SOCIAL SUPPORT AND LIVED EXPERIENCES OF PRIMIPAROUS WOMEN IN ASIKUMA ODOBEN BRAKWA DISTRICT

BY

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JULY, 2018
DECLARATION

I, Eunice Ayimbono Ayimbila, hereby declare that apart from references cited in this work, which have been duly acknowledged, this dissertation is the result of my own research work carried out in the School of Public Health, University of Ghana, Legon, under the supervision of Dr. Kwabena Opoku-Mensah. In furtherance, I declare that this work has not been presented in part or in full for a degree or certificate in any higher institution. Finally, I declare that all errors of misrepresentation and misinterpretation of data are solely mine.

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(SUPERVISOR)

DATE
DEDICATION

This study is dedicated to the entire Ayimbila family as well as Simon K. Agbodeka (SP) for their steadfast love and support. They have made my world very engrossing.
ACKNOWLEDGEMENT

First of all, I thank Almighty God for seeing me through this program, but for his grace and mercies where would I be? I also thank my mother and all other family members for their love, understanding and support. My heartfelt appreciation also goes to Simon K. Agbodeka (SP) for all the fatherly guidance and his unflinching support. Oh daddy, what could I have done without you?

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ABSTRACT

Background: Motherhood is cherished and defines the identity of a woman in most African societies. However, new mothers have to adjust physically, socially, psychologically and even spiritually in their transition. Social support has been identified in a number of studies to help first-time mothers adjust in picking up their new maternal responsibilities. The main aim of this study was to explore first-time mothers’ lived experiences and their prenatal and postnatal support systems.

Methodology: Twenty participants were purposively selected. Sixteen first-time mothers and four social support providers from three communities in Asikuma Odoben Brakwa District participated. Data were collected using in-depth interviews with the aid of a semi-structured interview guide over a period of three weeks. Interviews were transcribed verbatim and analysed using thematic analysis.

Results: Results from the data showed that, most unmarried mothers had unintended pregnancies. Mothers reported a lot of physical and psycho-social distress during pregnancy and after childbirth. Different kinds of social support were received by mothers: physical, informational, emotional and spiritual. Most of the young and unmarried mothers had less social support compared to the older and married mothers. Maternal mothers of primiparous women provided the most support. For most of the mothers, social support weakened with time.

Conclusion: This study shows that childbirth is a defining point in women’s lives and it is coupled with physical, emotional and other live changing challenges. Social support served many purposes for the sample of first-time mothers as it helped them to recuperate from their birthing experience, gained maternal childcare self-efficacy and also gave them hope for the future. It is recommended that a state sponsored social security scheme be designed by the government for first-time mothers who have no or limited social support networks.
# TABLE OF CONTENTS

DECLARATION ...........................................................................................................................................i
DEDICATION ...............................................................................................................................................ii
ACKNOWLEDGEMENT .......................................................................................................................... iii
ABSTRACT..................................................................................................................................................iv
LIST OF TABLE ........................................................................................................................................viii
LIST OF FIGURES .................................................................................................................................... ix
LIST OF ABBREVIATIONS .....................................................................................................................x

CHAPTER ONE .........................................................................................................................................1
1.0 INTRODUCTION ....................................................................................................................................1

1.1 Background of the Study ...................................................................................................................1
1.2 Problem Statement ............................................................................................................................2
1.3 The Research Questions ....................................................................................................................3
1.4 The Research Objectives ..................................................................................................................4
1.4 Rationale for the Study .......................................................................................................................4
1.6 Organization of the study ..................................................................................................................5
1.7 Operational Definitions of Key Terms ............................................................................................5
1.8 Theoretical Framework .....................................................................................................................6

CHAPTER TWO .........................................................................................................................................9
2.0 LITERATURE REVIEW ....................................................................................................................9

2.1 Introduction .......................................................................................................................................9
2.2 Pregnancy Experience .......................................................................................................................9
2.3 Childbirth Experience .......................................................................................................................12
2.4 Postpartum Experience ...................................................................................................................13
2.5 Social Support ..................................................................................................................................15
2.5.1 Types of Social Support ..............................................................................................................16
2.5.2 Sources of Support for Primiparous Women ............................................................................18
2.4.3 Factors Influencing Provision of Social Support .................................................................22
LIST OF TABLE

Table 3.1 District Health Facilities ................................................................. 28

Figure 3.1 Map of Asikuma-Odoben-Brakwa District ...................................... 28

Table 4.1 Characteristics of Primiparous Women ............................................. 38

Table 4.2 Characteristics of Support Providers .................................................. 38
LIST OF FIGURES

Figure 1.1: Theoretical Framework of Social Support for Primiparous Women ....................... 8

Figure 3:1 Map of Asikuma-Odoben-Brakwa District ............................................................. 28

Figure 3.2: Steps in Data Analysis ........................................................................................... 34
## LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOB</td>
<td>Asikuma Odoben Brakwa</td>
</tr>
<tr>
<td>CHPS</td>
<td>Community-based Health and Planning Services</td>
</tr>
<tr>
<td>GDHS</td>
<td>Ghana Demographic and Health Survey</td>
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<td>GHS-ERC</td>
<td>Ghana Health Service Ethical Review Committee</td>
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<td>GSS</td>
<td>Ghana Statistical Service</td>
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<td>IDI</td>
<td>In-depth Interview</td>
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<td>OLG</td>
<td>Our Lady of Grace</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

Global concern about motherhood stems from its implication for maternal and child health (Koniak-Griffin et. al., 2000). For many women in developing countries, pregnancy, delivery and postpartum period are all known to be precarious to their well-being and survival of their children. This is evident in the high maternal and childhood mortality rates recorded in many developing countries. Out of three health-related Millennium Development Goals (MDGs), two are concerned with the health of mother and child (GSS, 2016).

Despite the health risks associated with pregnancy and childbearing, becoming a mother is the norm and a fundamental role for women in many societies (Amanbey et al., 2017). In sub-Saharan Africa societies where motherhood permeates family and social life, there may even be adverse social consequences for not bearing a child; consequences that may outweigh any medical or health risks (Bledsoe and Cohen, 1993; Yeboah, 1998).

A number of Studies have shown that the birth of the first child comes with physical, social, emotional, and psychological stress as well as new responsibilities to which the new mother has to adjust (Deave et al., 2008; Leahy-warren, 2005). For example, in a study of first-time mothers’ experience of motherhood, McVeigh (1997) reported that the women in his study indicated being overwhelmed with infant care, fatigue, the feeling of being unprepared and lack of personal time. Available evidence suggest that women are also at risk of experiencing depression, stress and other mental health challenges during their pregnancy and after childbirth (Oates et al., 2004; Sawyer, Ayers, & Smith, 2010).
Social support has been identified in a number of studies to be important for first-time mothers in adjusting to their new maternal roles (Sawyer et al., 2013). As noted by Darvil et al. (2010), transition to motherhood is a period of anxiety and unfamiliar experiences especially among new mothers that require social support to help them ‘normalize’ and cope with their experiences. Social support has been demonstrated to serve as a buffer against the stress of motherhood in a variety of studies (Hodnett et al., 2011).

Social support impact on the adjustment of first-time mothers has been documented in a number of studies such as those cited above but in Ghana there exists gaps in our knowledge on the experiences of first-time mothers and their access to social support. This study attempts to close this gap by exploring the issues of lived pregnancy experiences of first-time mothers and access to social support in the Ghanaian context. On the other hand, lack of support or the inadequacy of support provided for mothers during pregnancy and after delivery has been associated with postpartum depression, lack of confidence and fatigue among first time mothers (Ong et al., 2014).

1.2 Problem Statement

Different cultural norms shape ideas about pregnancy, birth and child care practices. Traditionally, women who become mothers are highly regarded, whilst infertile women are stigmatized. Although the rate of childbearing in Ghana has been declining since the 1980s, women still have, on average, about four children per woman (GSS, 2017).

In traditional Ghanaian societies, pregnancy and childbirth are recognized to carry a certain degree of health risks for the mother and child. For that matter, there were specific social support protocols to help reduce maternal stress during pregnancy and ensure successful birth outcomes. In some places the pregnant woman would be at her natal home or visit her natal home at some stage of her pregnancy, and receive all kinds of support such as provision of
nutritious food, traditional herbal medication, relief from the demands of certain types of work and advice from her mother, members of the extended family, friends and significant others. This is particularly common among the Fanti whom this study was conducted (Yeboah, 1998). However, this traditional social support system in Ghana that has supported mothers has been weakening due to the forces of modernization, westernization and migration (Yeboah, 2012). It is therefore not clear who and what types of support are provided to new mothers.

It is evident in context of several studies that have been documented, that those mothers who do not receive support or receive inadequate support during pregnancy and after birth may suffer from depression, anxiety, poor emotional attachment to children, low birth-weight, pregnancy complications and chronic health conditions (Brian 2002; Elsenbruch et al., 2007; Ong et al., 2014).

In Ghana, previous studies on maternal adaptation among first-time mothers have been restricted to teenage mothers (Gysewa and Ankomah, 2013) and mothers in general without emphasis on access to social support (Philippa et al., 2017). This study therefore attempts to contribute to the literature on maternal adaption in Ghana by focusing on the social support structure of first-time mothers and how it impacts on their adjustment to their pregnancy experiences and new maternal responsibilities in Asikuma Odoben Brakwa District.

1.3 The Research Questions

Based on the problem statement, the following research questions were asked:

1. What are the experiences of primiparas during pregnancy and childbirth?

2. Do primiparous mothers have access to social support and, if so, what kinds of support are provided and who are the providers of the support?

3. What challenges do social support providers face in providing support to primiparous women?
1.4 The Research Objectives

The general objective of the study is to investigate social support and lived experiences of primiparous women in Asikuma Odoben Brakwa District

Specifically, the study sought to

1. Investigate first-time mothers’ lived experiences during pregnancy, delivery and postpartum;
2. Identify the mothers’ access to social support regarding who provides support and the kinds and adequacy of support provided.
3. Determine the challenges that social support providers face in providing support to primiparous women

1.4 Rationale for the Study

The study of the experiences of first time mothers during pregnancy, delivery and in postpartum has considerable relevance.

The focus of the study on the reproductive experience of mothers at first birth is significant in the context of maternal and child health objectives in Ghana. Like other developing countries Ghana has been implementing maternal and child health programmes aimed at improving the health of mothers and children. A major problem faced by the government and stakeholders is inadequate resources to achieve maximum impact. Documenting social support and the pregnancy experiences of mothers help in the identification of vulnerable first-time mothers most in need of assistance as well as in designing social support interventions to complement other maternal and child health interventions. Researchers interested in the role of social support in health outcomes have drawn attention to the need for paying attention to the cultural
variations in social support. This study contributes to this perspective by looking at social support as embedded in the Central Region of Ghana.

1.6 Organization of the study

The study is presented in five chapters. Chapter one comprises the background to the study, statement of the problem, objectives of the research, rationale for the study and limitations of the study. Chapter two describes the research method use in data collection and includes selection of study site, sampling procedure, and research instrument. Chapter three provides a review of the literature relevant to the objectives of the study. Chapter four consists of data analysis and findings, while chapter five discusses the key findings, provides conclusion and recommendations.

1.7 Operational Definitions of Key Terms

The study uses some key terms to operationalize some variables and they have been explained below.

**Community**: the mediating structures, or face-to-face primary groups to which individuals belong. In this study, it includes the family, personal friends, neighbours, peers groups and organisations

**Primiparous women**: refers to women who have become mothers for the first time with their first-born child

**Social Support**: Social support is conceptualized to be the provision of instrumental (tangible), informational, emotional, and spiritual support by significant others including the family, friends, church members and co-workers during pregnancy and after birth. *Instrumental support* involves direct help or services such as cash, gifts, child care, helping with domestic work, cooking etc. *Informational support* include giving advice to help solve a problem, and
providing feedback as to how a person is doing. Emotional support include intimacy, attachment, and reassurance.

1.8 Theoretical Framework

Social Ecological Model of Social Support as an Environmental Resource

The theoretical framework for the study is informed by the social ecological model of social support as an environmental resource developed by Bronfenbrenner (1997). The model states that human behaviour is affected by several environmental factors and at multiple levels, namely, micro-system, meso-system, exo-system and macro-system levels. The micro-system level refers to the face-to-face influences in a particular setting that the individual interacts. It could be the individual immediate family, work group or other members of other social networks. The meso-system level refers to the interrelation among the various settings in the micro-system in which the individual is involved. The exo-system refers to the forces within the larger system that the individual is embedded while the macrosystem refers to the cultural beliefs and values that influence all other levels.

Figure 1.1 provides a theoretical framework of social support for the study. In line with the above social ecological model, the study considers four levels the influence first-time mothers’ access to social support: the individual level (micro-system level), the interpersonal level (meso-system level), organizational level (exo-system) and community levels (meco-system level).

The intrapersonal level refers to the individual first-time mother’s own demographic, social, and psychological characteristics that may influence her access to social support. The interpersonal level extends to her social networks of family, friends, co-workers, and peer groups as sources of social support. At the organisational level, the mothers may receive support from health workers at the health facility, whilst a mother’s community’s culture,
norms and beliefs about process of childbirth and motherhood may influence the kind and adequacy of support provided.

The study postulates that the experiences and support structure of the primiparous women can be affected by individual factors, family and social network structure, organizational factors and community factors from the health facility. At the individual level, factors such as mother’s age, marital status, economic status, education may influence her access to social support that can affect her prenatal and postnatal experience. For example, young and unmarried mothers may receive less support compared to older and married women. The mother’s social network of family, friends, and significant others may influence her access to social support and lived experiences of her pregnancy. At the organizational level, support received from health workers at antenatal and postnatal clinics may determine the pregnancy outcome of a mother. Family support, financial status can influence the experience of mothers positively or negatively. At the community level, the wider socio-cultural context of values and belief systems regarding social support for first-time mothers may influence overall assistance provided during pregnancy and after birth.

Two hypothesis have been suggested to explain how social support works to affect health outcomes such as maternal and child health. The first hypothesis postulates that social support influences health outcomes through acting as a buffer to stress that enable individuals to re-adjust their usual behaviour in response to challenging demands such as the birth of the first child (Cohen & Hills, 1985). The second hypothesis explains that social support is an existential human need and directly affects health outcomes. In this sense, the absence of social support can produce stress (O’Reilly, 1988). Both theoretical perspectives are considered in this study.
Figure 1.1: Theoretical Framework of Social Support for Primiparous Women

Source: Adapted from Bronfenbrenner (1997) and McVeigh (1995)
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This section reviews literature in relation to the topic under study. Several studies have been conducted on first time mothers and social support in the West and a few others in Africa. The review will look at the experiences of first time mothers during pregnancy and childbirth, the definition of social support as explored by researchers, the types or kinds of social support and also the sources or providers of social support; from a global perspective to national.

2.2 Pregnancy Experience

The intention of pregnancy differs from mother to mother. While some mothers prepare and plan towards it, to some mothers, it comes as a surprise. In either case, there is an influence on health outcome for both mother and child. Barton, Redshaw, Quigley, and Carson (2017) indicated that planned pregnancy means it is timed and wanted and the woman is emotionally prepared for it and this result in happiness in the mother. However, there were mixed feelings in an unplanned pregnancy. The feelings are categorized into “unplanned, happy”, “unplanned, ambivalent”, and “unplanned, unhappy”. “Unplanned, happy” meant that “the pregnancy was a surprise and recalled being happy/very happy upon discovery of pregnancy; “unplanned, ambivalent” stated that the pregnancy was unplanned and they “were not bothered either way” and “unplanned, unhappy” stated that the pregnancy was a surprise and recalled being unhappy/very unhappy upon discovery of pregnancy.

