on how to control and comport herself during labour and delivery which was helpful because she (Talata) did not disturb the peace of other people in the ward with screams of pain.

*I will also want advice, which she [mother] told me, that as for labour, if I go nobody can take my pain. So this is not time for me to go and be there crying and be making noise and other things. So for me she told me already that if I go I should handle myself well. I shouldn’t go and be making noise and be saying “woo” and be crying and be making noise and be disturbing other people because at that moment, nobody can help you. .... So she advised me in that direction so, that one I think it actually helped me and I listened to her and when I went this time, I didn’t disturb anybody (Talata).*

4.5.2 Emotional Support

Respondents desired emotional support in the form of physical presence and interaction with the person, words of encouragement and motivating, saying sorry and reassurances. Such support would relieve tension and enable them go through labour difficulties, feel not being alone and happy in the childbirth process. Miriam, Tani, Sita and Atipe expressed their desires.

Miriam indicated her desired type of support as follows;

*He [husband] will actually encourage me and motivate me to go through the pain and he will give some encouraging statements that will motivate me withstand the pain and go through the labour. I would feel happy.* (Miriam).

Other respondents desired that if their husbands are with them in labour, they will feel accompanied and the husband will be saying sorry when talking to them (labouring mothers) as and when labour pains come. This was desired by the mothers because of the need to relieve labour tension. Tani declared that;

*If he [husband] is there may be he will be saying sorry to me... Sorry, Sorry and with that one you know, it releases my tension and not make me feel alone like say, I am there and I am feeling this pains and my husband*
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is not there with me. But if he is there to say sorry and other things too it will be ok for me (Tani).

Sita also added this;

When they [support persons] are with me, they will talk to me, and with their presence with me, when I need something they will do it for me (Sita).

Continuous reassurance was desired too as this is regarded a source of gathering courage.

I need my mum or husband to just be beside me and be reassuring me yeah! That’s all I need. It can help me gather courage (Atipe).

4.5.3 Informational Support

Mothers desired receiving information about the progress of labour or care rendered. It was found that conflicting information from health care professionals about the progress of labour could cause more pain.

Sita shared her story;

As they keep on checking and checking, I remember the one [midwife] in the morning she was even better she told me that oh! now I’m at seven [referring to cervical dilatation], she even brought the card and showed me the arrangements, and that any moment anything can happen. But when the afternoon people came, she just came and did the thing [referring to vaginal examination] and told me that it’s four [cervical dilatation] but the other lady also told me that it was seven and she told me that it was four, so the pain was becoming too much and I felt like ‘puu-puuing’ [defaecating] and I tell them I feel like ‘puu-puuing’ they will not mind me (Sita).

Lahiri indicated that the lack of information about her care could possibly put her into undue worries and thinking about the outcome of labour and delivery. She explained as follows;

If you are unaware of what is going on with you that can be a source of worry to you, denies you peace of mind and will not contribute to speedy recovery. Without information about my care, I would be thinking; is everything well with me? Or will I recover or not? (Lahiri).
However, Rukaya was curious to know about the nature of inducing labour.

I asked the doctor to tell me what induction was and whether it was painful and he explained that I will be given a drug so that it will help the baby turn and I will deliver soon but I will experience some pain before I deliver (Rukaya).

Ashetu also received information about the presentation of her baby and the implications of trying to deliver per vagina. She was also told of a laboratory tests on her blood sample.

The only information I had was that the child was not laying well because the hands were straight up, she straight up the hands and was pushing the head to come out and the hands were still hanging and that was the more reason why they have to operate. Because if they were to also force the child to come out normally it either we would have problems with the hands (Ashetu).

It was about testing our blood to know how the level of our blood is. So the midwife came inside and informed all of us before the doctor came and took the [blood sample] for the test. So they informed us that they will come and do us some test to know how the level of our blood is and then that one we have to pay (Ashetu).

4.5.4 Physical (instrumental) Support

Physical (instrumental) support refers to the type where respondents desire relatives to assist them by going to collect or buy drugs, accomplishing activities of daily living including providing foods, drinks, supporting to get out of bed or walk around, assisting with a urinal to empty bladder, cleanliness and getting transportation after discharge.

Most of the mothers said they needed somebody to help them care for the newborn in such ways as holding the baby, changing diapers or bathing after they had given birth and was moved to the postnatal room.

Ashetu and Bodua expressed their desire for assistance in getting medications or going for laboratory activity when required.
If they [Nurses and Doctors] are in need of drugs for me, and my relative is there, she can help me. She can rush and go outside the hospital and get the drugs for me (Ashetu).

Maybe they will say go and buy medicine, go and do this, go and do lab test so if nobody is with me it’s not good you yourself the time you deliver you are not strong so you can’t do this work alone that’s why I need somebody with me to do this work for me (Bodua).

Respondents indicated their desire to have foods and drinks to gain some strength to push during delivery, to wet their lips and throats and to satisfy their hunger and thirst.

Talata said she expended energy in engaging in some physical activities which her mother could have been helpful if she were inside with her, besides she (Talata) had not eaten for long. She said;

I am choosing her [mother] because when I want something like she should get me food, she knows the kind of food to get for me. So if my mother was around, some of these things like [picking urinal and others] she could have helped me with some of these petty, petty things. And I’m sure it could have helped a lot. I could have reserved a lot of energy to push and because of that when we went to the delivery room it took time for me to gather much energy to push and they were just on me. I wasn’t having the strength because I ate in the morning so the strength it wasn’t there (Talata).

Rukaya and Lamisi also reported that they desired to have water or food to satisfy thirst or hunger but suffered a while for it.

.....it got to a time when I needed water because my throat and lips were dry and I was in pain too. So if my sister were allowed in she could have given me water but I had to complain and complain and complain until I had the water (Rukaya).

Lamisi particularly reported sleeping in hunger till the following morning before eating.

I felt hungry and thirsty later and did not get anybody to give me food and water. It was late in the night and my people had gone home, I begged for water from a colleague but slept with the hunger till the following morning before I got tea to take (Lamisi).
Sana added that;

*This person will prepare tea and provide items that the Nurses may need. My sister will get me food and water (Sana).*

Some other physical supports desired by Sita and Talata were to have their desired companion to help them get out of bed or hold their hand to the delivery room.

*...and maybe if I want to get down from the bed, you know the beds are high, and with the pain, they [relatives] can help me get down (Sita).*

Talata spoke with passion when she indicated her desire to have her mother to hold her hand and accompany her into the delivery room. Talata felt that, being wheeled into the delivery room would be uncomfortable for her and so she lamented;

*She [mother] can help me get up when I am struggling to get up from bed. Because I am in labour, sometimes you need a person to help you, hold your hand, you can’t get. Something like when my time was due for me to get into the delivery room itself, they [Midwives/Nurses] brought a wheel chair for me to sit and I said no, my condition is not too terrible for me to sit on a wheel chair, for what! So personally, I refused I wasn’t comfortable I just needed somebody to hold my hand to send me to the delivery room but they said no that I should..... I did not get any assistance. They said unless I sit on the wheel chair I also told them no! No wheel chair. So I have to go myself (Talata).*

Assisting to urinate or defaecate were some other physical support desired by some of the respondents. Rukaya and Lahiri remarked as follows;

*... it was urination that I did frequently using a chamber pot so if I want to urinate she could assist me and afterwards she would discard the urine (Rukaya).*

*When I defaecate my relative could take it and dispose of it because it won’t be hygienic if the faeces are not disposed of, the smell alone may be discomforting (Lahiri).*

Respondents also wished to have their blood-stained clothes washed before they are discharged.

*And the washing; in the hospital, if you just deliver, your things will just be blood so by all means you need somebody to wash them for you. I want...*
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the support because I can’t help myself alone unless they help me. (Bodua).

My things [clothes] will become wet of blood... Maybe she [sister] might help wash those things (Ashetu).

Atipe reported that her mother brought hot water to clean her and her baby after she had been operated (caesarean section).

My mum always brought hot water to clean the baby and myself (Atipe).

Feeling dizzy or experiencing abdominal pain and fatigue after delivery were commonly reported by most of the respondents. It was also indicated that intravenous infusion on their hands posed interference with caring for their babies. Lahiri, Sana and Talata shared their story;

The drip in my hand was making me feel pain, my baby too defaecated and I just needed somebody to clean-up the baby for me but I didn't get it done at that time because there was nobody with me there (Lahiri).

Because after delivery, I may not be strong enough (dizzy or have abdominal pain) to prepare tea for myself or even take my baby when he is crying so the person with me would help me out (Sana).

However, Talata who had her mother with her at the postnatal room specifically noted how her mother supported her to breastfeed and care for the baby.

Because that day when we went to the resting place [postnatal room], she [respondent’s mother] supported me because I was tired, I was weak already, the strength it wasn’t there so she helped me with the baby, dressed the baby and other things. There, she cared for me as at that time the milk it wasn’t coming you know when give birth newly you don’t have breast milk and the baby will be crying and other things. So she helped with the baby and other things and she was trying to pamper her (Talata).

It was narrated that family members could assist if health workers would teach them how to do sacral massages to minimise labour pain. The narration was by a respondent who happened to be a midwife and therefore understood the importance of such massages. This was her statement;
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You know for the pains, if your relative is there unless the health provider will show him or her what to do to release small, small of the pain by massaging the sacral part; the waist, because if the pain is there at times and you do it small, it will soften it (Tani).

After discharge, transportation was a need that mothers expressed. The mothers said they would want their relatives to organise transportation for them when they have been discharged to go home.

Miriam expressed;

...and being around to pick me home when I am discharged yeah! (Miriam).

Lahiri shared this;

He [husband] was able to organise transportation for me when I was discharged from the hospital (Lahiri).

Though the desire for companionship was largely surrounding the period of labour, it was also interesting that the mothers desired some companionship at the postnatal room.

4.5.5 Spiritual Support

Spiritual support bothered on having faith in God and praying that He takes control of the childbirth process so that delivery would be a success. Lariba shared this;

As for the delivery room I can say there is no help unless the help of God. There is no help in the delivery room not even from the Nurses, only from God. When you are about to deliver, everything moves into the hands of God and you have to be praying. The Nurses only know when the baby will be born. The rest of the matter is to pray whilst the Nurses also support you with more prayers because they also tell you to be patient God is in charge (Lariba).

Ashetu and Sita delivered by a caesarean section and wanted prayers from their relatives who accompanied them to the hospital. They believed that the relatives, though were outside waiting, kept on praying for a successful operation.
... they [husband and sister] might be outside the theatre room waiting and then praying, hoping for me to come out successfully but not in the same theatre room with me (Ashetu).

As for them [sister in-law, landlord and senior aunty] I knew they did that a lot because through prayers, so the only help they can give is to pray for me for God to help me through what I am going through (Sita).

4.6 Perceived Barriers to Companionship

These are factors perceived by respondents to prevent birth companionship in facility births. There are four sub-themes under this theme. They are unfriendly hospital rules and regulations, lack of space and physical structure, taboos as barriers and interference with care. These are presented as follows with verbatim quotes from respondents.

4.6.1 Unfriendly Hospital Rules and Regulations

Respondents noted that, the rules and regulations of the hospital was a factor that prevented them from having their relatives with them during labour and delivery. The regulation or rule is such that, family members who accompany a pregnant woman to the facility are made to wait outside whilst only the labouring woman is allowed in. At instances when a relative even gets access to the labour room, he or she does not stay long in there. Respondents shared their views as follows;

Actually the Nurses told them (husband and mother in-law) to wait outside until I deliver safely. They don’t allow relatives into the labour and delivery rooms (Lariba).

Maybe that’s the hospital rule they will not allow them [relatives] to be with me during that time (Atipe).

