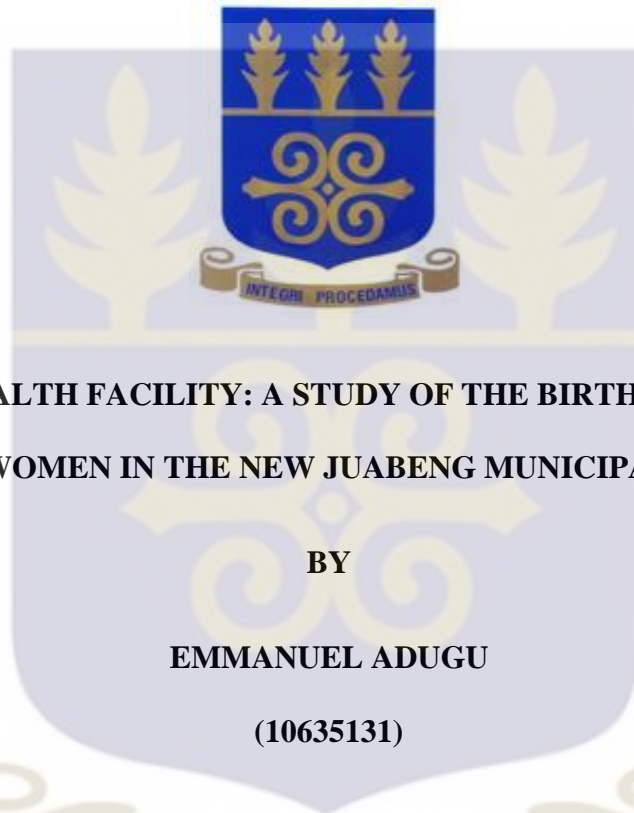


UNIVERSITY OF GHANA

SCHOOL OF PUBLIC HEALTH

COLLEGE OF HEALTH SCIENCES



DELIVERY IN HEALTH FACILITY: A STUDY OF THE BIRTHING EXPERIENCES

OF WOMEN IN THE NEW JUABENG MUNICIPALITY

BY

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DECLARATION

I hereby declare that except where specific references have been made, this thesis is the result of my own research conducted under the supervision of my supervisor. This work has not been submitted in part or whole to any institution for the award of a degree.

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DEDICATION

This dissertation is dedicated to the Lord God who counsels me, my parents and my siblings for their kind blessings, support and encouragement throughout the study period.

ACKNOWLEDGMENT

I wish to thank the Almighty God for His divine protection and guidance throughout this course. I would also like to express my profound gratitude to Prof. Phillip Baba Adongo, immediate past Head of Department and my supervisor, for his patience, guidance and understanding throughout this course.

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Also, my utmost appreciation goes to the participants who availed themselves for the study.

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May God richly bless you all.

ABSTRACT

Background: Childbirth experiences are some of the most sensitive indicators of utilization of health facilities for delivery purposes. Women who go through the child birthing process are reported to be faced with either negative or positive experiences. This study therefore sought to document women's childbirth experiences.

Methods: The study was a qualitative exploratory using in-depth interviews to elicit information from newly delivered women. Twelve participants were purposively selected from the obstetrics and gynaecology unit of the Eastern Regional Hospital and interviewed. Interviews were audio-taped and transcribed verbatim. Results were analyzed using thematic analysis and presented under themes as narratives and supported with quotes.

Results: This study found that, some actions of health care staff towards labouring women demoralized such women in the birthing process and resulted in negative birthing experiences. Some of the participants however lauded some health care staff for responding swiftly to their calls for help. It was also revealed that most women upon safe vaginal delivery of babies expressed being fulfilled and satisfied with the process and described the experience as a positive one irrespective of what they had gone through. Some also cited availability of support persons as one factor which culminated into their positive birthing experiences.

Conclusions: Several factors such as sociodemographic characteristics, health system factors, environmental factors, labour conditions and sociocultural factors have been identified to influence birthing experiences. It is thus imperative that decision making skills, behavior of healthcare staff within the labour and delivery rooms and professionalism of such staff be looked at and improved upon. This will help women going into labour go through the process safely and come out successfully with positive birthing experiences.

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LIST OF ABBREVIATIONS

| | |
|-------------|--|
| GHS..... | Ghana Health Service |
| IDI..... | In-depth Interview |
| SOBS | Social and Behavioral Sciences |
| UNICEF..... | United Nations International Children Education Fund |
| WHO..... | World Health Organization |

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background to the study

Childbirth is an important event in a woman's life. It marks an important transition to motherhood and is associated with myriads of experiences. These experiences are subjective and involves physical and cognitive processes which have significant social, emotional and physical effects on the woman (Mohammad, Alafi, Mohammad, Gamble & Creedy, 2014). These experiences are influenced by women's expectation of safe and successful delivery, health system related factors, sociodemographic characteristics and sociocultural factors. The experiences can be positive or negative and are dependent on the individual woman and the facility in which one delivers. Although childbirth can be seen generally as positive, such birthing experiences can be distressing and traumatic life events to some women (Knol & Geraghty, 2017). Larkin, Begley and Devane (2009) described three main attributes of birth experience as individual, complex, process and life event. They observed that, the concept of childbirth is an individual life event incorporating interrelated subjective psychological and physiological processes influenced by social environmental, organizational and policy contexts.

Childbirth experiences are very unique and involve subjective individual feelings. Recollections of such experiences might fade, however feelings are harked back to over one's lifetime. In some instances birthing experience has been associated with consequences such as lower quality of life, lower self-rated health, persistent memory of pain and the development of post-traumatic stress disorder or its symptoms and these outcomes have been related to increased caesarian births (Smarandache, Kim, Bohr,& Tamim, 2016). Such obstetric outcomes of a woman's

birthing experiences are important indicators of quality service provision and a major measure of quality of care provided (Karlström, Nystedt, & Hildingsson, 2015). It is also worth noting that such experiences have significant impact and wellbeing of future mothers (Smarandache et al., 2016).

Studies by Hunter et al., (2008), as cited by Dahlberg and Aune (2013), in Norway acknowledged that a positive emotional birth experience is associated with the trusting relationship a woman shared with the midwife. In a related study by Aschenbrenner, Hanson, Johnson and Kelber (2016), women had a positive personal experience of childbirth based on the intention by nurses to provide a professional labour support. However, in Eastern Africa a study by Adinew and Assefa (2017) in Ethiopia described a range of experiences such as disrespectful treatment, poor client health care provider interactions, unskilled care, lack of privacy and non-continuous care faced by women using the hospitals for child birth services. These experiences caused women to resort to non-facility based remedies for their most recent childbirth services. Meanwhile in some Guinean health facilities, study by Balde et al., (2017) demonstrated multiple forms of mistreatments of these labouring women. They reported physical abuse, verbal abuse, abandonment and neglect, women being yelled at for non-compliance by care providers, giving birth on the floor and without skilled attendants, poor physical conditions of health facility and workforce constraints. In the Ghanaian context Dzomeku, Wyk and Lori (2017) reported of women being faced with mixed experiences that is both negative and positive childbirth experiences. These women who reported of negative experiences alleged to resort to other assisted means of childbearing other than the health facility for future deliveries. In addressing such issues Ojelade et al., (2017) suggest that health care workers should appreciate the uniqueness of the woman and the importance of each woman's needs during childbirth.

Childbirth can be distressing and a traumatizing life event which leaves the woman in an everlasting painful experience. Some women end up losing their lives and babies in the course of it. World Health Organization (2016) estimates that every day, approximately 830 women die from preventable traumatizing pregnancy and labour experiences and such deaths occur in developing countries. This endangers the attainment of Sustainable Development Goal Three, that is to promote social wellbeing of women and end preventable maternal death. In some instances as observed by Ishola, Owolabi, and Filippi (2017), women in the course of labour were disrespected, mistreated and abused. They stated lack of provider training, weak health systems and lack of women education on their rights as some factors which resulted in such abuses and disrespect. Mselle, Moland, Mvungi, Evjen-Olsen and Kohi (2013), also observed that quality of care rendered to women in labour were inadequate. This resulted in serious birth injuries and undermined the reputation of health care system. Again a study by Moyer, Adongo, Aborigo, Hodgson and Engmann (2014), reported abuse and maltreatment of women by healthcare workers in Rural Northern Ghana. As such, these abusive experiences prevented women from accessing healthcare facility for delivery services. The issues that arise here is how do sociodemographic characteristics, sociocultural factors, health system related factors and women expectation of childbirth contribute to birthing experiences of women within the Juabeng Municipality?

Gyesaw and Ankomah (2013), acknowledged women facing numerous challenges during the childbearing process that put demand on their obligations to adapt to parenthood. Whilst a positive birth experience can be remembered as an empowering life event connected to personal growth and self-knowledge affecting the transition to motherhood (Bell & Andersson, 2016), a negative birth experience increase the risk of negative health outcome such as postpartum

depression and future fear of giving birth that can lead to a request for caesarian birth in future pregnancies and have impact on future reproduction (Ryding et al., 2016). Ono, Matsuyama, Karama and Honda (2013), acknowledged sociodemographic characteristics such as maternal age, education, parity and income as factors that influenced such childbirth experiences.

This study therefore attempted to examine how sociodemographic characteristics, sociocultural factors, health system related factors and women expectation of childbirth influenced facility based childbirth experiences of women within the New Juabeng Municipality of the Eastern Region of Ghana as these experiences relate to future utilization of health facilities for delivery purposes by these women. The objective was to assess the factors which contributed to such experiences. As far as these experiences affect women positively or negatively, a scientific study of such phenomenon was imperative.

1.2 Statement of the Problem

Childbirth experiences are some of the most sensitive indicators of utilization of health facilities for delivery purposes. According to UNICEF (2008), an estimated 10 million women are faced with birth outcomes such as injuries, perineal tears, infections, disease or disability during childbearing that results in life long suffering. In some instances these women are met with disrespect and abusive treatments (WHO, 2015). It is evident in Ghana that, three quarters of all maternal deaths occur during birth and immediate post-partum period (Akoto, 2013). A study by Bohren et al., (2015) however states that despite growing recognition of neglectful, abusive, and disrespectful treatment of women during childbirth in health facilities, there is no consensus on how these occurrences are defined and measured.

Women who go through the child bearing process are reported to be faced with either negative or a positive experience. Whilst, the positive birth experiences leaves the labouring woman in a confident, satisfied and a happy mood after delivery (Attanasio et al., 2014; Henriksen, Grimsrud, Schei, & Lukasse, 2017; Karlström, Nystedt, & Hildingsson 2015), women who are faced with mistreatment and abused are left in a state of fear, depression, anxiety, and neglect. Some even lose their lives and babies in the course of the mistreatment (Moyer et al., 2014; Henriksen, Grimsrud, Schei & Lukasse, 2017; & Gravensteen et al., 2013). This could put the woman in an unstable psychological and emotional state and even morbidity in extreme cases. There is thus an adverse effect on productivity that is loss of man hours to the economy, apart from the negative effect it may have on the individual and the family at large.

In the context of the Eastern Region as far as the New Juabeng Municipality is concerned women are confronted with poor treatment during childbirth including abusive, neglectful, or disrespectful care (Maya et al., 2018). Some of these women according to Maya et al., (2018)

reported of non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment and in some cases detention after delivery. Such negative aspects of maternity care influence women's decision in their present or subsequent deliveries thus contributing to women avoiding health facilities for delivery purposes of which repercussions are higher number of births assisted by non-skilled persons (Mehretie & Abera, 2017).

In some extreme cases women lose their lives out of such negative birth practices thus becoming a threat to the elimination of preventable maternal morbidity and mortality (Banks, Karim, Ratcliffe, Betemariam, & Langer, 2018). The resultant effect has catastrophic consequences for families, communities and countries with economic consequences; households disintegrate and existing children becomes motherless.

Despite these reports, it is still not very clear what factors defined women experiences of childbirth within the New Juabeng Municipality. It is in this regard that the current study seeks to examine women experiences of their childbirth process, how their expectation of childbirth, sociodemographic characteristics, socio cultural factors and health system related factors contribute to the birthing experiences of women within the Juabeng Municipality.

1.3 Research questions

1. What factors contribute to birth experiences of women?
2. What are the expectations of women relating to their labour and delivery needs?
3. What are the behaviors of care providers towards women in labour?

1.4 Objectives

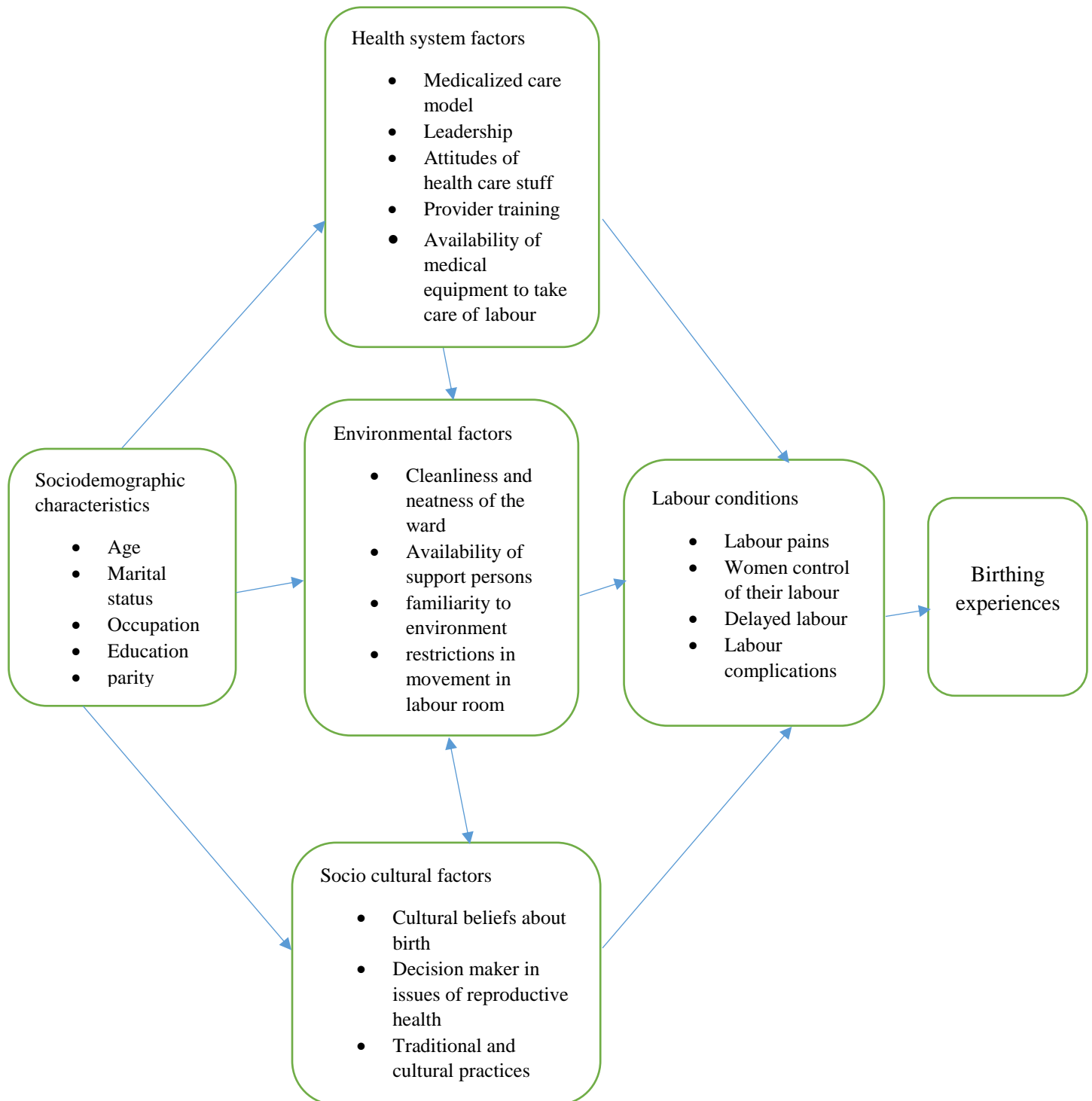
1.4.1 General objective

To examine the facility based childbearing experiences of women and factors which contributed to such experiences in the New Juabeng Municipality.