Unplanned pregnancy is common globally. A global approximate of 85 million births out of 213 million births (53 per 1,000 women aged 15-44) resulted from unplanned pregnancy in 2012, (Sedgh, Singh & Hussain, 2016). Sedgh et al. (2016) indicated that the unintended pregnancies are low in traditional societies because of large family size. In a US National
Survey of Family Growth found that in 2006–2010, approximately 23% of pregnancies occurring in marriage were unplanned, and approximately 51% of those occurring amongst cohabiting mothers (Mosher, Jones & Abma, 2012). Similarly, the third National Survey of Sexual Attitudes and Lifestyles in Great Britain found that approximately 5% and 18% of married and cohabiting mothers respectively, described their pregnancy as unplanned, and a further 19% of married mothers and 34% of cohabiting mothers stated that they felt “ambivalent” about their pregnancy (Wellings et al., 2013). In developed countries, for example, United Kingdom the rate for teen mothers is substantially low, unplanned pregnancies occurs among women aged between 20 – 30 years old. Here, the definition of pregnancy as intended is solely an individual experience where in most developing countries such as Africa, the status of the pregnancy is influenced by extended family members and that of societal norms.

Unlike the developed world where teen pregnancy is low, Darroch, Woog, Bankole & Ashford (2016) reported that nearly 49 percent of 21 million pregnancies among adolescents were unintended (45 percent in Africa) and some factors associated with the high rate were contextual: individual, interpersonal, community and societal level factors. These high rates therefore call for interventions to increase contraception uptake as low contraception uptake among adolescents was a contributing factor.

At the population level in Ghana, GDHS (2014) reported that 69 percent of all births in the five years preceding the survey were planned, 24 percent were mistimed, and 7 percent were unwanted and the proportion of planned births is lowest for the youngest mothers under age 20 (42 percent). In a study by Eliason, Baiden, Yankey & Awusabo-Asare (2014) in Mfanteman Municipality of the Central region among pregnant women reported that, 70 percent of the 1943 pregnancies were unintended and it was prevalent among multiparous women.
Barton et al. (2017) also reported that, a greater proportion of first-time partnered mothers (married/co-habiting), though unplanned were happy about their pregnancies. They indicated that, postpartum depression was seen in unplanned unhappy mothers and they were 1.5 times more likely to develop postpartum depression than others. Postpartum depression and unplanned happy pregnancy was not statistically significant. This finding also supports the work of (Nunes, Brito, Alves, & Ludermir, 2015) in Brazil, which reported women who had unintended pregnancies were (1.74) more likely to have symptoms of postpartum depression compared to women with intended pregnancies and developing countries having high (29.5%) prevalence of it.

Pregnancy intent is regarded to attract different levels of support experience’. Barton et al. (2017) indicated that those mothers whose pregnancies were planned and they felt happy reported having received greater support family support during the pregnancy and postpartum compared to unplanned ambivalent and unhappy. This support brought about healthy outcome (lower depression) among women with planned pregnancies than unplanned pregnancies. Brito et al. (2015) further reported that such women received little to moderate social support.

Zasloff, Schytt and Waldenström (2007) study among first time mothers in Sweden indicated that the experience of a first-time mother during pregnancy varied with age. They indicated that young women aged 15-20 years, were more worried and had a depressive mood in upcoming birth compared with older women aged 26-29 years. The negative feeling arose from unemployment and lack of support and the remembered being more afraid and experiencing more pain and lack of control during delivery. They also indicated that majority of the youngest mother had normal vaginal birth compared with oldest mothers aged 35 years and above. So, while youngest mothers were concern about psychosocial problems, oldest mothers were
disadvantaged biologically. This experience is universal across cultures but individually different.

Letting out the secret that one is pregnant in the early stage can bring about joy and loneliness for the mother (Modh, Lundgren & Bergbom, 2011). The women in this study expressed a sense of security with their partners, families and the wider community as a whole. Some women noted that once the pregnancy was known, they received support and understanding especially from work. What about support from the family and partners? Being the only one that can give the family a grandchild hence giving the family a sense of power called for support from the family. For these mothers, they had positive experiences as opposed to those whose parents expressed lack of interest in their pregnancies as they received less support. Obedience to parents was also a factor that contributed to full support from parents. Mothers’ socials network and her relationship with the networks influence her experience as bad connectedness of mothers across generations makes them experience intense feelings.

2.3 Childbirth Experience

Giving birth or delivery of a baby is one of the most important events in the life of a woman and the experience is solely individual. Among first time mothers, the experience will impact on how the mother will develop a positive or negative feeling for the baby and even adjust into motherhood (Nilsson, Thorsell, Wahn, & Ekström, 2013)

Nilsson et al. (2013) indicated in their study that, first time mothers’ experiences of giving birth were categorized into whether the women “trusted their bodies and endure the pain, the interaction between the body and the mind in giving birth and the consistency of support. They indicated that mother’s body strength was affected by order to go into themselves, knowing that nothing else matters and that they allow the body to work all by itself and mothers had a positive trust of their bodies which gave them sense of power and endurance.”
Mothers in the study indicated that delivery was accompanied by a newly painful experience that they had not been through it before, it was however a satisfactory experience because of the support they have from professionals and family. This support was dependent on the environment in the maternity ward: peaceful, tolerant and even the personal chemistry between the mother and the midwives. The mothers also expressed impatience especially when there was delay in the vaginal rupture stitched.

In sub-Saharan Africa, (Sawyer et al., 2011) in their study of women in The Gambia reported that the women expressed worries about complications during pregnancy and childbirth and they also experienced severe pain which they endured as they believed that it was part of the normal of birthing process. Some ailments accompanied pregnancy and childbirth such as loss of appetite for certain foods, vomiting, tiredness etc. In this study, some of the women used their faith in helping them cope with the pain they faced.

In a rural Ghana, delivering mothers indicated that some midwives were harsh, impatient, unhelpful and even shouted at them and this made them prefer delivery at home than in the health facility (Crissman et al., 2013)

### 2.4 Postpartum Experience

Postpartum is a period that first time mothers adjust to after giving birth. During this period, some women express a sense of isolation and hardship as they have to do things by themselves. Some women also express a feeling of frustration and boredom. Some mothers developed depression after childbirth and so resort to drinking especially where there was no support (Jonge, 2001).

A qualitative study of primiparas in Singapore indicated that there is mixed emotional feeling of happiness and stress during this period. It is a period of upheaval of emotion expressed in
both sadness and happiness. During this period, mothers express the need for postpartum support from the health centres and families to be able to cope with the activities. Some women view postpartum classes as good and that they share experiences and also get information from their colleagues (Saligheh, McNamara, & Rooney, 2016)

During postpartum, the feeling of concern for the wellbeing of the baby is highest. Women turn to think more about the baby and the desire to be in-charge of the baby. While some women will forgo every other thing they engaged in before childbirth in order to care for the baby, some others like to still engage in these activities such as physical exercise. It can also occur that some others will not have the baby as a central focus.

Again, mothers in Singapore also expressed concern and anxiety towards child care activities such as breastfeeding, bathing the child etc. and they regard it as a “demanding task” hence posing a lot of challenges to them (Ong et al., 2014). This indicates that postpartum period is a hard period especially for primiparas and they need support. The women in the study however expressed having received maximum support from families especially grandmothers of children to help them cope with the stress of caring for child.

Hung (2007), in his study of primiparas and multiparas in Southern Taiwan showed that these two group of women have different psychosocial stressors. While primiparas experienced high postpartum stress and were concerned with negative changes in their bodies, picking up maternity roles, and also gaining support from families and friends, multiparas were not (Shorey et al., 2015).

Among African American unmarried first time mothers, Cosey and Bechtel (2001) reported a positive relationship between social support and maternal parental self-efficacy level as mothers who have strong support from family tended to have high level of maternal parental
self-efficacy. Where there is availability of support for mothers, it helps them develop good behaviours towards their children hence promoting a healthy outcome for themselves and their children.

In Ghana, aside childcare, these mothers are both mothers and daughters and they have to combine these roles together. Mothers’ inability to combine and balance these roles could lead to stress, and when the mothers get stressed up, depression can set in. One negative effect of this is the inability of the mother to breastfeed the child well (Scorza, Owusu-agyei, Asampong & Wainberg, 2015). A study conducted by Aidam, Pérez-Escamilla and Lartey (2005) in Ghana also reported a link between social support and breastfeeding and that support provided during prenatal services was high compared to that of postnatal support for breastfeeding. At the point where breastfeeding was practiced, the support was rather low and this could affect the health of the child. These studies were done in the urban setting where most nuclear family system is predominant and the pressure to work and earn a living is high. The family is barely home to support the mother in these activities. It is therefore necessary to understand the situation in the rural setting, which is a reason why this study is been conducted.

2.5. Social Support

The definition of social support has not been consistent in literature though it is present everywhere. It has been researched by many people but there has not been a consensus on its definition. Social support can also be seen as a first-time mother’s expectation, thoughtfulness and dependence on health workers, families and the community at large after their discharge from health care facilities” (Masala-Chokwe & Ramukumba, 2017). McVeigh (1995, p. 41) also refers to social support as what is “done to or for an individual believed to be in need of support, and also the extent to which the individual is connected or attached to the social network”. Where social network is the web of social relationship that surround individuals. The
linkages between people that may or may not provide social support and that may serve functions other than providing support.

2.5.1 Types of Social Support

Social support has also been defined to include a combination of both structural and functional support. Where, structural support consists of the various social networks or sources that provide the support and it can further be categorized as coming from formal sources (professional or paraprofessional) or informal (the family and other significant people from the community), functional support comprises of the various supports given which include four elements appraisal, information, instrumental and emotional (House 1981; House & Khan, 1985; Leahy-Warren, 2005, Leahy-Warren et al., 2011).

Information support is the advice, suggestions and information received by new mothers that can be used to address a problem. Information support may include information on baby sleeping, weaning, infant care practices etc. Loudon, Buchanan and Ruthven (2016) in their study of ‘the Everyday life information seeking among First Time Mothers in United Kingdom’, indicated that new mothers needed information about so many things and that they sought for information from different sources. They indicated that the mothers in most cases sought information from their peers and families and it was valued the most. Mothers also sought for information from, health visitors, websites, books and social media. Seeking of information support from health professional depended on the relationship between them.

Leahy (2005), in her study of 99 Ireland first time mothers also found that diverse supports were received from diverse sources. She reported in her studies that, mothers received informational support mostly from professional and public health nurses and that of the midwives. Lesser informational support from midwives due to the shorter length of time mothers stay at the facility after delivery. However, they provided more instrumental support
to mothers compared to the public health nurses. And since these mothers tend to stay longer with families, maternal mothers also played a critical role in providing informational support for the mothers.

Instrumental support involves providing tangible aid and services that directly help the mother who is in need. They may include bathing the child, wearing of pampers, washing, cooking, immunization services, etc.

Delivery and postpartum period is critical to the well-being and survival of mothers and their children. In view of this, all societies realize this period is crucial and has diverse threats to the health of children and so first-time mothers especially are expected to internalise sociocultural accepted practices related to pregnancy, childbirth and child care. Childbirth is a key life experience and a rite of passage that women keep in memory for so many years. Having a high satisfaction with care/support received can contribute to the self-confidence and self-esteem of women.

By this need, the Safe Motherhood Programme initiated in Ghana since 1995 has helped improved maternal morbidity and mortality through antenatal and postpartum care services and it even recommends that women receive a check-up of their health status within 2 days after delivery and there should be a follow up on the mother in a form of home visit 3 days, 7 days and 6 weeks after delivery. In response to the increasing number of postpartum deaths and complications, WHO (2013) recommended the timing, contact and content of postpartum care for postpartum mothers especially in low-resources areas.

Many factors affect the level of support that first time mothers received such as the age of the woman, the family structure, socio-economic status of the family, marital status, cultural beliefs and practices, perceived criticism by mothers, state of pregnancy (Gao, Chan & Mao,
Maternal support during pregnancy to post-delivery from health facilities are affected to a large extent whether the person is insured or not. In Ghana, the national health insurance card renders all antenatal and postnatal services for free. However, a new mother who is not insured will have to pay for all the services during pregnancy, delivery and postpartum. The extent to which she can benefit from the support depends on her income level of the woman and the family to insure her under the health insurance scheme (Browne et al., 2016).

2.5.2. Sources of Support for Primiparous Women

First time mothers are expected to look for help in their adjustment in picking up maternal roles. As a result of these roles, they may become tired or fatigued and may seek for help from health professionals, family friends and other people in the community. A lot of literature has indicated that primiparous women receive support from various sources including their husbands, fathers of children, grandparents of children, healthcare providers, friends and from the other significant people (Leahy, 2005; Corrigan et al., 2015; Nath et al., 1991). For the purpose of this study, the sources of support are categorized into two: community source and health facility support.

The term “community” has been defined in different ways and used in various contexts including the psychological sense it (Newbrough, 1986), a political entity (Long, 1986), a functional spatial unit meeting sustenance needs (Cox, 1979), a unit of patterned social integration, or an aggregate of individuals in the geographical location (Hunter, 1947). For the purpose of this work, it adapts the definition of community by McLeroy, Kenneth, Bibeau, Seckler & Glanz (1988, p.363), which refers to “mediating structures, or face-to-face primary groups to which individuals belong. This view of community embraces families, personal
friendship networks and neighbourhood. Secondly, community is also thought of as the relationships among organizations and groups within defined areas, such as local voluntary agencies, local governmental health providers, local schools etc”.

However, for the purpose of this study, the first definition of community which includes families, personal friendship networks and neighbourhood will be used to refer to community source of support while the second definition will be used here to refer to support received from the health facility only.

Community Support

Literature has shown that first time mothers receive support from their communities and for some studies, community source was the primary source of support for new mothers. Literature identified that mothers have received emotional, physical and informational support from their community. In this study, community is defined widely to include, mother’s family (nuclear and extended), friends, associations or organizations such as religious bodies

A study done by Leahy-Warren, Mccarthy & Corcoran (2012, pg 6) in Ireland indicated that “there was a statistically significant inverse relationship between informal structural social support and postnatal depression”. The study also showed that the informal structural support received were mostly from families and friends rather than formal structural support which included the health professional because of the limited time that mothers spend in the hospital after delivery

Husbands and maternal mothers were identified to have provided the highest instrumental, appraisal and emotional support to mothers. Leahy-Warren (2005) study revealed a positive and statistically significant relationship between appraisal and informational support to confidence of the mother in infant care practices
Freund (2007) also indicated that the child’s father offered great emotional support to the mother. Even in instances where unmarried mothers feared that their boyfriends would not help, they were there to provide support for them during postpartum. These people provided resources and helped them care for the children in many ways: bathing the child, helping to calm the child when he/she cried, helping with their house chores et cetera (Masala-Chokwe & Ramukumba, 2017; Aubel & Alvarez, 2011; Hans, 2013; Hock, Gnezda, Mcbride, Journal & May, 2017; Kuo, Chuang & Lee, 2012; Morikawa, Okada, Ando, Aleksic & Kunimoto, 2015; Naanyu, 2017; Quaye, 2011)

**Healthcare Providers**

Ensuring healthy mother and child is a public health concern globally. International bodies such as the World Health Organisation, developed strategies to improve the health of the mother and child. One of these strategies was the United Nation Millennium Development Goal 4 and 5 which sought to reduce maternal mortality by three-quarters between 1990 and 2015. Efforts have been made by Ghana through free antenatal and postnatal care services, the Community-Based Health and Planning Services initiative are examples. Data from the GDHS (2014) indicates a high prevalence of antenatal and postnatal visit by women. This is indicative of national efforts to improving maternal health.