Sita lamented how Midwives prevented her relative from entering to give her a cloth when she needed one and shared this experience as follows;

After they [relatives] just brought me they [Midwives/Nurses] will not even allow my people to enter. I remember when my relative was even bringing me the tea inside, they (Midwives/Nurses) were driving her away.
I requested for a cloth, she was bringing the cloth they drove her away. They said if I need anything I should tell the nurse and my relative will come and stand at the entrance and the nurse will pick it for me. They will not even allow a relative to enter (Sita).

4.6.2 Lack of Space and Physical Structure

Lack of space and physical structure explains the poor orientation of the labour and delivery environments. The ward’s physical structures are described as being open or having ‘shared rooms’ which does not allow for privacy of mothers in labour and delivery. This deficiency of the wards compelled respondents to express their fear of exposing their nakedness to other relatives. It also talks about the inadequate space in the labour and delivery rooms which would not allow other persons’ presence.

Tani and Miriam wished that the environment was well structured to make room for their support persons and protect their privacy.

…if only it is room by room may be one room for one client for that one it is better but if it is just an open place for everyone to come and be and labour and deliver, I won’t encourage relatives to be by their clients. Because as a woman in labour, you can just expose yourself and be there like that and apart from your husband and the health providers who have the right to see you naked, nobody is supposed to see you with your nakedness and for labour; you can behave anyhow (Tani).

Miriam buttressed the point by exposing the nature of lack of privacy in the wards saying they are ‘shared rooms’ where a woman can easily be found completely naked and the presence of somebody’s husband in there will inconvenience other women.

But the problem is when you are looking at the current structures at our hospitals because they are shared rooms and then the shared rooms, is it possible for somebody’s husband to be there? because the person’s presence is going to be inconveniencing other people’s wives because that room is not actually a room where people are comfortable sitting, it is a room that you really can find somebody completely naked (Miriam).
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To curtail this problem of space and physical structure, Miriam thought that hospitals could restructure the labour ward environment to fit for relatives’ presence without compromising privacy and confidentiality of labouring women. However, she sounded pessimistic concerning how soon this will be.

So if we are going to be looking at husbands or relatives then we have to actually be looking at generally how to change our structures, hospital facilities or the labour wards when it comes to giving birth and I am sure that will take us a very long time (Miriam).

Lamisi also mentioned that the ward has no adequate space to accommodate support persons during labour and delivery and that may be the reason why Midwives do not allow relatives to stay during labour.

The room has not enough space to accommodate us with our support person maybe that’s why they don’t allow people to be present otherwise my aunty could have been there (Lamisi).

Miriam indicated that the wards were not safe because women’s belongings like bags were at the mercy of thieves who in one way or another may be purported to be part of the ward or on visit or anything else. This occurrence therefore required Midwives/Nurses to return labouring women’s bags to relatives to keep instead of keeping it with the women in the ward. The openness and vulnerable nature of the wards may have necessitated this behaviour and Miriam in her responses indicated that;

when you go and they [Midwives/Nurses] pick the necessary things they need, they will return the bag to your people to take it away because thieves nowadays will go and pick the bags so they prefer to give it to your relatives (Miriam).

4.6.3 Taboos as Barriers

Taboos are the don’ts or the avoidance of engaging in an activity by which defaulting may result in the occurrence of the phenomenon for which that avoidance sort to prevent
or curtail. In this sense, respondents reported taboos some people may have against seeing a fresh baby hair and umbilical cord. Therefore, women who may desire the support of their husbands or persons who are morticians may not have their desire achieved. Sana and Dangana reported that;

*What I hear is that some people don’t see the fresh hair of the baby and also the umbilical cord before it dries and falls off (Sana).*

*Well, I know about the fresh hair on the baby’s head; that locally, those who dig graves and also receive corps into the grave taboo seeing a baby with that fresh hair. They would only see the baby after the baby’s hair is shaved and usually is on the seventh day (the outdooring day) (Dangana).*

**4.6.4 Interference with Care during Labour**

Ashetu reported that the presence of relatives in labour and delivery may interfere with care.

*He [husband] cannot be there because in case a doctor came inside to check on you people, he will be disturbing the doctor. May be in the presence of him, the doctor might want to check me then he will also be sitting here...the doctor have to excuse him before getting to me. All those things are just disturbance to or disrespect to the rules of the hospital. A relative of a patient should not be so close to the patient that a doctor cannot attend to her (Ashetu).*

**4.7 Experiences of Childbirth in a Health Facility**

This theme considers the environment in which respondents gave birth. It elaborates on respondents’ experiences of care rendered by healthcare providers. It includes the interaction between mother and healthcare providers. It also includes respondents’ personal encounters and observations of issues around the ward environment that have a direct or indirect bearing on their health. Thus, eight sub-themes emerged and are presented below with verbatim quotes of respondents.
4.7.1 Reception and Admission

Respondents shared their experiences on how they were received and admitted into the labour wards. There were expressions of nice receptions and women were always required to present labour items to the attending Midwives upon arrival into the ward. The mothers were accompanied by their family members. Rukaya, Tani and Lariba shared their experiences on how they were received.

Rukaya indicated that her experience on this was welcoming; she was asked to wear only a cloth and lie on the bed. She said;

*We [together with sister and brother in-laws] were welcome and the items the Midwives required taken from my bag including dettol and two soaps then I was given a bed but asked to undress myself and wear only a cloth, pick polythene and another cloth and then lie on the bed (Rukaya).*

Tani also said;

*I was warmly received; they received me nicely, gave me a bed and allowed me to change into different clothes (Tani).*

As for Lariba, she reported that her husband was asked to take a patient’s folder as she was being prepared for admission.

*We were received fine; my husband was told to get a patient’s folder which he did. The Midwives collected the necessary items they needed from my bag after which I gave the bag to my mother in-law to keep (Lariba).*

However, Sana experienced an unfriendly welcome when she arrived in the hospital at the labour ward at an hour which she attributed to be the reason for the harsh reception.

Sana’s relative was not allowed to help her to her bed, she narrated;

*Actually when we arrived in the hospital, it was around 3am. We called on the Nurses but there was nobody seen until after some few minutes somebody came out from a room to ask and we told her I was in labour. She shouted at my people to leave me to go and lie down [says this with a frown]. They left me and I struggled to the bed. She shouted again that I*
should remove all my clothes including my pants but I don’t think she should have shouted at me like that, is it because we woke her up at that hour (Sana)

4.7.2 Clinical Care and Clinical Environment

Respondents gave accounts of the care they received from the Nurses and Midwives. The clinical care respondents recounted included; physical examination, medications and investigations, intravenous infusions, facilitating labour, wound and cord care. The clinical environment was not friendly as described by the women. Bad smells, poor rodent control and inadequate beds were reported by respondents. This brought sleepless moments, fear and feeling of insecurity and other discomforts to the women especially after they delivered. Sita, Tani and Talata shared that the Midwives did vaginal examination and checked their contractions to determine the progress of labour.

....when I entered they did VE [vaginal examination], and said it was now three [3cm, referring to cervical dilatation] (Sita).

...somebody was by me monitoring my contraction that’s the labour pains and my baby’s movement too till….it was time to deliver and they send me and deliver the baby (Tani).

I think that when I was there, they came and re-examined me again in my private part to see the centimetres of the baby...how the contraction and other things are taking place in my system (Talata).

Similarly, respondents said they were served medications and asked to carry out some other investigations.

Atipe remarked;

I think I was to be induced because my time was post-date so they took care by serving my medication and reassuring me, ermm... yah! (Atipe).

They [Midwives] gave me drugs; injections and all those things but the baby was not ready to come. It seems I was in bad labour or the baby was not laying well (Ashetu).
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The investigations that were ordered included ECG, X-ray and abdominal scan and the mothers reported this as follows;

….he [doctor] came and checked my heart beat and all those things and said that I have to do…ECG and do X-ray and add (Sita).

I went downstairs and did a scan [abdominal scan] and it was realised the operation was not necessary but they will induce me, that’s what I was told (Rukaya).

Sita was transfused three pints of blood after she was operated for prolonged labour. She stated;

After the operation, when I was there, they gave me the blood transfusion and it was left with two more (Sita).

Respondents also reported that they were given intravenous fluids as indicated by Sana and Lamisi;

The Midwives were giving me ‘water’ [intravenous fluid] through my veins (Sana).

They set up ‘water’ [intravenous fluid] on me both during the labour and delivery room (Lamisi).

Respondents who had caesarean section shared their experiences on how their wounds and baby cords were cared for. Sita was concerned about the frequency with which her wound was dressed.

Very, very bad because it [wound dressing] is not done regularly they do it like three times in a week like if they dress it on Monday unless on Wednesday they will not dress it again (Sita)

Respondents also complained that the Midwives did virtually nothing about the umbilical cords of the babies. For instance, Atipe particularly lamented on how her fellow women handled their babies’ umbilical cord and described it as ‘not hygienic’.

And like the toilet wasn’t good enough some people will just go without washing their hands, may be the tap too is not flowing, they come and pick
their baby and use spirit that they are cleaning the cord, it’s not hygienic (Atipe).

She added that;

Like, some of the babies, the cord was just, they were just laying there because they [Midwives] couldn’t tell the mothers that they have to use spirit and clean the cord or something like that. So I have to go and those who are not aware, I have to ask some whether they used the spirit to clean the cord because some of them are first time mothers they don’t know anything about that (Atipe).

Sita talked about the fact that the mothers themselves take the responsibility to clean their babies’ umbilical cords using shear butter after cleaning with spirit.

They [Midwives] don’t do anything about it [cord], it is you the mother who has to do everything. When they bath, you have to put your spirit, your shear butter till it cuts off they don’t do anything about it (Sita).

Facilitating labour by induction or breaking the water bag was one thing commonly reported by respondents. Respondents indicated that the labour pain increased when Midwives burst the water bags but acknowledged the procedure was always preceded by putting on gloves. Fuseina, Lariba and Bodua shared;

As soon as the Midwife just wear the gloves and put the hands and said the place has open but the baby is dodging she is not touching the head that the way it is, I will deliver right now so they had to burst the water, so when they just burst the water it didn’t reach fifteen minutes and I gave birth (Fuseina).

The doctors from time to time asked me if I was experiencing pains I said no until about 12 mid-day when they had to give me a certain fluid [described as ‘hot water’] then I started feeling pains on and off, on and off.....The midwife put on hand gloves and examined my private part and broke my waters and my clothes were soaked, then the labour started seriously (Lariba).

They [Midwives] said I should come and lie down and they checked on me and said its remaining small but my waters did not come, so they inserted me some medicine (Bodua).
The clinical environment posed a major challenge for respondents. They were put on floor mattresses after they had just delivered and this was a source of discomfort to them and they hoped that someday, they will have a bed to themselves and not lie on the floor.

Dangana and Miriam shared their experiences below;

_There was no bed available and when the ward is full they make us lie on floor mattresses. It was discomforting but I just had to manage, there was nothing to lean my back on. In my previous delivery which happened at night, it was the same thing: I was on a floor mattress throughout the night not sleeping until the next morning and was discharged_ (Dangana).

Miriam underscores that she always lie on floor mattress whenever she goes to deliver at the hospital. She therefore describes the situation of inadequate beds as “that’s how it’s always been”

_Mostly it is always full and no beds and people will be....mostly, I don’t know whether I am always not fortunate I have never given birth and gotten a bed. The room is always full anytime you go people give birth and the beds are full and then they have to use mattress on the floor for people to sit and that's how it’s always been. It is not that good, it’s not good though but what can we do? because that’s what is available so we hoping that in the near future there will be more beds for mothers and their babies so that people will not lie on the floor_ (Miriam).

The inadequate number of beds in the wards also caused women to lie on the floor and this was reported as impeding free passage in the wards. Rukaya declared, beginning her narration with a sigh.

_(Sighs..Hmm!) the wards were congested especially at the prenatal and postnatal rooms, the beds were all in use and women were laying on mattresses put on the floor and waiting for a bed to become empty and this impeded free movement within the wards and between the beds_ (Rukaya).