1.4.2 Specific research objectives

1. To assess the factors that contribute to women birth experiences.
2. To explore the expectation of women relating to their labour and delivery.
3. To examine the behaviors of care providers towards women in labour.

Figure 1: Conceptual framework on Delivery in Health Facility: A Study of the Birthing Experiences of Women in the New Juabeng Municipality



1.5 Conceptual framework

Figure 1 depicts the relationship between variables and dependency of the individual variables on the outcome variable. The variables in the conceptual framework were measured and accounted for in this study. The expected outcome which is women experiences is associated with a number of independent variables which are discussed below.

According to Ghana Demographic and Health Survey (2014), demographic characteristics influence positively or negatively an individual's birthing experiences. Age, marital status, religion, socio economic status, education and parity among others have significant relationship with birthing experiences. Besides maternal age, parity is one factor which is considered to influence childbirth experiences of mothers. Multiparous women go through obstetrically easier labour as compared to primiparous women. They however, may at certain times experience more physical discomfort but few worries during pregnancy as there are no conclusive evidences on obstetrically easier births for multiparous women.

Socio-cultural factors involving cultural beliefs about birth, traditional and cultural practices and decision making about reproductive health are said to have an impact on an individual's birthing experience. It is true that motherhood is often a positive and pleasing experience, however this is coupled with pregnancy related experiences and challenges which if not taken care of can lead to maternal as well as infant mortality (Muzaffar & Akram, 2015). According to Nilsson, Thorsell, Hertfelt Wahn and Ekström (2013), several sociocultural factors account for these experiences and their related pregnancy outcomes.

The quality of health system factors such as attitudes of health care staff, provider training, and availability of medical equipment to take care of labour is reported to have telling effects on birthing experiences of women. An individual's choice of maternity care provider and birth

settings can affect the kind of care one receives. Subsequently, it does affect the choices and options one will have during labour and birth. Hence one's choices of childbirth are either influenced positively or negatively. Making a good choice about the kind of care one receives about the birth settings helps a woman go through safe and satisfying birth experience. In Ghana, midwives have been attending to and supporting women during pregnancy and childbirth and teaching other women to do so. These midwives carry out these functions in a quest to help women deliver safely. However, attitudes of such midwives either influence these women positively or negatively and thus affect childbearing outcomes.

Whereas, cleanliness, neatness of the birthing environment and the care given to the women in labour are very critical to the birthing outcome of the woman, anything short of these can result in some birthing experiences one may not have envisioned. Consequently, it is very necessary that birthing environment is examined and care given to women relooked for best birthing outcomes.

Labour conditions can affect birthing experiences be it negative or positive. Information availability to women during the antenatal service and during the childbearing process has significant effects on women and enables them make informed choices regarding their birthing needs and expectation. Anything short of needed information to these women can lead to negative birth experiences. Hence the need for requisite information to these women.

1.6 Justification

It is obvious that Ghanaian women who go through labour process may have come across some form of experiences. Notwithstanding that, there seems to be inadequate existing evidence based on studies with specific experiences and to commensurate needed supports in such critical moments, thus leading to improved midwifery care for women with such experiences. The investigator thus believes that for lack of exhaustive information regarding birth experiences, health professionals would not be able to provide the needed care to such labouring women. In view of this, findings of this study will help in two ways; in the view of education it will serve as a guideline for health care providers to better understand the plights of the childbearing woman. This study will again be significant to new graduates who are learning the skills of conducting delivery by knowing those factors which minimize negative childbearing experiences and yield positive childbearing outcomes. The second dimension is that in the field of research, it can help by acting as a stepping stone for further studies by future researchers in the health care setting.

It is envisioned that, the findings of this study will help guide service delivery and inform healthcare policy makers to make policy to favor pregnant women. Also, where a big gap is identified in terms of childbirth regulations, the study will help draw new childbirth regulations which will in turn benefit the whole New Juabeng Municipality. This will make childbearing services friendlier and appealing to community members as well as beneficial to their health and birthing experiences. The study will also help equip the health worker with the emotional and psychosocial needs of the woman in labour.

Additionally, the study will add to existing knowledge on the experiences of women during facility based child delivery. Finally, the study can also help stakeholders including government

agencies involved in maternal health issues to take key interest in developing strategies to minimize negative childbearing outcomes.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Childbirth is a physiologic process during which fetus, membranes, umbilical cord and placenta are expelled from the uterus. It is also known as labour or delivery and is the end stage of pregnancy. Childbirth occurs in a continuous fashion and is characterized by experiencing regular, strong uterine contractions, accompanied by cervical changes primarily effacement and dilation. The process of childbirth is divided into four stages and has different birth experiences associated with it. While childbirth is considered as painful, some women report painless labour experiences. According to Zhang and Lu (2014), childbirth is a complex, multidimensional life event characterized by rapid biological, social and emotional transition which results in a safe delivery of a baby. Nilsson, Lundgren, Karlström and Hildingsson (2012), observed that giving birth is one of the most important events in life, which is a highly individual experience and thus plays a major role in how some mothers develop good self-esteem.

2.2 Sociodemographic characteristics

There is some amount of relationship between sociodemographic characteristics and childbirth experiences. These characteristic features varies across pregnancies (Cheng et al., 2016). According to Jafari, Mohebbi and Mazloomzadeh (2017), such characteristics influence birth satisfaction and are an important measure of quality of maternity care services.

2.2.1 Maternal age

Maternal age has been found in studies to have some association with women's experiences of childbirth. A Norwegian Mother and Child cohort study which sought to test the relationship

between advanced maternal age and experience of childbirth by Aasheim, Waldenström, Rasmussen and Schytt(2013), showed a woman's age 32 years and above marginally affected her birth experiences. They reported that women of advanced age expressed worry about their birth experiences as compared to women of younger age group and this was revealed by an adjusted crude odds ratio of 1.13. Other work by Shan et al., (2018), has reported poorer outcomes of pregnancy experiences such as caesarian births, increased risk of preeclampsia, postpartum bleeding, anxiety feelings with women aged 35 years and above. According to Aldrighi, Wall, Souza and Cancela (2016), women of advanced age during childbirth feel physically and emotionally fragile. They reported women experiencing irritability, depression, emotional oscillation and dealing with conflicts among adolescent children immediately when baby is delivered. In the Ghanaian context study by Gyesaw and Ankomah (2013), on the experiences of pregnancy and motherhood among teenage mothers in a suburb of Accra revealed several challenges of these new mothers. They reported myriads of experiences by such teenage mothers. Among the many experiences is their inability to respond and assume parenthood status after delivery. Aldrighi et al., (2016) also reported of women of advanced maternal age being emotionally balanced, tolerant, matured and more responsible during the birthing process and towards motherhood.

2.2.3 Parity

Parity is an important factor in the assessment of perinatal distress (Sia et al., 2017). According to Schwartz et al., (2015), there is an inconclusive evidence around sociodemographic factors in relation to parity and childbirth confidence. Bossano, Blomquist and Mhs (2017) reports that maternal satisfaction with the birth experienced is influence by several factors of which parity is of no exception. Study by Schwartz et al., (2015) revealed that women who had previously given

birth may enter the birthing process with more confidence of a positive birth outcome as compared to nulliparous women. Also Bossano et al., (2017) reports of low distress experiences for parous women in spontaneous vaginal delivery. Furthermore, they stressed that parous women had higher fulfilment of birth experiences as compared to women with no birth experiences. Multiparous women are confident going into labour and have more birth satisfaction than primiparous women (Ferrer et al., 2016).

2.2.4 Maternal education level

There is evidence of association between maternal education and birthing outcome. According to Karlsen et al., (2011), in the study the relationship between ‘maternal education and mortality among women giving birth in the health care institution’, Analysis of the cross sectional WHO Global Survey on Maternal and Perinatal Health, reported lower levels of maternal education were related to higher negative birth outcomes and subsequent maternal deaths among women giving birth in health care institutions. Correspondingly, there was a positive perception and decreased fear regarding childbirth among educated women prior to delivery (Kızılırmak & Başer, 2016). Data from a report by Pradhan (2015), on the relationship between maternal education level and fertility in Ethiopia, Kenya and Ghana suggests that women with lower education levels had more children and as such tend to have more childbirth experiences as compared to women with higher education.

2.2.5 Socioeconomic status

Poverty is one of the major determinants of maternal health. Poor mothers are at increased risk of developing pregnancy related complications as they are not financially sound to pay for required services they may need during the pregnancy period. This most at times results in unnecessary labour interventions and puts pressure on scarce resources(WHO, 2018).

According to Lindquist, Kurinczuk, Redshaw and Knight (2015), women in low-income groups experience worse care during pregnancy with most deprived being sixty percent (60%) less likely to have received any antenatal care compared with least deprived. Their study also reported of evidences of differences in care seeking behavior in most deprived women. Scorgie, Blaauw, Dooms and Coovadia (2015) report that, support grants during period of pregnancy serves to acknowledge and addressed particular problems of women during pregnancy. It helps in some ways in securing health of newborn. It is worthy of note that, with decreasing socioeconomic status, women are more likely to report of mistreatment by health care workers (Lindquist, Kurinczuk, Redshaw & Knight, 2015).

2.3 Labour conditions

Knowing a woman's needs, labour expectations, values, preferences and labour conditions during labour and delivery assists healthcare professionals in providing high quality care to such women (Iravani, Zarean, Janghorbani, & Bahrami, 2015). Maternal childbirth expectations play an important role in determining a woman's response to her childbirth experiences (Pirdel, 2016). Women hold different expectations during childbearing based on their knowledge, experiences, belief system, culture, social and family backgrounds (Iravani et al., 2015). According to Goldbort (2009), every woman giving birth has expectations. Identifying such expectations, needs and fears empowers the healthcare provider to achieve toward a common target of a positive birth experience. Sengane and Malmsey (2013) posits that women develop expectations regarding care givers during labour and when these expectations are not met such women become dissatisfied and eventually have negative experiences of their labour. Notwithstanding that Iravani et al., (2015) observed that knowing a woman's needs, values, preferences and expectations pre and post labour and during the childbearing process helps

healthcare professionals especially midwives in providing high quality care to such parturient women.

Labour pain expectations could be attributed to previous information on labour pain and personal or other people's previous experiences with labour (Lally, Thomson, MacPhail, & Exley, 2014). According to Aziato, Acheampong and Umoar (2017), there are notions that, labour pains are natural and should be endured in the child bearing process, however such notions should be deemphasized during health education programs and women given adequate pain reliefs during labour. Zhang and Lu (2014), posits that labour pain is an important unique life experience of important meaning to women. Their study found that women had relatively negative expectation of labour pain as few of their study participants planned to use analgesics during their childbearing process. In an in-depth semi structured interview Gibson (2014), observed that women expressed concerns about childbirth pain during pre and postnatal periods. These women expressed having undergone negative childbirth experiences when their expected pain reliefs could not work for them during the delivery process. Some other study by Pirdel (2016), revealed women describing their labour pains as more intense than what they anticipated and this resulted in negative birthing experiences.

Fawsitt et al., (2017), report of women anticipating and selecting the kind of obstetrical care to guide their prenatal care and childbearing expectations. Midwives and other maternity healthcare providers play a very key role in this regard (Puente, Monge, Morales, & Gallardo, 2016). Roudsari, Zakerihamidi and Merghati (2015), posit that most women preferred vaginal births contrary to surgical births. Findings from a descriptive cross sectional study by Mohammad, Alafi, Mohammad, Gamble and Creedy (2014), showed that women were dissatisfied with their birthing experience as the care rendered were incongruent with what they expected. They

reported of some women undergoing emergency caesarian sections and some going through assisted delivery process using instruments such as forceps which were what they never opted for and expected.

In their study, factors influencing positive birth experiences of first time mothers Nilsson, Thorsell, Hertfelt and Ekström (2013), reported of women being in anticipation to be in control of their childbearing process and as well receiving necessary supportive care from close relations and midwives. This is common with women who go through their birthing process at home. Jouhki, Suominen and Åstedt-Kurki (2017), reported of women giving birth at home having control over the process, however they experienced negative attitudes from people about their choice and decision of home delivery. Meyer (2013) observe that women who had control of their delivery process reported of birth satisfaction, emotional wellbeing, fulfillment and positive transition into motherhood. However some nonetheless who had given birth without much control reported of negative birth experiences. These negative experiences had the potential to affect perinatal outcome and subsequently health care cost. Takehara, Shimane, Misago, Bloemenkamp and Stiggelbout (2014) also noted that women who had much control of their childbearing process reported of the experience being a positive one. Some reported of having experienced a trustful and a supportive relationship. This of which they attributed to the presence of their husbands.

Martin, Bulmer and Pettker (2013) using a qualitative descriptive study approach reported of information needs of women. Some of these women during their prenatal period made unnecessary visits to the hospital or clinic because of something that is normal in pregnancy for example Braxton-Hicks contractions or constipations. Correspondingly, a lack of information may cause such women to forego treatment that is needed before or during labour. In a related

study Iravani et al., (2015) reported of the need for women to get familiar with their childbirth process, however it was revealed that labouring women did not have basic knowledge about labour and delivery process. Attanasio, McPherson and Kozhimannil (2014), observes that a positive child birth experience is related to good communication between the midwife and the labouring women. Some women as reported by Iravani et al., (2015), had their expectations changed and felt calm as they were furnished with the requisite information during the childbearing process.

2.4 Health system factors

According to Bohren et al., (2015) there is a growing recognition of neglectful, abusive and disrespectful treatment of women during childbirth in health facilities. Several health system related factors contribute to such negative birthing practices and hinder access to health care services. Thus, there is the need to avert women experiences which may later results in maternal and new born death and morbidity (Mannava, Durrant, Fisher, Chersich & Luchters, 2015).

The attitudes and behaviors of maternal health care providers influences utilization of maternal health care services by women and are an important element of health systems as they influence both positively and negatively how women and their partners and families perceive and experience maternal health care (Bohren et al., 2017). According to WHO (2015), many women experience disrespectful attitudes and abusive treatment during childbirth in facilities worldwide. Such treatments not only violate their rights to respectful care but also threatens their fights to life, health, bodily integrity and freedom from discrimination. In a similar vein, Ishola Owolabi and Filippi (2017) emphasizes that promoting respectful attitudes of care at childbirth is important to improve quality of care and encourage women to utilize facility skilled delivery services. Again, Mannava, Durrant, Fisher, Chersich and Luchters (2015) affirms that attitudes

and behaviors of maternal health care providers are an important determinant of maternal and infant health outcomes and influences health care seeking and quality of care.