Healthcare providers such as doctors, midwives and nurses have been identified by new mothers to be primary source of informational support, appraisal and sometimes emotional support. Studies of new mothers’ support indicate a strong midwife support during delivery and postpartum which increases maternal self-efficacy on infants’ care practices such as breastfeeding, bathing of child et cetera (Leahy, 2005). This is because midwives turn to provide mothers with informational support regarding childcare.
However, Johnson, Kirk, Rooks, & Muzik (2016) showed that some African American mothers in Southeast Michigan indicated their distrust of the information and recommendations provided by healthcare workers regarding breastfeeding and therefore relied more on their peers and families. They also indicated that the support they needed was not available at the time they needed it. WHO (2013) indicated that (postnatal) support was lower compared to antenatal support. That is, the information was provided during antenatal services when the baby was not out for them to practice, so at the time they needed it, such information wasn’t given. There is therefore the need for continuous postnatal information feed or postnatal childcare information given a few weeks prior to delivery.

Jonge (2001) showed that teenage mothers in Netherland expressed their discomfort in attending antenatal or postnatal classes because of the disparities in ages of mothers who attended the classes. As a way of support, mothers felt that these classes should be organised in groups where mothers of approximately same age could attend and confidently express themselves. By this they would be able to make friends and share experiences and emotional support among themselves while the healthcare providers would discuss with them concerning other topics.

Maternal support during pregnancy to post-delivery from health facilities are affected to a large extent whether the person is insured or not. In Ghana, the national health insurance card renders all antenatal and postnatal services for free. The extent to which she can benefit from the support depends on her income level of the woman and the family to insure her under the health insurance scheme (Browne et al., 2016).
2.4.3 Factors Influencing Provision of Social Support

New mothers’ relationship with family influenced the support they received. No matter the relationship, mothers of first time mothers remained the primary support for them in a study of social support and symptoms of depression among new mothers in Eastern Turkey by Ege, Timur, Zincir, Geçkil, & Sunar-reeder (2008). The study also indicated that there should be intensive prenatal and especially postnatal teaching for at least 1 year for new mothers for and mothers should be taught by healthcare professionals as to how to ask for support.

Support received from friends and the wider community is dependent the kinds of friendship mothers had with the friends and others before they become pregnant. Also, depending on whether the mother is married or not and the age of the first-time mother determine the level of support received. Ngum Chi Watts, L iamputtong, & M cmichael (2015) in their study on the experiences of African Australian teenage mothers in greater Melbourne, Australia, indicated that unmarried adolescent mothers were seen by the community as serving a bad example for the other young girls and so did not receive any support from the community. However, loyal friends to these mothers still supported them during the pregnancy and in postpartum.

Howarth, Swain, & Treharne (2011) in their study of first time New Zealand mothers showed that partners of mothers were the main source of continual support for them. Alongside their partners, midwives, friends and other family members were of great support to them.

It can be seen that greater support for new mother comes from families and friends and it continues to postpartum. Cronin (2002) however indicated that this support diminishes when the novelty of having a new baby has diminished. This means that, as weeks and months pass by mothers are seen to have full control over children and the joys and excitement of having a new baby and new mother changes. So, women are expected to do work and take care of their babies themselves.
At the population level of Ghana, Storey et al. (2016) reported that about 6 out of 18 males in the northern region were not involved financially and emotionally during obstetric emergency. Some reasons given were due to the non-marital status of the partners, far distance. In instances where the mother was not married, she relied mainly on her mother for support. From the health workers perspective, there was a mixed reaction to male involving during childbirth. While some midwives advocated for male involvement during childbirth to provide emotional support for the mothers, others saw no need for men to come to the facility. This involvement was not active as males should be “bystanders”.

Yeboah (2012) also indicated that social support influenced early prenatal visits of teenage mothers. Aside support, and marital status of the teenage, being an expectant teenager acted as a hindrance to seeking early prenatal care. He explained that this could be as a result of the socio-cultural norms where in traditional Ghanaian societies it is regarded immodest for a pregnant woman, especially a primipara, to publicly disclose her early pregnancy status. This finding supports the study done by Ngum Chi Watts, Liamputtong, & Mcmichael (2015), where in greater Melbourne, Australia, unmarried adolescent mothers were seen by the community as serving a bad example for the other young girls and so did not receive any support from the community.

2.4.4. Culture of Social Support

Postpartum is a period women to recover and take up their new roles as mothers and in many cultures around the globe, it is regarded a perilous period that new mothers are considered vulnerable to illness. In this wise, certain activities are put in place to ensure the wellbeing of mother and child and prevent ill health in later years. For instance, in the Japanese culture, the practice of “satogoeri bunben” entails that the pregnant woman travels to her family home at 32-35 weeks of gestation to be cared for by her mother until about 8 weeks of postpartum
(Yoshida, Yamashita, Ueda & Tashiro, 2001). The Amish of Tennessee in USA also organise support from extended family members and the community to help mothers (Finn, 1995). Nigerian, Chinese and Jordanian also practice similar organised support. Some of these supports include helping with house chores, and caring for the baby. In the Chinese culture one prominent cultural practice that serve to support women in postpartum is “Doing the month”. Here, for the first 30 days, certain rules and cultural activities are laid down for the new mother to follow to ensure rest and recover in order to allow ‘loose’ bones to be restored (Leung, Arthur & Martinson, 2005; Chien, Tai, Ko et al., 2006). To a larger extent, these traditional activities would serve as a buffer against stress and depression for mothers. However, these traditional activities should be done in the light of modern postpartum practices.

In conclusion, several studies have highlighted the importance of support for first time mothers as some researches made use of quantitative measures based on certain Western standard questionnaire but there is cross cultural difference. A few qualitative studies have been done in Ghana on maternal mental health of first time mothers, for this reason, qualitative research is valuable. This study there sought to address the gap by conducting in-depth interviews on the experience of first time mothers during pregnancy and childbirth and the support received to help them cope.
CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This section explains how the research was conducted and the data collected. It covers the study site, study design, target population, sample procedure, tools used in gathering data, quality of data, data handling and management, and ethical considerations.

3.2 Study Area

The study took place in Breman Asikuma sub-district of Asikuma-Odoben-Brakwa (AOB) District in the Central Region of Ghana. Within the sub-district, three communities Breman Asikuma, Jamra and Ahomasu were selected for the recruitment of the study participants. Ahomasu and Jamra are rural farming communities, whilst Asikuma is an urban setting. These communities were chosen based on the researcher’s familiarity with the communities from previous research in the district. Details of the physical features, demographic characteristics, climate, vegetation, economy and health of the study areas are discussed below.

**Physical Features**

The Asikuma-Odoben-Brakwa (AOB) District is located on the north-central portion of the Central Region of Ghana. It is bordered on the North by Birim South District of the Eastern Region, on the South by Ajumako-Enyan-Essiam District, on the West by Assin North and Assin South Districts and on the East by the Agona East District. The district covers a land area of about 884.84sqkm. Proportion of land area to region is 9% of the total land area of the Central Region. There are three urban centres, thus Breman Asikuma, Agona Odoben and Breman Brakwa. The district capital is Breman Asikuma.
Demographic Characteristics

According to the 2017 district health annual report (AOB), the total population was 129,754 which included Women in their Fertility Ages (WIFA) 29,843; children 0-11 months 5,190; and children 0-59 months 25,951. The number of expected pregnancies was about 5,190. In term of sex distribution, the males constituted 48.17 percent and 65 percent of the projected total population lives in the rural areas.

Climate

The District lies in the semi-equatorial climatic zone. Monthly temperature ranges from 34\(^\circ\)C in the hottest (March) to about 26\(^\circ\)C in August. Mean annual rainfall range from 120 centimetres in the south east to 200 centimetres in the North West. The district experiences double maxima rainfall with peaks in May-June and September- October. Relative humidity during the rainy season is high around 80 percent but falls between 50 percent and 60 percent during the dry hot season.

Vegetation

The forest and savannah type of soils found in the District are suitable for the cultivation of a variety of cash crops including cocoa, citrus, oil palm and staple crops such as cassava, yam, cocoyam, maize, rice and vegetables. The district contributes significantly to the production of industrial crops such as cocoa, pawpaw and oil palm and also has a substantial share in the district production of maize, cassava, and oil palm. Available also in the district are exotic crops such as black and white sweet pepper, rubber and mangoes, which are all gaining importance as export commodities. The vegetation, which basically semi-deciduous forest, contains commercial trees such as Odum, Mahogany, Wawa and other hard wood.
**Economy**

The district is richly endowed with human and natural resources, particularly mineral deposits, forest and timber species, rich soil and good climatic conditions. The district produces large quantities of cassava, maize, rice, plantain, cocoyam and vegetables. Cocoa and palm nuts are the major cash crops. The district has diverse occupational structure. However, the informal sector takes the majority of the employed population with the formal sector absorbing the rest. The major occupation in the district is agriculture which employs 65 percent of the labour force. About 52 percent of those engaged in other occupation still takes up agriculture as a secondary occupation. This is primarily because of the favourable climatic conditions prevailing in the District. Crop farming is the major Agricultural activities carried out in the district.

**Health**

The district is endowed with a variety of health facilities at various levels as shown in Figure 3.1. According to the 2017 District Annual Progress Health Report, there has been improvement in maternal and child health indicators in the district. For example, the rate of antenatal care visit was at 77.4 percent in 2017 compared to 77.0 in 2016. Delivery by a skilled attendant also improved from 64.0 in 2016 to 65.9 in 2017. However, per the year’s records, fourteen neonatal mortality had occurred.
Table 3.1 District Health Facilities

<table>
<thead>
<tr>
<th>Health facility</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital (CHAG)</td>
<td>1</td>
</tr>
<tr>
<td>Health centre (Government)</td>
<td>3</td>
</tr>
<tr>
<td>Maternity Home (Private)</td>
<td>1</td>
</tr>
<tr>
<td>Clinics (Quasi-Government)</td>
<td>3</td>
</tr>
<tr>
<td>Functional CHPS with compound</td>
<td>15</td>
</tr>
<tr>
<td>Functional CHPS Zones without compounds</td>
<td>3</td>
</tr>
<tr>
<td>Licensed Chemical Sellers</td>
<td>44</td>
</tr>
</tbody>
</table>

Source: District Annual Health Report, 2017

Figure 3.1 Map of Asikuma-Odoben-Brakwa District
3.3 Study Design

The study employed a phenomenological qualitative design. Burns and Grove (2003:19) describe a qualitative approach as “a systematic subjective approach used to describe life experiences and situations to give them meaning”. Holloway and Wheeler (2002: 30) refers to qualitative research as “a form of social enquiry that focuses on the way people interpret and make sense of their experiences and the world in which the live in”. By these definitions, qualitative research seeks to explore behaviour, perspectives, feelings and experience of people and having an understanding of these elements. This design was chosen because it allowed respondents to give in-depth information on the subject under study in their own words through open ended questions. It also allowed the researcher the flexibility to probe responses from the respondents for clarification. By this, responses that were meaningful and culturally relevant to the respondents were called to mind. Through this study design, issues that were never anticipated by the researcher was discussed as the respondents gave their responses (Mack, Woodsong, MacQueen, Guest & Namey, 2005).

3.4 Participants

The study was conducted among sixteen first-time mothers aged 35 years old and below, and with one child aged up to twenty-four months, and four social support providers. In all, twenty respondents were involved in the study. This framework allowed the researcher to study women who still had vivid and good memories of their experiences. Also, that stage of the child life needs even more support as feed was introduced to the child and other necessities of life. Primary support providers of first time mothers were also included.

3.5 Sampling technique

A purposive sampling technique was used to select participants. Parahoo (1997 pg232) describes purposive sampling as “a method of sampling where the researcher deliberately
chooses who to include in the study based on their ability to provide necessary data”. This approach was therefore used to select mothers in order to provide insightful information pertaining to the research questions to achieve the research objectives. A Community Health Nurse (CHN), a friend, who works in the Community-based Health and Planning Services (CHPS) and partly lives in a rural setting and the urban setting (dual residence) was contacted to aid in selecting the first-time mothers from the community. Her dual residential characteristic helped to recruit mothers from both the rural and urban part. Contacts with made with some community members who knew some first-time mothers in the community. Through her contact the researcher visited Ahomasu CHPS compound where the nurses helped in recruiting some of the mothers from the community since they work with these mothers.

**Inclusion criteria**

The following criteria were used to select the respondents. A first-time mother

- aged 35 years old and below, married or unmarried
- with child aged twenty-four months old or less

However, mothers aged 36 years and above, with two or more children aged beyond twenty-four months old were excluded from the study.

**3.6. Data Collection Method**

In-depth Interviews (IDIs) were conducted for data collection. In-depth interview is a face-to-face, one-on-one discussion and it involves an interviewer and a participant. This is done to elicit a “vivid picture of the participant’s perspective” on the research topic Mack et al., (2005). Mack et al., (2005) describe this form of interview as a “student-expert” chat where the researcher is considered a student and the interviewee is the expert. This is because the researcher wishes to know more about the research topic by asking the interviewee questions and then aims to understand and not miss any vital information by listening attentively and
asking follow-up questions and probes for clarification. In-depth interviews helped the researcher to elicit rich and complex information from the respondent. In-depth interviews were chosen as the primary data collection method to enable respondents ‘tell their story in the deepest and richest way possible during the interview process’ (Roberts & Taylor, 2002 p. 388).

Field notes were taken as a back-up to the audio recordings in the sense that the observed non-verbal clues could add some meaning to the verbal recordings during the write up of the report. The notes were taken during the interviews and immediately after the interviews the were typed (expanded) into the computer to record key words and actions exposed by the respondents during the interview section (Flick, 2009). Some of the field notes taken were captured non-verbal clues such as movement of body, laughter or prolong silence before answering a question that was asked, facial expression of surprise, sadness, etc.

Data Collection Instrument

The validity of any research is dependent on the extent to which it can be imitated by another researcher. For this reason, apart from having a clear data collection approach, it is equally important to have good data collection instruments. The study therefore employed the use of a semi-structured interview guide for the discussions. A semi-structure guide was used because it only serves as a guide, as the name suggest, while it allowed participants to speak on other issues through probing by the moderator, in the discussion. The guide included information on participants’ socio-demographic data such as age of mother and child, marital/partner status, occupation, educational level, and the main questions that were asked for responses to meet the objectives of the study.
3.7 Data Handling and Management

Record keeping is as imperative as collecting the data. To avoid loss of data and also for future reference a note book was used to write all vital points raised by participants during discussion. Data collected from field, both audio recording and notes taken were transferred into a computer and were given password protection with a backed up. The audio recorded data were then transcribed verbatim into word document for analysis.

3.8 Pilot Study

Before the actual data collection in the study area, a pilot study was conducted to test the interview guide in order to improve the quality and efficiency of the interview guide (Karimi, 2015). The pilot study being a small-scale version of the full study to be performed later (Wheeler, 2010) gave me the opportunity to experience some of the challenges I was likely to face in the field during the actual data collection and so prepared for that. The pilot study helped designing a further confirmatory study and helped in testing the study procedures, validity of tools, estimation of the recruitment rate, and estimation of parameters. The pilot study was conducted with two mothers to find out if the questions were clear and understandable. This gave me the opportunity to add more items as follow-up questions and possible probes.

3.9 Interview Procedure

The interviews conducted with mothers and primary support providers were done in a quiet and convenient environment. To guarantee efficient time management, the interview process started as soon as the first mother was recruited. Before the interview, I introduced myself as a student and then the purpose of study, the structure of interview, length of interview, the benefits and risks of participating, volunteer agreement and also confidentiality of any information given. Consent form was given to participants to read, though everything in it was explained, and then made to write their names and append their signature or thumbprint to
indicate their willingness to participate. Permission to use tape recorder was sought from participants before interview. The tape recorder was positioned close enough to the researcher and participants to record conversation to preserve participants words during the interview. This enabled the researcher to maintain eye contact with the participant. Note taking of non-verbal behaviour was done to give additional meaning to audio recorded interview.