_[Sighing in this case suggests the enormity of the concern raised as experienced]_
Even though respondents said there were discomfords with laying on the floor, Miriam still expressed that, since her stay in the hospital was only for some short time period, laying on the floor was not really much of an issue to her.

Even though it’s [laying on the floor] discomforting but because we are only there for some few hours there isn’t much effect (Miriam).

As Lariba had a sleepless night because of poor rodents control in the ward, Sana was unhappy about the bad smell that was emanating from the washrooms anytime the washroom door was opened as she reported laying close to the entry.

At mid-night, when the nurse put off the lights, mice started running round in the room...It was past 2a.m. and I was still awake because that [mice] was something I had not seen in my room; mice running up and down!. One of them even entered my basket and I scared it out (Lariba).

...I was put on the floor just near the doors of the washrooms, it’s a path actually I wasn’t happy laying there, I wasn’t happy but I had no option. As for that place, the scent! Mmm.... faeces! [Squeezing her face] I covered my nose in fact my entire body with clothe because the smell alone, when the door was opened...my tummy, the odour was nauseating (Sana).

Lamisi similarly shared that;

There were mice in the room running up and down through our legs and we were laying down, angrily looking at them because what can we do? (Lamisi).

Women thus require giving birth in an environment devoid of bad odours, peaceful and calm without any manner of entertaining fears.

4.7.3 Personal Hygiene

Personal hygiene here talks about body care including bathing, elimination or hand washing. Respondents shared their experiences on how their personal hygiene was maintained during labour and after delivery. Some women acknowledged the difficulty
they faced to reach on to their chamber pot when they needed it. Talata echoed that engaging in all these things were stressful.

....it came to a time I was throwing up so I asked for [chamber pot]. So they picked it for me alright, but I vomited on myself, the cloth, the bed so I needed an assistance but no, it wasn’t easy, I didn’t get. I had to clean myself, I vomited on myself, so I cleaned myself and I changed into another cloth and when I wanted to urinate, I had to get down myself and pick the chamber pot under the bed those things it’s stressful (Talata).

She continued to complain that she had not bathed since she delivered;

....you are keeping us here.... I have given birth and I haven’t bathed since yester-evening till the following morning and I am still here, the time too is also going have you seen? (Talata).

The site of the washroom for the women was outside of the ward and so they had to get downstairs if they needed to use the washrooms. Fuseina resorted to urinating in her chamber pot so her family members will later come during visiting hours and discard the urine.

....as I am laying down even to get bathroom and go and urinate that it’s far away from us how can a baby mother go outside and urinate and come back?. The bathroom that is inside is for staff only....So I had to use my chamber pot and urinate when my people come they will take it far away and go and pour it whilst it’s not good (Fuseina).

Rukaya expressed that she had not bathed after she delivered her baby. She indicated as;

I was tired staying because I had not taken my bath (Rukaya).

Sita however expressed satisfaction with her stay as a transfer-in client in the Intensive Care Unit (ICU) from the post-delivery room. Her satisfaction was because she had access to hand washing facilities. She acknowledged;

....when I go and ‘wee-wee’ and come they allow me to use the soap and wash my hand, if I want to eat they allow me to use the soap and wash my hand. When I just tell them ooh! Please can I use this? They will say use, at least that two days, I lived a good hygienic life there [referring to the ICU she was transferred to later] (Sita).
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4.7.4 Interaction with Healthcare Providers

Interaction with healthcare providers refers to the communication between the labouring
women and Nurses/Midwives/Doctors and how they perceive being involved in the
childbirth process. Some respondents alluded that healthcare providers politely explained
to them the reasons why certain clinical procedures were done on them. For instance

Talata and Ashetu proffered that;

\[
\text{So, anyway they spoke to me politely ... in terms of human relationship,}
\text{they did well. They had to explain to me the reason why they have to put}
\text{their hands inside me, that to check the opening. So for me, it was ok. They}
\text{weren’t harsh on me, it was ok I was ok with that (Talata).}
\]

Ashetu added;

\[
\text{The Doctor on duty who made them operate on me, he tried well; he had}
\text{the time to explain everything to me. Even in the theatre he was standing}
\text{by my side; even to close my eyes he was not allowing me to close my}
\text{eyes. They [theatre team] did well, they kept me in conversation. I did not}
\text{even realise the time they removed my baby only to just see that they}
\text{brought my baby to show me (Ashetu).}
\]

Interacting with birthing women in a manner that will give respect and honour to them
was something that postnatal mothers reported. They echoed that the attending Midwives
touched, patted and consoled them in the course of any engagement with them. However
others reported otherwise. Lariba, Lahiri and Sita orated as below;

\[
\text{But with this particular childbirth, they were asking me about the}
\text{contractions and pains and calming and pleading with me to have a little}
\text{patience my time will soon come. They touched me and patted me with}
\text{their hands [respondent demonstrates this on her right thigh] telling me to}
\text{be patient, just a little while (Lariba)}
\]

\[
\text{The attending Midwife was patient with me and had time for me during}
\text{delivery. She will say sorry to me and console me when what she is doing}
\text{caused me pain (Lahiri).}
\]

\[
\text{The way they [Midwives] approach us, with the way they even do it}
\text{[vaginal examination], when you are even feeling the pain, they don’t talk}
\text{to you in a way that you feel happy (Sita).}
\]
However, some postnatal mothers were not happy with the engagement they had with the Midwives. Mothers argued that the pain and other problems associated with childbirth manifested in ways that the attending Midwives needed to be tolerant and understanding. Sita and Sana lamented about how the attending midwife shouted and insulted and uttered discomforting words capable of producing tears.

*I was vomiting; I’m on the bed, vomit comes unconsciously so like my chamber pot was on the floor I was on the bed, the thing just came at once, when it happened like that they [Midwives] just started insulting you can’t get down and pick your thing and vomit (Sita).*

*...... and she [midwife] was shouting at me that I was lazy to push and that if I don’t push the baby will die, the head is already down, and that would be my own problem because I have carried the pregnancy for months...... She shouted at me until God granted me a safe delivery (Sana).*

She added that the attending midwife remarked that her [Sana] baby will die. Sana reported that this remark caused her shed tears because she found the comment rather repugnant.

*When a person is in pains, she doesn’t know her own where about. The midwife shouldn’t have said my baby will die...this made me weep though I am not the type who disturbs when in a labour but I was weeping. She [midwife] said weeping will not solve the problem what and what, meanwhile you said my baby will die...so I have to weep (Sana).*

Rukaya also experienced some form of mistreatment from the midwife in such manner that made her upset and rather caused her a “double pain”.

*I encountered one midwife who I thought was harsh and impolite in the way and manner she spoke to me, she said that I should lie down and she will check me to see how far the baby has come and that, it was even too early to be crying like that, so I lay down and she checked and said that I still have a long way ahead and I am there making noise like that. But if she was patient enough for me the pain would maybe reduce a little but her rudeness in approaching me was upsetting and so I was now experiencing double pain but if she had approached me with a calm voice that would calm my heart too and the pain will reduce (Rukaya).*
Sita expressed sentiments of neglect from the demeanour of Midwives in the ward especially when women were in pain. She shared below;

....they [Midwives] were playing music! Music there [in the labour ward], they were singing and dancing and people were going through pain. They don’t care they sit down and be talking they don’t care (Sita).

Involving mothers in their own care especially during childbirth process is noted an important component. However, postnatal women in this study did not really find this necessary to them once the care did not cause any harm to them. Also it was found that women had trust and confidence in the Midwives and the care they rendered, therefore mothers found it needless to say anything about their own care.

I think maybe whatever Nurses feel is right to be done and it will be good for both mother and baby then it is important that they do (Miriam).

The midwife asked me whether she should cut [episiotomy] me. I said I wouldn’t know, because she is seeing “down” and she is a nurse and so she doesn’t need to ask me because she knows the right thing to do for the baby to be born, but she was asking me whether she should cut me so I said yes (Sana).

Similarly, lack of information about the care expected from Midwives during the childbirth process could make labouring women unable to take part in decisions about their care as Dangana submitted;

Truly, the Nurses they know the care they are supposed to give me. So I cannot tell them how I want them to care for me because I don’t know what it entails (Dangana).

Some respondents gave submissions to show that the care they are receiving from the Midwives are out of sympathy from the Midwives and so women in labour have no say but to abide by the directives from the Midwives. Miriam, Lariba and Lahiri opined as follows;

[Exclaims...Eeih! For the delivery room when you go I am not sure you have a say yeah! Because people are always sure that they are helping
you and you are also sure that people are helping you to give birth. So mostly whatever they [health professionals] tell you to do, you just do (Miriam).

Health issues in the hospital about labour and delivery is just a matter of one day. So you just need to be patient and accept whatever you are told to do.....the hospital is not your home where you can go and tell them how you want them to care for you. I have never told any nurse how I want to be cared for (Lariba).

Lahiri asked, with surprise, if she had the right as a client to contribute or say something about her care in the hospital.

Do I have that right to say anything about my care? Hmm.... I don't know what to say (Lahiri).

4.7.5 Enduring Labour Pain

Enduring labour pain refers to how respondents during childbirth coped with labour and other associated pains. There were reports of enduring the labour pain through holding on to objects, twisting mouths and preferred to walk round the ward (but this was restricted). Medication in the form of anaesthesia was given when one of the respondents had a tear during delivery. Some wished they had been operated and others said they would not get pregnant again. Respondents talked about how other medical interventions caused them extra pain and frustrations. Some respondents resorted to enduring the pain without any means of minimising it because labour pain is physiological and naturally accompanying childbirth thus is expected to run its course. Mothers indicated that the Midwives did not do anything in this situation but rather urged them to endure until after delivery when the pain will subside because there was no medication to reduce the labour pains. Bodua and Sana mentioned that;

I didn’t do anything, I didn’t do anything to reduce the pain, because whether I like it or not the pains, It’s there so I can’t do anything to reduce it (Bodua).
They [Midwives] did not say anything about how I will reduce the pain. When I complain about the pain, they only tell me there is no medicine for the pain that the pain will stop when I deliver (Sana).

Lamisi too lived with the pain by twisting her mouth and holding firmly to objects around. She added that the pain was so much that she wished for a caesarean section.

Lamisi put it this way;

*When the pains presented, I only twist my mouth and just endure the pain, hold on to something available and keep twisting my mouth because there is nothing else to do. I only have to try and obey what the Nurses want me to do (Lamisi).*

She went further to say that;

*When I felt the pain, it came a time I told them [Midwives] if I am not delivering, they should operate me and she told me to be patient a little for the time to come for me to deliver (Lamisi).*

Similarly, Miriam implied she missed her husband’s presence in the labour ward as he was her source of comfort when she experienced contractions on their way to the hospital. However, at the ward, when contractions set in, she only held on to her bed.

*When we were even climbing the stair case, I climbed the stair case and immediately after climbing then the contractions came I was going to just kneel on the floor but he [husband] held me and I was holding him tight till it subsided. ...but when you go to the ward, you are there with your bed alone and so whatever you do you will have to just hold on to your bed (Miriam).*

The women reported that they needed to be walking around the ward because walking was seen to help relief the pain. However, they were restricted from walking round.

*When you are going through the pain and all that, for me like this, I needed...I wanted to be walking, because laying down alone it wasn’t helping, I will be feeling the pain more so may be as you even walk it helps, when I want to walk they prevent me, so like with that, I really endured it (Sita).*

Lahiri suffered a tear during childbirth and was given a pain controlling drug before suturing was done. She said;
Like, during delivery I had a tear so she [midwife] used a pain controlling drug to inject me before suturing the tear (Lahiri).

Sita did not go through a vaginal delivery but a caesarean section done under anaesthesia.