Every woman has the right to highest attainable standard of health, which includes the right to dignified respectful healthcare throughout pregnancy and childbirth as well as right to free from violent and discriminatory attitudes (WHO, 2015). However, in their study disrespect and abuse during facility based childbirth in low income countries Okafor, Ugwu, and Obi (2015), reported of women being physically abused. Some of these women were restrained or tied during labour and episiotomies given were sutured without anaesthesia. Some were as well pinched, slapped and beaten and even to the extent of being sexually abused by health workers. Also Maya et al., (2018) made similar observations where these women's human rights and autonomy were infringed upon and thus contributing to preventable maternal and newborn mortality and morbidity. Again, findings from study by Ojelade et al., (2017) revealed that to improve women's childbirth experiences in health facilities, their psychosocial and communication needs have to be met and such health care systems must appreciate the uniqueness and importance of each woman's needs during the childbirth process. In another study most women reported of non-consented procedures such as labour augmentation, shaving of pubic hair, sterilization, caesarian delivery and blood transfusions (Okafor et al., 2015).

In other related study, fear of experiencing disrespect, abuse and negative attitudes influences a woman's decision to seek care during labour and delivery (Abuya et al., 2015). Studies also documented physical abuse towards women, absenteeism or unavailability of providers, corruption and lack of regard for privacy, poor communication, unwillingness to accommodate traditional practices and authoritarian or frightening attitudes (Maya et al., 2018; Ratcliffe et al., 2016; Balde et al., 2017). These behaviors according to Mannava et al., (2015) were influenced

by provider workload, patients' attitudes and behaviors, provider beliefs and prejudices, and feelings of superiority among maternal health care providers. Overall, negative attitudes and behaviors undermined health care seeking and affected women well-being.

Respectful care during childbirth has been described as “a universal human right that encompasses the principle of ethics and respect for women’s feelings, dignity, choices and preferences” (Gea, 2015). According to WHO (2012), the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality for women to include the consideration of women's basic human rights comprising the regard for women’s autonomy and inclinations, as well as companionship during maternity care. Findings from a study by Mannava et al., (2015) reported of some positive provider attitudes as midwives being caring respectful, sympathetic and helpful. In a similar study Karlström et al., (2015) observed that a positive birth experience is associated with a trustful and respectful relationship the midwife or care giver shared with the labouring woman.

The increased medicalization of the birth process which most at times results in high caesarean birth rates are undermining to a woman's own capability to give birth and negatively impact her birth experiences (WHO, 2018). It must be noted that the driving force behind such medicalizations of pregnancy is the assumption of risk connected to fetus and sometimes maternal health. It is worthy of note that, pregnancy and childbirth, previously considered natural or normal have been transformed into an unnatural condition or illness whereby there is an assumption of risk to both maternal and fetal health. Such risk is the focus of medical professionals who determine, control, and rectify potential or actual problems during pregnancy and childbirth.

2.5 Environmental factors

According to Mensah et al., (2014) in a study at the 37 Military Hospital in Ghana, birthing women described the need for neatness and cleanliness of the birthing environment. Such birthing environment enhanced comfort, allowed women to be of themselves and eliminated fear among these women. Correspondingly Iravani et al., (2015) affirmed the need for a comforting and a pleasant environment during the childbearing process. Women appreciated the need for privacy, regular changing of bed linens and the need for satisfying physical environmental conditions. Some women also described feeling of trust which was influenced by the environment in the maternity ward, tolerate and peaceful atmosphere. Notwithstanding the above, mothers also associated safety and security to a pleasing and good environment (Nilsson, Thorsell, Hertfelt, Ekström & Annette, 2013).

Iravani et al., (2015) cited social and relational needs as factors which informed the delivery needs of women. These factors entailed a good communication between health care professional and the availability of a familiar (partner, relative or family) person during the delivery process. The presence of a child's father during the childbearing process was essential for most women, as this made women felt safer. Again, the presence of a midwife was stated to be another significant factor which made the birth experience a very positive one for women (Karlström et al., 2015). Findings from study by Dahlberg and Aune (2013) affirms the need for a good relationship between the care provider and the labouring woman. According to Karlström et al., (2015) women felt supported, heard and helped in decision making which helped in their positive childbirth experience.

In the study 'Factors Influencing Positive Birth Experiences of First-Time Mothers' Nilsson, Thorsell, Hertfelt, Ekström and Annette, (2013), reports that women described feeling of trust as

influenced by the environment in the maternity ward. First time mothers alleged having experienced a peaceful atmosphere and felt safe throughout the child bearing process. According to Whitburn, Jones, Davey and Small (2017), the quality of the environment contributes to the woman having a more positive experience of the childbirth process. Women who are in supportive environment feel more in control and are therefore able to have a better labour and birth experience. They thus concluded that the meaning of pain to a woman is shaped by the social environment and other contextual factors within which it is experienced.

2.6 Sociocultural factors

According to the World Health Organization (WHO), almost all maternal deaths (99%) occur in developing countries, with more than half occurring in sub-Saharan Africa (WHO, 2013). Studies have revealed certain health beliefs pose danger to the health of women. Although, many health beliefs have been mentioned to influence decision-making for different kinds of delivery. Decision-making for vaginal delivery is observed to be under the influence of culture, perceptions coupled with and values influences the birthing experiences of women (Zakerihamidi, Roudsari, khoei, & Kazemnejad , 2014). Healthcare practitioners need to be aware of these beliefs so as to contextualize their practice.

According to Roudsari, Zakerihamidi and Merghati (2015), women are normally involved in decision making process regarding their birth and mode of delivery based on their cultural beliefs about birth. In a focused ethnographic study Roudsari, Zakerihamidi, Merghati-Khoei, and Kazemnejad (2014) observed that cultural norms and values influenced a woman's choice of caesarian delivery over a vaginal delivery. Also Roudsari, Zakerihamidi and Merghati (2015) in a qualitative study reported childbirth as an experience which is sacred based on the woman's religious beliefs and thus influenced the choice of delivery a woman undergoes. They (Roudsari,

Zakerihamidi & Merghati 2015) reported in a similar study that women perceived non vaginal delivery as a facilitator of women's physical and mental health promotion and saw caesarian section as a painless mode of delivery.

Findings from a study by Beinempaka et al., (2014), revealed that childbearing in Kinyankore culture was considered sacred, held in high esteem and shrouded in mystery. However, the following potentially risky traditional pregnancy and birthing rituals were described; herbs being ingested orally and vaginally inserted to cleanse the unborn baby through to term and after delivery, mother's first milk prohibited as it is believed that such milk makes the new born child ill. Consequently, some pregnant women in a study by Roudsari, Zakerihamidi and Merghati (2015) mentioned the use of cyclamen (a plant which grows in Mecca, Saudi Arabia) for an easy natural birth. They also ascribed the cyclamen plant to Mary mother of Christ and considered it as the agent for fetal development in their womb. In other related study, Ekpoanwan, Idongesit and Bassey (2017) revealed that women were restricted from taking milk during their gestational period.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the description of the methods that were used in attaining the stated objectives and these includes the research design used, research setting, target population, sample and sample method that was used. It also looked at the tools used, the method of data collection and data analysis as well as data management. In addition the chapter contains information on how ethical requirements were met and trustworthiness of the study

3.2 Study design

Qualitative research is based on a worldview that is holistic; it has the belief that, there are multiple constructed realities in life where the knower and the known cannot be separated, inquiry is also value bound and all applicability are bounded by time and context (Burns & Grove, 2012).

A qualitative research involves the act of perceptually putting pieces of information together to make wholes. When meaning is produced from varied individuals who have varied perceptions it becomes possible for many different and comprehensive meanings to be derived concerning the phenomenon in question (Munhall, 2012). The findings from a qualitative study usually direct the understanding of the phenomenon under study, develop new concepts (Leedy & Ormrod, 2010). It gives the insight which can be applied in similar situations to guide public health practice and also to help in theory building or refining, providing avenues through which phenomenon outside the traditional view of public health can be examined (Burns & Grove,

2012). Therefore the varied experiences that were collected were grouped and interpreted to make meaning about the experiences of the childbearing women.

3.3 Research setting

The study was conducted in the New Juabeng Municipality of the Eastern Region of Ghana. The New Juabeng Municipal Assembly was established by the Legislative Instrument (LI) 1426 of 1988. The Municipality has fifty two (52) communities with Koforidua as its capital. The Assembly is made up of eighty two (82) Assembly members; fifty four (54) elected, thirty five (35) government appointees, Municipal Chief Executive and two (2) Members of Parliament. There are two (2) constituencies in the municipality. These are New Juabeng South and New Juabeng North. The sub-district structures consist of thirteen (13) Zonal Councils and eighty six (86) unit committees.

The Eastern Region is the sixth largest region in Ghana. It lies between latitudes 6 and 7 degrees North and longitude 1.30 degree West 0.30 degree east. It shares boundaries with five other regions: Greater Accra, Volta, Brong Ahafo, Ashanti and Central regions. The vegetation is tropical and the rainfall pattern is the double maxima with dry and wet seasons. It has a total population of 2, 921, 437 (2015) representing 10.7% of Ghana's total population. The population is the 3rd highest after Ashanti and Greater Accra regions. Its population is made up of 49% males and 51% females, giving a sex ratio of 96.8 males to 100 females.

The Eastern Regional Hospital is the biggest public hospital in the region. It caters for persons in and around the region's Administrative capital, Koforidua. The hospital also handles referral cases from all the districts within the region. The hospital is one of the ten regional hospitals in Ghana and has a staff strength of 813 comprising 62 Doctors, 261 Nurses (64 Midwives), 248 support staffs and 242 non mechanized staff.

It has a main OPD for adults and children's OPD for children below 12 years of age. The various wards and departments are; Pharmacy, Administration, Laboratory, Male and Female Surgical Wards, Operating Theater, Children's Ward, Labour Ward and Lying in Wards and Neonatal Intensive Care Units (NICU). An average of 456 mothers is admitted to the labour ward for skilled delivery monthly and 90 neonates are admitted at the NICU per month for special care

Out of 26 districts and municipalities, 18 have at least one hospital. The figure below illustrates the health facilities in the region.

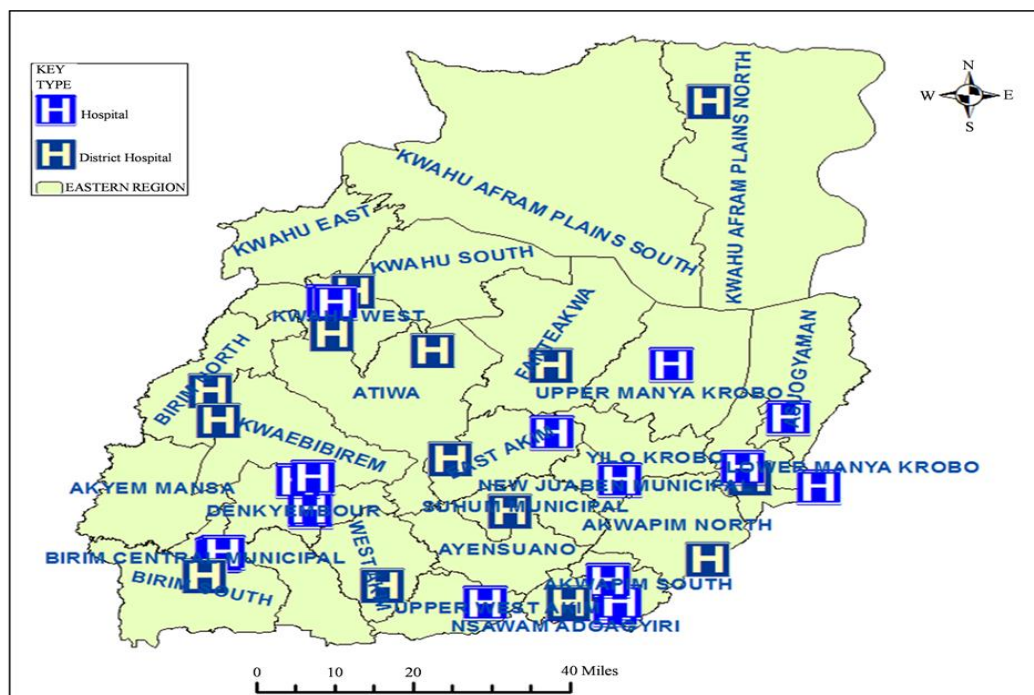


Figure 2: Map of the Eastern Region showing various health facilities

3.4 Variables

The dependent variable for this study was childbirth experiences of women.

The independent variables are:

- Sociodemographic characteristics
- Health system factors
- Environmental factors
- Socio cultural factors
- Labour conditions

3.5 Target population

The study population in research is the entire set of persons or elements who meet the sampling criteria of the study. In this current study, all women who were admitted onto the obstetrics and gynaecology wards of the Eastern Regional Hospital prior to delivery and more the 24 hours post-delivery and leaves within the New Juabeng Municipality were recruited for the study.

3.5.1 Inclusion Criteria

Inclusion criteria is used to select samples from collection of all possible units of the general population, it decides who qualifies to be in the target population. They are the characteristics that restrict the population to a homogenous group of participants; where homogeneity is not ensured in a study the ability to interpret finding meaningfully is challenged and likewise the act of transferability and applicability. Inclusion criteria are put in place to control biases as well as extraneous variables therefore contributing to accuracy and transferability of the findings (Polit, 2014). The study population included women who had experienced childbirth, resident in the

Juabeng Municipality who are English, Twi, Ga, Ewe speaking and gave their consent to be participants.

3.5.2 Exclusion Criteria

Women known to have psychiatric problems, women whose gestation is less than 28 weeks, those who are deaf and or dumb, women who cannot speak English, Ga, Ewe and Twi as well as those below eighteen years were not recruited into the study. The mental state of these women must be a healthy one so that the data collected will be devoid of contamination from psychiatric symptoms; this was ensured by gaining consent from them and making reference to their antenatal document to establish their mental health status. Effective communication is vital to the outcome of this study, barriers to communication such as languages other than those mentioned or deaf and dumb women were excluded in the study. Women who did not consent to participate were not included in the study.

3.6 Selection of Study Participants

A purposive sampling method also known as judgmental sampling is a non- probability sampling method often used in qualitative studies. With the choice of purposive sampling, there is the assumption that a researcher's knowledge about the population and its elements is used to hand pick those deemed appropriate or typical for the study (Polit, 2014). According to Wood and Haber (1994), when a highly uncommon or unusual group is being studied, purposive sampling is the ideal sampling method to be used. This type of sampling method also allows for a more homogenous group to be studied thereby increasing the ability to transfer findings as well as the ability to apply the knowledge gained in managing similar situations in the future.