The questions took the form of a narrative and then problem focused. The narrative part requested the mother to tell her story of her pregnancy including whether it was planned or not, reaction to news of pregnancy by mother, partner, relations, friends and wider community. Then followed the problem focused questions on her actual experiences, physical changes, antenatal services, delivery, and few weeks after delivery, support received and sources of social support. During the interview section, follow-up questions were asked based on the responses of the respondents to help understand issues better and to obtain more information for the study.

The interview was in three sections. The first section included the background data of participants such as their age (mother/partner), marital/partner status, occupation (partner/mother), age of child, education level (partner and mother), and partner’s occupation. The second section solicited information on the mothers’ experiences during pregnancy, giving birth and a week after childbirth. The last section was on social support received and sources of such support (see appendices for details). The interviews lasted thirty-eight to sixty-three minutes. This is because some respondents were engaged in household chores during the interview and so had to attend to some such issues from time to. Data saturation was reached after the sixteenth respondent where no additional interview could give any new or additional information than those already gathered. Additional information was obtained from four social
support providers to find out about the type of support they provide and challenges they faced in providing those supports.

3.10 Compensation of Participants

To show appreciation for the time lost by participating in this study, key soap bars and powdered soaps were provided for mothers to help them wash their babies’ clothes.

3.11 Data Analyses

The approach used in the analysis of data was based inductive thematic analysis, implying that the analysis moves from actual data to emerging themes and leading to writing of the report as demonstrated in Figure 3.2. As with most qualitative research work, this study does not claim to generalize the findings to a larger population of first-time mothers, but it can be used to back concepts and theories, which may be helpful for further studies.

Figure 3.2: Steps in Data Analysis

The systematic technique outlined by Braun and Clarke (2006) was employed to organize the data analysis. First, the transcripts were read and re-read, line-by-line to be familiar with data
by grasping every detail of the conversation with the participants. After completing the transcription, the data was ordered using line-by-line coding to examine the data systematically and as closely as possible. This process was followed by organization of the most frequent and significant line-by-line codes into broader themes.

Themes were reviewed in relation to the generated codes and the entire data set to ensure that they were coherent and reflected the content of the data set and also to discover the participants’ meaning. Triangulation was done using the data gathered from the interviews with the various participants, both the mothers and those who provide them with support to find out about similarities and differences. Key issues discovered have been reported in text with some quotations from the interviews to support such relevant issues.

3.12 Validity of Data

In order to achieve a high level of validity and quality data, which is of particular concern in qualitative research, several methods were incorporated in the process as suggested by Lincoln and Guba (2000). First, confidentiality was emphasized in order to establish rapport with the participants to ensure that they would be comfortable in sharing more intimate and comprehensive descriptions of their experiences of first time pregnancy and motherhood. Second, the interview guide was tested in a pilot study to identify potential issues such as sensitivity of certain questions, length of interview, motivation, which were rectified before the full scale data collection. Third, data was collected from varied participants until common understanding emerged; saturation was reached on the sixteenth participant and four social support providers were added to solicit information on their challenges. Finally, debriefing and peer-reviewing were employed with my supervisor helping to keep the main focus on the quality of the study.
3.12 Ethical Consideration

Ethical approval was obtained from the Ghana Health Service Ethical Review Committee (GHS-ERC). Permission was sought from the District Health Director of Asikuma Odoben Brakwa District before the field work began. All participants were given a written informed consent, in which the aims, objectives, risks and benefits of the study were described. For those participants who could not read, a family member was employed to translate the informed consent to the participant. Participants were asked to be free to agree or refuse to participate in the interview and she could withdraw from the study at any time, upon verbal notification, without causing any risk to himself or herself. So, only those participants who consented to participate were enrolled in the study by signing in the informed consent form.

Contacts of my supervisor and that of the administrative secretary of GHS-ERC were provided in the informed consent for participants to contact for further clarification. Participants’ views were respected and the researcher did not degrade any participant for any reason. Permission was also sought to audio record all interviews. Pseudo names have been used for participants in the presentation of the data.
CHAPTER FOUR

4.0 FINDINGS

4.1 Introduction

The study sought to explore the lived experiences and social support structure of selected first-time mothers at Asikuma-Odoben-Brakwa District in the Central region of Ghana. The chapter presents findings from the study.

4.2 Characteristics of Participants

Twenty participants were involved in the study, of which, sixteen were first-time mothers and four were primary social support providers. Of the sixteen mothers, eight mothers were teenagers aged 17-19 years, while the others were young adults (20-32 years). Four of the mothers were married, eight cohabiting mothers, and four single mothers. All the participants indicated they were Christians by religion. They had varied educational backgrounds ranging from junior high school level to tertiary level of education: Concerning occupational background, four of the participants were seamstress, two were apprentices learning a vocational skill, two were health workers, a teacher and the rest had no job doing. As expected, the young participants were living with their mothers, while the older mothers lived with husbands/partners at the time of interview (Table 4.1).
Table 4.1 Characteristics of Primiparous Women

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age (years)</th>
<th>Educational level</th>
<th>Marital Status</th>
<th>Occupation</th>
<th>Residence (Pregnancy)</th>
<th>Residence (After delivery)</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rita</td>
<td>18</td>
<td>JHS 2</td>
<td>Single</td>
<td>None</td>
<td>Mother</td>
<td>Aunt</td>
<td>Ahomasu</td>
</tr>
<tr>
<td>Clara</td>
<td>19</td>
<td>JHS 2</td>
<td>Single</td>
<td>None</td>
<td>Mother</td>
<td>Mother</td>
<td>Jamra</td>
</tr>
<tr>
<td>Joyce</td>
<td>17</td>
<td>JHS 3</td>
<td>Single</td>
<td>Student</td>
<td>Mother</td>
<td>Mother</td>
<td>Asikuma</td>
</tr>
<tr>
<td>Mansa</td>
<td>18</td>
<td>JHS 2</td>
<td>Single</td>
<td>Trader</td>
<td>Mother</td>
<td>Mother</td>
<td>Asikuma</td>
</tr>
<tr>
<td>Abena</td>
<td>17</td>
<td>JHS 1</td>
<td>Single</td>
<td>None</td>
<td>Grandmother</td>
<td>Grandmother</td>
<td>Ahomasu</td>
</tr>
<tr>
<td>Naana</td>
<td>20</td>
<td>JHS</td>
<td>Cohabiting</td>
<td>None</td>
<td>Mother, in-law</td>
<td>Mother in-law</td>
<td>Asikuma</td>
</tr>
<tr>
<td>Sarpomaa</td>
<td>19</td>
<td>JHS</td>
<td>Cohabiting</td>
<td>None</td>
<td>Mother</td>
<td>Mother</td>
<td>Ahomasu</td>
</tr>
<tr>
<td>Gifty</td>
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<td>None</td>
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<td>Parents</td>
<td>Jamra</td>
</tr>
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<td>Nmrepah</td>
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<td>SHS</td>
<td>Cohabiting</td>
<td>Food Vendor</td>
<td>Mother</td>
<td>Mother in-law</td>
<td>Asikuma</td>
</tr>
<tr>
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<td>Cohabiting</td>
<td>None</td>
<td>Mother</td>
<td>Mother</td>
<td>Asikuma</td>
</tr>
<tr>
<td>Afia</td>
<td>23</td>
<td>JHS</td>
<td>Cohabiting</td>
<td>Seamstress</td>
<td>Partner/mother in-law</td>
<td>Partner</td>
<td>Asikuma</td>
</tr>
<tr>
<td>Adwoa</td>
<td>30</td>
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<td>Cohabiting</td>
<td>Seamstress</td>
<td>Mother</td>
<td>Mother</td>
<td>Jamra</td>
</tr>
<tr>
<td>Fosua</td>
<td>24</td>
<td>JHS</td>
<td>Cohabiting</td>
<td>Seamstress</td>
<td>Mother</td>
<td>Mother</td>
<td>Asikuma</td>
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<tr>
<td>Serwa</td>
<td>28</td>
<td>Tertiary</td>
<td>Married</td>
<td>Health Worker</td>
<td>Husband</td>
<td>Mother/alone</td>
<td>Asikuma</td>
</tr>
<tr>
<td>Aba</td>
<td>29</td>
<td>Tertiary</td>
<td>Married</td>
<td>Health Worker</td>
<td>Husband</td>
<td>Husband</td>
<td>Asikuma</td>
</tr>
<tr>
<td>Yaa</td>
<td>32</td>
<td>JHS</td>
<td>Married</td>
<td>Seamstress</td>
<td>Husband</td>
<td>Husband</td>
<td>Ahomasu</td>
</tr>
<tr>
<td>Bernice</td>
<td>29</td>
<td>Tertiary</td>
<td>Married</td>
<td>None</td>
<td>Husband</td>
<td>Husband</td>
<td>Jamra</td>
</tr>
</tbody>
</table>

Social support providers were also interviewed and table 4.2 shows their characteristics

Table 4.2 Characteristics of Support Providers

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Occupation</th>
<th>Marital Studies</th>
<th>Community</th>
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<tr>
<td>Maame</td>
<td>47</td>
<td>Petty Trader/Farmer</td>
<td>Married</td>
<td>Asikuma</td>
</tr>
<tr>
<td>Akos</td>
<td>52</td>
<td>Farmer</td>
<td>Widowed</td>
<td>Jamra</td>
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<tr>
<td>Sophia</td>
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<td>Farmer</td>
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<td>Ahomasu</td>
</tr>
<tr>
<td>Alberta</td>
<td>41</td>
<td>Farmer</td>
<td>Widowed</td>
<td>Asikuma</td>
</tr>
</tbody>
</table>
4.3. Mothers’ Lived Experiences during Pregnancy and Childbirth

The first objective of the study was to explore first-time mothers’ experiences during pregnancy, delivery and postpartum. Two themes that captured this objective from the analysis of the transcripts were (a) pregnancy intention, I’m pregnant, what next? and (b) pregnancy experience.

4.3.1. Pregnancy intention, I’m pregnant, what next?

Most of the women in the study indicated that they were not planning to become pregnant, whereas the three of the married women reported planning their pregnancies. Some of the reasons leading to the unplanned pregnancies included poverty, misconceptions about contraception, sexual coercion, and rape.

A seamstress in her 20s, reported why she didn’t use contraceptive during sex which led to her pregnancy.

“I was in school and I knew nothing, so a certain sister came and gave me some medicine (secure pills) to use. I didn’t like the medicine because if I take it I feel like vomiting or nauseous. I didn’t also use condom, though I knew I could get pregnant we still didn’t use it. I also fear family planning because I hear some people say that when they do it, they get heart problems, their hearts beats faster” (Fosua, 24 years. Breman Asikuma).

A student in her late teens, recounted similar erroneous belief about contraception.

“I went out and the boy saw me and said he wanted me as his girlfriend and I accepted. One day we had sex together but I didn’t know I will get pregnant. Although I have heard about things that prevent pregnancy, my mother told me it was not good” (Rita, 19 years, Ahomasu).

Sexual abuse featured prominently in the stories of some of the women. A 20 year old mother described how she was drugged and raped by a boyfriend she was dating.

“It was my birthday and I came to him. He asked that we have sex but I refused told him to wait until I complete school. He went and bought a drink and we drank it, I don’t know how it happened, when I was awake, I realized I was naked and I asked him what happened and he said, we had finished doing it already. So I should forget it, it is ok. And I said ok. I narrated what has happened to my mother and sister. One month into the experience, my menses didn’t come and my sister bought me some medicine to abort the pregnancy but it didn’t abort. I also bought some medicine and the guy too, and
still the pregnancy was there. So I said to myself, what will happen is what has happened”. (Naana, 20 years, Asikuma)

Abena, a 17 year old junior high school student, was also sexually abused by a guardian with whom she was living as a housemaid. The man of the house took advantage of her situation and asked for her friendship, promising to send her to school if she agreed. Though the girl knew it would involve sex, she was not prepared for it when one day the man forcefully had sex with her leading to her pregnancy.

Joyce was also 17 years old when she became pregnant after being raped by a boyfriend.

“I was in the house when he (the boyfriend) called me to come to his house, so I attended to his call. He wanted to have sex with me, but I said no but he forced me and I had sex with him. So I didn’t go there again”. (Joyce, 17 years, Ahomasu)

Most parents of the teenage mothers felt angry and disappointed when they were confronted with their daughters’ pregnancies. Joyce’s mother had this to say.

“It is not good at all, that you will send a child to school and the child cannot complete it and get pregnant. It is not an accepted norm but the problem is, though you will talk about it and try to guard the child against it, while you (parents) are asleep, the child gets up and go to see the guy, so it is disobedience”. (Alberta, Joyce’s mother, Asikuma)

The older married women, however indicated that their pregnancies were planned. They all indicated preparing financially, psychologically and emotionally for their pregnancy experiences. One of the women reported actually praying with the hope that God would bless her womb.

Serwa, a 28 years old health worker described the genesis of her first pregnancy.

“My pregnancy was planned and it happened within 3 months of marriage after several attempts. We had prayed to God for a baby just after marriage. My husband wanted a girl and I wanted a boy but it turned to be a girl. And we were grateful to God anyway. We knew it requires a lot financially to care for a baby so we also planned to save GHC 100.00 every month for the care of our baby. We agreed my husband would contribute GHC 60.00 while I contribute GHC 40.00 into an exclusive account for that purpose. Psychologically, my mind was prepared through the antenatal counselling. The midwives informed us of all the physical changes the body would go through after child birth. So, I wasn’t really surprised”. (Serwa, 28 years, Asikuma)
Afia was 23 years old seamstress living with her partner when she became pregnant and recounted her experience.

“Oh, as for my pregnancy, it wasn’t all that planned but it was something that I always wished to have, and when it happened I was excited and my partner too was excited, in everything. Although it was not easy, my friends that I had, you see that when you are pregnant the friends that you walked with would be boring because of the pregnancy but with all of that I was free with it, it felt normal because as a lady, no matter what you will get pregnant one day”. (Afia, 23 years, Asikuma)

Most of the mothers didn’t know they were pregnant because some of them had irregular menses and for that matter thought it was a usual thing until they were sick and had to visit the hospital where it was revealed that they were pregnant.

Nmrepah, a 24 year old Food Vendor, described her experience when confronted with a positive pregnancy test at the hospital.

“I didn’t plan for it. I was sick, and the man I worked for told me to go to hospital and check on my abdominal pains. So when I got to the hospital, and they made me to do a scan and they told me to come in a month time. Before then, I had irregular menses so even when my menses didn’t come I thought it was the normal irregular menses that had occurred. It was later that I realized I was pregnant and I told my partner and he came and saw my father”. (Nmrepah, 24 years, Asikuma).

Clara, a 19 year old single mother, expressed similar experience.

“I wasn’t ready to get pregnant. One day I was sick and I told my mother. She looked at me and said I was pregnant but I didn’t believe her. I told them I wasn’t pregnant, I was just sick. So she took me to the hospital where I tested positive for pregnancy”. (Clara, 19 years, Jamra)

Other mothers reported not having experienced their menses for a month but thought they could not be pregnant because they had their most recent sexual activity during their safe periods. For example, a 20 year old unemployed, Gifty, reported being shocked when she discovered she was pregnant.