She described the ordeal she had with pain issue as below;

I remembered the other doctor told me that they will just inject me even I can see and hear whatever they are doing but just that my legs will be dead, I said ok. He did that but he told me when they start and I feel any pain, I should tell him. When they cut, I really felt the pain as if they didn’t even inject me anything. So I told him that I was feeling the pain. So he had to just kill me, so they just killed me and I was just in another world I didn’t know (Sita).

Sana recounted that the strength of labour pain she experienced put her off the idea of getting pregnant again.

Actually after my childbirth encounter, I lost interest in birth I never liked to be pregnant again because of the strength of pain. I said to myself that me! With this, I won’t give birth again [laughing] God forbid, woi![signifying fear]... Why should a person suffer this way, why are others seem to be finding it easy and what is wrong with me that I had to suffer that way (Sana).

Respondents became increasingly frustrated, angry and hurt when indeed medical interventions brought some form of discomfort to them. For instance, flashing to cause patency in intravenous fluid in situ, frequent vaginal examination for cervical dilation or multiple needle pricks to access a vein were such interventions that the women reported to be causing extra pain. Statements made by Sita and Miriam elicited these;

...you [health professional] came and like I was already having one [Intravenous cannula] already, that one you came to put the thing and the blood wasn’t moving. He flashed, he flashed more than three times and the flashing too is painful. I feel the pain I complain I said oh! Please it’s painful because it has swollen. You told me that ok you will look for a different place, a different place?[raising eyebrows]....look at still the marks (shows forearm) not knowing like he couldn’t even see a vein and he just did the.....when he just kept the needle the thing was paining me I said no he should remove it, he is hurting me. I said please if you know you cannot do it look for the expert people to come and do it because you
are hurting me, needles everywhere, here...here...here...[Pointing at both arms] Why? (Sita).

She continued to say;

I also became angry because I’m not a wood, I feel the pain and I’m already there with a lot of pains already and you want to add me more. (Sita).

Miriam too had this to add;

....you go to the labour room and then somebody will come and check the number of centimetres that you have opened to then ideally that it’s supposed to be four hours later then somebody can check but then, thirty minutes another person will come and want to check and then when they check the pain increases....(Miriam).

Sita emphasised that the size of the hands too contribute to pain in a vaginal examination.

It is [vaginal examination] really painful and the hands differ so it depends on the hand, some people own are abnormal so you feel the pain very much. And when they are even doing that and you are in that pain, at least just show some care; oh! Sorry or something, the person would not (Sita).

4.7.6 Fear of Survival

Respondents expressed fears about the unknown outcome of labour and delivery. Some of these fears were based on what they have heard people talk about childbirth and some were scepticisms about the competence of the young Midwives who were at post then. However, in the midst of all these fears, the women put God first. Ashetu, Miriam, Lariba and Sita proffered the following;

At the time of labour, locally we say; one leg is on heaven one leg is on earth, so you don’t know what will happen. What I was hearing was that, operation room if you enter theatre it’s either you come out or you remain there; it’s either you come out alive or dead so that was what was making me scared, so I didn’t know. But we were all safe and sound well, It’s only those who God said this is their time will go; I don’t think operation can make somebody die unless it’s your time (Ashetu).
When I was there I said mmm! My God! These people [referring to two young female Midwives and one male] will they have the requisite experience? I thought they were going to use me for experiment (Miriam).

You know, when you go to deliver; everything is left in the hands of God because childbirth is a matter of life and death, you either live or you die in the process. So when you leave everything in the hands of God, He shall help you out, so I delivered well without any problem (Lariba).

I endured this pain around 3:00pm they [Midwives] burst my waters by force. And even, bursting of the waters they wanted to use a needle if you see how the needle was big (stresses with eyebrows raised) it’s just God’s intervention, the needle was big like that (shows with her forearm) (Sita).

4.7.7 Expectations in the Hospital

This sub-theme highlights expectations the post-natal women had in the hospital. It included privacy during physical examination, God fearing staff, caring staff, enough human resource with requisite knowledge, cost-free service.

I expected them [the Nurses/Midwives] to provide a screen at my bed when they come to do VE [vaginal examination] but they will just come and start checking they will only tell me to lie down so that they check how near the baby has come. And I know if I tell them they will say I am not the only woman laying this way in the room. But I would prefer they respect my privacy by seeking my opinion when dealing with me (Rukaya).

Atipe was praying to meet God fearing Midwives so that she could be handled well.

My prayer was that I should meet somebody that is God fearing and truly almost all the staffs I met and the doctors, the doctors they were good to me, they took care of me, talked to me in a good manner and all those things (Atipe).

Most of the expectations the respondents had were tied to their idea about the status of the hospital. The idea was that a “big hospital” should have enough personnel with the requisite knowledge to care well for women coming to deliver.

I thought because it was like a regional hospital I thought things would have been better than the district. May be they would care; they would have concern and all those things (Sita).

I thought because it is a big hospital and the Nurses will be many, so I would be attended to well, but... [Pauses] (Sana).
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She continued to add that;

> When a woman comes to deliver, it is not good for them [Midwives] to be shouting at them [women] or beating them to put their thighs apart, it’s not fair. They [Midwives] have to be consoling you [woman] (Sana).

Talata believed personal relationship was necessary in the care of women in labour. She expects a ‘big hospital’ to have their human resource with good personal relationship.

> …because it’s a big hospital, they have all the facilities and everything in it. So in terms of human resource too, the human beings should also have that kind of personal relationship, they will be caring and I mean so many things, but when I got there, I think they didn’t meet my expectations (Talata).

Miriam believed that the hospital is safe because the staffs have the requisite knowledge to render a safe delivery.

> …but I always prefer to go to hospital, I believe that is where they have the requisite knowledge to support me to deliver safely (Miriam).

Some respondents expected a cost-free service but there were some financial obligations they had to meet before being discharged home. Lariba said she had health insurance upon that she still made a payment amounting to about twelve Ghana cedis.

> I have health insurance but I was asked to pay 12 Ghana cedis for which I did not understand why I was paying that money. Meanwhile they gave me only two different medicines so which one is not covered by health insurance? I know these two medicines will not cost up to 12 Ghana cedis if I were buying from a drug store outside (Lariba).

Women who could not instantly pay this amount waited for their relatives to come and pay before they could leave the ward premises.

> So for me when they mentioned my name and told me the amount, there was no money with me I waited for my people to come and pay before we left the ward (Dangana).
Similarly, Miriam recalled in her second delivery, she was unable to pay the charged amount and so it costed her the afternoon’s medication. In other words she said she was denied her medications.

*When you give birth the drugs that you are supposed to get they are free but there are some unnecessary costs that those who are just around pass on to you. In my second birth they made it look like if I don’t pay, was it eighteen or twelve Ghana cedis? then they will not give me my drugs. They asked me to pay for something I didn’t even understand but at that particular point in time there was nobody, I had no phone, I had no money so how do I pay for and my inability to pay for those things she [health professional] denied me my medications I was supposed to take that afternoon and that’s not good enough (Miriam).*

4.7.8 Delays in the Health Facility

This is where respondents have spoken about delays in the ward after discharge. Women after the hustles of labour wanted to go home without any undue delays after the doctor had confirmed they were fit to go. However, the protocol of health insurance in dispensing drugs was one thing that Talata echoed to have delayed her in the ward for more than three hours post-discharge. She described this period as a “total waste of time”

*I remember the doctor discharged us between 9am and 10am, but it took more than three hours for me to get medicine, all in the name of doing registration at the health insurance side. ….it even got to a time and it was like we were wasting our time over there, so three hours, it was a total waste of time for us. At a point in time I told them that they could even write the medicine for us to go outside and buy (Talata).*

*I was really fed up staying long in the hospital after discharge (Rukaya).*

Other delays happened when Lariba visited one week after discharge for a postnatal review. She complained waiting so long for her folder to be retrieved. Lariba reported;

*I remember I was discharged on Friday and was to come for review a week later, when I came my folder could not be located, for well over four hours I was waiting for this folder. My delay, suffering plus my pains made me shed tears. I was there until the morning shift workers at the folder collection point closed and the afternoon took over (Lariba).*
In summary, postnatal mothers expressed desire to have companionship during labour in the hospital because of the workload nature of the Nurses and Midwives, to receive support from their companions as childbirth process comes with a great amount of concerns. Some mothers thought the activities in the labour and delivery rooms are exclusively for Nurses, Midwives and Doctors and relatives have nothing to offer there. Other reasons were concerned with worries about confidentiality, secretiveness or trust of support persons, fear for husbands collapsing or receiving abuses from labouring women. Mothers desired companionship too during the immediate postnatal stage in the hospital to help care for the newborn.

Postnatal women wished to have support from the variety of their informal support networks. They desired spousal support, extended family support and support from affinal relations and gave varied reasons for desiring these sources.

The mothers reported they desire emotional support and physical support the most. They indicated that, words of encouragement and motivation, presence of the support persons and interacting with them, saying sorry and receiving reassurances were central to making them feel loved and cared for, feel not being alone, happy and relief of labour tension. Respondents wished their relatives would give them assistance when they want to urinate, provide them with foods and drinks, hold hands and escort them to the delivery room, go for medications and do sacral massages to minimise labour pains. The other types of support were informational support where women desired to receive information about their care and labour progress and advice on self-comportment during childbirth. However one of the postnatal mothers said conflicting information about her labour progress increased her pains and made her feel like ‘puu-puuing’ [defaecating].
Mothers prefer receiving words that enable them to self-evaluate their potentials, development the ability to do things right in labour. These were appraisal supports desired by postnatal mothers. Spiritual support was a type the respondents had faith in God and wanted prayers from relatives. Prayer to God to help them through labour was noted a vital component of the support types desired by the postnatal mothers. Unfriendly hospital rules and regulations, lack of space and physical structure, raising privacy and possible theft concerns, taboos and interference with care during labour were perceived barriers to companionship that the mothers reported.

Postnatal women also shared their childbirth experience and it was noticed that Midwives rendered routine clinical care to women in the ward and giving little or no attention to their social and relational requirement. There were mainly reports of bad communication behaviours by Midwives/Nurses towards the mothers. Postnatal mothers also experienced issues with personal and ward cleanliness, unnecessary delays in the health facility, enduring labour pain and expression of fear of survival. The presence of companions was desired so that some of the avoidable experiences would not be experienced.
CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter presents a discussion of the findings of the study in connection with the available and relevant literature related to the phenomenon under study. The discussion of themes is preceded by a discussion of the demographic characteristics.

5.1 Demographic Characteristics

Even though the level of education of the women in this study spanned from no formal education to tertiary education, almost all of the women perceived the need of having a family member during labour in a health facility. This means that educational background may have no bearing on women’s decision to have a family member during labour. This finding is similar to the findings of Al-Mandeel in Saudi Arabia where the level of education had no impact on women’s choice to have a companion (Al-Mandeel et al., 2013). However, this finding contradicts a report in Nigeria that educational level of a woman influences the likelihood of deciding to have a support person during labour (Aiken-Adenekan, 2009; Vehviläinen-Julkunen & Emelonye, 2014). Prior experience of childbirth in a health facility may have contributed to the postnatal women wishing to have a family member to provide companionship. Considering the age brackets (27 years to 40 years) of the women in this study, one would have thought that they would be spoken to nicely and their privacy accorded them as they wished or their desire for a companion allowed. However, most of the women did not have their desires met. A study in South Africa proffered that maternal age was significantly linked to disrespectful care from Midwives and women did not receive the care they expected especially with regard
to support from family members or partners (Oosthuizen et al., 2017) which resonates with the findings of this current study. Therefore midwifery care should be sensitive to older mothers who come to deliver at the health facilities since adulthood commands some respect especially in the Ghanaian cultural setting.