A purposive sampling method was applied to contact and recruit twelve women from the obstetrics and gynaecology unit of the Eastern Regional Hospital. In this study for convenience

sake, the study units that happened to be available at the time of data collection were selected. Thus, newly delivered mothers were recruited to provide the necessary information needed to adequately answer the research questions. The Eastern Regional Hospital was chosen due to the fact that the hospital receives referrals from other health institutions across the region and its strategic location makes it accessible to all districts therefore the sample would be geographically representative of the municipality. The researcher after being granted the permission to undertake the study visited the labour ward at least once a week and worked with the midwives on duty, the researcher spent the rest of the week with post delivered women on the ward; by so doing was able to establish rapport and also gain confidence of the new mothers. In the process of working on the ward the researcher ensured that he did not influence the practice on the ward. The intention of recruitment was declared to potential participant and those who showed interest, the researcher obtained their detailed residential address as well as telephone numbers. As a backup method of recruitment in the absence of the researcher, a book was left with the midwives on the ward to document the contact addresses of women who delivered safely. These women were contacted to seek their interest to partake in the study.

3.7 Data Gathering

Qualitative data gathering can be done by various means, often a combination of methods are used to obtain the needed data based on the set objectives and the research design chosen. These means or methods range from observation, self-reports or interview transcripts, written documents, audio visual material and also electronic documents (Leedy & Ormrod, 2010). Most qualitative research uses data collection methods to obtain information. The major tool often used is the interview method combined with one or more of the other methods such as observation of subjective data; which is documented as memo or field notes, written documents, like hospital records. These data collected from multiple sources makes the data rich and in turn promotes trustworthiness of the data. Qualitative studies are characterized by an emerging design therefore the data collected could influence what other data the researcher gathers subsequently.

A semi structured interview is undertaken when the researcher has full knowledge of the questions to ask but cannot predict the responses that will emerge. The researcher by using this method is assured that all the information anticipated is obtained and it offers the participants the freedom of what response to give: they give description they think is best for the phenomenon under study (Morse & Field, 1998). Creswell (2009), stated that the use of a protocol for observational method and an interview guide to conduct an interview, among others is key in qualitative data collection. In-depth interview have the advantage of obtaining detailed information which is fuller and richer from the subjects (Polit & Beck, 2008).

3.7 Data gathering tool

An in-depth interview was conducted using an interview guide prepared in English, made up of open-ended questions to obtain data for this study. It had main question areas in line with research questions and also contained probing questions to elicit clarification to obtain detailed

and accurate information. The interview guide used sought information on their personal profile and some obstetric information, the general experiences of the mothers; information about their experience in the process of delivery, their perception on the attitudes and behavior of care providers during their delivery process, support systems available and their expectations of labour and delivery needs.

Data was collected at a venue decided by the participants; these settings were predominantly outside of the hospital and most of them were homes of the participants or where ever we agreed to meet, since they were better relaxed in their comfort zone. The interview lasted between 35 minutes and 90 minutes. With the interview guide to direct the questions to be asked, information elicited were digitally recorded with the participants' consent.

As part of the preparation towards the implementation of this study, the interview guide was reviewed by my supervisor and peers for validity and reliability. A pilot interview was done on four (4) women to assess the reliability of the interview guide; questions that seem to be unclear or did not elicit the expected answers after the pilot test were reviewed for clarity and efficiency. Preconceived ideas and especially personal views of the researcher about the birthing experiences in the clinical area; was written down and shared with my supervisor to guard against being biased, this is described as "Bracketing".

In the process of interview and recording, nonverbal messages and objective pieces of information observed were recorded into a field note book, these pieces of information supported the data collected and helped to enrich it. Where the responses to the questions indicates a participant does not understand the question, the participant was given explanations to such questions so as to help in a successful data collection.

3.8 Data Processing and Analysis

Data analysis in a qualitative study is an approach used to organize, reduce, provide structure and give meaning to the data collected. It is an on-going process which involves the researcher reflecting on the data, asking analytical questions, and writing memos in the process of study (Creswell, 2009). Thematic analysis was used to analyze the data from the study. The recorded interviews were listened to over and over again, translated and transcribed word-for-word. After reading the interview transcripts several times in search of meaning and deeper understanding (Morse & Field, 1998), coding was done. Significant statements in relation to women birthing experiences were identified, line by line, without making any assumptions. Identified codes were sorted into relevant categories. Main themes were then identified and categories brought together and rearranged under the identified themes. Significant statements were put together under themes, to form the architecture of the finding. These were then used to describe the participants experiences.

3.9 Data Management

The voice recordings and other soft copies were protected by a password, the transcribed scripts and other hard copies were kept under lock and key by the researcher. They were accessible to the researcher and supervisor only. The participants were given pseudonyms to promote easy identification and confidentiality. Transcripts will be stored for at least five years after the study is completed to enable availability if need be.

3.10 Quality control

To ensure data quality, care was taken in data collection, data handling and data management. Necessary considerations were given to the research objectives in designing the data collection instrument. Data collected each day were checked for consistency to minimize human error. Rigour and epistemological integrity was ensured in order to maintain methodological coherence by precisely representing the participants' experience. Credibility was ensured by interviewing only people who had experienced the childbirth phenomenon. Representative quotations from transcribed words were submitted to experts to seek their agreements on whether the audio recordings were same as transcribed information. Peer debriefing was done with those interested in women childbirth experiences. In relation to Interpretative Authority which represents the trustworthiness of the data interpreted, the researcher made sure feedbacks were obtained from the participants to check if he had the stories right.

3.12 Ethical consideration/issues

Prior to commencing any research, it is necessary for the researcher to consider whether the study is ethical or not, also the safety of the participants involved in the study needs to be ensured therefore ethical clearance and approval was obtained from the Institutional Review Board of the Ghana Health Service.

Formal permission was obtained from the administration of the Eastern Regional Hospital to recruit participants from the hospital department of obstetrics and gynecology. In addition, the objectives of the study were explained to the respondents and their informed consent was obtained before soliciting information on the scheduled date, these activities were done in respect to participants' human dignity. They were made aware that they can decline to partake if they do not want to do so, they also have the liberty to withdraw from the study at any time if they so wish, without any repercussion. The possible emotional effects the interview could have on them were explained to them and they were assured of counselling services available if the need arises.

Participants were assured of their anonymity; pseudonyms were used to identify each of them. They were also reassured that data that had been collected, that is their responses would be kept confidential and safely with the researcher and the supervisor to use only for research purposes.

An arrangement was made with a counselor to provide support in case the process of data collection adversely affects any participant at the participant request.

3.13 limitations

Limitations of the study include the following:

1. The use of a qualitative design dictates that these findings cannot be generalized. The purposive sampling provided information unique to the participants who had experienced childbirth.
2. The study was a facility based one, experiences of mothers who delivered at home were not captured but which could have been very informative in enriching the findings of the study.
3. Despite the rapport established with all the participants spontaneous response to the beginning of the interview was not achieved in some of the participants therefore a questioning and answering mode was adopted till the client spontaneously start flowing verbally with their experience.
4. Though the current findings reported of some negative experiences, the possibility of psychosocial challenges cannot be ruled out. Some women who declined to be recruited as well as those who turned down the interview appointment could be in a psychologically challenging state therefore avoiding the researcher. (it's a challenged because they could not present their experiences based on what they were faced with)

CHAPTER FOUR

4.0 RESEARCH FINDINGS

4.1 introductions

The chapter presents the findings of the study under the themes and subthemes that emerged as a result of triangulation of analyses of data collected and presented. The first section of the chapter presents the personal and obstetric profile of the participants and the subsequent sections presents the key findings under varying themes and subthemes.

Table 1: Participants profile

| Personal profile | | Obstetric profile | |
|-------------------------|------------------------------|-----------------------------------|------------------------------|
| Age in years | Number of participant | Maturity | Number of participant |
| 18-29 | 6 | Post 9 months | 3 |
| 30-40 | 6 | 9 months | 9 |
| Religion | | 8 months | Nil |
| Christians | 9 | Parity | |
| Muslims | 3 | No previous delivery (primi para) | 3 |
| Education | | One delivery | 6 |
| Tertiary | 2 | Two previous delivery | 3 |
| Secondary | 4 | Delivery type | |
| Basic | 6 | Caesarean section | 6 |
| Marital status | | Vagina delivery | 6 |
| Married | 12 | | |
| Not married | Nil | | |
| Tribe | | | |
| Ewe | 2 | | |
| Twi | 6 | | |
| Hausa | 3 | | |

The twelve women interviewed in their own environs predominantly, were at least a week post-delivery. These women were traders, hair dressers, unemployed house wives, teachers and a student.

4.2 Women birthing experiences

The respondents described physical and psychological elements as factors that might have contributed to their birthing experiences. Six sub-themes emerged from factors which contributed to birthing experiences: behavior of health care staff, expressions of health care staff, parity, availability of antenatal services, sociocultural factors and cleanliness of environment.

4.2.1 Behavior of health care staff

Behaviors of maternal health care providers were vital elements that influenced experiences of childbirth. They submitted that, these behaviors were important indicators of their maternal health experiences. These behaviors they alleged influenced their childbearing process either positively or negatively and how they perceive and experience maternal health care. The following are some of the responses of participants when they were asked to tell of their experiences with respect to health care staff behaviors:

I had heard previously that, most of the health care staff at the Eastern Regional Hospital Maternity Unit were mean and abusive. However that was not what I encountered. Some of the midwives were good and helpful. They responded to my calls in as a matter of urgency. Some as well were offensive, they frowned their faces anytime I called them. They were not sympathetic. They made me felt demoralized in the birthing process. (IDI with Participant 12, gravida 2 para 2)

I reported earlier and a doctor admitted me into one of the wards. I have since been sitting here waiting with no bed offered me. It took the intervention of my sister for a bed to be prepared for me. One midwife retorted, 'they were attending to those already on admission before getting me a bed.' Some health care workers I came across were repulsive. They were always busy and playing with their phones anytime I called them. They never cared about the pain I was going through. They frowned anytime I called them and this made me cried most of times I was under their care. (IDI with Participant 5, gravida 3 para 3)

Some of the midwives were good. I remembered I soiled myself and ruptured membranes in the course of the childbearing process and called for help. The midwife rushed to my aid at the point of my call even without her gloves (disposables) on. She later called for assistance from her other colleagues and helped me through the process. They helped me delivered the baby and cleaned me well. I felt refreshed in the process. (IDI with Participant 4, gravida 1 para 1)

No ill attitude was shown me in the course of my birthing process. The reception provided me by some of the midwives was okay. I did what was expected of me during the birthing process. I would say generally that they were good. Others nonetheless still needs to be more professional in the course of their work. (IDI with Participant 8 gravida 2 para 2)

The participants in their responses above believed they were mistreated in one way or the other in the course of their childbirth process by the health care workers they came across, though some did well in the discharge of their duties. They claimed there are growing recognition of such neglectful and abusive care by the health care providers. This confirms WHO's (2015),

explanation that many women experience disrespectful attitudes and abusive treatment during childbirth in facilities worldwide. Such treatments not only violates their rights to respectful care but also threatens their fights to life, health, bodily integrity and freedom from discrimination. The participants also revealed that the attitudes and behaviors of the health care providers always influenced their birthing experiences.

4.2.2 Expression of health care staff

Expressions of the health care staff during delivery process played an important role in the childbirth experiences of the women. Health care staff are to communicate and help women make informed choices with respect to their delivery needs. Midwives expressions should empower women and increase the possibility of positive birthing experiences. Midwives are required to inform, encourage and to provide the necessary enabling environments for positive birthing experiences. In questioning whether the midwives did communicate and provide the requisite information that yielded a positive birthing experience, some of the participants responded as follows:

Some of the midwives screamed at us the clients on the wards in the dispatch of their duties. One midwife who passed a urethral catheter for me couldn't do it any better, no procedure was explained to me, no privacy provided. I experienced pain with the urethral catheter in situ and even strained on urination. I complained bitterly to her about how I feel. She retorted and yelled at me. 'The urethral catheters we have on the ward are all that of smaller sizes. And they easily get off when passed. That was how come I inserted a big urethral catheter for you.' I cried in the process. I called another midwife to help fix my infusion set for me which was taken off when I visited the washroom. The midwife shouted 'You "kuraaa!" why are you worrying us like that! Can't you see I am engaged

doing other stuffs?!' I kept quiet and resorted to prayers. My husband was there at the scenery during the encounter with the midwife. I asked him to go else he might get intimidated by the midwives on duty. (IDI with Participant 6 gravida 2 para 2)

I had tears of my vaginal walls during the childbirth process. The midwife in the course of repairing the tears never explained any procedure of repair to me. I screamed and felt much pain in the process. (IDI with Participant 4 gravida 1 para 1)

The midwife who attended to me was calm and patient. She was with me throughout the birthing process. She engaged me in conversations and explained all procedures to me until she eventually left me when she closed. She being with me made me forgot about the pains associated with the birthing process. (IDI with Participant 7 gravida 1 para 1)

Generally, some of the participants perceived themselves as being physically and psychologically abused by the health care workers. Regarding expressions of health care staff and care meted out to them, they see some of the health care professionals as not efficient enough as some of these labouring women reported of non-consented and non-dignified care. Some of the health care workers carried out most of their procedures without their prior notice. They maintained, as clients under the care of these health care professionals, they could have been patient enough, explaining necessary procedures to them and not screaming at them. Such negative aspects of maternity care influenced a woman's choices of future usage of such health facility for future births.

4.2.3 Parity of respondents

Women who had previously given birth entered the birthing process with more confidence of a positive birth experience as compared to nulliparous women. Unlike the multiparous women,

who most at times had obstetrically easier labour, nulliparous women spent more hours in their labour encounter which in the extremes resulted in surgical births. The participants perceived that their parous state was of great influence in their respective childbirth process. The following are some of the responses of the participants in relation to their experience with regards to parity:

It took so long for me to get through the delivery process during my previous delivery. I was in labour from 12am till 1:45pm but for this current delivery it was okay. I had not experience much pain. The whole process was not as how I envisaged it to be. I could say my previous birth experience helped me. (IDI with Participant 2 gravida 2 para 2)

This delivery is my third childbirth experience. My first experience was a vaginal delivery whereas the second was through a caesarian section. This current delivery was as well through a caesarian section. My doctor had previously told me the fetus was big in my womb and that I should get prepared for surgery. This was confirmed by the midwife when I reported at the maternity unit. The process during the surgery was a smooth one as I dwelled on my previous caesarian section experiences. In as a matter of urgency, I was prepared preoperatively and sent to the operating theater. Within a shortwhile the doctor had taken the baby out of my womb. the staff I met on duty that very day helped me. I had not experienced much pain as was with my previous deliveries. I was happy. I want to say they did well. (IDI with Participant 10 gravida 3 para 3)

I had spent so many hours in labour. I got tired in the process. It got to a stage I could no longer push. The alternative of a surgical birth was put before me which I declined. The midwife explained to me she had to rupture my membranes and give a cut in my vagina to pave way for the baby to come out of which I consented. She did the rupturing and the cutting and lo and behold my baby's head was out. I felt relieved. She pulled the baby out

and placed it on my stomach. I was real happy and expressed my appreciations to the midwife. (IDI with Participant 7 gravida 1 para 1)

This is my second childbirth experience. I had already had a taste of what goes into childbirth. My first experience was of great exposure to me. so this current delivery went well. I was already prepared for the whole process. I could remember it took so long a time for me to get through my previous delivery and that was associated with much pain. with this current one, I delivered safely and it was within a very shortwhile the moment I entered into labour. The midwives I came accross were good. (IDI with Participant 12 gravida 2 para 2)

The responses suggests that, multiparous women were more prepared and dwelled much on previous birth expeirnces entering into the delivery process with the hope of a positive birthing outcome. However, there are inconclusive evidences of parity as an indicator of a positive birthing experiences. Some of them reported of distress which eventually resulted in surgical births, others sustaining vaginal tears in the course of vaginal births.