“I didn’t plan the pregnancy. It was the boy who noticed I was pregnant and made fun of me, he used it to joke with me. It was about a month later that I noticed the signs. We were just having fun and the pregnancy came, I least expected it”. (Gifty, 20 years, Jamra)
### 4.3.2 Abortion options

One of the options available to a woman who is confronted with unexpected pregnancy is abortion. According to the 2015 Maternal Health Survey, one-fifth of women age 15-49 years in Ghana have ever had abortion. In spite of whether the pregnancy was planned or not, all the mothers in the study proceeded with their pregnancies. However, two of the teenage mothers had initially thought of aborting their pregnancies for fear of terminating their education.

Gifty was about to write her Basic Education Certificate Examination (BECE) when she became pregnant. She reported being worried about the consequences of the pregnancy for her education and considered abortion.

> "When realized I was pregnant, I wanted to abort it but the boy didn’t support it because he said he has never made a girl to abort before, he could not let me do it. I wanted to abort it because I was writing my final exams. My parents also realized I was pregnant and my mother said if I abort it she would deny me as a daughter. I am her only daughter". (Gifty, 20 years, Jamra)

Mansa, an 18 year old Junior High School student, was rather encouraged by a friend to abort the pregnancy.

> "I told my best friend about it and she said I should abort it and I said no because I don’t know if she (the baby) is the one that will care for me in future or not, so I will not abort it. Because of that my friend became angry with me and stopped talking to me". (Mansa, 18 years, Asikuma)

Fear of abortion and its complication if not done well were expressed by some of the participants as reason for not choosing the abortion. Sarpomaa, a 19 year old unemployed JHS graduate shared her fear of abortion though she heard that pregnancy and childbirth wasn’t easy.

> "I hear from women who had given birth before about the journey of pregnancy and that it is painful. I was already pregnant and I didn’t want to abort because something terrible might happen to me as a result". (Sarpomaa, 19 year, Ahomasu).
4.3.3 Reactions to the news of Pregnancy

The mothers expressed mixed feelings about the news of their pregnancies. Some expressed happiness, some expressed sadness, others showed happiness and unhappiness altogether, and yet others regretted being pregnant. As expected, the unmarried teenage mothers expressed sadness, fear of dropping out of school or sacked from home or beaten, while others considered themselves too young to be pregnant.

Rita was 18 years old and in her second year at junior high school when she became pregnant. She described being sad because of her fear that she had to drop out school because of the pregnancy. She expressed her regret as:

“It was really a painful experience when I realized I was pregnant. It meant I couldn’t finish school and I got pregnant. I am not going to be happy until she (the baby) starts to walk and I am able to return to school”. (Rita, 18 years, Ahomasu)

Nmrepah, a 24 year old mother who was cohabiting with her partner described how becoming pregnant was a shock to her.

“I was shocked! So I called him (partner) and told him and he said ok. He actually wanted the pregnancy so he was happy but I was happy a little because at the time I was too young to give birth”. (Nmrepah, 24 years, Asikuma)

A similar experience was described by 19 year old Sarpomaa.

“I went to Asikuma hospital and they did a lab test and I was pregnant. I was really shocked and it pained me as well because I didn’t even think of getting pregnant at the time. But after a while I let go the pain and that feeling and accepted the pregnancy”. (Sarpomaa, 19 years, Ahomasu)

However, acceptance of the pregnancy by either mother or partner served as a relief of that feeling of despondency because it was perceived as a sign of support for them. While some partners accepted the pregnancy, other denied it because they were still students or married and didn’t want it cause any problem in their marriage, and yet others because of poverty. Some parents especially the mothers beat up their children for been pregnant at that tender age but
later consoled them and accepted the pregnancy and supported them as there was nothing they could do about it. And also, for fear of over reacting which may lead to the child aborting or harming herself.

A parent reaction to the news of pregnancy of a teenager:

“I was very sad, it really pained me, I beat her up, I really beat her, my neighbours can attest to that fact. It pained me very much, because a girl you put in school, spend on her and expect that she would complete, only for her to get pregnant while in school. She was in form 2 when she became pregnant so I told her she would not drop out of school, she should still attend the school in her pregnancy, in shame, until she delivers and that was what she did. It pained me, so i beat her up, it even made me sick because she is very intelligent and even her uncle is very ‘mad’ at her and had refused to talk to her until she delivered of her baby. It really pained me. But afterwards I consoled her and told her not to take in any medicine to abort the pregnancy”. (Aberta, Joyce’s mother, Asikuma)

“There was nothing I could do, she was already pregnant and if I try to insult or beat her up and she goes and does something to the pregnancy (try to abort) and loses her life, who caused it, it is me”. (Sophia, Sarpomaa’s mother)

Partner’s reaction to news of pregnancy

“When I told him about the pregnancy, he told me to give the pregnancy to another person because he was in school, so when he completes and starts working and gets money, he would come for the baby” (Rita, 18 years, Ahomasu)

“The man that impregnated me too when I told him he was happy. If he had not accepted the pregnancy I would have cursed him.” (Afia, 23 years, Asikuma)

Reaction to news of pregnancy by members of society

“Before the pregnancy, people used to call me barren and disrespected me because my former husband divorced me. So when they realised I was pregnant, it was a big surprise to them and some of them began to thank God”. (Yaa, Married, 32 years, Ahomasu)

The older unmarried mothers though were not very happy about the pregnancy because they were not married before getting pregnant, they were however proud as it was not teenage pregnancy. Some of the parents were also proud of their daughters saying they were old enough to give birth even though they were not married. They were however hopeful that the partners would come and perform the marriage rites soon.
“Oh, you know my pregnancy wasn’t teenage pregnancy, so when she heard of it, she was ok”. (Afia, 23 years, Asikuma)

“She is about 30 years now before getting pregnant though not married yet. I was happy about that because she is old, most of her age mates have given birth 3 or 4 times but she has now given birth to her first child”. (Akos, mother of Adwoa, Jamra)

4.3.4 My pregnancy, my experience

The study asked mothers to share their experiences from the time they were pregnant and also their experiences during antenatal care visits and delivery. All participant testified to the physical changes in their bodies and the pregnancy posing physical and psycho-social disorders to their health.

Physical difficulties

All mothers described the general ailments that pregnancy posed on their health such as general bodily weakness, change in sleeping patterns, easy fatigability, nausea and vomiting, loss/gain of weight and restlessness.

“It wasn’t easy during the pregnancy though. I lost my appetite and occasionally threw up when brushing my teeth in the morning. I had no appetite for food except boiled plantain with grinned pepper and dry herrings and milo beverage. My sleeping pattern even changed. I liked to sleep on my back, for instance. But the midwife advised me to rather try to sleep on my left, as sleeping on my back frequently could harm my baby. So, I did this. Once in a while, when I am tired of sleeping on my left, I switch to the right for a very short while, then I switch to the left again. This is very uncomfortable. Again, I suffered unpredictable mood swings and sleeping in the company of others becomes very uncomfortable because of all the heat I feel in my body. I had to get my husband off our bed to sleep on the floor. If the man doesn’t understand such changes, he might complain and not be supportive”. (Serwa, 28 years, Asikuma)

“I lose weight, so some thought I had aborted it, but when they later realised, they didn’t say anything”. (Adwoa, 30 years, Jamra)

Some mothers also became anaemic as a result of the continuous vomiting leading to their inability to eat well for food to stay in their stomachs. They also experienced oedema of the feet/legs, rashes on the face, enlargement of some body parts like the nose, change in voices and above all the pain that accompanied pregnancy.

“About two to three months I could not eat or drink water well and I was vomiting, so it made me look very ‘white’ (pale)”. (Nmrepah, 24 years)
“I looked very pale, easily got tired after walking small or working.” (Abena, 17 years, Ahomasu)

“I was the type who experienced hyperemesis and it happened throughout my pregnancy. So I didn’t take the routine drug that I was given. My blood was also going down. It was just reducing, because of some condition I was having. My nose, oh, my nose was big and my voice, it became very deep. So because of that, I wasn’t able to even go for rehearsals. I used to join our singing”. (Aba, 29 years, Asikuma)

As a result of the pregnancy, most of the mothers complained of their inability to do certain house works as before.

“There were certain works I couldn’t do such as vigorous works or sitting down to do laundry for a very long time like I am doing now. My stomach became bigger and in fact it wasn’t easy, sometimes when you are bathing you cannot bend down to easy wash your feet well or even your sex organ unless I put a stool and raise my leg on it before I could wash my legs. Sometimes my husbands helped me”. (Yaa, 32 years old, Ahomasu)

Psycho-social difficulties

Mothers also complained of how the pregnancy made them isolate, shy and also attracted negative perceptions from friends and other community members due to severe loss of weight.

“I lose weight, so there were rumours that I had aborted it, but when they later realised that I was still pregnant, they didn’t say anything”. (Adwoa, 30 years, Jamra)

Some mothers also became very conscious of the safety of their baby other than themselves by limiting their movement with friends and games they used to play with friends. They talked about the change in dresses which they were not so proud and because of that could not attend social gathering.

“Before the pregnancy, life was normal but when I became pregnant, I kind of isolated myself like I have done something bad. When I was not pregnant I could go anywhere, outing, joining friends, do everything but when I became pregnant, everything was at stake. My dressing, it wasn’t all dresses that I could wear, you have to wear some long and big dress for the sake of the baby. I felt like one old woman and walked like some old women but when I wasn’t pregnant I could dress and feel proud of myself, but with the pregnancy, when you are walking, then your stomach is leading you, you feel ashamed ashamed ashamed”. (Afia, 23 years, Asikuma)
Some of the single and cohabiting mothers also felt shy of their pregnancies because they were the only ones among their friends that became pregnant. This also brought about social isolation. They felt they were the bad ones and some family members even called them “bad and stubborn”.

“When I informed my aunt too, she said I was a bad child, very stubborn. I was shy to go to my friends because they were not pregnant but I was, so I felt I was a bad girl, so I gave them that distance”. (Sarpomaa, 19 years, Ahomasu)

“Because I grew very lean I didn’t like to mingle with people for them to say I had change so much, and all of that, so I was mostly indoors...except for my family who were around to see me. This kept on for about 7 months when I had gained some flesh and was looking good enough to go out”. (Nmrepah, 24 years, Asikuma)

In all of these changes, the mothers acknowledged that the physical experience is normal and part of the birthing process that every woman will go through sooner or later in life.

“I became very fat and it was normal to me and people also told me it was normal to grow fat when you are pregnant”. (Ama, 25 years, Asikuma)

Most mothers indicated that the pregnancy had given them new status in society as they are now mothers and have experienced something that their colleagues have not experience.

“I have experienced something that my colleagues have not and by that they are not my co-equals anymore”. (Sarpomaa, 19 years, Jamra)

**Antenatal care experiences**

In Ghana, women are encouraged to attend antenatal visits. All mothers attended the antenatal care services during the first trimesters while others during the second trimester. About three thirds of the mothers said they went for antenatal care on the first day with a mother or a relation, after which they went alone. While some mothers wished they had someone to go with them every time, others were okay after the first visit with someone. About one-third of the mothers had information about antenatal care visit from relatives and friends. Two mothers who were health workers already knew about it while others had information about it on the first day they went to the hospital.
Mothers’ pregnancies were examined and their routine medicines such as vitamin B-complex, folic acid, polymaltose were given to them. Mothers acknowledged the essence of attending the antenatal services as their pregnancies were checked to ensure that the foetus was doing well. They were also advised to do moderate exercises and eat healthy food like green leafy vegetables and fruits. For some mothers, they are told of some of the changes that might occur in their lives because of the pregnancy. This helped them to adjust properly during the pregnancy because of the pre-notice.

“The nurse made me to lie on the bed and she examined my lower abdomen to see if the baby was breathing”. (Fosua, 24 years, Asikuma)

“They advised us to eat well. And how to sleep, so that we don’t sleep on the child. They said we should eat vegetables and fruits and also we should eat early and avoid late eating and also not to eat oily foods. So we should eat vegetables like kontomire, cabbage, carrot etc. we should eat such foods because they will help the baby to be strong and healthy” (Bernice, 29 years, Jamra)

Reception of some nurses towards mothers differed with the age of the mother. For the teenage mothers, most of them voiced out maltreatment such as disrespects, insults and ridicules that they had received from some nurses and midwives which demoralized them. This made them wished never to attend antenatal visits again but for the sake of their babies, they overlooked the insults and encouraged themselves continued.

“At the hospital, once I was a teenager the nurses were not hmmm, they were not receptive, they would talk to you anyhow, and even insult you, calling you names. They said hmm, small girl when you ask you to stay home you will stay and then go and get pregnant. And if they show you something to do hmmm, and you make a mistake, oh, they can insult you and speak in unmannerly way to you. They insulted me and said I am a bad girl... (Breaking voice – feeling of hurt recalling those memories), my parents sent me to school and I refused and got pregnant, they just maltreated me. I felt so belittled, shy and sad”. (Sarpomaa, 19 years, Ahomasu)

“It wasn’t that, when you are a child and you go the hospital pregnant, the nurses normally insults you”. (Joyce, 17 years, Asikuma)
Delivery experience

The study inquired of mothers to recall their labor and delivery experience. Time of labor was a time unknown to all mothers. According to the mothers, there was no information about labor signs during their antenatal care visits. So, when they experienced frequent and severe waist and abdominal pains, it was their relatives especially mothers, mother-laws and aunts who made them aware that they (mothers) were in labor and sent them to the hospital for delivery. For some mothers, they had a strong feeling to defecate in addition to the pains, they nearly visited the lavatory when their mothers stopped them and quickly sent them to the hospital. This would have been a big threat to the baby’s life if they went to the lavatory out of ignorance. For this reason, mothers implored that some of these information should be given during antenatal to avoid any risk to the baby.

“I was watching TV with my sister and I felt like going to the toilet and she said no, she would take me to my mother, so when we went, I could not sleep. I felt pains often and around 10 to 11pm, she sent me to Our Lady of Grace (OLG) Hospital”. (Naana, 20, years, Asikuma)

“It was late night, I couldn’t sleep, my abdomen, it pained me very much, I will sleep, after a while, it will pain me, I will get up, cry small and try to sleep again hm, so I cried and then I saw that some fluid was coming out from my vagina, so my mother went and called one woman in the neighbourhood who came and helped me to deliver.”. (Rita, 18 years, Ahomasu)

“I began to feel cold and I went to the hospital and they said I was in labor and then admitted me. I haven’t given birth before, so I was there when I felt like defecating seriously and when I wanted to go, the nurses said no because my time was almost due for delivery so they asked me to walk around a bit until the child’s head fully turned. I was really in pain and suffering so I went and laid down”. (Yaa, 32 years, Ahomasu)

With the exception one mother who delivered at home by the traditional birth attendant because it was late into the night and there was no means of transport to the hospital, all other mothers delivered at the hospital (OLG). Though there are CHPS compounds and a Health Centre, most mothers preferred to deliver at the hospital because they perceived that it was a higher facility and the midwives and nurses there had more expertise and would take very good care.
of them. However, this perception was distorted by the actions and inaction of some nurses and midwives as almost all mothers had a very bad experience during their delivery.

At the facility, most mothers spoke of hostile and inattentive behaviour of some nurses that nearly caused their lives and that of their babies. Some of them were insulted and ridiculed.