The medicalised environment of childbirth coupled with the seemingly busy Midwives with other routine interventions may have influenced women to want to have somebody with them during childbirth. This is because, whether a first time mother or an experienced mother, it did not change mothers’ desire for birth companionship. Contrary to this finding, older women and women with multiple births as compared to first time mothers were influenced by their experience to become more selective and sensitive in their choice of companion considering the gender role of their support networks (Emelonye et al., 2017). Mainly, women preferred having their mothers as companions in subsequent births instead of spouses because of the perception that men had no role to play (Emelonye et al., 2017). In another study in Australia, first time mothers expressed fear of the unknown, however, this fear was comparatively higher than with experienced women (Dahlen et al., 2010). This therefore suggests that experience counts when it comes to childbirths and women giving birth for the first time would require a relatively extra attention during labour.

In the Ghanaian tradition, people cherish vaginal births as it is a mark of strength and womanhood. Most women would therefore prefer and strive to labour and deliver per vagina so she could contribute to the lots of stories her colleagues would share about vaginal births. This current study reported only three of the mothers delivering by caesarean section. Records of the mothers’ obstetric assessments showed that the event of
the caesarean section was as a result of prolonged labour and a resulting foetal distress and maternal exhaustion but not the desires of the mothers. It is not consistent with a study in Northern Ireland where women preferred medical interventions including opting for a caesarean section to facilitate labour and relief labour pain and birth complications (Greer et al., 2014). These two opposing findings point to the different cultural values and beliefs about labour and delivery in these environments.

5.2 Desire for Companionship during Labour

Desire for companionship during labour is the expression by mothers to have or not to have their family members with them during labour in the health facility. In this current study, most of the mothers indicated that they wished to have family members with them in the labour/delivery rooms whilst few expressed no need for support.

Mothers expressed their desire for companionship during labour. Mothers desired support from family members because of the significant role family members could play in the process. It was found that Midwives were engaged in attending to other clients and were not always available to render further services to mothers who may be in need of help. Again, the demands of mothers during childbirth were so enormous that Midwives alone could not meet them. Consistent with the current finding are the studies in Malawi (Banda et al., 2010) and Nepal (Sapkota et al., 2014) where companions were found to have been of tremendous assistance to both labouring women and health care providers. In other studies in Greece (Iliadou, 2012) and Nigeria (Morhason-Bello et al., 2008), mothers desired companionship during labour. In the Ghanaian system, it is common that women in labour are accompanied to the health facility by at least two family members who were of assistance to the women at home. Usually, these people have experience of
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childbirth and are anticipated by the women to be of significant assistance in the birthing process. Therefore, if women are allowed to have companions with them, they will be of dual purpose in the ward as they will complement the work of health care providers (Sapkota et al, 2014).

This study also found that few women who expressed no need for companionship regarded the activities of childbirth to be the exclusive role of health care providers such as Nurses, Midwives and Doctors. This corroborates a study in Russia where mothers tagged the childbirth environment to Midwives and other health professionals and family members did not have any responsibility to play there (Bakhta & Lee, 2010). The findings imply that women view childbirth process sacred and technical requiring only the labouring woman and the health professionals’ engagement. This implication draws further on to support why mothers viewed family members incapable of reducing labour pains. There were equally expressions by some mothers about a likely broadcast of whatever happened in the labour and delivery rooms to the outside world if relatives or friends served as companions. Fear of gossip and concerns of mistrust with the presence of companions during childbirth were similarly reported in a Kenyan study (Afulani et al., 2018). This is in consonance with the current findings where mothers expressed issues of mistrust and fear of possible bridge of confidentiality in having companions during labour. The feeling of trust and confidence in the competence of the Nurses and Midwives was therefore viewed in the present study as key during childbirth and was likely to influence the mothers’ expression of no need for companionship during labour. Sapkota and colleagues (2014) found that trust in care providers (both Midwives and family members) was central in making women in labour feel cared for, but in this
current finding, some of the postnatal mothers had confidence in the Midwives but not in family members hence thought family members should not be in during labour. As a result, there would be a great task and expectation on the Midwives and Nurses to live up to the demands of mothers during childbirth. This will require that Midwives improve their communication with labouring women and expand their (Midwives’) knowledge on the job so to provide the care required (Sengane, 2013). The question that may still linger would be that, can Midwives alone meet the care mothers may want, more especially in the settings of this current study, where there remains a deficit of Midwives and Nurses working as against the constantly growing population in attendance to the health facility? If the staff strength is boosted such that Midwives are enough in a shift to render one-to-one care to mothers in labour, it may enhance and make care better. Another way could be that, during pregnancy, women may be assisted to identify a trusted person within her informal networks and pre-labour discussions and education provided to them such that the mother may feel safe and secured (Emelonye et al., 2017) working with this identified support person. In doing this, one must be mindful of the individuality and request from mothers in order not to coerce them into choosing a support person against their wish.

Furthermore, some of the mothers interviewed stated that their husbands in particular were not the right persons for companionship especially during the delivery stage of the childbirth process. Some mothers pointed out that some husbands may not be able to witness the birthing of the baby because they may be frightened by the process. Some of the mothers raised concerns of possible collapse of some husbands on seeing this process of birthing. Another study described likewise, showing mothers concern about husbands’ presence and that the childbirth process is unsightly and repulsive for
husbands to see (Bakhta & Lee, 2010). The mothers find it strange and ridiculous for a man (husband) to be in the delivery room, therefore mothers fear for the reaction from their husbands at this moment of childbirth. Mothers may be encouraged to increase spousal dialogue on how to improve and maintain the support they may be getting from their spouse during childbirth. Perhaps couples’ prior discussions with Midwives about the nature of delivery and the delivery room may help couples handle the perceived fears. This study also reported that there was the tendency of postnatal mothers abusing (biting) husbands if they were found in the delivery room. Similar to this finding, Afulani and colleagues (2018) proffered that women during labour were more likely to abuse or being abused by support persons. This reaction may either be describing the extent to which a mother is experiencing labour pain or has hatred towards the spouse for being the cause of her labour pain.

5.3 Desired Sources of Companionship during Labour

The tendency to desire a support person is reliant upon such factors as the availability of the person, the trust and confidence one has in the person and the ability of the person to provide the desired support during labour. Based on these, postnatal mothers desired support from diverse sources like spouses, extended family (mother, sister, aunty) and from affinal relations (in-laws).

The findings of this study suggest that mothers would appreciate the presence of their spouses during childbirth. Other studies across the globe have also reported similar findings about the support from husbands/partners (Adeniran et al., 2015; Aiken-Adenekan, 2009; de Lacerda et al., 2014; Kabakian-Khasholian et al., 2015; Morhason-Bello et al., 2008; Palinski et al., 2012). The women in this current study have raised
various reasons for desiring spousal support. The reasons were that spouses can provide
the desired support leading to a safe birth, own the right to see them naked, to accord
respect, value and appreciate the mother if they (husbands) witness labour pain and
associated struggles and to consider limiting the family size. It was reported in Nigeria
(Adeniran et al., 2015; Emelonye et al., 2017; Vehviläinen-Julkunen & Emelonye, 2014)
and Brazil (Dayana et al., 2014) that women feel safe and better comforted with spousal
support during childbirth. When spouses provide companionship during childbirth, it is
likely to bring the husband closer to the woman, tighten the bond of love and physical
attachment between spouses and may make women feel secured. In the urban settlement
as in the setting of this study, it is common to find husbands accompanying wives to the
health facility to labour. Men, in the cultural setting of this study, have the responsibility
to take care of their wives including periods of pregnancy through to childbirth. This
known responsibility could be explaining why some postnatal mothers desired their
spouses with them during labour. Spousal presence may give an opportunity for spouses
to feel a part of their wives’ giving birth and an opportunity to show their wives how
much love they can give. When mothers in labour are allowed to have their spouses to
support in the activities of childbirth, it may serve a greater avenue to contribute to the
decisions their wives’ may be making during labour and delivery (Backstrom & Wahn,
2011). The presence of spouses may also enhance their relationship with the baby after
birth and possibly enthuse them in the acceptance of responsible parenting (Johansson,
Fenwick, & Premberg, 2015). Besides, the witnessing of the labour pain may reshape the
thinking of the spouses to have few children as was expressed by one of the mothers.
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Fewer number of family size may be helpful to the health of the mother and proper upkeep of the children.

The present study revealed that, postnatal mothers desired to have labour companionship from their extended family members who are females. This is because such persons have experience, have a bond by blood relationship with them and are more likely to be opened to each other regarding the desired support types. This conforms to the findings in Brazil (Dayana et al., 2014; de Oliveira et al., 2014) and Syria (Abushaikha & Massah, 2012) where majority of women preferred to have support from mothers or sisters or aunties. Mothers as desired sources of labour support were found important to the postnatal women in this study because of the desired sources’ experiences accumulated over years of their childbearing lives. Therefore, postnatal women reported that their own mothers had given birth severally before and were experienced enough to assist them through the stressful childbirth process. This is similarly reported in Malawi (Banda et al., 2010), three Arab countries (Kabakian-Khasholion et al., 2015) and Thailand (Yuenyong et al., 2012) that females who have had childbirth experience are capable of providing physical and psychological support during labour. It is obvious that having personally experienced childbirth puts one in a position to offer beneficial support. Much as the women in this present study may desire extended family’s support, other findings in Zambia showed that women expressed dissatisfaction with their mothers’ companionship making allusion that they had no proper training to give support (Kungwimba et al., 2013). Much as experience counts, training on providing the support would strengthen the quality of it.
The present study found that postnatal mothers also desired companionship from affinal relations during labour likewise reported by Yuenyong and colleagues (2012) in Thailand where mother in-laws were chosen as labour support persons. In the setting of this current study, a woman after marriage moves in to stay with her husband in his family house and live with her in-laws. Therefore, mother in-laws equally have some responsibility of taking care of the wife right through pregnancy to labour and postpartum. This kind of sociocultural environment in marriage has an influence on desiring the presence of affinal relations, like a mother in-law, during childbirth.

5.4 Desired Types of Companionship during Labour

There are five support types postnatal mothers in this study desired to receive from their desired support sources. These types of support include appraisal, emotional, informational, physical (instrumental) and spiritual supports. Appraisal supports are capable of making the mothers in labour feel abled and can withstand the stress and struggles of childbirth. This current study found that women wished to be given words of advice for self-evaluation to empower them and make them realise the reason and essence for having to have a successful childbirth. This study indicated that, postnatal mothers wished they had this support as it would make them feel loved, cared for and have a peaceful mind to give birth successfully. One respondent expressed how the advice she got from her mother prior to going for labour helped her to control and comport herself during labour and delivery. Obviously the advice came from someone who has had an experience of childbirth and was in a better position to assist appropriately. It was similarly reported in another study in Ghana among pregnant women where appraisal support was desired by the women to enable them know they
were doing things right (Alexander et al., 2014). Another quantitative study showed that mothers received high level of appraisal support (Leahy-Warren et al., 2011). Words that portray self-evaluation in labour and delivery are thus needed by mothers who go to deliver in hospitals. Such support is necessary to develop self-efficacy as mothers would feel control over the childbirth process.

Postnatal mothers in this study wished to receive emotional support. The findings are in line with the study in Syria (Abushaikha & Massah, 2012) and Nigeria (Emelonye et al. 2017; Morhason-Bello et al., 2008; Vehviläinen-Julkunen, & Emelonye, 2014) where women giving birth at a health facility desired to receive or were satisfied with emotional support provided by relatives. Emotional support was desired in the form of words of encouragement, motivation and reassurances, being present and interacting with them. These are consistent with the findings in Syria (Abushaikha & Massah, 2012), Brazil (de Lacerda et al., 2014) and Nigeria (Emelonye et al. 2017). It was perceived by postnatal mothers in this study that emotional support would help calm their anxiety and tension accompanying childbirth. The reduction of anxiety during labour was reported in a randomised study to reduce labour pain (Hodnett et al., 2013). This means that when labouring women are provided with emotional support from their desired companions, pain associated with labour may be reduced. Furthermore the effects in the use of pain medications may be avoided since more concern would be drawn to non-pharmacological management which is safer with no or less cost. The provision of emotional support from desired sources also result in a feeling of happiness and belongingness as reported in this study and similar to the findings of Dayana and colleagues and Palinski and colleagues in Brazil where such support took away the feeling of loneliness and created happiness,
calmness and confidence to the labouring women (Dayana et al., 2014; Palinski et al., 2012). These contribute to softening the experience of anxiety and thus reduce labour pain and end up with a satisfactory birth experience.