4.2.4 Availability of antenatal services

Antenatal care services were one of the most essential services provided these women and its potential contribution to positive birthing experiences was reported in a number of ways by the women. These services provided opportunities for reaching the pregnant women with a number of interventions that was vital to their health. The resultant effects were manifested in positive safe deliveries of the women. Such services are potential contributing factors to Sustainable Development Goal Three which has to do with reducing global maternal mortality ratios. Most of the respondents had patronized one or more antenatal care services. They acknowledged it being beneficial to them as it helped them prepared physically and psychologically for their

birthing experiences ahead. The following are some of the responses of participants regarding antenatal services patronized:

It was a very good encounter with the midwives during the antenatal clinics. I was educated on the relevance of eating nutritious foods, the need to adhere to the medication regimen that was given us in the course of the antenatal visits. I was particularly happy with the way they carried out their assessment on me. They took me through series of teachings which were very helpful to me. (IDI with Participant 1 gravida 2 para 2)

The reception of the midwives were good. I was introduced to all the necessary things I needed to know pertaining my pregnancy. The tetanus immunizations, the folic acids and malaria prophylaxis tablets. I was very cautious not to go contrary to all the tutelage I had undergone during my antenatal schedules. I was given education on the kinds of food I should eat during the course of the pregnancy and after delivery. (IDI with Participant 2 gravida 2 para 2)

I always met one midwife in consulting room two, this midwife has always been good to me. After each teaching sessions and assessment of my pregnancy, she asks me questions on how I am able to keep up with the pregnancy. Her assessments during one of my schedules revealed I was postdate. That got me disturbed and worried emotionally. That notwithstanding, she spoke to me and prepared me psychologically. She answered all questions regarding my worries. I felt safe in the process. I must say the midwife was good. (IDI with Participant 3 gravida 3 para 3)

I had always enjoyed going for my antenatal schedules. I always had the chance to ask about any unusual experiences I came across in the course of the pregnancy. All

midwives I come across always had time for me and attended to my worries. I was also prepared for the pains ahead during labour. (IDI with Participant 9 gravida 1 para 1)

The midwives were excellent! The manner in which they handled and treated me, made me calm and relaxed throughout the nine months of pregnancy. (IDI with Participant 6 gravida 2 para 2)

The responses and expressions from these participants are indication of the relevance of antenatal schedules. Majority through the antenatal schedules had basic knowledge of the whole delivery process. Most had adhered to basic instructions that had to do with tetanus immunizations schedules and adherence to treatment regimen such as malaria prophylaxis during such period. Most of them had their misconceptions and worries addressed during their respective antenatal schedules.

4.2.5 Cleanliness of the environment

The women described feeling more secured, protected and subsequently more at ease and relaxed as a result of how clean and secured the birthing environment was. Some alleged that the need for cleanliness and neatness of the environment and the privacy that were enhanced are some indicators indicator which made them deliver in the hospital. The following are some of their responses on the cleanliness of the hospital environment and its effects on their delivery:

The wards are now very neat and clean. Every client has a room to herself. There were orderlies around who always came to mop the floors. Unlike previously where the rooms were filled to capacity with beds and you could see dirt all over the place, it has improved. The nature of the rooms enhanced privacy and the midwives always checked on us to ensure we were doing well. They always ensured we breastfed our babies. They

have really improved the place and I could recommend it to any one on any day. (IDI with Participant 11 gravida 3 para 3)

Participant 9 gravida 1 para 1 had this to say in an in-depth interview:

I have always been scared of going to deliver at the Eastern Regional Hospital based on some experiences of my auntie. My mother had always complained about how disorganized and crowded the labour wards were. The situation however, was a different one for me. Everything was in place and orderly. The wards are clean, orderlies were always around to clean and mob the place. I will always recommend it to anyone.

A clean environment made the women felt safe during their respective childbirth process. Subsequently, it improved their experiences and likelihood of normal birth process. Furthermore a clean undisturbed environment promoted relaxation. When this was not achieved, women experienced fear-tension- pain-syndrome, which impeded labour and resulted in severe labour pains. The cleanliness of the environment thus always enhanced comfort and made the women relaxed.

4.2.6 Sociocultural factors

One key way in which socio-cultural norms and practices endangered the health of pregnant women is their substitution for modern medical practices. A question was asked to this effect and this was expressed on religious terms. One of the participants presented her report as follows;

The doctor attending to me had requested for a unit of blood to be used for me in the operating theatre. But I refused it. I am a Jehovah's Witness and I do not accept blood transfusions as part of my beliefs. It is against my religious leaning. The health care

professionals did their best and I went through the delivery process without any blood transfusions. (IDI with Participant 6 gravida 2 para 2)

Social and cultural factors influences the health of pregnant women in a number of ways, especially in settings where traditional philosophies challenges or replaces contemporary medical practices and where every day needs of the pregnant women are not recognized.

4.3.0 Labour conditions

All delivery accounts as reported by the women were unique. They went through completely different experiences with each labour and successful delivery. Being conversant with the women's needs, familiar with their preferences during the labour process, values and their respective labour conditions during the labour and delivery process assisted the healthcare professionals in a number of ways in providing high quality care to these labouring women. Most of them (the women) expressed varying emotions and experiences with regards to their labour conditions. They expressed their feelings in words such as 'very severe pains' 'prolong or delayed labour' 'indescribable feeling of extreme exhaustion' more intense than what was anticipated.

4.3.1 Labour pains

All the women experienced some form of recurrent pains in their childbearing process. Such pains were unpleasant and could have serious effects on the unborn baby. The pattern of pains were subjective and differs between nulliparous and multiparous women. These pains were observed to be more intense in the nulliparous than the multiparous women. The expressions, very painful reflected in almost all participants' submissions. The interactions had incomplete

sentences indicating feeling of very severe labour pain experiences. Some of the women describe their labour pain experience in the following manner;

It was painful, very painful right from home until I got to the hospital. I had a terrible experience. I could not even push the baby out in the delivery room. I was exhausted and short of energy. I was prepared thereafter and sent to the operating theatre where the baby was eventually taken out. (IDI with Participant 1 gravida 2 para 2)

The pains were real bad, very bad, very bad, infact I never envisaged it to be that bad. I had heard a lot of people spoke about it and how they went through it successfully. But mine was something else to the extent that it landed me on the theatre table. (IDI with Participant 4 gravida 1 para 1)

Oh! As for labour pains, you know it's in degree right? I had prepared myself already of what I was going to be faced with. It was a moderate one for me, perhaps because I had gone through such experiences some years back. (IDI with Participant 3 gravida 3 para 3)

I suffered, the pains were rhythmic, and they became so severe that I felt like passing a stool. I screamed all through in the process. For almost eight hours I was all in pain, infact that was not the kind of pain I ever thought of experiencing. I was told to walk around and breathe through the mouth, but it never got any better. Labour pains are real pain (IDI with Participant 2 gravida 2 para 2)

The pains were moderate, infact very minimal, until a drug was inserted into my vagina that drug worsened everything and the pains started shortly thereafter. The experience

was terrible. The pains becomes more severe and it is associated with each contractions.

(IDI with Participant 9 gravida 1 para 1)

4.3.2 Delayed labour

Some of the participants interviewed experienced delayed labour in their childbearing process. This occurred as their labour failed to progress and lasted for over twenty hours. Delayed labour most often causes suffering and difficulties that may have lifelong implications for women. Women who went through this phenomenon reported of negative birthing experiences as most of these experiences resulted in surgical births. Some participants reported feeling of extreme tiredness when they could no longer help push their unborn babies out. The following are some of the responses from participants when asked about their delayed but prolong labour experiences:

At a point where I realized I was out of energy. And could no longer push, one midwife came to my aid. She brought a machine and fixed it on the head of the baby in my vagina. The machine helped pushed the baby out and I was relieved. (IDI with Participant 12 gravida 2 para 2)

I spent so many hours pushing but all to no avail. I remembered one of the midwives saying that, my baby was huge and could not easily get through my vagina, in the process she had to give me a cut in other to help deliver the baby. (IDI with Participant 11 gravida 3 para 3)

Expressions from one of the participants also corroborated the responses where participants were assisted with their birthing process and in some extreme cases surgical births alternatives provided. One participant had this to say:

After so many hours of being in labour and the baby not forthcoming. I was helped in to the operating room where I was operated upon and the baby finally taken out of my womb. (IDI with Participant 6 gravida 2 para 2)

Feeling of exhaustion was expressed when some narrated how they felt after being in labour for so many hours without any signs of progress:

(IDI with Participant 7 gravida 1 para 1): I was in the labour ward all night through to the next day with the doctors and midwives all around me, monitoring and assessing how I was responding to the labour process. There was no progress in labour. I was weak, I couldn't even scream. I was thus rushed to the theatre and caesarean section done (sighs hmmmmmm)

Also presenting her experience (Participant 5 gravida 3 para 3) stated that:

All efforts to get my baby delivered proved futile after several attempts. I felt frustrated in the process. The midwives at the time attending to me were also shouting at me as though I intentionally just decided not to push. The doctors eventually came and upon their assessments asked that I fast till the next day. I did the fasting thinking I will be the first to be operated on, but that was not the case. I was hungry and became angry in the process. Eventually I was the fourth to be operated on (talked with some sense of anger and frustration)

IDI with Participant 2 gravida 2 para 2: (Takes a deep breath and sighed very audibly, sounding very low) well, I suffered, I suffered, and that experience wasn't that cool. For so many hours I kept pushing and the whole process was like passing a constipated tool. It was very painful, very stressful, eventually the baby came out.

4.3.3 Labour pain management

Women experiences of pain varied during the childbearing process from one woman to the other. Whilst some felt the pain to be moderate and bearable, others found it to be extremely distressing. These pains left some of these women with negative birthing experiences in cases where such pains were not well managed. The participant expressed various reactions as to how their pains were managed. Some lauded the health care staff for responding timely when the pains got severe. Others nonetheless perceived the healthcare staff to be unprofessional in their line of care, unempathetic and cruel. The women in varied ways presented their experiences of labour pain managements in their narrations:

I came across so many midwives who attended to me whilst on the labour ward. Some of them were good, they will not wait for you to complain about pain before they administered the various pain medications. However, others will just watch on whilst you groan in pain. Others will even shout at you. That shouting attitude of such midwives made the whole labour experience awkward. They were just not empathetic. It is very terrible under the care of such midwives and I felt bullied and mistreated. (IDI with Participant 12 gravida 2 para 2)

I sustained some cuts in my vagina in the course of the childbearing process. The cuts were very painful. I expected the midwife to administer some pain medications before repairing such cuts. However, it was done without any pain medication. I screamed all throughout the process. Not even my screaming could cause this lady get the pain medication administered. I suffered, I cried and that was the most painful aspect of the whole process (IDI with Participant 11 gravida 3 para 3)

The midwife who attended to me was good. She was with me throughout the childbearing process and reassured me of safe delivery and of minimal pains. Her interactions with me made me forget about the pains I was going through. I wished she was always on duty. (IDI with Participant 9 gravida 1 para 1)

One midwife retorted, 'Labour pains is all about endurance, it was high time I endured it and stop complaining.' She watched on whilst I suffered in pain. At a point in time, I was even scared calling for help, because that help won't yield anything. (IDI with Participant 3 gravida 3 para 3)

Though some of the submissions by study participants indicated effective pain management by the midwives and any other health care provider available. Some of them however, finds it difficult to approach nurses and midwives on the ward to report about their pains since such complaints were met with responses which has to do with endurances on the part of the women. This prevented early recognition of problems. For example Participant 3 gravida 3 para 3 endured all through her painful experiences and did not report what she was going through at a point she was experiencing much pain. The health personnels were not very passionate about the state of the women. The participants perceived the health professionals as not interested or were adamant in making decisions regarding their welfare

4.4 Expectations of labour

Labour expectations played an important role in determining the participant's responses to their respective childbirth experiences. Women need to be helped to identify factors which influence such expectations positively. Participants had varied expectations in relation to their childbearing process. Some health care providers knowing these expectations of such women assisted them in providing high quality care to these women. Some of these expectations as reported by the

women are; participants' control of their labour, availability of support persons, care meted out to participants and a very good health system factors.

4.4.1 Women control of their labour

The women control of their labour reflected in their responses as choices they had to make pertaining to their respective childbearing process. These controls of their labour consisted of the process which influenced their feelings about their birth experience. These controls reflected the women ability to take decisions including interventions, supports and how to give birth. A lack of control on part of the woman in the childbearing process is more likely to be associated with negative birthing experiences whereas a feeling of control reflected positive labour experiences. These choices to some of the participants gave them some sense of fulfillment. Some of them recounted when interrogated on their control of labour as:

During my antenatal schedules, I had decided that I was going to deliver through caesarean sectioning. But the moment I entered into labour, I never knew where the strength came from, though painful, it was all smooth till the baby came out. (IDI with Participant 4 gravida 1 para 1)

(IDI with Participant 10 gravida 2 para 2) also had this to say about her control of labour:

I was encouraged by the other women on the ward. Some had narrated their experiences to me, so that got me prepared. At a point where I felt I could no longer help myself, the midwife just ruptured my membranes and within a short while, the baby just came out. I was happy, I felt fulfilled, after all the outcome of the nine months pregnancy journey is to go through a safe delivery with minimal complications.

Participant 2 gravida 2 para 2 in an IDI expressed herself of her control of labour in this manner:

At a point, I was told I could not deliver all by myself and that I needed a surgery. All options available were against me just for the surgery. I experienced much more severe pains (takes in a deep breath with both eye closed). I endured it and lo and behold baby's head eventually came out. Everybody was surprised, I was elated and thanked God the surgery never came on.

Also presenting her experience Participant 3 gravida 3 para 3 stated:

I reported to the hospital on that fateful morning for my routine check-ups. I had experienced labour pains at home throughout the night. Upon the examinations done by the midwife, she asked that we move to the delivery room. It wasn't easy (sighs) 'hmmm'. The midwife fixed some infusions, added some medications and connected it to my wrist. Within some few hours I pushed the baby out. I couldn't just imagine, me going through the childbearing process with minimal pressure and screaming of push! Push! Push! from the midwife.

The responses suggested that some of the women had control of their labour and delivery process. This means a positive experience to them. It was obvious from the various submissions that the women were satisfied with the birthing process. This was manifested in their emotional wellbeing, fulfillment and positive transition into motherhood.

4.4.2 Availability of support

The participants received various assistance which were predominantly expressed in words such as encouragement, advice on how to go about the delivery, comforting words which boost confidence and morale going into the labour and reassuring words of safe delivery. These supports were found to improve the whole birthing experiences of the women. Some of the

women experienced average labour hours and such supports culminated into less medical and surgical births. These supports were seen to have come from family members, mainly the husbands and close family relations who were available at time of the delivery. Other sources of supports were from some of the health care staff, chatting and interacting with other clients on the ward.

(Participant 2 gravida 2 para 2) had this to say on questioning:

My husband! I thank God for him, he was around throughout, constantly checking on me and calling the midwives to my aid where the need be. Immediately the baby came out and I was brought to the lying in ward, he went home and fixed some food for me. That experience of having him around was refreshing.