“When we arrived, the nurse asked that I climb the stairs to and fro. I was in so much pain so it was difficult for me. A certain woman who also brought her daughter saw me and told me to take my time and take it easy. She was the one who helped me to climb the stairs to and fro. While the woman was climbing the stairs with me, then the nurse came shouting, leave her, leave her, you make her feel pampered, did anyone ask her to get pregnant! The nurse went and came again kom kom kom kom, walked passed me with a push, I nearly fell but I leaned on the wall nearby and sat. Then she came and said, hurry, hurry, the child’s head will come. Then I told her, an elderly person doesn’t do that. She went and came back, hurry up, hurry up hurry up, did anyone ask you to be pregnant!” (Naana, 20 years, Asikuma)

“The nurse gave me a container and asked me to go and bring a sample of my urine but because I was in severe pain and I have never been there before, I didn’t know where the urinal was, so I was confused! The nurse did not spare me at all, she insulted me and I told her I didn’t know where the urinal was, she insulted me again and showed me where it was and I went and brought the sample and gave to her. The nurse then injected me and the injection was hmm, aw, the injection was very painful, (silence, took a deep breath) so I held her uniform and she brushed me off. While it was painful, I wept and I tried to endure it, I held her uniform because she was closer to me that I could hold, but she brushed me off and said I should leave her and not make her uniform dirty with my hands. She asked me to lie down but the pain was just unbearable so I could lie down continuously, a little while then I sit up and the nurse shouted at me and said I should go and lie there, nobody asked me to get pregnant!” (Sarpomaa, 19 years, Ahomasu)

Some mothers complained of nurses leaving them on the bed and going away to chat/eat with their colleagues when they needed them the most. They called for their attention but the nurses didn’t attended to them saying their time wasn’t due for delivery when in fact the baby’s head was showing.

“I went and they took me to lab for some test and then the other ones that I went the nurse would check on me and the baby and give us some medicines to take. One day I had a strong felt to go and defecate and severe pains in my waist and abdomen and I told my mother. So she took me to the hospital and the nurses told me to walk about for a while. After that I went and laid on the bed and the nurse told me not to push. So some
a while I realized the baby was coming so I called the nurses but they told me my delivery time was not due, so I was there for about 3 hour until a cleaner in the hospital saw that the baby’s head was out and went and informed the midwife and she came. I was by then very weak that I could push so the midwife cut my vulva and the baby came out”. (Gifty, 20 years, Jamra)

“They asked me to walk around a bit until the child’s head fully turned. I was really in pain and suffering so I went and laid down. I called the nurses to come and attend to me because I was suffering but they told me my time would be due at 3:30pm and refused to come. I kept calling them but they rather insulted and shouted at me and asked me to lie down. Some of them even get angry. It was a certain doctor who was passing by and saw that blood had come out of me so much with some green water. So he quickly removed his shirt and put on a gown and helped me to the operation room and removed the baby. They nearly killed me, if it was death, I would have died. I heard the doctor telling the nurses that if he sends me and anything terrible happens to me, he would expose all of them and they would expelled them. He strongly warned them. It was the white man that took me to the operation room, they didn’t even help him. They did nasty things but I just overlooked them”. (Yaa, 32 years, Ahomasu)

Most mothers indicated that the some of the midwives were not comforting at all. Childbirth is a painful time and mothers needed some support from the midwife but according to mothers, some of the midwives turned a blind eye to their pains without any conforming words or action.

**Interviewer:** wow, so at the time you were in pain, how helpful were the nurses or midwife to you? What did they do to help you?

**Nmrepah:** “they did nothing! They were not even there. It was one nurse who attended to me and said they should send me to the theatre and then she left and never returned. So it was a different nurse who sent me to the theatre and that ended it. During the painful moments I just endured it and encouraged myself”. (Nmrepah, 24 years, Asikum)

**Interviewer:** so during this period, what did the nurse do when you were in pain? Did she try to comfort you or say or do something to calm you down?

**Sarpomaa:** “the nurses didn’t know what comforting someone meant!” (Sarpomaa, 19 years, Ahomasu)

Some of the mothers such as Aba, Adwoa and Serwa, however had a good and pleasant delivery because their relatives worked in the hospital (the maternity ward). Aba and Serwa are health workers and they were known by the nurses and midwives.

**Interviewer:** How were you treated in the labour ward? Were the midwives or nurses receptive?
Serwa: “Fortunately for me, my mother in-law is a midwife there, so she came to monitor my progress, gave me medicines to relief the pains when the pain had aggravated. In fact, I was fortunate. But what I can’t tell is whether that treatment was because I am a health worker and because of my mother in-law. I was received really well and treated very nice. Some of the workers asked me if there is something they could get for me to eat. They were really nice”. (Serwa, 28 years, Asikuma)

Regardless of all the challenges, pains that mothers went through, becoming a mother was a positive experience. They were generally happy to have a safe and natural delivery although there were some mothers who had episiotomy.

“I must say that the feeling of being a mother, having a safe childbirth, is such a joy! It gives me an inner satisfaction and happiness to even see my baby sucking my breast. I feel very happy when I see my baby playing”. (Serwa, 28 years, Asikuma)

“I was happy that I have given birth in peace, and seeing my baby. So I was happy”. (Adwoa, 30 years, Jamra)

“I was very happy because when I was pushing, it was very painful and when the baby came out I was ok”. (Fosua, 24 years, Asikuma)

Gifty expressed her joy after childbirth because of the female sex of the child as she was the only daughter of her parents. And for cultural reasons also she was also very glad since the child will succeed her in future.

“I was very glad that I had someone like me, a baby girl because I am the only girl child in my family and also she baby will succeed me not the man because of the matrilineal system”. (Gifty, 20 years, Jamra)

There was the fear of caesarean section in most mothers. Mothers were hopeful that they would deliver the natural way without operation. Some mothers resorted to prayer for a safe delivery and they were grateful to God for the safe delivery. Two mothers had operation and they were also grateful to God for safe operation because some go through it and loss their lives and/or that of the baby.

“She asked everyone to pray before the delivery. She said that there are some people they are unable to deliver and the baby might die or both the mother and baby. So we should pray. Even when I was laying on the bed I was praying, because I didn’t want
to be operated upon, I was very afraid of the caesarean section”. (Clara, 19 years, Jamra)

Interviewer: but why did someone tell you that they would operate you?

Clara: I went to church and the pastor said they have tied my baby in my womb so during delivery I would go through the caesarean section. So I was scared that they were doing to operate on me”. (Clara, 19 years)

First Breastfeeding experiences

While some mothers started breastfeeding at the facility others did not for two reasons - some mothers’ breastmilk did not flow and also the midwife or nurse did not initiate the breastfeeding for them. Some of those mothers that started the breastfeeding in the hospital, a number of them indicated that, it was not the nurse or midwife that taught them, the children were just giving to them to breastfeed with no teaching. The mothers however indicated that it was after one week after birth that the nurse taught them when the returned to the hospital for postnatal care.

Some of the mothers’ breastmilk did not flow for weeks after delivery. Naana and Yaa for example, their breastmilk did not flow until after a month.

Interviewer: did you start breastfeeding at the facility?

Yaa: “no, the breastmilk wasn’t flowing so they even gave me medicine to take to aid its flow but still. So at the hospital, the prepared food for the baby and later when I was home for about one month before the breastmilk started coming out”. (Yaa, 32, years, Ahomasu)

This is what Adwoa had to say when I asked about the first breastfeeding of her child.

“How do I say it? The baby was crying, the baby was laid on a table after they dressed her. There was this nurse who was selling earrings, so when she came in, she raise the baby for me to breastfeed. So I breastfed the baby”. (Adwoa, 30 years, Jamra)

This baby was not given to her for mother-and-child contact. The baby was dressed and put on her bed (table) until she was crying before the different nurse lifted her up and gave to her
mother for the first time. Meanwhile, there is the need for mother and child bonding soon after delivery but this did not happen for most mothers.

**Life at four weeks after childbirth**

About eighty percent of the mothers narrated that the early days (first 1 week) after childbirth was associated with physical pain as some had episiotomy and caesarean section; sleeplessness because they woke up very often to breastfeed the child. Mothers also complained of their inability to do house chores and care for themselves and their babies. Parents also considered this period to be very delicate for the survival of the child and also considered mothers to be weak and for that matter needed maximum rest. Parents, parent in-laws and grandparents also acknowledge that fact that these mothers were inexperienced in caring for themselves and especially the child, and due to that needed their maximum support from them.

“I was still in pain because I had a cut but I was shown the medicine to take and over time I was ok. Grandma was bathing the baby while my mother helped did the cooking, fetching of water and the washing. So about a month later, I started to do some house chores. Grandma said when you deliver, you are weak and not very strong and needs to rest”. (Gifty, 20 years, Jamra)

“...not really, just that you are not yourself again and the time that I wasn’t pregnant or given birth, I could sleep anytime and wake up anytime but now that the baby is here, I cannot sleep when the baby is awake. Unless the baby is asleep I cannot sleep. The baby can wake up anytime and I have to wake up too” (Ama, 25 years, Asikuma)

“...but deep into the night while I am asleep, then she would wake up. It really destructed my sleeping patterns and I could have very good sleep”. (Mansa, 18 years, Asikuma)

**4.4 Mothers’ Social Support Structure**

The second key objective of the study was to explore the first-time mothers’ access to social support during pregnancy and after delivery. This was captured from the transcription of the data under the theme *social support structure* comprising kinds of support received and providers of support.
4.4.1. Kinds of Social Support Received

All the mothers in the study reported receiving different kinds of social support, which can be categorised into instrumental support, informational support, and emotional support. The support received was given freely to mothers.

**Instrumental (tangible) Social Support**

Tangible support was the most common support received by all mothers. The support received included gifts in the form of dresses/clothes, shoes, pampers, wipes, umbrellas, soap, food staffs, firewood and assistance in child care activities such as bathing the child, massaging the child with herbs, dressing the child, wearing of pampers, carrying and playing with the baby. Also, provision of food for the mother was very important as mothers heartedly reported been cared for with food to eat and water to bath. The mothers also talked about the help received in carrying out their house chores such as cooking, laundry, fetching of firewood, water; accompanying mothers to antenatal and postnatal care. Again, they received gifts in the form of money to mothers for transportation and purchasing of other essential items needed. Some of the mothers narrated the support they received as indicated by Nmrepah and Mansa in the following.

“Oh, my partner has supported me a lot from the very day I told him about the pregnancy to today. When I was pregnant, life was very difficult for me, there was nobody with me except him. He did almost everything for me, the chores I would have done, by the time I wake up, he had done them all. Chores such as sweeping and washing of bowls”. (Nmrepah, 24 years, Asikuma)

“My mother provided food for us, bought for us clothes and dresses, umbrella and other things. She carries her and plays with her, sometimes sings lullaby to her to sleep or stop crying while I do some chores. Sometimes she bathes her and sometimes my grandma does that too until six months later that I started to bath her and wear her pampers. They said she was very fragile for me to handle and bath her, I might not hold her well and break her bones. I was also afraid of holding her at that tender age. I was afraid I might break her bones or she would fall from my hands, she was very small”. (Mansa, 18 years, Asikuma)
**Informational Social Support**

As first-time mothers, information concerning childcare and self-care was considered very vital to them because of their inexperienced nature in pregnancy and childbirth. Informational support in a form of advices and correction are giving to these first-time mothers. Information regarding care for pregnancy, eating and sleeping patterns, caring for the baby such as wearing of pampers, breastfeeding the child, bathing the child, caring for themselves and also information about antenatal and postnatal visits were received from diverse sources.

“They would advise me to take care of the baby well: in breastfeeding her, wearing her heavy clothes when the weather is cold, sleeping under net”. (Serwa, 28 years, Asikuma)

**Emotional Support**

Emotional support in the form of appraisal, encouragement and acceptance of pregnancy were received by most mothers. As mentioned earlier, most of the mothers had mixed feelings about the news of their pregnancies as many were not planned. Some mothers were not happy and expressed fear of denial by partners. Fear of parents engulfed the younger ones making them emotionally unstable. Most of the teenage mothers feared for their future as some of them had dropped out of school and did not know what the future holds for them. They were, however, happy when some of their partners accepted the pregnancies. Their parents’ acceptance of the pregnancy and words of encouragement added to their joy. During the pregnancy and delivery, physical pain which led to some emotional distress was experienced by most mothers.

Parental and other community members’ encouragement was one thing that gave mothers hope.

“... when someone encourages you it makes you realize your mistakes and be careful and hopeful. They told me to take good care of the baby if not she would become sick and that if she grows I can still go back to school, it gave me hope”. (Rita, 18 years, Ahomasu)

“Oh my bonafide property...wow! Emotionally, he’s been very supportive. I liked to be kissed on my forehead and he always does that every time he comes around. After I gave birth and the baby was dressed up, he was the first person to kiss the baby on her
forehead. So it has become part of us. When he gives me perk, he gives the baby too”. (Serwa, 28 years, Asikuma)

A parent (mother of teenage mother) speaks on why she should encourage her teen daughter who is now a mother herself.

“I also encouraged her and told her to be calm, once the pregnancy was there, I will care for her. I did this because, she had friends that she could have sought for advice from them about her situation, like giving her some medicine to take that I would not have been in the known, and that could have caused more pain or hurt to the both of us”. (Maame, Mansa’s mother, Asikuma)

Having someone to chat with or share your problems with was also considered an emotional support as mothers perceived that as love.

“For about 2 weeks, he didn’t go to work. He sat with me and chatted and comforted me. This showed that he was a good person and that he loved me”. (Nmrepah, 24 years, Asikuma)

In some Ghanaian societies, it is believed that pregnancy carries with it spiritual dangers and therefore create anxieties in the expectant mother. The belief in the ability of God to bless and avert every evil attack on the mother and her child was strong among participants. As Christians, all mothers talked about praying and being offered prayers by other believers to enable them successfully cope with pregnancy and delivery. The following narratives be some of the respondents gives the extent of in-depth of such a believe system.

Nmrepah described her delivery experience and how she coped with the associated anxiety.

“When I arrived there, things were difficult because when I arrived there the midwife told me that the fluid coming out from the baby was not good so they would send me to the theatre and check the baby because it was dangerous for the child and if there was any delay i could lose the baby. So, it was all about prayer! We prayed until I delivered. I called my pastor and we prayed and after five minutes I delivered”. (Nmrepah, 24 years, Asikuma)
Clara talked about similar experience on admission for delivery,

“When we arrived at the facility, the midwife prayed for me and she asked everyone to pray before the delivery. She said that there are some people they are unable to deliver and the baby might die or both the mother and baby. So we should pray. Even when I was laying on the bed I was praying, because I didn’t want to be operated upon, I was very afraid of the caesarean section”. (Clara, 19 years, Jamra)

Gifty expressed how concern for survival of her grandchild led the grandma to pray for the baby.

“My grandma also prayed for baby. When she was still a baby, sometimes she sleeps and talks, so, it was believed that something supernatural was tormenting her, so grandma prayed for her”. (Gifty, 20 years, Jamra)

In the case of Yaa it was her pastor and church members who antirecessionary prayers for her from conception to delivery.

“My church members also prayed for me and it is very good because they would ask for protection for you. Everybody needs supernatural protection, otherwise times would come that you can be very sick and cannot even open your mouth to talk. So, in that case the church members intercede for you. The prayers helped during my pregnancy, delivery and even now. About a year ago, I became sick and it was through the prayers, little by little and I became well again. God was merciful on me and healed me”. (Yaa, 32 years, Ahomasu)

Sarpomaa also talked about her pastor’s role in making her cope with fear and anxiety.

“She prays for me and the child. When I returned from the hospital, she took the child from me and prayed for him, blessed him. I was really touched when I saw her did that”. (Sarpomaa, 19 years, Ahomasu)

Serwa reported about her mom’s persistence in prayers for her and the child.

“Spiritually, my mom would make sure she holds morning devotion with us before she starts her work. She also like inspiring words; she often says blessings over my child when bathing her. I like her for that. She says good things over his future. She hates discouraging words. Spiritually, she has been of the best support and that is how she has brought us up with, it has become part of us”. (Serwa, 28 years, Asikuma)

The study also asked the first-time mothers about whether the support they received was adequate enough for their needs. Most of the mothers indicated that the support that they
received was enough. As expected, there was a clear difference regarding the reported sufficiency of support for the married/older mothers and the single and teenage mothers. The support that mothers received was strongest during the first three months after delivery. But as the days, weeks and months passed by, the support began to dwindle. It is believed that, by the end of the third month of delivery, the mothers would have learnt the basics of maternal care and responsibilities to able them do a lot of things on their own. One of the parents of the first-time said this about how long she would assist her daughter.

“Support is needed by new mothers for three months. By then she would have learnt to do some of the things and also by then the child is old a bit and not fragile to handle” (Sarpomaa, 19 years, Ahomasu)

For some other mothers, they didn’t get this longer period of support but had to start doing things for themselves soon after delivery. Abena, a teenage mother, was staying with her old grandmother who was too weak to support her. All the grandma could do to help was bathing the child for her. She described this as a limited support she received

“I really didn’t get a lot of clothes, soap, my grandma too didn’t teach me a lot of things, like feeding for the baby and other helps. My grandma too weak to help with house chores and washing” (Abena, 17 years, Ahomasu)

It was clear from the data that several factors influenced the support received by the participants in the study. These factors include age, marital status, and employment status.

**Age**

Age was a major factor that played out in the extent to which mothers received social support. The participants can be categorized into young mothers (17-20 years old) and older mother (21-32 years old). It was evident that the younger mother had challenges in accessing support especially from the health facility as their pregnancies were considered teenage pregnancies and they were ridiculed. Though most of the pregnancies were not planned, for the teenagers,
when the question on support sufficiency was asked, most of the teenagers’ responses indicated that, they had this feeling of been favoured by their mothers.

Earlier on, it was reported that, most of the teenage mothers were expectant that their mothers would beat them, or even sack them from the house without any support. This initial perception hindered them from even asking for support. Sarpomaa shared her experience during the interview that;

“What they could do to help me is what they have done for me. When I became pregnant I was afraid that my mother would have insulted me or done something bad to me, I was really afraid but she didn’t do anything to me, rather she supported me and took care of me through my delivery until now. So I am very grateful to her. What she was able to do is what she has done” (Sarpomaa, 28 years, Ahomasu)

Occupation

The ability to move to the clinic for antenatal and postnatal care, purchase clothes, food, and other necessities of life for the mother and child depended on the financial status of the mother and partner and/or family. Most of the teenage mothers were unemployed and therefore depended on their parents for support.

Abena, a 17 year old unemployed mother described her situation.

“Oh, things were not that good because we had no money to buy foodstuffs, soap for bathing or even washing. One time the baby became sick and I took her to the hospital. I didn’t have any money to pay for medicines, and other bills, I was very sad. Grandma became very angry and informed the man who impregnated me, it was the next day that he came and settled the bills before they gave us the medicines we needed”.  
(Abena, 17 years, Ahomasu)

Unemployment affected even some older mothers in a similar way. Bernice, a 39 year old married mother had this to say;

“For the support, as I am not working now, is like the man is the only one working to support. If I was working, I would have added my pay or money for all the expenses. And if you need something, because you are not working, the man cannot afford all. Even if he will do it, he will do a little but not that much as yourself”. (Bernice, 29 years, Jamra)
For those mothers who were in the formal employment, transfer from the place of work separated them from primary support providers, limiting the amount of support received.

Serwa, a health worker had this to say.

“I wish had more of the support but I had to resume work so I don’t have the support as I wish I would. The distance between my husband and myself because we work at different place is one challenge for needed support”. (Serwa, 28 years, Asikuma)

**Marital Status**

Whether the mother was married or not, to a large extent also determined the extent of support received. Though some mothers were not married, their partners accepted the pregnancy and contributed their quota of support. They however indicated that the support was not sufficient in most cases but for those who were single mothers, their mothers (mother of first-time mother) were their main source of support. The married mothers reported continuous husband support even when their mothers and in-laws are not there to support them. For example, upon asking if the support received by married mothers and those who are not married are the same, Yaa, a seamstress, had this to say:

“Not at all because when you give birth and you are not working, your husband can work and bring money home to care for you. There may be certain things you need to buy for the child, maybe medicine, soap and other things that you may not be able to buy but with the presence of a husband, he would try to work and help for you to be healthy”. (Yaa, 32 years, Ahomasu)

Social support served many purposes for a first-time mothers as it helps them to recover from their birth experience, maternal childcare self-efficacious and also give them hope. This is what Nmrepah had to say about the how social support has been of help to her.

“...yes, for example if I was not helped or supported, like today I don’t know what would have become of me, I would have been hopeless. There are some mothers when they give birth and there is no one to support them, they can be so sad and go through agony. They would be thinking a lot and this can lead to them having mental problem and then she would not enjoy her birthing experience” (Nmrepah 24 years, Asikuma)
Due to insufficient social support, most of the adolescent mothers had no plans of returning to school. They also expressed fear of being stigmatized by their peers. With the exception one teenage mother who was already in school after four months of childbirth and enduring the ‘shame’ (stigma), the remaining wished to learn a vocational skill especially seamstress work (dressmaking). To a large extent, this decision was not solely a personal decision but is also influenced by the poverty level of the family. Already, it was difficult to care for the mother and child, so if she return or wish to further her education, who would take care of the extra expenses? So, most mothers were encouraged to learn a vocation which would later bring in money to support herself and her child.

Naana for example, started learning the skill, but for lack of support, she could not continue to the end. Even transportation to the place of work was a big problem.

“My sister was like if the child is one year, she would take her and let me go back to school but I told her no, I will rather learn a trade. After the 1 year, I started work (seam stressing) but the money to use for transportation to work and back wasn’t there, so after 3 months I stopped” (Naana, 18 years, Asikuma)

Sarpomaa’s mother expressed similar sentiment.

“I want her to go and learn a vocational skill but it is still about money to get her enrolled in it”. (Sophia, Sarpomaa’s mother, Ahomasu)

4.4.2 Providers of Social Support

The participants reported receiving assistance from a variety of providers including family members (mothers, grandmothers/aunties, and siblings), husbands/partners, mother in-laws, friends, church members, and health care professionals.

 Mothers of Primiparous Women

Mothers of first-time mothers were the main providers of support for the primiparous women most especially few weeks before delivery and up to three months after childbirth. Mothers
continually gave support to daughters in the form of instrumental support especially childcare activities and house chores. According to Fanti custom, women who give birth, especially at the first time are expected to move to their mothers’ home where they receive help in the area of childcare activities such as bathing the child, providing food, and learning about child care practices, In the case where the mother is weak, a mother in-law performs this role.

Serwa describes her stay with the mother for support after birth.

“My mother took care of us. She knows me very well; knows how to cheer me up with jokes. She normally says a particular incorrect English sentence which makes every laugh. She also supports us financially with the buying of gas and charcoal when I lived with her after my child birth. She never asked me for money for such things, she does them herself when the need to buy arises. That is a cultural thing we do: when you give birth you go to you mom. I am the first daughter”. (Serwa, 28 years, Asikuma)

Most of the cohabiting mothers unanimously reported that their partners had not performed their marriage rights so they could not have stayed with them anyway.

“I don’t stay with him because he has not yet performed my marriage rite but if he had performed my rite, I would have been staying with him and most of the support would come from him”. (Fosua, 24 years, Asikuma)

Mothers showed their unflinching support for the teenage mothers though they were not very happy about their pregnancies. The mothers indicated that no matter how wayward the child has gone, they needed their help as their mothers. They however strongly warned the teenage mothers that, if the phenomenon repeats itself, then they are on their own. The mothers were mainly responsible for providing all the kinds of the support mentioned above with few from friends and other people.

Sarpomaa’s mother’s statement echoes that of other women with teenage mothers in the study.

“It is my responsibility because the man has refused to come and support and this child is also very stubborn, your father is deceased and I am the only one. This man will give you a penny and it can’t even buy something to eat for a day. I will not also sit there and let them be hungry, so as a mother I have the responsibility to take care of them. Sometimes, if she asks me for something and I don’t have, I just tell her to be patient
and that if God blesses me and I get it I will give her. However, if she gets pregnant again, there is no way I will involve myself or even talk to her! The man that impregnated her too is not helpful at all” (Sophia, Sarpomaa’s mother, Ahomasu)

Although the mothers of the participants provided antenatal and postpartum support at home, the information on maternal and child care practices provided were sometimes in conflict with those provided by health care workers at the clinics. For example, the mother of Adwoa expressed the problem:

“Now, the health professionals say if a woman gives birth enema shouldn’t be done for her with the herbs but hitherto, we used to do it because it helped the mother. Some of the things they tell us, we don’t do them. Except the woman went through caesarean section, other than that I see no reason not to do it. We use camphor (naphthalene) in water and she sits on it, it makes her strong and we give her some herbs to take”.

(Adwoa, 30 years, Jamra)

**Husband/Partner Support**

Partner support for most cohabiting mothers was limited especially emotional and financial support. Among the reasons was the fact that they did not stay with them, and also lack of employment for partners. And some of them were student in the senior high school that were cared for by their parents. Though some first-time mothers understood the situation and therefore expected their parent in-laws to pick up the responsibility, in most cases, it did not happen. For Afia, her partner did not have enough to take care of her, so the mother in-law took the responsibility of caring for her. Below is her reaction when I asked her these question.

“...yes, because she (the mother-in-law) is the mother of my partner so when he is not around, she is supposed to take care of me. Ooh, it would have been very hurtful or painful if she didn’t because if your son is not around or is not prepared enough to carry that responsibility and you the mother ought to do it for your son.”

(Afia, 23 years, Asikuma)

By contrast, the married mothers acknowledged strong support from their husbands. The perception was that the men had married them and for that matter are responsible for satisfying
their basic needs. They also perceived continuity of support from their husbands as compared to the single mothers.

Yaa, a 32 year old married seamstress said that.

“It is not every woman that gives birth that has a husband. It is not everything that your own mother can do for you. They can help to some extent but if you have a husband, you are his and therefore his responsibility. In that case there is continuity of care. If he wasn’t there I am very sure I would have gone through a lot of hard times and I could have been sick or stress up or break down because I had to do all the work when I returned from the hospital and that can affect the child also”. (Yaa, 32 years, Ahomasu)

**Significant Others-Friend, pastors and other community members**

Neighbours and friends of the first-time mothers were also of great support to them. Some of them advised them to take good care of their babies, they learnt certain childcare activities such as wearing of diapers, and breastfeeding from them. Some friends visited them with gifts, fetched firewood and prayed for them.

Clara, a 19 year old apprentice seamstress described the support she received from her madam (trainer) and some colleagues.

“My madam came and visited me with one of my colleagues but when she was coming, she didn’t come with anything. But the fact that she came to visit me and ask how I was doing, it was fine by me compared to those friends who didn’t come at all. My friends also told me to always cover the baby and do not expose him to so much wind other than that he will get cold. The also told me to always sleep under the net with the baby. Some of them have given birth and the others too, they have not given birth but they all advise me”. (Clara, 19 years, Jamra)

However, no advice given by significant others was perceived by the mothers as supportive. For example Clara described her anxiety based on the advice given by her pastor a few weeks before delivery.

“I went to church and the pastor said they have tied my baby in my womb so during delivery I would go through the caesarean section. So I was so scared that they were doing to operate on me”. (Clara, 19 years, Jamra)
4.5 Some challenges faced by Social Support Providers

The study also attempted to find out the challenges that social support providers face in providing social support to primiparous women. Social support providers reported facing many challenges in supporting the mothers. Poverty was a major factor at the family level due to general harsh economic conditions in the country. Providers who were traders complained of very low sales that rendered some of the perishable goods damaged. Other providers, especially partners, were unemployed limiting their ability to provide any kind of support. The following are excerpts from conversations with some providers.

“If the mother is very young and for that matter is not working and the guy who impregnated her to is not working, it will bring some constrains/pressure of her mother. I care for them, even if you say the man should support, this village what work is here for him to do and get money to support my daughter. So my dear, the little stuffs I sell, that is what we use to support ourselves. It is all about money, I did well to send her to school until she completed, and just after that she became pregnant. We need money to open businesses or trade, so if you get the money and you are not lazy, you can make a good living. If you send it to the near communities, you can sell those items and get some money.” (Sophia, Sarpomaa’s mother, Ahomasu)

“So I had to stop work in order to take care of her all alone since her father passed on and the boy also denied the pregnancy. In times of finances, it was hard but we manage.” (Maame, Mansa’s mother, Asikuma)

One adolescent mother talked about how sad she becomes whenever her mother refers her to go to the unemployed man who impregnated her for money. A recall of this feeling of single mother supporting another single mothers reminded providers of the stubbornness of their daughters.

“It is my responsibility because the man has refused to come and support and his child is also very stubborn, your father is deceased and I am the only one. You will tell them to sleep but they will not sleep, they will sneak out and go and play with boys. If they go to school and refuse to come back early, while you are thinking they are doing extra classes, they are somewhere with men playing. What they have purposed in their heart to do, they will do it. And when they are pregnant they pressure come to us.” (Alberta, Joyce’s mother, Asikuma)
Yet another challenge was the fact that the demands of work did not allow providers enough time for the mothers continually. Some work schedules separated a mother and provider from each other. A case in point is that of Nmrepah, a 24 year old food vendor who is cohabiting with her partner.

“My partner’s support wasn’t that much but I accept it like that because now that I am here with my mother, if I ask my partner for something, it will take longer time for me to have it which was not so. It will take like 3 to 5 days before I get it. Work had brought a big distance between us and because the baby is still very fragile, I cannot go and stay with him because he cannot help care for the little baby like my mother does. But when the child grows a little I can go to him and have his full support.”

(Nmrepah, 24 years, Asikuma)
5.0 DISCUSSION

5.1 Introduction

The study mainly sought to explore the first-time mothers’ experiences of pregnancy, delivery and after childbirth and their social support systems. To achieve, the experiences of primiparous women during pregnancy, delivery and after childbirth were explored; the various kinds of support that first-time mothers receive and the sources of the support were identified and finally the extent to which receipt or non-receipt of support influenced their ability to deal with the challenges of their new maternal roles were examined. This sections seeks to discuss the major findings of the study based on the objectives.

First-time mothers’ lived experiences during pregnancy, delivery and after childbirth

Consistent with Barton, Redshaw, Quigley, and Carson (2017, page 3) the study found that the pregnancy intention to a large extent determined the psycho-social state of the mother. Only three out of sixteen mothers planned for their pregnancy and this brought great happiness to them. The other mothers had mixed feeling of happiness and unhappiness concerning their pregnancy several reasons. Firstly, they were not married while the pregnancy happened. Secondly, they were too young to be pregnant, examples adolescents. Thirdly, the pregnancy made them school dropout. Fourthly, fear of pregnancy denial by partners, and lastly, fear of bad/overreaction from parents. This caused a lot of anxiety and distress in mothers and some sought for crude abortion.

One key finding was that, though parents of adolescent mothers were not very happy about the pregnancy, they however accepted it and refused abortion, for fear of death. Denial of pregnancy by partners caused a lot of psychological distress in such mothers because of their ambivalent behaviour towards them (Owoeye, Aina, & Morakinyo, 2006). However, older
mothers aged 20 years and older were happy about their pregnancy though they were not married because they felt they were old enough to give birth. Three of four married mothers at the time of study planned it, the last one had the pregnancy and as a result, the marriage rite was performed. Against the finding of Sedgh, Singh and Hussain (2016) that unintended pregnancies are lowest in traditional societies, this study found a lot of unintended pregnancies in the rural areas and even more among the unmarried and cohabiting/single (Mosher, Jones & Abma, 2012) and adolescents (GDHS, 2014). High unintended pregnancy meant low contraceptive use among mothers.

Most of the mothers did not know they were pregnant at the initial stage because some of them had irregular menses. While some mothers had information about their pregnancies at the health facility because they were sick and had to visit the hospital, others were told by family members and other people in the community. This is consistent with the findings of Ankomah and Konadu Gyesaw (2013).

As noted in literature, mothers experienced a lot of health problems including physiological and psycho-social problems due to the pregnancy. The pregnancy risked the mothers to a lot of ailments such as abdominal and waist pains, anaemia, hyperemesis, insomnia, easy fatigability, weight loss/gain, loss of appetite, oedema of the feet and inability to do their normal house chores. As a result of the pregnancy, many mothers reported changes in their social lives as it limited their movement and some of them isolated themselves (Jonge, 2001; Sawyer et al., 2011). Due to some of the physical ailments that made mothers like weight loss, mothers attracted bad perception from society. Society members regarded especially the teen mothers as bad influence as reflected in the names they called them: bad and stubborn girls. This study confirms Ngum Chi Watts, Liamputtong, and Mcmichael (2015) study of adolescents mothers in Australia.
During antenatal visits, most adolescent mothers reported maltreatment from some nurses such as insults, ridicules, disrespect, shouting, impatience as a result of their teen age. Most of the mothers indicated that pregnancy and childbirth-related information was taught. However, it was not adequate so most of them relied on families for information (Johnson, Kirk, Rooks & Muzik, 2016). It is therefore important to find out the similar and contrasting information between health facility information and the traditional health practice and see how to merge both to benefit the modern mother.

Almost all mothers didn’t know they were in labour, they were however told by their mothers, aunts and grandmothers because such information was not given during the antenatal visits. They reported severe abdominal and waist pains during labour. However, except two mothers who spoke of been given pain reliefs, all other mothers endured the pains as they told by their parents it was part of birthing process. Only one mother delivered at home while the fifteen mothers delivered at the hospital. This reflects the GDHS 2014 data on increase in skilled attendant delivery. All mothers reported that delivery was not easy as they went through pains and some had episiotomy. There was little information on pain reliefs given to mothers during labour. It is therefore important to further research on mothers’ knowledge and use of pain reliefs to make their delivery experience better.

Similar to literature, most mothers reported impatience, inattentiveness, unsupportive and hostile treatment from nurse and midwives during delivery which could have caused their lives and that of their babies (Crissman, et al., 2013). There is the need therefore to further investigate on the attitudes of nurses and midwives at the facilities that make health care utilization difficult for mothers. Since such attitudes are detrimental to the health of babies and mothers and can lead to mortality, in the fight to reduce mortality, it is important to reconsider the
professionalism of health workers. Most first breastfeeding initiation was not done in the facility by a professional instead, families members such as mothers.

Mothers complained of sleepless nights, pains and body weakness few weeks after childbirth which brought a lot of stress on them. In accordance with previous studies childbirth was seen as positive experience that every woman should go through, and that it cannot be described except one goes through it. Mothers were very happy to see their children and the joy of breastfeeding their children was greatly expressed (Sawyer et al., 2011). In sub-Saharan Africa anthropological research suggest that childbirth can be a positive experience for mothers for several reasons. First, social perpetuity, that is, children will continue the family heritage. Second, social security where children would grow to care for their parents (Inhorn & van Balen, 2002). Mothers were also happy that they had natural delivery as most of them feared caesarean section.

In relation to the social ecological model framework upon which this study is carried out, it is clear that the experience of the mothers are affected by different factors and at different level ranging from the individual, to the family, to the community and the organization. At the individual level, the age of the mother influenced how happy or unhappy she was about her pregnancy. For the older mothers, they felt proud that they were pregnant since it was not teenage pregnancy but for the adolescent, they were filled with fear and anxiety. Other individual factors that influenced the mother’s experience were her marital status, employment status. At the community level, people did not expect a teenager to be pregnant or drop out of school because of pregnancy. At the family level, the partner’s or mother’s acceptance or denial of pregnancy greatly had influence on the mother’s experience, whether positive or negative. At community viewed them as bad influence and this affected them socially and
psychologically. Though health facilities were available for the mothers to use, the unprofessional attitudes exhibited by health workers also impacted on their experience.

**Kinds and sources of social support received and the extent of social support and how it helped primiparous mothers**

First-time mothers perceived social support to be very important to them during pregnancy, delivery and postpartum because of their inexperienced nature. Through social support they gained confidence and maternal and childcare self-efficacy by learning from the experienced ones. They also had rest from their birthing experience. In consistent with previous studies, mothers received social support of different kinds and from different sources. Spiritual, emotional, physical and informational support were the various kinds received. They also received social support from both the formal and informal sources. Family members especially their mothers and husbands provided the most support (Leahy-Warren, Mccarthy & Corcoran, 2012; Leahy-Warren ,2005; Freund, 2007). For adolescent mothers, their mothers were their major source of support as partners denied pregnancies and some of them were not working to support them (Story et al., 2016). Mothers however warned their daughters strongly not to get pregnant again out of wedlock otherwise, they would be on their own. Mothers’ acceptance of their pregnancy was a great support given to their daughters.

In most cultures in Africa and Asia, it demands that a woman who gives birth stay with her family to care for her during the postpartum period at least up to 8 weeks (Yoshida, Yamashita, Ueda & Tashiro, 2001). In this study, because the unmarried were already in their family homes, this practice was not seen. But among the married women, some of them moved to their family homes for their mothers to care for them, and for others, their mothers or in-laws moved and stayed with them to care for them and their babies for about three (3) months.
The study found that partner support for most of the unmarried was limited and the burden was laid on their mothers who were mostly single parents. This finding contrast with Freund (2007) finding where partner support was strongest for mothers. The unsupportive partners who did not help mothers during pregnancy and after childbirth did not make their experience easy. Emotional and physical support were very important to mothers. Support from mothers was massive during the first three months of childbirth but it diminished as the weeks passed, as evidenced in a study by Cronin (2002). This led mothers to have more responsibilities hence high distress. Social support received differed with mothers for several reasons.

**Challenges in providing and receiving social support**

The challenges that providers and mothers faced in providing and receiving social support respectively were seen to be influenced by several factors at different levels. At the individual level, the mother’s socio-demographic factors such as age, economic level, respect, marital status affected the extent to which she received support. Adolescent mothers didn’t have confidence in their pregnancies, and the fact that their mothers accepted the pregnancy was seen as a big time favour to them. For that matter, this feeling of been favoured hindered them from freely asking for support except what the providers could do for them. And they were very appreciative that their mothers did not sack them from home but went ahead to support them though it was not very enough for them. Continuity of support was rare among the unmarried especially the adolescent mothers compared to those who were married. The age and marital status also influenced their social networks hence the support received (Yeboah 2012).

At the family level, poverty was a major reason why support was not sufficient for most mothers. Most of the key support providers for the unmarried were single parents (mothers) and this brought pressure on the finances and less support and attention for the mothers.
At the community level and health facility level, discrimination and stigmatization by some community members and health workers hindered some mothers from receiving the necessary support that they needed. Lack of employment opportunities for most partners also limited their level of support to the mothers. Work distance and the hassle to make ends meet did not allow supporters enough time and space to support mothers to the maximum.

One major finding was that most adolescent mothers could not return to school because of lack of continuous support and so had to engage in vocational skill training that could fetch them income sooner to support themselves and their children.

5.2 Limitations of the study

A key limitation of the study concerns the generalizability of the findings. Like all qualitative studies, findings of the study cannot be generalized to the population of first-time mothers due to the sampling design (non-probability) and the small sample size.

As noted earlier, the questions were designed to elicit long and detailed answers to questions about pregnancy experience. Some of the young participants were not comfortable with questions concerning their dating behaviour before they became pregnant. Although attempt was made to debrief them and re-emphasizes the purpose of the study, I cannot be absolutely sure that this point did not influence their responses.
CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter gives a summary of the findings of the study in a form of conclusion and then suggests some recommendations based on the findings of the study.

6.2 Conclusion

This study shows that childbirth is a defining point in women’s lives and it is coupled with physiological and psycho-social distress during pregnancy and childbirth. Unplanned pregnancies contributed greatly to this problems. Inadequate information and hostile attitudes of health care workers towards mothers compounded their bad experiences.

Pregnancy exposed mothers to a lot of health risk such as hyperemesis, edema, insomnia, loss/gain of weight. It also brought about social isolation and other social changes in mothers. Delivery was accompanied with severe pains in the abdomen and waist of women and mothers reported being worn out, restless and tired after childbirth. They also spoke of their inability to care for themselves and their children and their inadequate knowledge about maternal childcare activities, hence their need for maximum support.

Social support of different kinds were received by mothers: physical/tangible, informational, emotional and even spiritual. Mothers of first-time mothers, their mothers in-law, husbands, partners, friends, church members and neighbours. Level of support received by mothers varied with their age, occupation and marital status. Mothers provided the most support for the unmarried mothers. Partner support has been low though mothers were expectant of massive support from them and continuity of support was rare for most mothers. Though mothers acknowledged receipt of support during antenatal, most of them reported unsupportiveness of
midwives during delivery. Social support given to mothers diminished over time; it was maximum with the first 3 months for most mothers.

Social support served many purposes for a first-time mother as it helps them to recover from their birth experience, maternal childcare self-efficacious and also give them hope. Poverty, demands of modern work among others were factors that inhibited social support providers from providing adequate support to primiparous women.

6.2 Recommendations

Based on the findings of this study, the following are recommended.

- Aside the medical check-up during the antenatal and postnatal visits, social life issues of mothers should be discussed. Adequate information regarding changes during pregnancy, labour signs, delivery and child care should be provided by health workers during antenatal and postnatal care. The Ministry of Health/Ghana Health Service should collaborate with the Department of Social Welfare to provide counselling interventions to mothers who may experience social and psychological difficulties during pregnancy and after pregnancy.

- Health workers should be trained and checked by the Ministry of Health and Ghana Health Service and Health Facility Administration to provide health care services professionally without discrimination based on age, marital status, economic status and whom you know. A family member or any significant person should be present during delivery to provide emotional support to mothers since midwives and nurses are not doing it.
• The reliance of new mothers on a weakening traditional form of support was clear in this study. It is recommended that a state sponsored social security scheme be designed by the government for first-time mothers who have no or limited social support networks. Programs and policies should be designed to increase and nurture social support networks while also building on the evident resilience and resourcefulness of these young women. Micro loans can be provided to mothers (who are the main support providers) by financial companies to start and improve their businesses.

• Non-governmental organisations can also establish social groups for first-time mothers to interact among themselves and increase their social networks.
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81


APPENDICES

Appendix I: Interview Guide

Section A: Socio-demographic Background of Participant

<table>
<thead>
<tr>
<th>Age</th>
<th>Education</th>
<th>Occupation</th>
<th>Religion</th>
<th>Marital Status</th>
</tr>
</thead>
</table>

✓ Who they stay with?

✓ Affiliation to social groupings/associations, eg. Women’s fellowship, trader associations, etc.?

Section B: Experience during pregnancy and following delivery

Discuss with participant her experiences during pregnancy.

PROBE for

➢ whether she wanted to become pregnant at the time or later
➢ whether husband/partner wanted the pregnancy
➢ what she was doing when she became pregnant
➢ what was it like to be a mother?
➢ Antenatal care
➢ Delivery
➢ physical or emotional experiences
➢ What was the first few weeks at home following birth like?)

Section C: Social Support

Now I’d like us to talk about how you are coping following the birth of your child. I mean things like taking care of the child, getting money for daily expenses, hospital expenses, food and assistance in cleaning the house, cooking, washing etc.

I am also interested in the people who provide you with assistance.

a. Discuss with participant the kinds of assistance she has received or is receiving (Probe for all assistance including emotional support and at hospitals/clinics)

b. Discuss with participant providers of the assistance (Probe for all providers including family, friends, relatives, community members and health professionals).
c. Discuss with participant the extent to which the assistance received has been sufficient for her needs (Probe for the types of assistance which have been most helpful)

d. Discuss with participant any other the types of help she needs.

e. Any suggestions to improve support for first time mothers?

Section D: Perception and Challenges of Primary Social Support Providers

Discuss with providers what they think about supporting first time mothers:

Probe for
   a. childbirth by under 20, unmarried, school girls (social norms around childbirth)
   b. how/ways to support mothers
   c. why support mother

Also discuss the challenges they face in providing the support:

Keep in mind the social ecological model

Way forward

THANK YOU FOR YOUR TIME AND COOPERATION!!!
Appendix II: Written Informed Consent for Primiparous Women

Section A: Researcher’s Name and Address

Ayimbila Eunice Ayimbono
Department of Social and Behavioural Sciences
School of Public Health, University of Ghana
P. O. Box LG 13
Legon – Accra

Mobile Number: 0245202503/0500222729
Email Address: goodvictory24@gmail.com

Introduction

I am a student from the School of Public Health, University of Ghana and I am conducting a research on the topic “Social Support and Lived Experiences of Primiparous Women in Asikuma Odoben Brakwa District”.

Section B: Consent to Participate in Research

General Information about Research

This research seeks to explore the experiences and support available for postpartum first time mothers. The research will focus on the experiences of first time mother during pregnancy, delivery and in postpartum in relation to the support that they receive from the health facility and the community at large.

Target Population

The Primiparas in Asikuma sub-district of Asikuma Odoben Brakwa District

Procedure

The study is targeted at the residents of Asikuma sub-district especially first time mothers and their primary support providers. Participants will be selected purposively to provide information that will aid answer the research questions. Data collection will take the form of interviews. The interview will last between 45 minutes and 1 hour. The research would take place over a period of 3 months from April to June, 2018.
Benefits of the study

You will have no direct benefit from participating in the study. You will not receive payment for participating. However, the information will enable the health care and regulatory authorities to adopt better health promotion strategies to help support first time mothers especially in postpartum to reduce stress and infant mortality.

Risk of the Study

There are no direct risks associated with this study except that, participants may share some personal or confidential information or they may feel uncomfortable talking about some of the topics.

Confidentiality

This information will be secured and stored at the School of Public Health, University of Ghana. Other researchers may see the data; however, your name or any other identifying information will be removed from the data.

Compensation

There will be a package containing soap for respondents or participants except the above stated benefits to be derived.

Withdrawal from Study

- Participation in this study is voluntary and participants may withdraw at any time without penalty.
- Participants can choose not to participate or to answer any individual question or all of the questions.
- Participants will be reliably informed or legal representative would be informed in a timely manner if information becomes available that may be relevant to the participant's willingness to continue participation or withdraw.
- Participants participations may be terminated if they feel too uncomfortable talking about the subject, become tired or find the study too intrusive.

Contact for Additional Information

If you have any additional questions or complaints please call on Dr Kwabena Opoku-Mensah, 0244273182

You may also contact the Ghana Health Service Ethical Review Committee’s Administrator, Hannah Frimpong, on 0507041223 for further clarification.
Section C: Volunteer Agreement

I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and I am willing to give my consent to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I have agreed to be a participant. During the interview session, I would like to audio record the conservation in order to have high concentration in conducting the interview other than writing everything you tell me. However, you have the absolute right to allow me or disallow me record the interview session.

_____________________________
Name of Volunteer

_____________________________                   _______________________
Signature or mark of volunteer                       Date

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.

__________________________
Name of witness

________________________                                  _______________________
Signature of witness                                 Date

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.

_______________________________
Name of Person who Obtained Consent

_____________________________                   ______________________
Signature of Person Who Obtained Consent                        Date
Appendix III: Written Informed Consent for Primiparous Women’s Support Providers

Section A: Researcher’s Name and Address

Ayimbila Eunice Ayimbono
Department of Social and Behavioural Sciences
School of Public Health, University of Ghana
P. O. Box LG 13
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Mobile Number: 0245202503/0500222729
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Signature of witness                       Date

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Name of Person who Obtained Consent

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Signature of Person Who Obtained Consent                       Date