Informational support was perceived by respondents in this study to mean receiving correct information about labour progress and care. This study found that postnatal mothers desired to have information about their care and on the progress of labour and they relied mostly on Midwives and other healthcare professionals for this. These were in line with Sakopta et al. (2014) study among Nepali women, and in Iran (Askari et al., 2014; Iravani et al., 2015) where mothers depended largely on health care professionals for information on labour. Consistent information on cervical dilatation, labour induction, foetal presentation and its implication on delivery per vagina as well as information on laboratory investigations were desired by postnatal mothers in this study.

The present findings also suggest that conflicting or lack of information on this may leave mothers in hopelessness creating unnecessary worries about labour outcome. In line with another study, varying information served as grounds for labouring women to lose confidence in the source of the information (Bäckström et al., 2017; Regan et al., 2013). Receiving correct information is key among the desired types of labour support and its absence could deny mothers the ‘peace of mind’ and perhaps retard recovery. Information about one’s care creates a feeling of being part of the care package rendered to the mother during labour and delivery and may be regarded in equipping mothers well enough for decision making about their own care. Though postnatal mothers preferred information about their care and progress of labour, few of the mothers were really unworried if Midwives did not involve them in the process. This evidence seem to suggest that women
in labour believe in and trust the competence of Midwives in providing the requisite clinical care (Sapkota et al., 2014). Possibly too, the pain associated with labour make women to accede to the instructions given and keep quiet on whatever care healthcare professionals may be rendering to them. It is imperative that Midwives are circumspect with the information they provide to mothers during labour. This is to make them feel empowered, confident and develop control over their labour process (Kungwimba et al., 2013).

The mothers indicated that they desired to have physical (instrumental) support during labour because of the challenging demands in labour. The postnatal mothers expressed their desire to have physical support in the forms of giving assistance to urinate, providing foods and drinks, assisting in walking around, sacral massages, supporting in breastfeeding post-delivery, as well as financing drugs and transportation. These were similarly reported in other studies in Kenya (Afulani et al., 2018), Iran (Iravani et al., 2015) and Malawi (Kungwimba et al., 2013). Most of these forms of physical support are noted to minimise labour pain (Hodnet et al., 2013; Kungwimba et al., 2013) and relief the mother of further stresses. The exhaustion accompanying labour may require that mothers are allowed foods and drinks so that they may nourish their bodies with the energy required for the process of childbirth. The findings suggest that Nurses and Midwives should be aware of these physical supports and their associated benefits or harm to the mother in labour. The mothers also desired to receive support post-delivery at the postnatal room because of feeling of exhaustion and dizziness after delivery. Initiation of early breastfeeding is greatly recommended by WHO and the presence of a relative at this time is important in the facilitation and initiation of
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breastfeeding as reported in this present study and supported by a prior study (Morhason-Bello et al., 2008). Transportation back home after discharge was important to the mothers. In the setting of the study, the commonest means of transportation is a taxicab whose services are mostly sought and borne by either a family member or the spouse to transport the mother home after discharge. In this study, the mothers indicated this desire was met by their spouses. This was necessary to give comfort and guarantee safety to mother and baby as both experienced fatigue after childbirth. Spouses should be aware of this important physical support and encouraged to provide them.

Spiritual support desired by respondents in this study was prayers. The women in this study emphasised the central role God plays for a safe and successful labour and delivery. They believed that the success of the work of the Midwives was complemented with prayers to the Almighty God. This assertion is backed by other studies in Syria (Abushaikha & Massah, 2012), Ghana (Aziato et al., 2016), Iran (Fathi et al., 2017), Malawi (Kungwimba et al., 2013) where prayers were believed to have a significant impact on labour and labour pains. Desiring prayers from support persons for God to take charge of the labour process indicate that postnatal mothers hold a strong faith in God and believe that God is the reason for a safe and successful labour. Childbirth is a time of uncertainties, a matter of life and death requiring the hands of a divine source to make the process devoid of adversities. Therefore, Midwives, Nurses and Doctors should recognise that, spirituality is a significant parlance, and can play a critical role, in childbirth process in the Ghanaian health care systems.
5.5 Perceived Barriers to Companionship

This study identified unfriendly hospital rules and regulations which postnatal mothers stated as a perceived barrier to companionship during labour. In other studies, where health professionals were the respondents, it was reported that staff disagreed to or institutional policy did not allow the presence of family members during labour (Brüggemann et al., 2014; Maimbolwa et al., 2001; Senanayake et al., 2017). The absence of a national policy in Ghana supporting birth companionship possibly accounts for Nurses and Midwives turning away family members after receiving and admitting the accompanied woman in labour. This occurrence contravenes the directive by WHO that women be allowed a companion of their choice during health facility delivery (WHO, 2015). As mothers talked about Nurses and Midwives disallowing the presence of family members in childbirth, this behaviour by the health staff may be attributable to the fear that their roles as Midwives may be downgraded (Kabakian-Khasholian et al., 2015). This suggests that healthcare institutions should understand the enormous benefits that come with birth companionship and the support the companion may render to complement care provided to the labouring women. They should also consider the desires of the labouring women as core in the offer of care. Understanding of these may influence Midwives and management of healthcare facilities to change such unfriendly institutional rules and regulations.

Furthermore, lack of space and physical structure as reported in this study was consonant with studies in Brazil (Brüggemann et al., 2014), three Arab countries (Kabakian-Khasholian et al., 2015) and Sri Lanka (Senanayake et al., 2017). The open and “shared room” nature of the labour room was noted in this study to have privacy
concerns. The stay of family members as companions would therefore cause a bridge of privacy and may be a source of discomfort to other mothers in labour. Privacy was notably expressed as an enormous challenge as a result of the structural arrangement and this impacted on postnatal mothers’ desire for the presence of family members as birth companions. Privacy issues were similarly raised by health providers in a mixed method study in Kenya (Afulani et al., 2018). The inadequate space coupled with the high number of labour cases at a time plausibly brought about why some women were laying on floor mattresses; an observation the researcher noted in the course of recruitment of respondents for this study and similarly expressed by the postnatal mothers. As a result, the wards looked overcrowded and this practice may be facilitating cross-infection as ventilation could be compromised. Therefore, the lack of space and physical structure was perceived by the respondents as a barrier for companionship during labour. There is a need to modify the physical space in the labour wards to guarantee comfort to women giving birth in the hospital and support birth companionship.

Taboos were raised as some sort of barriers to having the desired companion during childbirth. The existing evidence from this study suggests that it is a taboo for an undertaker or a mortician to see a fresh baby’s umbilical cord or hair. Interestingly, such persons would not see the baby until after seven days when, per the cultural practice of the people from the locality of this study, the hair would be shaved and the cord is expected to have fallen. The findings in a study by Afulani and colleagues (2018) in Kenya talked about cultural inclinations as similarly adduced in this present study. In the Kenyan culture, however, the belief is that men’s presence during labour can prolong the labour. Whereas that from Kenya talks specifically about men, the finding noted in this
study was not gender specific though. If women desire to have a family member; male or female, who portray a taboo of not seeing a fresh baby’s hair or cord, it would not be possible. However, it is worthy to indicate that none of the mothers interviewed in this study said they had such persons accompanying them to deliver or said they desired companionship from such persons. Perhaps it is so because of this known taboo.

Mothers think that the presence of their family members during childbirth may be interfering with the activities of the health staff during labour and that may pose some form of disturbance or is a sign of flouting the rules of the hospital. Previous studies also reported similarly (Kabakian-Khasholian, & Portela, 2017; Maimbolwa et al., 2001; Senanayake et al, 2017). Possible interference maybe thought of if a companion has no idea about the support he/she would give during labour and delivery. Thus if companionship would be considered in healthcare facilities, there is a need to clearly delineate the role of a companion from that of Midwives.

5.6 Experiences of Child Birth in a Health Facility

Women’s childbirth experience in the health facility is an important aspect capable of influencing women to deliver or not to deliver in a health facility. It is capable of influencing the desires for companionship during labour. Most studies have commented on birth outcomes as either satisfactory or unsatisfactory which are usually measured out of the experiences of childbirth reported by women giving birth in a health facility. The findings discussed here ascribe to the experiences of childbirth as reported by mothers who delivered from a tertiary level hospital. The experiences shared show how Midwives and health care systems need to improve on services to women giving birth in hospitals. Mothers’ experiences of health facility childbirth were categorised into reception and
admission, clinical care and clinical environment, personal hygiene, interaction with healthcare providers, enduring labour pain, fear of survival, expectations in the hospital and delays in the health facility.

Postnatal mothers reported that, their receptions and admission into the labour ward was marked with nice and disdainful experiences. Establishing good rapport with mothers should begin on arrival into the wards as this sets the pace for feeling secured. Midwives’ first contact with the pregnant woman in the labour ward in the hospital is important for the woman as it makes her to get acquainted with the Midwives. This acquaintance may be facilitated when the pregnant woman is received nicely by the attending Midwives and an opportunity may be created for Midwives to also get to know the desires of the woman. In other findings in Nigeria, pregnant women were met on arrival in the labour ward with verbal abuses (Bohren, et al., 2017) as in line with findings in this study where reception and admission of the mothers during labour was disdainful. Such unfriendly reception may discourage women from health facility delivery and Midwives and other health professionals should be conscious of establishing good relationship with mothers during labour.

The mothers also shared their experiences on the clinical care they received from the Midwives. The mothers reported various clinical care procedures carried out on them some of which were frequent therefore, becoming discomforting. The findings substantiate earlier reports on the clinical care rendered to mothers during childbirth (Askari et al., 2014; Bohren et al., 2015; Floyd et al., 2014; Hatamleh et al., 2013a, 2013b; Hussein et al., 2018; Pazandeh et al., 2017). This implies that clinical care during childbirth is important however, such procedures should be carried out with caution and
to the barest minimum in order to avoid undue discomforts to mothers. The clinical environment also plays a crucial role in the experience of childbirths. Experiencing bad odour, poor rodent control and inadequate beds in the ward were described by the mothers in this study as discomforting and frightening. In other studies in Brazil (Jamas et al., 2011) and Ghana (Mensah et al., 2014), which this present finding contradict, are reports that mothers experienced a clean, calm and organised environment during childbirth in a hospital. However, the present finding is in line with Sapkota and colleagues’ (2014) study where mothers reported experiencing childbirth in a dirty environment. Discomforting and frightening ward environment is likely to bring sleeplessness and inadequate rest to mothers during childbirth in the hospital. Besides, a dirty ward environment with poor rodent control is detrimental to the health of mothers during childbirth. Childbirth should occur in conducive terrains devoid of bad scents.

This study also reported how mothers had difficult times in achieving and maintaining personal hygiene in the ward. Personal hygiene included; emptying the bladder, bathing and hand washing before and after eating or using the washrooms. Mothers indicated that the washrooms in the ward were for staffs only and they had to either go outside the ward or use a chamber pot. These were found stressful to the mothers. The study particularly showed that mothers did not have the opportunity of taking their baths after they had given birth. This situation could be as a result of post-delivery challenges coupled with absence of a birth companion. In the Ghanaian cultural setting, it is commonly believed that a person is considered to have taken a bath if she feels water and soap all through her body. The women desired the presence of companions to help them maintain adequate personal hygiene. The finding in this study
aligns with a study in India where about sixty percent of postnatal mothers experienced poor personal hygiene (Missiriya, 2016). Measures should be taken to ensure postnatal mothers practice good personal hygiene to minimize risk of infection.