And:

(IDI with Participant 6 gravida 2 para 2): my husband was with me in the waiting room of the operating theatre, he prayed with me and reassured me of safe surgery. I was even expecting him to be with me in the operating theatre room but that was welcomed with some form of hostility from the operating theater staff. He waited for me until the surgery was over. In the theatre room, I came across some male nurses, they engaged me in lengthy conversions. I never even felt the pains throughout the whole process except the pains from the injections they gave me prior to the start of the surgery. I was calm and felt safe throughout.

Also two of the participants expressed themselves as:

Participant 8 gravida 2 para 2: I received a lot of support from my mother and sisters. They were there for me, they encouraged me and reassured me of safe delivery.

Participant 10 gravida 2 para 2: I had lots of encouragement from the operating theatre staff. The doctors encouraged and reassured me of safe surgery. They even introduced me to others who had gone through such surgery and were successful. I felt safe and my husband too was around praying for me.

4.4.3 Care meted out to participants

The participants described the care rendered by the health care workers as good and provided the needed requisite care where the need be. However, some participants felt treated with insolence and abused.

One of the women put her negative experiences about the care rendered:

At a point, I was to be wheeled to the operating theatre on a stretcher, this midwife made me walked from the labour room to the operating theatre. I was in so much pain by then but it never occurred to her to wheel me into the theatre room. I tried suggesting to her if she could assist me by helping with a wheel chair, she felt offended, got angered and flared up. She insulted me, shouted at me, that wasn't enough for her, in an attempt to pass ureteral catheter for me, she used a bigger size with no anesthetic lubricant which caused me more pains. I cried in the process and when my husband came around to comfort me, she sacked him. I felt helpless and started praying. (IDI with Participant 6 gravida 2 para 2)

Another women put her experiences as:

After delivery, I was put to bed and within a short while, my bed with the floor was full of blood. I was bleeding via my vagina. One midwife came and saw the scene. Instead of helping arrest the situation, she rather resorted to verbally abusing me. I was almost losing myself, started sweating profusely and became weaker. In the quest of helping arrest the bleeding, she had to harshly keep pushing and withdrawing her whole arm into my vagina to expel extra blood and clots. It was a terrible experience but I survived it at the end. (IDI with Participant 10 gravida 2 para 2)

Also narrating her experience, one of the participants had this to say as well:

I had a bad experience the midwives I came across. They were always on their phones at their station. They easily get irritated when you call for help. They never were interested in the pains I was going through, not even to help with the pain management. They lacked urgency. (IDI with Participant 5 gravida 3 para 3)

CHAPTER FIVE

5.0 DISCUSSION

5.1 Introduction

The research sought to explore the facility based childbearing experiences of women within the New Juabeng Municipality. This chapter discusses the research question, methods employed and results obtained. The chapter also provides interpretation of findings in relation to relevant literature and explains their significance. The findings are discussed based on three main themes which are; women birthing experiences, women labour conditions regarding their birthing experiences and their experiences based on their labour expectations.

5.2 Birthing experiences (physical and psychological)

Childbirth experiences may be positive or negative and are dependent on the individual woman and in the facility in which one delivers. Although childbirth can be seen generally as positive, such birthing experiences can be distressing and traumatic life event to some women (Knol & Geraghty, 2017). Behavior of health care staff towards the labouring woman during the childbearing process may result in both positive and negative experiences of these women. For example, whilst some of the labouring women lauded the midwives for the good work done as a sign of positive birthing experiences which confirms the findings of study by Mannava et al., (2015), others also reported some negative experiences by the current study as some of the women submitted that some midwives they came across were offensive, unwelcoming and at sometimes frowned their faces in the course of discharging of their duties. In some situation, midwives were always repulsive in attending to the women when they needed help. The women thus felt neglected, demoralized and not cared for. In some instances, some midwives shouted at these labouring women, sutured their vaginal tears with no anesthetic agents and did not display

any sign of professionalism as corroborated by studies from Whitburn, Jones, Davey and Small (2017) , Bohren et al., (2015) and Mohammad et al., (2014). These caused the women more pain, birth injuries and resulted in some not calling for help when it was necessary. They resorted to these practices as the health care workers did not provide any comforting and expertise care when they thought that was needful. In the qualitative study by Moyer, Adongo, Aborigo, Hodgson and Engmann (2014), which delved into health care provider attitudes towards childbearing women in rural northern Ghana, a report of abuse and mistreatment of the women was established. The women expressed that most of the times they were neglected, some of the midwives were too busy to attend to them. These built some kind of tension and uneasiness. The situation made them felt bad. In Nigerian, Ishola Owolabi and Filippi (2017) emphasized respectful attitudes and behaviors during childbirth as very important in improving quality of care and encourage women to utilize health facilities for skilled delivery services; nonetheless there were reports of abuse, disrespectful care and gaps in professionalism of care rendered.

Parity of the women was another factor that contributed to their birthing experiences. It is an important indicator for the assessment of perinatal distress. Schwartz et al., (2015) revealed that women who had previously given birth may enter the birthing process with more confidence of a positive birth experience as compared to nulliparous women. Some of the participants expected a spontaneous vaginal delivery coupled with a swift and a less stressful delivery. However, some of the respondents who had reported for vaginal deliveries ended up with prolong distress labour which resulted in caesarean section deliveries. This is contrary to study by Bossano et al., (2017), which reported of low distress experiences for parous women in spontaneous vaginal delivery. These caesarean section deliveries as observed from findings of studies by Ryding et

al., (2016) and Mohammad et al., (2014) indicated that there were some forms of negative birthing experiences.

Antenatal services provided by the health care workers were found to have greatly influenced women experiences. Abuya et al., (2015) reported of some form of abuse and mistreatment such as non-dignified care, non-consensual care, physical abuse and detention of women who do not patronise antenatal services. In this study, women reported of positive experiences of the services provided as it prepared them physically and psychologically for the labour. They acknowledged that the services helped to address one or more problems which may have resulted in negative birthing experiences. These findings confirmed what was reported by study from Lindquist, Kurinczuk, Redshaw and Knight (2015). It is thus necessary that resources for antenatal services are made available and women encouraged to patronise such service to help reduce such negative birth experiences as advocated by Scorgie, Blaauw, Doms and Coovadia (2015).

Cleanliness and neatness of a birthing environment enhanced comfort and eliminated fear among women. This yielded a positive birthing experiences as reported by Mensah et al., (2014) among women delivering at the 37 Military Hospital of Ghana. In the current study, respondents were surprised about how neat and serene the birthing environment was. Some of the respondent felt secured and were happy about the privacy that was provided them. One of the respondents also acknowledged how the state of the environment had made her relaxed during the childbirth process. Some said they will always recommend such environment to other women who are yet to have their deliveries. These statements of confidence and trust in the system based on the neatness of the birthing environment confirms studies from Iravani et al., (2015) and Nilsson et al., (2013). It is thus necessary that hospital authorities keep the hospital environment neat and

put necessary structures in place so as to enhance positive birth experiences as advocated by Nilsson, Thorsell, Hertfelt and Ekström (2013).

Religious values influence the health beliefs of people and this is manifested in their decision making during birthing process. These values affects birthing experiences negatively or positively (Zakerihamidi, Roudsar, khoei & Kazemnejad , 2014). Generally, the narration from one of the respondents that made her refused blood transfusion suggested that there is a Supreme Being who handles everything and one must submit to His wills. The participant had the expectation that with the help of the Supreme Being, she will go through the delivery process safely and with a positive outcome. This demonstration of faith held by the participant supernaturally made her go through the delivery process safely though the mode of delivery was through a caesarean section. This observation is consistent with the work of Roudsari, Zakerihamidi and Merghati (2015). Such acknowledgements by the participant must be handled holistically as such beliefs can result in mortalities in cases of extreme blood loss.

5.3 Labour conditions

There were varied emotional responses to pain by the women. Whilst some expressed their experiences as negative, others saw it as positive. Also, upon delivery of babies, most of them intimated that, they were satisfied and described the experience as a positive one irrespective of the experiences they had gone through. This aspects of their presentations was described by Sengane and Malmsey (2013) as the childbirth experience being a positive one the moment the baby is delivered safely. Pirdel (2016), explains that these childbirth expectations of safe delivery determines a woman's birthing experiences. According to Iravani et al., (2015), it is necessary that the health care worker understands the labouring woman's needs, her

expectations, values and preferences so as to help in providing her with high quality care in an attempt to yield positive birthing outcomes.

Labour pains are natural and an important unique life experience to the childbearing woman. Findings of the study revealed that, most of the respondents had experienced severe pains associated with weak contractions and inability to push, which resulted in caesarean section deliveries. These negative childbirth experiences are inconsistent with the work of Basso and Monticelli (2010) which posits that most women preferred vaginal births contrary to surgical births. Also Mohammad, Alafi, Mohammad, Gamble and Creedy (2014) in a descriptive cross sectional study revealed that women were dissatisfied with their birthing experiences as the care rendered (surgical birth) were incongruent with what they expected (vaginal births). Perhaps this could be the reasons for the expressions of incomplete sentences by the women in relation to labour pains. Also these descriptions could be indicating feeling of severe labour pains.

The current study reports that delayed labour and labour pain management by some of the health care workers influenced their (women) birthing experiences. The current study reports delayed labour and labour pain management by some of the health care workers influenced their birthing experiences. Most women who were dissatisfied with the birthing experiences spoke painfully of never to have envisaged being in labour for over twenty hours. They further stressed that the over twenty hours in labour got them extremely tired and exhausted which later resulted in caesarean section deliveries. Sengane and Malmsey (2013) in their presentation reported of instances where respondents expectations were not met as envisioned.

Aziato, Acheampong and Umoar (2017), stated that there are notions that labour pains are natural and should be endured in the child bearing process, however such notions should be deemphasized during health education programs and women given adequate pain reliefs during

labour. In this current study some participant expressed various reactions as to how their pains were managed. A few lauded the health care staff for responding timely when the pains got severe. Others also felt the health care workers were unconcerned about the pains they were going through. There were barely any submission which indicated effective pain management by the midwives. These findings of negative birthing experiences agrees with study conducted by Gibson (2014) as some women pains in the current study could not be managed as expected.

5.4 labour expectations

Maternal expectations of childbirth contributed to some extent the variations in mother's childbirth experiences. The expectations were developed right from conception and played an important role in defining their experiences. The expectations developed by these women were in the form of their ability to control labour, availability of support systems during the labouring process and the care by health care professionals. It is very necessary that health care providers identify these expectations so as to help provide these women with the needed care (Goldbort, 2009).

Women control of their labour is one of the major maternal labour expectations that contribute to positive childbirth experience. Prominent in this finding is the sense of fulfillment the women had after vaginal deliveries. The study revealed that, most of the women were active decision makers during the course of the labouring process. They expressed fulfillment and satisfaction of all stages of the labouring process which culminated into safe vaginal deliveries. These findings supports previous work by Takehara, Shimane, Misago, Bloemenkamp and Stiggelbout (2014) where they studied women control of their labour during the childbearing process. Their study showed that women who had controlled of their labour process always had safe vaginal deliveries with no instrumental or surgical interventions. It is worthy of note that, these women

associated their positive birth experiences to the control they had over their labour. It is thus necessary that those factors which contributed to women control of their labour be studied extensively so as to help minimize practices which results in negative birthing experiences.

Women expectation of any available support systems is key to helping reduce negative birthing experience. As observed by Nilsson, Thorsell, Hertfelt Wahn and Ekström (2013), when they studied factors influencing positive birth experiences in Sweden. They report that women who received supportive care from close relations and midwives went through the birthing process with confidence. They further explained that the most important and impacting form of support was the availability of midwives, husbands of labouring women and other close relations. Mothers who had this support perceived the health care professionals to be efficient and competent as these always yielded positive birthing experiences. Likewise the current study found family, close relation and health worker support. Most participants expressed how valuable the supports from close relations were to them. This expression of valuable support system is supported by the work of Karlström et al., (2015).

Women develop expectations regarding care givers during labour and when these expectations are not met such women become dissatisfied and eventually have negative experiences of their labour (Sengane & Malmsey 2013). Poor care, poor decision making abilities, lack of communications on part of the health care staff resulted in negative experiences of birthing mothers in the current study. For example, poor care and poor decision making skills was recorded by the current study when a woman in labour was made to walk into the operating theatre instead of she being transported on a stretcher or with a wheel chair. Another example was when a big ureteral catheter was passed without a lubricant or an anesthetic agent to a woman infringing much pain on her. In other situation, mothers were verbally abused, left

unattended to immediately after delivery, mistreated, some midwives were sometimes seen to be playing with their phones rather than attending to the mothers. In some instances, urgency was not attached to the signs of obstetric challenges. These findings are consistent with the works of Okafor, Ugwu, and Obi (2015) and Mannava et al., (2015). They reported that mistreatments prevented women from patronizing health care services. Some mothers in the current study were helpless in some of these instances. They felt they should be quiet and suffer the pain rather than being abused. The situation frustrated them.

CHAPTER SIX

6.0 SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Introduction

This chapter presents the summary and the conclusions drawn, the implication for midwifery practice, management, education, policy as well as further research. Limitations encountered in the course of the study plus suggested recommendations are also presented in this chapter.

6.2 Summary and Conclusions

Childbirth experiences are subjective and involves physical and cognitive processes. Such experiences are very unique individual feelings and may be positive or negative. Reminiscence of such experiences might vanish, however feelings recur over one's lifetime. It is also worth noting that such experiences have significant impact on wellbeing of future mothers. Several factors such as sociodemographic characteristics, health system factors, environmental factors, labour conditions and sociocultural factors have been identified to influence such experiences. Investigating into this phenomenon, it was envisaged that the women may not want to be reminded of their experiences for fear of being victimized by the health care workers or should that fall within the negative domain and therefore would shy away. However, on the contrary the women were eager to express themselves with respect to their experiences for society to know what they went through under the care of the health care professionals and how they felt.

With respect to the major themes, improving decision making skills on part of the health care professionals, improving behavior of health care staff within the labour and delivery rooms and lack of professionalism were identified. Some participants however, reported positive health

worker attitudes and behavior. Some also lauded the health care staff for helping managed their pains swiftly which culminated in positive birthing experiences.

It was identified in the study that availability of a strong support system was key to a woman's positive childbearing experiences. The support was from close relations such as husbands and family members as well as some midwives. The supports given were basically emotional support in the form reassurance and encouragements of safe deliveries. Pieces of advices were as well given on what to do and what not to do in relation to their respective deliveries.

Communication, a vital tool for effective service delivery was presented as compromised. There were reports of communication lack or gaps; in most of the instances, health care workers were offensive, unwelcoming and sometimes frowned their face in the course of discharge of their duties. In some situations, some midwives were always repulsive in attending to these women when they needed help. In some instances too, the urgency to attend to clients were deficient. The women thus felt neglected, demoralized and not cared for. Other occurrences also revealed some midwives shouted at these labouring women, sutured their vaginal tears with no anesthetic agents and did not display any sign of professionalism. Women who had experienced these encounters resorted to not calling for help from such midwives to avoid being ill treated.

Some religious sects of the Ghanaian society have some beliefs that have been handed down to members of such religious groups. From observation and the report of this study, it came up that one of the participants refused blood transfusion based on religious grounds.