Interaction with healthcare providers is an experience shared by the mothers in this study. It was found that the interaction between the mothers and healthcare providers was strikingly poor as found consistent with other studies (Bohren et al., 2017; Bradley et al., 2016; Floyd et al., 2014; Hussein et al., 2018; Jamas et al., 2011; Sengane, 2013) and good as supported by a study in Iran (Iravani et al., 2015). It appears interaction with healthcare providers is a major aspect in the care of mothers during labour. When Midwives poorly interact with mothers it may affect the confidence of the mothers, likely make them feel disrespected or neglected. Therefore, healthcare providers have a vital responsibility in ensuring that they interact positively with women during childbirth.

Enduring labour pain was one key finding in this study. Mothers lamented how they endured labour pain throughout the childbirth process and the Midwives appeared virtually helpless. Women are expected to cope with and endure the pains of labour because it is perceived a normal phenomenon in the Ghanaian context. Therefore, the mothers endured the labour pains by holding on to objects and twisting their mouths. They also desired to walk around in the ward as this was noted to reduce the labour pain. In many instances, walking around was restricted in order to avoid any mishaps of having to give birth on the floor and cause injury to the baby. The implication is that extra attention is required for mothers during labour and their views may be relevant when dealing with labour pains. Perhaps women in labour may find solace in the presence of support persons. This may further provoke other means of handling labour which may be
Fear of survival was emphasised as an important experience of childbirth. Childbirth process is a period described as ‘life and death’ or ‘one leg in heaven, one leg on earth’ by the mothers interviewed in this study. Childbirth is the period when Midwives’ experiences in Midwifery practice means a lot to the mothers. Competence or clinical skills of Midwives seem to be tied to being in long practice as perceived by one of the mothers in this study. The findings of this study suggest that stories heard about childbirth, the impression about the competence of young Midwives, and the frightening procedures, make some of the mothers entertain fears of surviving the childbirth process. Prior studies reported that pregnant women had fears of childbirth because of fear of developing complications or not surviving labour and delivery (Geissbuehler & Eberhard, 2002; Greer et al., 2014). This is consistent with the current findings even though it reports on postnatal mothers. The fear of surviving may possibly be attributed to mothers not receiving accurate and reliable information about labour and delivery and from the right sources. Therefore Midwives need to inform mothers about labour and delivery to reduce some of these fears. The findings attest that the only source of motivation that appears to have kept these mothers was the faith in God.

The mothers also reported on their expectations in the hospital. The expectations included; meeting God fearing and caring staff, adequate human resource with requisite knowledge, providing privacy during physical examination and receiving a cost-free service. These expectations of the mothers were influenced by the status of the hospital as being a tertiary level hospital. Therefore, this was an attraction to most mothers to seek healthcare delivery from such hospitals. The mothers expected to meet an adequate
human resource with requisite knowledge to render care. Few of the mothers expressed that their expectations were met. The findings were similarly described in prior studies in Italy (Cipolletta & Sperotto, 2012), Australia (Jenkins et al., 2014) and Iran (Rabor et al., 2015) where mothers expected staff to have specialised knowledge to provide quality care without compromising on their privacy. A systematic qualitative review also reported findings consistent with the expectation reported by mothers in this study regarding meeting God fearing staff who would be kind in their care (Downe et al., 2018). Another expectation was related to receiving a cost-free service. However, it was noticed that mothers were asked to pay monies that appeared unofficial and referred to by one respondent as ‘unnecessary cost’. The repercussions of failing to pay this ‘unnecessary cost’ were as much as being denied medications. In Kenya (Abuya et al., 2015) and Nigeria (Okafor et al., 2015), similar research evidences showed that mothers could not pay health bills and suffered further detention in the ward. In a study in rural Ghana, health facility charges were explained to be expensive and so women preferred to deliver at home (Bazzano et al., 2008). Such charges have a potential of reducing health facility births as mothers may not have the financial capacity and would fear to be humiliated as a result of defaulting such payments. Therefore, health professionals should not put undue financial burdens on mothers during childbirth.

Delays in the health facility have been reported in this study showing how postnatal mothers were detained in the ward after a formal discharge by a doctor was made. These delays were related to delays in dispensing drugs covered under the operation of the national health insurance scheme. As a result of this delay, mothers wished they had bought the drugs from a chemist shop outside the hospital. This seemed
that the mothers became unhappy and tired as they had to wait longer before leaving the hospital. This shows that the mothers were eager to get home may be because of the tiresome journey of childbirth, or because of the sleepless nights they might have encountered. The findings appear that mothers found the inherent process of the scheme rather delaying their departure from the ward. Meanwhile, other findings elsewhere show why mothers were detained for long after childbirth and this was because of not paying hospital bills (Abuya et al., 2015; Okafor et al., 2015). The study also adduces the finding regarding delays at the point of folder retrieval during one week postnatal review. Delays at health facilities could result in long queues and protracted waiting time. This likely will produce client fatigue, frustrations and more likely to cause clients to return home without any medical attention. Mechanisms need to be considered to address this concern.

In summary, the postnatal mothers have a social network (spouse, extended family and affinal relations) from which they desired some types of companionship (appraisal, emotional, informational, physical and spiritual). Mothers who did not desire companionship said childbirth was the role of Midwives only or expressed concerns about privacy and possible bridge of confidentiality. Postnatal mothers desired appraisal support to feel control over and empowered for the labour process, emotional support to relief anxiety, informational support to have certainty about labour, physical support to accomplish activities of daily living and spiritual support which appeared strongly as the backbone to a safe and successful childbirth. Other studies have described similar findings.
Unfriendly hospital rules and regulations and lack of space and physical structure were compelling barriers to companionship. Mothers have expressed varied experiences with childbirth in the hospital. However, the experiences basically pertained to clinical care and interaction with healthcare providers. Much as this study noted respectful and dehumanised care, studies elsewhere did not report differently. It was evident that, no matter how the experience of childbirth is, mothers still had faith and believed in the work of God.

The social support conceptual model has desire for labour support, desired source of support and desired type of support as constructs. In these findings, postnatal mothers desired to have labour support, which resulted into desiring particular sources (mostly informal support networks) because they believe such sources could provide the desired type of support. It was evident that having experienced childbirth in the health facility was enough to influence a decision as to desire or not to desire labour support. This was shown from the findings of this study as some postnatal mothers expressed no need for support. It also indicated the various types of labour support desired by postnatal mothers falling in place with the conceptual framework.
CHAPTER SIX

SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of the study, implications of the findings, and limitations of the study, conclusion and recommendations.

6.1 Summary of the Study

Birth companionship is the presence of a desired support person and the provision of desired support to women during labour and delivery in the health facility. Although, the practice occurs in many high income countries, studies on the phenomenon in Africa is inadequate and the practice is absent in Ghana. The social support conceptual model was used as a guiding framework to explore the perceptions of postnatal mothers about companionship during labour.

A literature review yielded quantitative and qualitative studies in the related area. Studies were largely reporting on the effect of receiving companionship or women’s experiences/perceptions/expectations of care during childbirth. It was concluded that very little report is available on the perceptions of birth companionship among postnatal mothers from a tertiary level hospital in the lower and middle income countries.

The study employed a qualitative exploratory descriptive design. Ethics review board of NMIMR-IRB in the University of Ghana gave ethical clearance (appendix A) for this study and a certificate of authorisation (appendix C) from TTH was also obtained. Fourteen mothers were recruited from the labour/postnatal wards. Consent was sought from these mothers before data were collected through face-to-face in-depth interviews using a semi-structured interview guide (appendix F). Interviews were audio-recorded
and transcribed verbatim which transpired concurrently with manual analysis of the data by thematic content approach. Methodological rigour employed Lincoln and Guba’s (1985) criteria. Data collection, transcription and analysis lasted between December, 2017 and March, 2018.

Five major themes with twenty-two sub-themes were derived after thematic content analysis was done. The major themes included; desire for companionship during labour, desired sources of companionship during labour, desired types of companionship during labour, perceived barriers to companionship and experiences of childbirth in a health facility.

The mothers desired to have companionship and from their spouses, extended family or support from affinal relations. Various reasons explained their desired sources; husbands to witness labour pain and have compassion and respect for them and also consider reducing family size and to give encouragement and motivation. The other desired sources in fact were all females who were reported capable of providing the desired companionship. Some mothers expressed no need for support owing to fear of exposing their nudity to their companions, issues with confidentiality and trust or the care was entirely the Midwives’ duty. Other issues were that husbands may collapse on witnessing the childbirth process or be abused and thus were not desired. Appraisal, emotional, informational, physical and spiritual supports were the main types of support desired by the mothers. They desired these companionships to either help reduce the stress or tension in childbirth, to feel cared for and loved or to feel encouraged and self-confident. Also, to know the progress of labour and be supported to acquire or maintain the energy their bodies require for childbirth and other activities of daily living. They
believed a prayer to God was necessary to have a safe and successful childbirth. Despite this desire for companionship during labour, there were institutional and sociocultural factors that stood as barriers to companionship. They included unfriendly hospital rules and regulations, lack of space and physical structure, possible interference with care and taboos as barriers to companionship. These perceived barriers were similar to other findings across the globe. These challenges therefore make the quest for companionship during labour problematic.

Postnatal mothers’ experiences of childbirth in the hospital were tainted with complaints of nice and disdainful encounters. Some of these experiences bothered on privacy, interaction with the healthcare providers, reception and admission, personal hygiene, clinical care and the care environment. The mothers wished to meet caring and respectful Midwives at the hospitals to show concern towards the desires of labouring mothers. However, some of the mothers reported their expectations or desires were either met or not fully accomplished. Such reports of unsatisfactory childbirth experience have been widespread and similar trends are found in other findings.

The clinical environment in which clinical care was rendered to mothers was described as dirty with bad odours emanating from washrooms and rodent control was poor. Inadequate number of beds caused mothers to lie down on floor mattresses thereby making the wards appear congested.

Mothers endured labour pains in differing manners such as twisting of mouths and holding on to objects, some mothers wanted to walk around but were not allowed. This restriction was meant to avoid a situation where the mother would deliver the baby on the floor. The endurance of labour pain is seen common and usual with most mothers and
therefore posing a justification to the little attention given to mothers when complaints of pain are made during labour.

The reports of fear of surviving labour and delivery were described reflecting a situation of life and death. This means that the mothers’ fear of surviving is expressive of the fear of death. This fear is heightened because of the impression conveyed by some of the mothers about the clinical competence and skill of young Midwives rendering care to labouring mothers. It was also noted that certain procedures appeared frightening to the mothers. Therefore, the mothers were worried about the outcome of labour and delivery indicating the unknown nature of it.

The Constructs of the social support framework depict that mothers in a state of stress or challenges (labour/delivery) would desire somebody from her social network (spouse, other members from extended family or from affinal relations) to provide support that would minimise the stress or the challenges that are associated with labour. In this study, the postnatal mothers had already given birth and experienced the demands and challenges of childbirth and therefore were in a position to desire or not to desire companionship during labour and from whom the support should come and what type of support should be given. It means that the companionship that would be provided would happen to be the desired type from the desired source therefore, would be more appreciated and effective than if the support was not the desired type and not from the desired source.

6.2 Implications of the Findings

The findings from this study have implications for nursing practice, policy formulation and future research.
6.2.1 For Nursing Practice

The findings show that Midwives were not absolutely nice in their interactions with the mothers during labour and delivery. Again, privacy was a serious issue raised by mothers as they reported living in shared/opened rooms where a mother could be found absolutely naked. Inadequate beds in the wards left mothers to lie on floor mattresses and in an environment with bad smells and poor rodent control. These are concerns for both the Midwives and management to provide a conducive and serene environment that will address all of these issues. Midwives would need to be tolerant and patient when dealing with mothers during labour. Good communication skills set the pace for a healthy interaction with clients and this must be a major attribute of Midwives. Therefore, there is a need for an immediate intervention to improve the interpersonal attitudes of Midwives so they can render appropriate professional care to mothers. Also, health professionals must ensure information given on labour progress must be right and consistent as it was noted that inconsistent reports raised mothers’ fears and anxiety and this has a potential for mothers to lose the trust and confidence they have about the competence of Midwives.