Findings revealed that most women who were active decision makers during the childbirth process had control over their delivery. The women who had control of their delivery process reported of birth satisfaction, emotional wellbeing, fulfillment and positive transition into

motherhood. It is thus imperative that factors which contributed to women being active decision makers and women being in control of their labour needs to be further investigated so as to help maximize positive birth experiences of women.

6.3 Implication for midwifery practice, Management, Education and Further Research

The results of this research have implication when it comes to midwifery practice as well as service provision of other paramedics.

1. Midwives must improve on their professional skills rather than what they are doing currently. Pregnant women expect to go through the labour process safe and come out with positive birthing experiences to fulfill their expectations of safe and sound deliveries.
2. Women do not enter the labouring process in expectation of negative childbirth experiences, they feel demoralized, neglected, bad and sad when they are faced with such practices, which result in negative birthing experiences. Midwives and other health care staff must personalize the care rendered, be sympathetic and empathetic enough and go the extra mile to find out how their actions resulted in negative birthing experiences. This will enable them provide the needed support to such women.
3. Findings of the study revealed that communication challenges started from the labour wards through to after delivery. The risk of negative birthing experiences is higher during these periods, therefore attitudes and behavior of health care workers must not be overlooked during these periods.
4. Nurse administrators must select nurses and midwives who are efficient in the management of delivery cases. These health care staff must be put in the labour wards to care for these women so as to help maximise positive birthing experiences.

5. The negative birthing experiences undermine the reputation of the health care system thus the resultant effect being deliveries out of the health facility. It is thus necessary that necessary measures are put in place to sustain facility deliveries and make it safer.
6. It is every woman's right to give birth in a woman centered environment free from abuse and disrespect. Understanding how women define abuse is crucial if the Ghana Health Service is to succeed in increasing the uptake of facility based birth to 100 percent.
7. Having companions and support persons around during the labour and delivery process were associated with positive birthing outcomes. Policy makers thus needs to consider quality improvement approaches and accommodation of support person in promoting positive birthing outcomes and obstetric care.

6.4 Recommendation

Based on the finding of this study, the researcher suggests that the following could be done to help minimize facility based negative birthing experiences of mothers.

1. A regular training programme on intensive obstetric care is advocated for service providers.
2. There should be a system put in place to easily identify women who go through the delivery process and present with negative birthing experiences. These may avoid giving birth in health facilities based on their negative experiences. Such women must be counselled and support given them at the hospital through to the community so as to help strengthen and psyche them for future but positive birthing experiences.
3. There is the need for the development of Birthing Experiences Tools by local authorities through Ghana Health Service by various stakeholders in obstetric, social and psychological service provision. These tools will measure birthing experiences be it negative or positive experiences, necessary interventions provided where possible to help minimize this phenomenon of negative birthing experiences.
4. There should be regular staff rotation on the various labour wards and delivery rooms. This will reduce and minimize staff burnouts which is likely to translate into poor work attitudes and low productivity.
5. Thoughtful deliberate attention must be given to those factors that promoted positive birthing experiences and help create circumstances amenable to enhancing quality obstetric care and improve outcomes for mothers and infants.

6. Health system drivers that influence provider behavior and health facility environment should be considered for quality improvement and reduction of negative attitudes and behaviors by health care providers towards labouring women.
7. There is the need to educate women on their rights, strengthening health systems to respond to specific needs of women at childbirth, implement and enforce policies on respectful maternity care.
8. The current study focused on the New Juabeng Municipality, therefore a regional replication of this study is recommended to obtain a National Birthing Experiences data, also studies to assess the negative birthing experiences of women within the Eastern Region must be done to support the current findings or otherwise. Finally an inquiry into the knowledge and practice of Service Providers on management of women in labour is important. The proposed research areas if studied will increase knowledge and also provide evidence for the improvement of obstetric care.

REFERENCE

- Aasheim, V., Waldenström, U., Rasmussen, S., & Schytt, E. (2013). Experience of childbirth in first-time mothers of advanced age – a Norwegian population-based study. *BMC Pregnancy and Childbirth*, *13*, 1.
- Abuya, T., Warren, C. E., Miller, N., Njuki, R., Ndwiga, C., Maranga, A., Bellows, B. (2015). Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *PLoS ONE*.
- Akoto, F. (2013). University of Ghana <http://ugspace.ug.edu.gh>, (10507117).
- Aldrighi, J. D., Wall, M. L., Souza, S. R. R. K., Cancela, F. Z. V., Aldrighi, J. D., Wall, M. L., Cancela, F. Z. V. (2016). The experiences of pregnant women at an advanced maternal age: an integrative review. *Revista Da Escola de Enfermagem Da USP*, *50*(3), 512–521.
- Aschenbrenner, A. P., Hanson, L., Johnson, T. S., & Kelber, S. T. (2016). Nurses' Own Birth Experiences Influence Labor Support Attitudes and Behaviors. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *45*(4), 491–501.
- Attanasio, L. B., McPherson, M. E., & Kozhimannil, K. B. (2014). Positive childbirth experiences in US hospitals: A mixed methods analysis. *Maternal and Child Health Journal*, *18*(5), 1280–1290.
- Balde, M. D., Bangoura, A., Diallo, B. A., Sall, O., Balde, H., Niakate, A. S., Bohren, M. A. (2017). A qualitative study of women's and health providers' attitudes and acceptability of mistreatment during childbirth in health facilities in Guinea. *Reproductive Health*, *14*(1).
- Banks, K. P., Karim, A. M., Ratcliffe, H. L., Betemariam, W., & Langer, A. (2018). Jeopardizing quality at the frontline of healthcare: Prevalence and risk factors for disrespect and abuse during facility-based childbirth in Ethiopia. *Health Policy and Planning*, *33*(3).
- Basso, J. F., & Monticelli, M. (2010). Expectations of pregnant women and partners concerning their participation in humanized births. *Revista Latino-Americana de Enfermagem*, *18*(3), 390–397.
- Beinempaka, F., Mnc, B., Tibanyendera, B., Med, B. A., Atwine, F., & Mnc, B. (2014). The practice of traditional rituals and customs in newborns by mothers in selected villages in, *19*(2), 2014.
- Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Gülmezoglu, A. M. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLOS Medicine*, *12*(6), e1001847.
- Bohren, M. A., Vogel, J. P., Tunçalp, Ö., Fawole, B., Titiloye, M. A., Olutayo, A. O., Hindin, M. J. (2017). Mistreatment of women during childbirth in Abuja, Nigeria: A qualitative study on perceptions and experiences of women and healthcare providers Prof. Suellen Miller. *Reproductive Health*, *14*(1).
- Bossano, C. M., Ms, K. M. T., Bs, A. C. W., Blomquist, J. L., & Mhs, V. L. H. (2017). after delivery. *The American Journal of Obstetrics & Gynecology*.
- Burns, N., & Grove, S. (2012). Practice of Nursing Research. *Appraisal, synthesis and generation*

of evidence, 8th edition. Saunders.

- Cheng, T. S., Loy, S. L., Cheung, Y. B., Godfrey, K. M., Gluckman, P. D., Kwek, K., Lek, N. (2016). Demographic Characteristics, Health Behaviors Before and During Pregnancy, and Pregnancy and Birth Outcomes in Mothers with Different Pregnancy Planning Status. *Prevention Science*, 17(8), 960–969.
- Conesa Ferrer, M. B., Canteras Jordana, M., Ballesteros Meseguer, C., Carrillo García, C., & Martínez Roche, M. E. (2016). Comparative study analysing women's childbirth satisfaction and obstetric outcomes across two different models of maternity care. *BMJ Open*, 6(8), e011362.
- Creswell, J. (2009). *Research design: Qualitative, quantitative and mixed methods approaches*. (3 rd Edito). London: sage.
- Dahlberg, U., & Aune, I. (2013). The woman's birth experience-The effect of interpersonal relationships and continuity of care. *Midwifery*, 29(4), 407–415.
- Dzomeku, M., Wyk, B., & Lori, J. R. (2017). Experiences of women receiving childbirth care from public health facilities in Kumasi, Ghana. *Midwifery*, 55.
- Ekpoanwan, E., Idongesit, I., & Basse, J. (2017). Cultural Diversity In Childbirth Practices In A Rural Community In Southern Nigeria. Department of Nursing Science, University Of Calabar, Nigeria
- F.Bell, A., & Ewa Andersson. (2016). The birth experience and women's postnatal depression: A systematic review. *Midwifery*, 39, 112–123.
- Fawsitt, C. G., Bourke, J., Lutomski, J. E., Meaney, S., McElroy, B., Murphy, R., & Greene, R. A. (2017). What women want: Exploring pregnant women's preferences for alternative models of maternity care. *Health Policy*.
- Fiona Scorgie, Duane Blaauw, Tessa Doms, Ashraf Coovadia, V. B. and M. C. (2015). "I get hungry all the time": experiences of poverty and pregnancy in an urban healthcare setting in South Africa. *BioMed Research International*, 2015(Suppl 1), 1–7.
- Gea, D. (2015). *I Nhe a Lt H*.
- Ghana Statistical Service. (2014). Ghana Demographic and Health Survey. *Studies in Family Planning*, 21(1), 1–5.
- Gibson, E. (2014). Women's expectations and experiences with labour pain in medical and midwifery models of birth in the United States. *Women and Birth*, 27(3), 185–189.
- Goldbort, J. G. (2009). Women's Lived Experience of Their Unexpected Birthing Process. *MCN, The American Journal of Maternal/Child Nursing*, 34(1), 57–62.
- Gravenstein, I. K., Écija Gallardo, C., Jacobsen, E.-M., Rådestad, I., Sandset, P. M., & Ekeberg, . (2013). Women ' s experiences in relation to stillbirth and risk factors for long-term post-traumatic stress symptoms: a retrospective study. *Group.Bmj.Com*.
- Gyesaw, N. Y. K., & Ankomah, A. (2013). Experiences of pregnancy and motherhood among teenage mothers in a suburb of Accra, Ghana: a qualitative study. *International Journal of*

Women's Health, 5, 773–780.

- Henriksen, L., Grimsrud, E., Schei, B., & Lukasse, M. (2017). Factors related to a negative birth experience – A mixed methods study. *Midwifery*, 51, 33–39.
- Iravani, M., Zarean, E., Janghorbani, M., & Bahrami, M. (2015). Women's needs and expectations during normal labor and delivery. *Journal of Education and Health Promotion*, 4, 6.
- Ishola, F., Owolabi, O., & Filippi, V. (2017). Disrespect and abuse of women during childbirth in Nigeria: A systematic review. *PLoS ONE*, 12(3), 1–17.
- Jafari, E., Mohebbi, P., & Mazloomzadeh, S. (n.d.). Factors Related to Women's Childbirth Satisfaction in Physiologic and Routine Childbirth Groups. *Iranian Journal of Nursing and Midwifery Research*, 22(3), 219–224.
- Jouhki, M.-R., Suominen, T., & Åstedt-Kurki, P. (2017). Giving birth on our own terms— Women's experience of childbirth at home. *Midwifery*, 53, 35–41.
- Karlsen, S., Say, L., Souza, J.-P., Hogue, C. J., Calles, D. L., Gülmezoglu, A. M., & Raine, R. (2011). The relationship between maternal education and mortality among women giving birth in health care institutions: Analysis of the cross sectional WHO Global Survey on Maternal and Perinatal Health. *BMC Public Health*, 11.
- Karlström, A., Nystedt, A., & Hildingsson, I. (2015). The meaning of a very positive birth experience: focus groups discussions with women. *BMC Pregnancy and Childbirth*, 15, 251.
- Kızılırmak, A., & Başer, M. (2016). The effect of education given to primigravida women on fear of childbirth. *Applied Nursing Research*, 29, 19–24.
- Knol, F., & Geraghty, S. (2017). Midwifery students and routine discussion of birth experience in the early postnatal period in hospital. *British Journal of Midwifery*, 25(6), 380–385.
- Lally, J. E., Thomson, R. G., MacPhail, S., & Exley, C. (2014). Pain relief in labour: a qualitative study to determine how to support women to make decisions about pain relief in labour. *BMC Pregnancy and Childbirth* 2014 14:1, 14(1), 6.
- Larkin, P., Begley, C. M., & Devane, D. (2009). Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery*, 25(2), e49–e59.
- Latifnejad-Roudsari, R., Zakerihamidi, M., Merghati-Khoei, E., & Kazemnejad, A. (2014). Cultural perceptions and preferences of Iranian women regarding cesarean delivery. *Iran J Nurs Midwifery Res*.
- Leedy, P. D., & Ormrod, J. E. (2010). *Practical Research: Planning and Design. Practical Research - Planning & Design*.
- Lindquist, A., Kurinczuk, J., Redshaw, M., & Knight, M. (2015). Experiences, utilisation and outcomes of maternity care in England among women from different socio-economic groups: findings from the 2010 National Maternity Survey. *BJOG: An International Journal of Obstetrics & Gynaecology*, 122(12), 1610–1617.

- Lo-Biondo-Wood, G., & Haber, J. (1994). *Nursing Research* (3rd Edition). London: Mosby.
- Lydia Aziato, Umoar, A. K. A., & Lazarus, K. (2017). Labour pain experiences and perceptions: a qualitative study among post-partum women in Ghana. *BMC Pregnancy and Childbirth*, *17*(73).
- Mannava, P., Durrant, K., Fisher, J., Chersich, M., & Luchters, S. (2015). Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. *Globalization and Health*, *11*, 36.
- Martin, D. K., Bulmer, S. M., & Pettker, C. M. (2013). Childbirth expectations and sources of information among low- and moderate-income nulliparous pregnant women. *The Journal of Perinatal Education*, *22*(2), 103–112.
- Maya, E. T., Adu-Bonsaffoh, K., Dako-Gyeke, P., Badzi, C., Vogel, J. P., Bohren, M. A., & Adanu, R. (2018). Women's perspectives of mistreatment during childbirth at health facilities in Ghana: findings from a qualitative study. *Reproductive Health Matters*.
- Mehretie Adinew, Y., & Abera Assefa, N. (2017). Experience of Facility Based Childbirth in Rural Ethiopia: An Exploratory Study of Women's Perspective. *Journal of Pregnancy*, *2017*.
- Mensah, R. S., Mogale, R. S., & Richter, M. S. (2014). Birthing experiences of Ghanaian women in 37th Military Hospital, Accra, Ghana. *International Journal of Africa Nursing Sciences*, *1*, 29–34.
- Meyer, S. (2013). Control in childbirth: A concept analysis and synthesis. *Journal of Advanced Nursing*.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis an expanded sourcebook* (2nd Edition). California: Sage.
- Mohammad, K. I., Alafi, K. K., Mohammad, A. I., Gamble, J., & Creedy, D. (2014). Jordanian women's dissatisfaction with childbirth care. *International Nursing Review*.
- Morse, J. M., & Field, P. A. (1998). *Nursing Research; the application of qualitative approaches* (second Edition). United Kingdom: Stanley Thrones.
- Moyer, C. A., Adongo, P. B., Aborigo, R. A., Hodgson, A., & Engmann, C. M. (2014). 'They treat you like you are not a human being': Maltreatment during labour and delivery in rural northern Ghana. *Midwifery*, *30*(2), 262–268.
- Mselle, L. T., Moland, K. M., Mvungi, A., Evjen-Olsen, B., & Kohi, T. W. (2013). Why give birth in health facility? Users' and providers' accounts of poor quality of birth care in Tanzania. *BMC Health Services Research*, *13*(1), 174.
- Munhall, P. L. (2012). *Nursing Research. A qualitative perspective* (3rd Edition). Boston: National League for Nursing Press.
- Muzaffar, N., & Akram, M. (2015). Pregnancy and childbirth experiences: A review of the care agencies and the nature of care. *International Journal of Prevention and Treatment*, *4*(3), 41–47.