6.2.2 For Policy Formulation

It was adduced from the findings that mothers desired to have a family member or spouse with them during facility births so that such persons could help them with their desired types of support. It is worth mentioning that probably, it is the status of the tertiary hospital which has influenced the mothers’ decision to patronise the services of the hospital. As a result of that status of the hospital, mothers carry some level of expectations when they come to deliver in the hospital. However, unfriendly hospital
rules and regulations together with lack of proper space become hindrances. There is the need for stakeholders concerned to consider this in policy decisions to make it mandatory for hospitals to allow companionship during labour. May be if that is done, it may now be incumbent upon hospitals to comply thus ensuring the availability of the physical structure and space.

6.2.3 For Future Research

Irrespective of prior experience of childbirth, most of the postnatal mothers expressed desire to have a support person during labour. There is the need for further research among other categories of women (prenatal mothers, first time mothers or mothers with several births) and among women receiving services from other hospitals. Furthermore, the phenomenon could be quantitatively studied to establish relationships between the constructs of the model and between demographic characteristics as well as parity. The views of service providers (Midwives and Management staffs) are imperative to have a broader understanding about the phenomenon for its operationalisation.

6.3 Limitations of the Study

The findings were the views of fourteen purposively sampled postnatal mothers in general who delivered from a particular setting with certain characteristics. Therefore, the transferability of the findings to settings or groups with similar characteristics may be done with caution as it may not be the case always. Some of the interviews were conducted in Dagbani (local language) and transcribed into English language. In the transcription process, some words or statements may have posed a possible threat to maintaining their meaning. However, in such instances, the researcher made efforts to use words closest in meaning to those statements or words. This was cross-checked with the
respondents during member checking. In the case of mothers who had no formal education, their witnesses were involved during the cross-checking of meanings given to the statements as they could understand and speak English.

6.4 Conclusion

Women desire companionship from family members during labour in the hospital. Companionship is desired from specific sources within the social networks of the labouring women. The findings of this study suggest that there is an imminent need for companionship during labour. However, there are some institutional challenges that impede the quest for companionship during labour. For instance, the use of a common delivery room is the main reason why the need for companionship during labour is problematic. As a result, there is a need for stakeholder engagement for the introduction of birth companionship to improve maternal health during labour.

6.5 Recommendations

The findings of this study have recommendations to the Ministry of Health and the Tamale Teaching Hospital.

6.5.1 Ministry of Health

The Ministry of Health should;

- Enact a policy that will allow mothers to have a companion of choice with them during labour and delivery in the hospitals and such a policy should subsequently be passed into law mandating health care facilities to become birth companionship friendly.
BIRTH COMPANIONSHIP

- Allocate enough resources towards improving maternal health care delivery in Ghana.
- Institute programmes and projects to raise awareness of this important component of childbirth.

6.5.2 Tamale Teaching Hospital

The management of TTH should;

- Commit to changing their rules and regulations concerning preventing companions during labour.
- Ensure that there is adequate physical space and privacy in the labour and delivery wards to allow for a companion’s presence and make them comfortable staying with the mothers.
- Ensure that the professional Midwives undergo regular and tailored in-service training and continuous professional development/education to update their knowledge on current best practices and develop avenues of making such best practices operational in the facility.
- Institute client feedback mechanisms that would enable objective comments from clients on various thematic areas of service rendered.
- Provide basic amenities like beds for all departments of the hospital especially the labour and postnatal rooms to cure the discomforts of having mothers lie down on floors.
- Ensure an improved job satisfaction for Nursing and Midwifery professionals working in the hospital.
BIRTH COMPANIONSHIP

- Ensure a serene clinical environment devoid of rodents and bad smell to make mothers feel comfortable during childbirth.
REFERENCES


BIRTH COMPANIONSHIP


BIRTH COMPANIONSHIP


doi:http://dx.doi.org/10.1016/j.ijans.2015.02.001


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BIRTH COMPANIONSHIP


BIRTH COMPANIONSHIP


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BIRTH COMPANIONSHIP


BIRTH COMPANIONSHIP


BIRTH COMPANIONSHIP


BIRTH COMPANIONSHIP


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BIRTH COMPANIONSHIP


APPENDICES

Appendix A: Ethical Clearance

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979
A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD
Post Office Box LG 581
Legon, Accra
Ghana

Ethical Clearance

13th November, 2017

FEDERALWIDE ASSURANCE FWA 00001824
NMIMR-IRB CPN 035/17-18
IRB 00001276
IORG 0000908

On 13th November, 2017, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL: Birth companionship: Perceptions of postnatal mothers in Tamale Teaching Hospital.

PRINCIPAL INVESTIGATOR: Yakubu Nabila Hamidu M.Phil Cand.

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 12th November, 2018. You are to submit annual reports for continuing review.

Signature of Chair:

Mrs. Chris Dadzie
(NMIMR – IRB, Chair)
Appendix B: Introductory Letter

UNIVERSITY OF GHANA
SCHOOL OF NURSING

SONM/F.11
Ref. No:.................................

October 23, 2017

The Chief Executive Officer
Tamale Teaching Hospital
Tamale

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Yakubu Nabila Hamidu, an M’ Phil second year student of the School of Nursing and Midwifery, University of Ghana, Legon. As part of the M’Phil programme, he is conducting a research on “Birth Companionship: Perceptions of Postnatal Mothers in Tamale Teaching Hospital.” Your outfit has been chosen as his data collection outlet.

I would be grateful if you could kindly offer him the necessary assistance needed to enable him collect data for his thesis.

Thank you.

Yours faithfully,

Dr. Florence Naab
SUPERVISOR
Appendix C: Certificate of Authorisation

Department of Research & Development
Tamale Teaching Hospital

THURSDAY, JANUARY 19, 2017

TO WHOM IT MAY CONCERN

CERTIFICATE OF AUTHORIZATION TO CONDUCT RESEARCH IN TAMALE TEACHING HOSPITAL

I hereby introduce to you Mr. Yakubu Nabilu Hamidu, an MPhil second year student at the School of Nursing and Midwifery, University of Ghana, Legon. He has been duly authorised to conduct a study on "Birth Companionship: Perceptions of Postnatal Mothers in Tamale Teaching Hospital".

Please accord him the necessary assistance to enable him complete his study. If in doubt, kindly contact the Research Unit on the second floor of the administration block or on Telephone 0209261020. In addition, kindly report any misconduct of the Researcher to the Research Unit for necessary action.

Please note that this approval is given for a period of six months, beginning from 14th of December, 2017 to 31st of May, 2018.

Thank You.

ALHASSAN MOHAMMED SHAMUDEEN
(HEAD, RESEARCH & DEVELOPMENT)

Please accept and give this letter necessary attention.

Zamorde
2-2-17
Appendix D: Consent Information

CONSENT FORM

Title: Birth companionship: Perceptions of postnatal mothers in Tamale Teaching Hospital.
Principal Investigator: Yakubu Nabila Hamidu
Address: University of Ghana, School of Nursing and Midwifery P.O. Box LG 43 Legon
Mobile number: 0242665329/0506302660

General Information about Research

This research is conducted to help the researcher understand what you think about having your relative or family member or friend present with you inside the labour and delivery room during the time of your labour and delivery in the hospital. If your delivery was normal or you went into labour and finally were operated on, then you are qualified to take part in this study. You will be invited for an interview which will be audio taped with your permission. The interview will be conducted after seven days of delivery, at your home and at a time convenient to you and without the presence of unapproved persons. The researcher will take your phone number and home address with your permission so that two days to the day of interview, you will be contacted on phone and reminded and to agree on a convenient time for the interview. The interview is expected to last between 30 to 45 minutes and will be conducted in English or Dagbani depending on which one you are comfortable speaking. The researcher will report to you the interpretations given to the information you will provide in the interviews so that you will confirm whether those interpretations reflect what you imply. You will be requested to sign a consent form before the interview starts. If you have any questions regarding what have been said, please you are free to ask.

Possible Risks and Discomforts

There is no known risk and discomfort associated with this study. However, you are not obliged to answer any question you are uncomfortable with.
Possible Benefits
You may not benefit directly from the study. However, the information you will provide will help in developing policies aimed at considering the inclusion of a relative or friend during labour and delivery in some hospitals.

Confidentiality
Information about you will be protected to the best of the researcher’s ability. You will not be named in any reports and only the researcher and supervisor will have access to the research records and sometimes look at your records. Identification codes will be used in place of your name so that the information about you cannot be easily traced to you. The information will be secured in files under lock and key in the investigator’s office and on password protected on the investigator’s personal computer for five years before they are destroyed.

Compensation
You will be given a can of malt drink and biscuit for your time at the end of the interview.

Voluntary Participation and Right to Leave the Research
Your participation in this research is voluntary and you can withdraw at any time or refuse to answer the questions without penalty.

Contacts for Additional Information
If you as a research participant seek answers to pertinent questions about the research, you can please contact the researcher or supervisor through the following numbers.

Name of researcher: Yakubu Nabila Hamidu
Mobile contact: 0242665329/0506302660

Name of supervisor: Florence Naab (PHD)
Mobile contact: 0204522332/0263741717.
Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh
Appendix E: Volunteer Agreement

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (Birth companionship: perceptions of postnatal mothers in Tamale Teaching Hospital) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date

Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:
I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date

Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date

Name Signature of Person Who Obtained Consent
Appendix F: Semi-Structured Interview Guide

SEMI-STRUCTURED INTERVIEW GUIDE

You are invited to participate in a study to explore and describe the perceptions of postnatal mothers about participation of a relative, or friend of choice during labour and delivery. This will enable the researcher understand what you think about the presence of a relative or friend, your desired source of support and the type of support you desire during labour and delivery in the hospital. The interview will be audio recorded with your permission and the session is expected to last between thirty (30) and forty-five (45) minutes.

Thank you.

ID NUMBER

SECTION A: DEMOGRAPHIC INFORMATION

Please tell me about yourself?

Age..........................
Ethnicity..........................
Nationality.......................
Marital Status:Single [ ] Married [ ] Divorced [ ] Widowed [ ] Cohabiting [ ]

Educational level:

No formal education [ ]
Basic Education (primary/JHS) [ ]
Senior High School [ ]
Tertiary education [ ]

Employment status:

Unemployed [ ] Self-employed [ ]
Private employee [ ] Government employee [ ] Student [ ]

Religious affiliation: Islamic [ ] Christianity [ ] Traditional [ ]

Number of pregnancies.............
SECTION B: GUIDING QUESTIONS

Womens' experiences of childbirth in the hospital

1. Please share the experiences of care received from the time you arrived till delivery in the hospital?

2. What were the expectations you had about your care in the ward?
3. Why do you think these expectations you had about your care were given or not given in the hospital?
4. What do you think can be done to improve your care during labour and delivery in the hospital?

Womens' desire for involvement of a birth companion during childbirth

5. What would you say about having a relative or friend at your side during childbirth?
6. What stage of childbirth would you want a relative or friend with you and why?

Womens' preferred sources of lay companion during childbirth

7. Who do you prefer to be with you during childbirth in the hospital and why?
8. Why have you not had that person with you during childbirth in the hospital?
   Probe:
   Cultural factors
   Personal factors
   Religious factors
   Institutional factors

Womens' desired type of social support (companionship) during childbirth

9. What help do you need during childbirth?
10. How do you want your relative or friend to help you during childbirth?
11. Why do you prefer this type of support from the relative or friend?
12. Please is there anything else you will like to say?

THANK YOU
Appendix G: Thematic Code and Description

Table 4.4

Description of thematic codes

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<th>Code</th>
<th>Description</th>
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