- Nilsson, C., Lundgren, I., Karlström, A., & Hildingsson, I. (2012). Self reported fear of childbirth and its association with women's birth experience and mode of delivery: A longitudinal population-based study. *Women and Birth*, 25(3), 114–121.
- Nilsson, L., Thorsell, T., Hertfelt Wahn, E., & Ekström, A.,. (2013). Factors influencing positive birth experiences of first-time mothers. *Nursing Research and Practice*, 2013, 349124.
- Ojelade, O. A., Titiloye, M. A., Bohren, M. A., Olutayo, A. O., Olalere, A. A., Akintan, A., Fawole, B. (2017). The communication and emotional support needs to improve women's experience of childbirth care in health facilities in Southwest Nigeria: A qualitative study. *International Journal of Gynecology and Obstetrics*, 139.
- Okafor, I. I., Ugwu, E. O., & Obi, S. N. (2015). Disrespect and abuse during facility-based childbirth in a low-income country. *International Journal of Gynecology & Obstetrics*, 128(2), 110–113.
- Ono, M., Matsuyama, A., Karama, M., & Honda, S. (2013). *Association between social support and place of delivery: a cross-sectional study in Kericho, Western Kenya*.
- Peñacoba-Puente, C., Carmona-Monge, F. J., Marín-Morales, D., & Écija Gallardo, C. (2016). Evolution of childbirth expectations in Spanish pregnant women. *Applied Nursing Research*, 29, 59–63.
- Pirdel, L. (2016). A comparison of women's expectations of labour and birth with the experiences in primiparas and multiparas with normal..., (January).
- Polit, D. F., & Beck, C. . (2008). Methods, appraisal, and utilization. In *Essentials of nursing research*. Philadelphia: Lippincott.
- Polit, D. F. (2014). *Essentials of nursing research : appraising evidence for nursing practice* . Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.
- Pradhan, E. (2015). Female Education and Childbearing: A Closer Look at the Data | Investing in Health. Retrieved August 28, 2017, from <http://blogs.worldbank.org/health/female-education-and-childbearing-closer-look-data>
- Roudsari, R. L., Zakerihamidi, M., & Merghati, E. (2015). Original Article Socio-Cultural Beliefs , Values and Traditions Regarding Women ' s Preferred Mode of Birth in the North of Iran, 3(3), 165–176.
- Ryding, E. L., Lukasse, M., Kristjansdottir, H., Steingrimsdottir, T., Schei, B., Schei, B., ... Wangel, A. M. (2016). Pregnant women's preference for cesarean section and subsequent mode of birth – a six-country cohort study. *Journal of Psychosomatic Obstetrics and Gynecology*, 37(3).
- Schwartz, L., Toohill, J., Creedy, D. K., Baird, K., Gamble, J., & Fenwick, J. (2015). Factors associated with childbirth self-efficacy in Australian childbearing women, 1–9.
- Sengane, M., & Malmsey. (2013). Mothers' expectations of midwives' care during labour in a public hospital in Gauteng. *Curationis*, 36(1), 9 pages.
- Shan, D., Qiu, P.-Y., Wu, Y.-X., Chen, Q., Li, A.-L., Ramadoss, S., Hu, Y.-Y. (2018). Pregnancy

- Outcomes in Women of Advanced Maternal Age: a Retrospective Cohort Study from China. *Scientific Reports* 2018 8:1, 8(1), 12239.
- Sia, S., Thome, M., Steingrimsdottir, T., Bara, L., Fridrik, J., Olafsdottir, H., & Swahnberg, K. (2017). Partner relationship , social support and perinatal distress among pregnant Icelandic women. *Women and Birth*, 30(1), e46–e55.
- Smarandache, A., Kim, T. H. M., Bohr, Y., & Tamim, H. (n.d.). Predictors of a negative labour and birth experience based on a national survey of Canadian women.
- Takehara, K., Noguchi, M., Shimane, T., Misago, C., Bloemenkamp, K., & Stiggelbout, A. (2014). A longitudinal study of women’s memories of their childbirth experiences at five years postpartum. *BMC Pregnancy and Childbirth*, 14(1), 221.
- United Nations International Children Emergency Fund. (2008). Progress for Children. A Report Card on Maternal Mortality. *A Report Card on Maternal Mortality*, (7), 48.
- Whitburn, L. Y., Jones, L. E., Davey, M.-A., & Small, R. (2017). The meaning of labour pain: how the social environment and other contextual factors shape women’s experiences. *BMC Pregnancy and Childbirth* 2017 17:1, 17(1),
- World Health Organization. (2012). Category of Disrespect and Abuse. [child_accountability/iERG/reports/2012_01S_Respectful_Maternity_Care_Charter_The_Universal_Rights_of_Childbearing_Women.pdf](http://www.who.int/reproductivehealth/publications/maternal_mortality_review/2012_01S_Respectful_Maternity_Care_Charter_The_Universal_Rights_of_Childbearing_Women.pdf)
- World Health Organization. (2015). The prevention and elimination of disrespect and abuse during facility-based childbirth. WHO statement: Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care. *World Health Organization*, 1–4.
- World Health Organization. (2018). *Individualized, supportive care key to positive childbirth experience, says WHO*.
- World Health Organization. (2016) Maternal mortality. [factsheets/fs348/en/http://www.who.int/mediacentre/](http://www.who.int/mediacentre/factsheets/fs348/en/)
- Zakerihamidi RL, Roudsari EM, Khoei Kazemnejad A delivery in the North of Iran: A focused ethnography. (2014). *Iran J Nurs Midwifery Res*.
- Zhang, X., & Lu, H. (2014). Childbirth expectations and correlates at the final stage of pregnancy in Chinese expectant parents. *International Journal of Nursing Sciences*, 1(2), 151–156.

APPENDICES

APPENDIX A: QUESTIONNAIRE

IN-DEPTH INTERVIEW GUIDE

TOPIC: DELIVERY IN HEALTH FACILITY: A STUDY OF THE BIRTHING EXPERIENCES OF WOMEN IN THE NEW JUABENG MUNICIPALITY

INTRODUCTION

I am going to ask you some questions about your childbirth experiences, take time in answering them and feel free to ask me to explain further if the question is not clear to you. You can skip question and return to it if you want to. If you do not want to comment on a question please say so. Please be assured that there are no wrong answers, so give me your honest response. Remember that whatever you share with me will not be identified with you but may be used as a valuable information in the study

1. Could you tell me something about your experiences with regards to your age?
2. What were your expectations in relation to your labour pains?
3. Please describe your experience of labour pain with regards to your childbirth process?
4. What are the things that soothed or aggravated your labour pain or feeling?
 - Attitudes
 - Expressions
 - Behaviors
5. Would you say you received adequate care concerning the management of your labour pain?
 - Tell me how the pain was managed for you with regards to the midwives
 - How about any available support person?
6. What were some of the expectations of your control on the childbirth process?
7. Do you think you had enough control of your childbirth process?
 - Kindly tell me how your control influenced your choices in the childbirth process
8. Were you provided with enough information regarding your childbirth process during your antenatal schedules?

- What were the relevance of such information to you in your childbearing experience?
9. Could you tell me about the hospital and place of delivery; the things that happened there?
 - How did it influence your childbirth experience?
 - Can you remember some of the things that were most helpful to you?
 10. Did you envisage receive any support from the midwives, family relation or support person during the childbearing process?
 - Tell me which people supported you?
 - How did they do that?
 11. What were the attitudes of the midwives and doctors towards you?
 12. Can you describe the treated meted out to you by the midwives or doctors?
 13. What is your assessment of the childbirth experience?
 - Could you tell me if it was a negative or a positive one?
 - What do you think contributed to the experience being a positive or negative one?
 14. If you were to tell another woman with your experience about the kind of things that will help her feel better that, what will you say?
 15. How has this interview been to you?
 16. Is there anything else you would like to tell me about which you think would be important for me to know?

Closing

I am grateful for the time you have spent with me and the contribution you have made to the study. If you think now or in the next few days that our discussion has brought up things that need to be talked about with the doctor or midwives please call me. I would be happy to send you the result of the study if you request for it. Thank you very much.

APPENDIX B: CONSENT FORM

INFORMED CONSENT

Title: Delivery in Health Facility: A Study of the Birthing Experiences of Women in the New Juabeng Municipality

Principal Investigator: Emmanuel Adugu

Address: School of Public Health, University of Ghana, Legon, P.O. Box LG 13. Legon

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General information about Research

This study is a quality descriptive research. It will involve the use of interview guide which seek to elicit information from participants which will be audio recorded, translated word for word and interpreted to bring out the experiences of birthing women. The objective of this study is to examine the facility based childbearing experiences of women in the New Juabeng Municipality.

The interview will last 30 to 90 minutes. It will focus on factors which contributed to the experiences of your child bearing process; explore your expectations relating labour and delivery needs and to examine attitudes of care providers towards your childbearing process. The time and venue of the interview will be determined by you. There is no right or wrong answers; you are therefore free to express yourself in whatever way you wish.

Possible risks and discomfort

The researcher acknowledges that the interview could make you become emotionally affected. However, He believes people become better when they express their pain, therefore you eventually feel much better after the interview. You would be allowed some time to put yourself together; the interview can be rescheduled for a more suitable time if necessary. There will also be counseling services available if you wish.

Possible benefits

By doing this research healthcare providers will better understand the plights of the childbearing woman. It will help graduate nurses who are learning the skills of conducting delivery by knowing those factors which minimized negative childbearing experiences and yielded positive childbearing outcomes. Your personal benefit will be the relief you will experience after sharing your experience; it is said that when people talk about their pain, their degree of hurts reduces.

Confidentiality (protecting your information)

Your identity and privacy will be protected; a number will be used to identify you instead of your name or anything that will be written about our talk or the document bearing your name. The consent form will be handled by the researcher and the supervisor only and these will be kept under lock and key (safety).

Compensation

There is no reward in cash or kind; however it is envisaged that the findings will go a long way to increase knowledge, influence care giving behavior of professional and provide information to society at large on women experiences of facility based child delivery and how such experiences should be managed.

Voluntary Participation and Right to Leave the Research

Your participation in this research is voluntary and so if you do not want to participate you are free to do so. You are not going to lose anything if you decide not to take part. If you participate and in the process you want to stop, you will be allowed to do so. You can contact the following persons or me if you have any questions.

Contacts for additional information

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School of Public Health, University of Ghana, Legon

P. O. Box LG 13. Legon.

Telephone Number: 0244806015

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedure for the research title Delivery in Health Facility: A Study of the Birthing Experiences of Women in the New Juabeng Municipality has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

.....

.....

Date

Name and signature of volunteer

If volunteer can not read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

.....

.....

Date

Name and signature of witness

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

.....

.....

Date

Name and signature of person who obtained consent

APPENDIX C



UNIVERSITY OF GHANA
DEPARTMENT OF SOCIAL AND BEHAVIOURAL SCIENCES
SCHOOL OF PUBLIC HEALTH

Ref. No.:

31st October, 2017

The Medical Director
Eastern Regional Hospital
Koforidua, Eastern Region

Dear Sir/Madam,

LETTER OF INTRODUCTION
EMMANUEL ADUGU - 10635131

I write to introduce to you Mr. Emmanuel Adugu who is pursuing a Master of Public Health programme in the School of Public Health, College of Health Sciences, University of Ghana, Legon.

Mr. Adugu's dissertation is entitled: **"Delivery in Health Facility: A Study of the Birthing Experiences of Women in the New Juabeng Municipality"**.

Mr. Adugu will pay a visit to your outfit to gather data for his work. We would be grateful if you could kindly give him the necessary assistance.

Thank you and counting on your co-operation.

Yours faithfully,

Prof. Philip Baba Adongo
Head of Department

COLLEGE OF HEALTH SCIENCES

P. O. Box LG 13, Legon, Accra, Ghana.
• Telephone: +233 (0) 289 109 012/3 • Email: sph-sobs@ug.edu.gh • Website: www.publichealth.ug.edu.gh

APPENDIX D



UNIVERSITY OF GHANA
DEPARTMENT OF SOCIAL AND BEHAVIOURAL SCIENCES
SCHOOL OF PUBLIC HEALTH

Ref. No.:

31st October, 2017

The Chairperson
GHS-Institutional Review Committee
P. O. Box MB 190
Accra-Ghana

Dear Sir,

REQUEST FOR ETHICAL REVIEW
EMMANUEL ADUGU

Emmanuel Adugu is a Master of Public Health student in the Department of Social and Behavioural Sciences, School of Public Health, University of Ghana.

I write as the Head of Department to support his application for ethical review of his proposal titled **“Delivery in Health Facility: A Study of the Birthing Experiences of Women in the New Juabeng Municipality”**

I would be grateful if the committee could review the research proposal for possible approval, to enable the student start his data collection.

Yours faithfully,

Prof. Philip Baba Adongo
Head of Department

COLLEGE OF HEALTH SCIENCES

P. O. Box LG 13, Legon, Accra, Ghana.
• Telephone: +233 (0) 289 109 012/3 • Email: sph-sobs@ug.edu.gh • Website: www.publichealth.ug.edu.gh

APPENDIX E

In case of reply the number and the date of this letter should be quoted.



REGIONAL HOSPITAL
P. O. BOX 201
KOFORIDUA

2ND NOVEMBER, 2017.

My Ref. No RHK/GF-91
Your Ref. No.

TEL. # 03420-23011 FAX # 034202529
Email: reghspkof@yahoo.com.

**THE HEAD OF DEPARTMENT
UNIVERSITY OF GHANA
DPT. OF SOCIAL AND BEHAVIOURAL
SCIENCES
SCHOOL OF PUBLIC HEALTH**

RE: LETTER OF INTRODUCTION
EMMANUEL ADUGU - 10635131

Your letter dated 31st October, 2017 has reference.

As part of requirements to permit Mr. Adugu to gather data in our outfit, a copy of the Research Proposal and Ethical Clearance is to be submitted to the hospital before the commencement of the research.

Thank you.

Yours faithfully,



**DR. KWAME ANIM-BOAMAH
MEDICAL DIRECTOR**

Dr. K. O. G. and all concerned

Permission has been granted to Mr. Adugu to carry out his research at the Eastern Region Hosp's Koforidua.

**DR. KWAME ANIM-BOAMAH
MEDICAL DIRECTOR
EASTERN REGION HOSPITAL
KOFORIDUA**

07/05/18

APPENDIX F

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.



Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com
17th April, 2018

MyRef. GHS/RDD/ERC/Admin/App 114/123
Your Ref. No.

Emmanuel Adugu
University of Ghana
School of Public Health
Legon, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

| | |
|------------------|---|
| GHS-ERC Number | GHS-ERC: 111/12/17 |
| Project Title | Delivery in Health Facility: A Study of the Birthing Experiences of Women in the New Juabeng Municipality |
| Approval Date | 17 th April, 2018 |
| Expiry Date | 16 th April, 2019 |
| GHS-ERC Decision | Approved |

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra