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BIRTH COMPANIONSHIP DURING LABOUR: A STUDY OF ACCEPTANCE FACILITATORS, BARRIERS/CHALLENGES AMONG MIDWIVES IN SEKONDI/ TAKORADI, GHANA.

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DEPARTMENT OF MATERNAL AND CHILD HEALTH

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DECLARATION

I Leticia Arthur attest that this thesis is the sole result of my effort to attain a Master of Philosophy Degree in Midwifery at the School of Nursing and Midwifery, University of Ghana. This work has never been presented in parts or whole to any institution for the award of any degree. However, the works of the authors and publishers that have been presented in this work have been duly acknowledged in the text and reference section.

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ABSTRACT

The World Health Organization (WHO) recommends birth companionship (BC) as a strategy to enhance maternal birth experiences, citing numerous benefits, chiefs among them being the emotional support it offers to women during labour. Despite this endorsement, the implementation of birth companionship remains inconsistent across healthcare settings. This study explored midwives' acceptance, facilitators, and barriers to the potential implementation of the birth companionship strategy in Sekondi and Takoradi. The research employed a qualitative descriptive design, underpinned by Ajzen's (1985) Theory of Planned Behaviour. Sixteen (16) midwives from four health facilities in Sekondi-Takoradi were purposively selected. Data were collected using a semi-structured interview guide, audio recorded, transcribed, and analysed manually using Braun and Clarke's (2022) thematic analysis procedure. Three (3) main themes and thirteen(13) subthemes emerged:1) Midwives' Attitudes Towards the Birth Companionship Strategy, 2) Social Expectations Regarding Birth Companionship, 3) Behavioural Control Factors Influencing Midwives' Support for Birth Companionship. Although midwives demonstrated knowledge of the benefits of birth companionship, this was insufficient to secure their support for its future implementation. Many expressed concerns about the challenges birth companions may pose to the care process. These included potential conflict and confrontation with clients, as well as perceived threats to professional autonomy. Additionally, midwives cited the design of labour wards, particularly dormitory-style layouts, as a significant barrier to maintaining privacy and confidentiality during labour. Some companions were perceived as disruptive, interfering with care, taking photographs, or documenting events for social media. The study concludes that for successful implementation, clear guidelines and context-related protocols on birth companionship should be developed. Furthermore, the strategy should be integrated into midwifery education curricula to foster a shared understanding and acceptance among midwives.

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DEDICATION

The study is dedicated to my Pastor and Daughter.

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All thanks and glory to the God who sees me for His grace, guidance, and strength throughout this academic journey. I am deeply grateful to my supervisor, Dr. Evelyn Asamoah Ampofo, and my co-supervisor, Dr. Emma Annan, for their invaluable support, constructive feedback, and encouragement throughout the research process. My sincere appreciation goes to all the participants who graciously shared their time and experiences through interviews. Your contributions were essential to the success of this study. To my pastor and friend, Pastor Joseph Willie Amoah, your spiritual, emotional, and practical support cannot be overlooked. God richly bless you. To my dear daughter, Ewurakua, and my sister, Maame Esi, you are truly priceless. Thank you for your love, patience, and understanding and encouraging words. To Norwegian Program for Capacity Development in Higher Education and Research for Development (NORHED) for awarding me a MIDRED scholarship, am forever grateful for the financial and educational support you offered throughout this academic journey. I also extend my gratitude to the staff of the Maternity Units of the four hospitals involved in this study thank you for your support during the data collection process. Lastly, to all the authors and publishers whose works enriched this research, your contributions are duly acknowledged and appreciated.

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LIST OF ABBREVIATIONS

RMC	–	Respectful Maternity Care
TPB	–	Theory of Planned Behaviour
TRA	–	Theory of Reasoned Action
TACT	–	Trustworthiness, Auditability, Credibility, and Transferability
TA	–	Thematic Analysis
BSc	–	Bachelor of Science
CM	–	Interview participant (Used as pseudonyms, e.g., CM1, CM2, etc.)
GHS	–	Ghana Health Service
IRB	–	Institutional Review Board
PUBMED	–	Public/Publisher's Medical Literature

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CHAPTER ONE:

INTRODUCTION

This chapter focuses on the background to the study, the purpose of the study, the statement of the problem, research objectives and research questions, as well as the significance of the study and operational definitions of keywords used in the study.

1.1. Background of The Study

Childbirth, though a normal physiological process, is associated with fear and anxiety. The level of anxiety, if not properly dealt with, may negatively affect the childbirth experience for the woman (Tavares et al., 2022). To ensure that women have a positive birth experience and indirectly discourage more women to engage the services of Trained Birth Attendants, the World Health Organization (WHO) has made some recommendations. One such recommendation is for the labouring woman to have continuous support from a companion of her choice (WHO, 2016a, 2016b, 2018).

Simkin and Cheyney (2024) explain that the concept of birth companionship dates back many centuries, and historically, women have given birth in the company of older women. However, with the institutionalization of childbirth, healthcare providers are ideally expected to provide continuous support and companionship. However, there is evidence to show that healthcare providers are unable to provide the needed support for individual women during labour due to some factors, including workload (Maputle, 2018; Perkins et al., 2019). A birth companion as described by WHO (2016) is any person of a woman's choice to provide her with continuous support during labour and childbirth. Birth companionship, according to Habib et al. (2023), is a situation where a pregnant woman is offered ongoing emotional, physical, and educational support throughout pregnancy, labour, and the puerperium. The notion of birth companionship,

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which is often referred to as labour support or doula assistance, has historical roots although it has only recently received official acknowledgement and attention (Hunter & Hurst 2016).

Different societies have embraced the idea of birth companionship in various ways throughout history. For instance, in ancient midwifery techniques, experienced local women were frequently present to offer assistance and emotional support throughout labour (Reed et al., 2016). Elders or female family members have traditionally supported birthing people in many indigenous societies (Chamberlain et al., 2019). But in the latter half of the 20th century, the modern doula movement which emphasizes offering emotional and educational assistance during childbirth started to gain hold according to Gabriel et al., (2023) having its roots buried in some theoretical underpinnings such as the social support theory by Don Drennon-Gala and Francis Cullen which was first published in 2017, Attachment theory, developed by John Bowlby (1969) and the Empowerment theory by Julian Rappaport(1981)

To offer birth and postpartum doulas tools, certification, and training, groups such as DONA International (previously known as Doulas of North America) were founded in the 1980s and 1990s. As a result, the function of birth companionship during the childbirth process became more formal and standardized (Roth et al., 2016). In recent times, doulas or birth companions have become crucial in helping women give birth by offering them advocacy, emotional support, and comfort (Lunda, 2018). In addition to aiding in communication between the person giving birth, their family, and medical personnel, their presence can help lessen tension, anxiety, and the perception of pain (Lunda, 2018).

The World Health Organization, as part of efforts to improve maternal and neonatal health, recommended the presence of a birth companion for a pregnant woman. The recommendation is based on evidence that shows the positive impact of continuous support during childbirth, both in terms of physiological and psychological well-being for the birth person (WHO 2020).

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Afulani (2018) reiterated that the recommendation for birth companionship aligns with the broader movement to promote respectful and humanized care in childbirth, furthermore a supportive companion, whether a partner, family member, friend, or trained doula, can provide emotional support, alleviate anxiety, and promote a sense of empowerment for the birthing woman. It can also help facilitate communication between the birthing woman and healthcare providers, ensuring that the woman's preferences and wishes are respected during the birthing process (Afulani et al., 2020).

Additionally, the integration of this concept in the management of expectant mothers have contributed tremendously to:1)Reduced rates of medical interventions such as caesarean sections and epidural anaesthesia, 2)Shorter labour durations, 3)Reduced use of pain-relief medications 4)Improved satisfaction with the childbirth experience 5)Positive effects on maternal and foetal well-being (Kabakian-Khasholian & Portela, 2017 &Sarwal et al., 2023).These benefits contribute to the overall goal of improving maternal and newborn health outcomes and ensuring a positive birth experience.

Despite mounting evidence of the advantages of birth companionship, several obstacles prevent its proper implementation in healthcare settings (Kabakian-Khasholian & Portela, 2017). Although the concept is becoming widely accepted in many western cultures; United States, United Kingdom and Canada, there are no clear guidelines as to how their activities should be carried out, so the practice varies in different nations and cultures (Levine et al., 2021).Levels of integration according to Chaote et al., (2018), vary among different nations; for example, access to birth accompaniment services is more prevalent in metropolitan regions and among socioeconomic categories.

Again, the dominance of the biomedical model of care poses another challenge to how well the concept is enacted in birthing settings. This assertion is supported by studies done by (Doenmez

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et al., 2022 &Wójcik-Brylska et al., 2023) on the perspectives of maternity care managers on the role of doulas in Poland and investigating how doulas respond to challenges of Western systems and revitalizing indigenous birthing care in Canada, respectively. In settings with limited resources or low- and middle-income nations, like Africa, the challenge has to do with its acceptance due to cultural norms, a lack of healthcare infrastructure, and labour scarcity (Vogel et al., 2016).

A study in Ghana revealed that indigenous cultures have maintained the customs surrounding childbirth, including the use of community members or elders as birth companions, but the concept of birth companionship has not been clearly implemented as recommended by WHO although there are pockets or parts of it being used in labour settings, having its tenets in ancient practices. There are ongoing efforts to incorporate ancient approaches into contemporary healthcare systems while maintaining cultural traditions (Ganle, 2016).

As the primary implementers of this crucial strategy, midwives' expected barriers, challenges, and facilitators to its successful execution must be investigated to formulate suggestions that will encourage the broad incorporation of birth companionship into routine intrapartum care and foster a positive birth experience.

1.2. Problem Statement

The concept of birth companionship in health facilities presents a critical area of concern that requires comprehensive exploration. While the World Health Organization (WHO) recommends the presence of birth companions during labour and childbirth for improved maternal and newborn health outcomes, the extent to which this practice has been successfully integrated is not really known (Bohren et al., 2019). Globally, birth companionship is recognized as an essential component of respectful maternity care (RMC) and a vital strategy for improving maternal and newborn health outcomes. The World Health Organization (WHO,

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2018) recommends that every woman in labour should have the companion of her choice, as continuous emotional, physical, and informational support has been shown to significantly improve birth experiences and clinical outcomes. Evidence from various countries demonstrates that birth companionship is associated with reduced labour duration, decreased need for analgesia, lower rates of cesarean section, and improved maternal satisfaction with care (Evans et al., 2023; Ma et al., 2019; Wanyenze et al., 2022). In many settings, the inclusion of birth companions has also strengthened women's autonomy, dignity, and participation in decision-making during childbirth, key elements of RMC (Jolivet et al., 2021).

Furthermore, birth companionship contributes to improved trust in the healthcare system, thereby increasing utilization of skilled birth attendants and reducing reliance on untrained providers (Dzomeku et al., 2022). As birth companionship forms one of the ten core components of RMC, women are ideally expected to receive support from partners, family members, or doulas who can assist them emotionally and physically throughout labour and childbirth (Kabakian-Khasholian et al., 2017). In countries where this model has been well implemented, the positive outcomes underscore the importance of ensuring that all women, including those in Ghana, benefit from continuous, compassionate, and supportive care during labour.(Id et al., 2025). Despite strong global evidence and recommendations, the integration of birth companionship into routine maternity care remains inconsistent across health facilities. Studies from multiple countries reveal that many labouring women are still denied the presence of a companion due to facility policies, spatial limitations, or provider attitudes (Bohren et al., 2019; Smith et al., 2020).

Traditional models of care often prioritize medical procedures and clinical efficiency over emotional and psychosocial support, leading to low acceptance of birth companionship among some healthcare workers who may view it as unnecessary or beyond their scope of training (Bocoum et al., 2023; Scott et al., 2017). In the Ghanaian context, birth companionship has not

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yet been adopted as a formal national policy, which contributes to variability in its practice. Anecdotal reports from the Western Region indicate that although midwives are aware of the concept, the level of implementation, the factors influencing their acceptance, and the challenges they face remain largely unknown. Additionally, the absence of standardized guidelines, clear protocols, and well-defined roles for birth companions results in inconsistencies and uncertainties in practice, further hindering implementation (Bohren et al., 2019; Smith et al., 2020; WHO, 2018). As a result, many women continue to labour without the presence of companionship despite its numerous benefits.

The lack of birth companionship during labour has significant implications for maternal well-being and overall quality of care(Getahun et al., 2020; McKelvin et al., 2021). Women who labour without supportive companions are more likely to experience heightened fear, anxiety, and feelings of isolation, which can negatively affect labour progress and satisfaction with care. Absence of continuous support has also been linked to higher rates of medical interventions, longer labour, increased pain perception, and decreased overall childbirth satisfaction (Bohren et al., 2019). From a rights-based perspective, inadequate psychosocial support compromises women's dignity, autonomy, and emotional safety, which are core principles of RMC (Jolivet et al., 2021).

In Ghana, where maternal health challenges persist(Adu & Owusu, 2023; Dzomeku et al., 2021), failing to implement birth companionship could mean missed opportunities to enhance trust in the healthcare system, increase skilled birth attendance, and improve maternal and newborn outcomes. Therefore, understanding midwives' attitudes, readiness, perceived barriers, and facilitators regarding birth companionship is crucial for informing effective implementation strategies. This study seeks to address this critical gap by exploring midwives' perspectives within the Western Region of Ghana, with the aim of generating evidence to

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support the integration of birth companionship into routine maternity care and ultimately improve the childbirth experience for women.

1.3 Purpose of the Study

The main aim of this study was to explore the acceptance, perceived facilitators, barriers, and challenges that are likely to affect the implementation of birth companionship within hospitals in Sekondi Takoradi in the Western Region of Ghana.

1.4.1 Specific Objectives

The study was guided by the following specific objectives: To

1. explore the attitudes of midwives towards the birth companionship strategy in hospitals within Sekondi-Takoradi.
2. examine the influence of social expectations on midwives' readiness to implement the birth companionship strategy in Sekondi-Takoradi.
3. identify the perceived behavioural control factors that may influence midwives' readiness to implement the birth companionship strategy during labour.

1.5 Research Questions

1. What is the attitude of midwives towards the birth companionship strategy Sekondi Takoradi?
2. What are the social expectations that may influence midwives' readiness to implement the birth companionship strategy within Sekondi-Takoradi?
3. What are the behavioural control factors that may influence the ability of midwives to implement the birth companionship strategy?

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1.6 Significance of the Study

Examining the facilitators, barriers, and challenges related to the implementation of birth companionship in Sekondi Takoradi hospitals is an important research project for several stakeholders, including medical professionals, policymakers, expectant mothers, and the public. This is so because:

- Numerous studies have been conducted regarding the advantages of the concept (Kabakian-Khasholian & Portela, 2017; Sarwal et al., 2023) yet there is a dearth of documentation about the acceptance, obstacles, problems, and enablers of its execution. By offering insightful information about the dynamics of birth companionship implementation within a particular cultural and healthcare setting, the study will add to the body of knowledge in academia. Future research can utilize this information as a guide to help build studies and interventions targeted at enhancing maternity care practices.
- The study's conclusions can potentially provide evidence on training needs for the implementation of the strategy to the Health Directorate.
- It will also help shape institutional policies looking at necessary administrative and structural adjustments necessary for implementation of the concept.
- The findings from this study will provide midwives with evidence concerning the acceptance, facilitators, barriers, and challenges that are likely to affect the implementation of the birth companionship strategy. This will give them a basis to educate pregnant women about birth companionship and be advocates for better ways to ensure its implementation.
- This information can guide training programs and interventions to equip midwives with the knowledge and skills needed to effectively collaborate with birth companions,

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fostering a holistic approach to maternity care.

1.7 Operational Definitions of Terms

1. Acceptance: The use of the birth companionship strategy in maternity care.

2. Barriers: Formation of structures or systems that impede the implementation of birth companionship.

3. Birth companion: A person who is present with the woman during pregnancy or labour, providing emotional, physical, and informational support.

4. Challenges: Difficulties faced during the implementation of the birth companionship strategy.

5. Facilitators: Factors that promote the implementation of birth companionship.

6. Respectful maternity care (RMC): Maternal health services that protect the dignity, privacy and autonomy of women during pregnancy, childbirth, and the postpartum period.

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CHAPTER TWO:

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.0. Introduction

A literature review is an extensive examination of academic sources concerning a certain subject or research question. A literature review's main goals are to set the scene for your research, point out areas of research gaps in previous studies, and create a framework for future investigations. The literature study used Google Scholar, PUBMED, Science Direct, Wiley and Scopus as search engines with search terms like "birth companionship," "implementation," "facilitators," "acceptance," and "barriers." 1) Acceptance of Companionship of Birth 2) Birth Companionship Implementation Facilitators 3) Barriers to birth companionship implementation 4) Challenges to birth companionship implementation.

This literature review features the empirical review on the concept of birth companionship and its importance in labour, as well as the theory of planned behaviour (TPB): the theoretical framework used for the study. It also empirically reviewed birth companionship, shedding light on its acceptance, identifying facilitators for its implementation, and exploring barriers to its successful integration into the childbirth process. The review was organised under two sections, with each having sub-sections. The first section documents the three main theoretical frameworks reviewed before finally settling on the TPB, and the second section documents the empirical review on the concept of birth companionship.

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2.1. Theoretical Framework

Introduction

According to Polit and Beck (2019), theories enable researchers to incorporate observations and facts into a structured framework. They are effective tools for gathering collected information, frequently from unrelated and isolated investigations. A theoretical framework serves as the foundational structure for understanding, analysing, and interpreting complex phenomena within a specific field of study (Garcia et al., 2019). It outlines key concepts, relationships, and assumptions that guide research or analysis, providing a roadmap for systematic exploration and comprehension. By establishing a theoretical foundation, a theoretical framework not only enhances the clarity of research objectives but also facilitates the development of hypotheses and the interpretation of findings (Collins & Stockton, 2018). In essence, it serves as a critical tool for organizing and framing the inquiry, offering a structured approach to unravel the intricacies of the subject matter (Aulls & Shore 2023).

In identifying the theoretical framework for this study, the researcher reviewed three theories which are Rogers' (1962) "diffusion of innovation theory", Fishbein & Ajzen's (1970) "theory of reasoned action" and Ajzen's (1985) "theory of planned behaviour"

2.1.1 The Diffusion of Innovations Theory (Everett Rogers 1962)

Rogers' book "The Diffusion of Innovations" describes one of the most widely used adoption models. The process of embracing new inventions has been researched for more than thirty years. The creator of this theory is a sociologist and communication expert, Everett Rogers. His 1962 book introduced the hypothesis for the first time. In later book versions, Rogers continues to hone and develop the idea (Sherry & Gibson, 2002).

The theory was developed to explain how and why novel concepts, items, or technological advancements gradually permeate a population. Understanding the adoption and dissemination

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process, pinpointing important variables that affect an innovation's rate of acceptance, and categorizing people according to their openness to embracing new ideas were among Rogers's interests. Chen (2024) and Jamel et al. (2022) listed political science, public health, communications, history, economics, technology, and education as a few of these fields, and described Rogers' theory as a commonly applied theoretical framework around the diffusion and adoption of technology. The best theory to study how technology is adopted in academic settings and higher education is Rogers' diffusion of innovations theory (Medlin, 2001; Parisot, 1995). Since technological advances are a major component of diffusion research, Rogers frequently used the terms "technology" and "innovation" interchangeably (Orr, 2003). The theory presents four essential components that impact the uptake of innovations:

Innovation

According to Rogers "An innovation is an idea, practice, or project that is perceived as new by an individual or other unit of adoption" (Rogers, 1995, p. 12) it can also refer to a novel concept, item, or technological advancement that is being presented. Even if something has been around for a while, people may still consider it innovative if they believe it to be fresh.

Communication Channels

Communication channels are the second component of the invention diffusion process. Communication, according to Singh (2024), is "a process in which participants create and share information to reach a mutual understanding", or the dissemination of knowledge about innovations. This process occurs through various channels that allow sources to communicate with one another. Rogers (1995) defines a source as "an individual or an institution that originates a message" (p. 204), and a channel as the means through which a message is transmitted from one party to another.

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Time

This is how quickly people accept the innovation over time. Most of the behavioural research, according to Orr, (2003), ignores the temporal component. He contends that one of diffusion research's advantages is demonstrated by adding the temporal component. The rate of adoptions, adopter classification, and innovation-diffusion process are all impacted by time.

Social System

The final component in the dissemination process is the social system. "A set of interrelated units engaged in joint problem solving to accomplish a common goal" (p. 23) is how Rogers (1995) described the social system. The social structure of the social system has an impact on the diffusion of innovations since it occurs within it. "The patterned arrangements of the units in a system" is what Rogers (1995) defines as structure (p. 24). He went on to say that the primary criterion for classifying adopters an individual's capacity for innovation is influenced by the social structure in which they live.

The innovation-decision process

Rogers emphasizes that innovation works when a person knows about it, does a personal assessment cognitively and effectively and judges the innovation based on public endorsement. This helps in understanding the benefits and drawbacks of the innovation, allowing the person to make informed decisions about its acceptance or rejection. (Rogers, 1995, p. 21).

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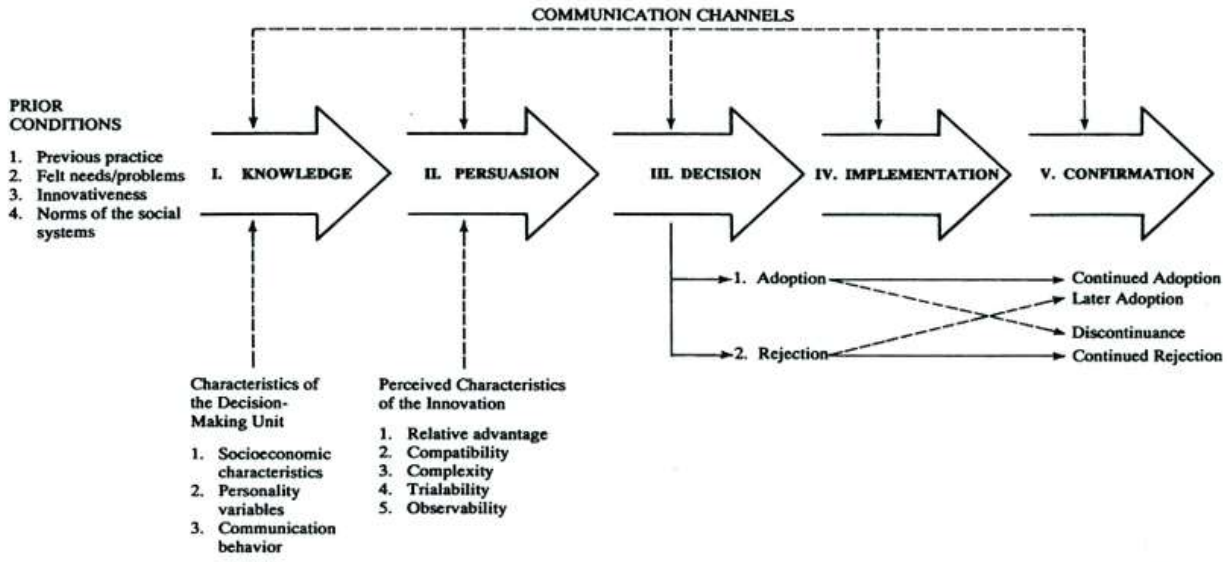

Figure 1: Diffusion of Innovation Model (Rogers, 1995)

However, the flaws that will make it difficult for it to be easily applied using the study's objectives are that it looks at how knowledge of the benefits of a particular innovation can influence a person's ability to adopt it, but knowledge alone cannot be used to measure attitude as the study objective seeks to ascertain.

Theoretically, the theory assumes a homogeneous social system however, individuals within a system may have different motivations, and characteristics that impact their adoption decisions. Furthermore, in the context of birth companionship, the location of the birthing suite, the organisational goals and the decision by institutional heads may determine whether the implementation can be carried out. These flaws led to the review of another relevant theory called the Theory of Reasoned Action (TRA) by Martin Fishbein and Icek Ajzen.

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2.1.2. Theory of Reasoned Action, (Fishbein and Ajzen,1970)

A popular framework for comprehending and forecasting human behaviour is the Theory of Reasoned Action (TRA). TRA was created by Martin Fishbein and Icek Ajzen in the late 1960s and early 1970s to address discrepancies in the way attitudes and behaviour relate to one

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another. According to the theory, the most direct predictor of a behaviour is an individual's desire to carry it out, which is impacted by two primary constructs: 1) attitudes toward the behaviour and 2) subjective norms.

2.1.3. Development of the Theory

Previous studies on attitudes and behaviour, which indicated that attitudes by themselves were not enough to predict behaviours, served as the basis for TRA. To close this gap, Fishbein and Ajzen developed the idea of "behavioural intention," which holds that intention acts as a mediator between attitudes and real behaviour. TRA emerged as a fundamental idea in social psychology that has applications in a variety of domains, including organizational behaviour, education, and health. Nonetheless, it assumes that actions are subject to volitional control, which means people are free to carry out their objectives without interference from outside forces.

2.1.4. Key Constructs of TRA

1. Behavioural Intention

The motivating component that indicates how hard a person is willing to try and how determined they are to do behaviour is the behavioural intention, according to Fishbein & Ajzen (1970).

They proposed that the best predictor of behaviour was intention; the more strongly one's intention, the more likely one is to carry out the behaviour.

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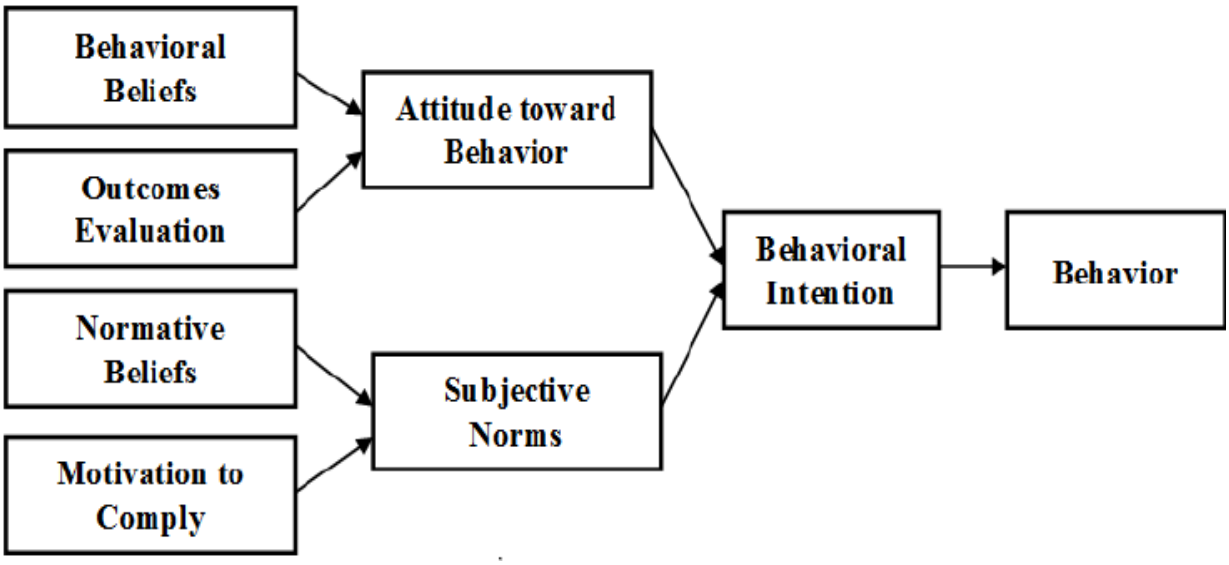

Figure 2: Theory of Reasoned Action - TRA (Fishbein & Ajzen, 1975)

1. *Attitudes Toward the Behaviour*

   Behaviour is also influenced by an individual's assessment of their performance of the behaviour, which is divided into two parts. (Fishbein & Ajzen, 1970). A) Behavioural Beliefs, which they defined as expectations for the results of the behaviour and B) Outcome Evaluation, which is the weight given to these results. Regarding this study, a real-world example would be a midwife's favourable attitude toward the profession if she believed that birth companionship improved patient satisfaction and maternal outcomes.

2. *Subjective Norms*

Once more, Fishbein and Ajzen (1970) clarified that a person's perception of social pressure to engage in or refrain from behaviour is also influenced by the views of important people. They go on to explain that normative views and compliance motivation are the two halves of these subjective norms. The former discusses whether significant individuals accept or disapprove of the behaviour, while the latter explains how much a person wants to live up to their expectations. For instance, midwives could feel inspired to embrace the practice if patients, co-workers, or hospital managers support birth companionship.

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2.1.5. Alignment of TRA with the Study

The Theory of Reasoned Action provides a structured framework to explore the factors influencing midwives' acceptance of birth companionship. It aligns with the study in the following ways:

1. Attitudes Toward Birth Companionship

The study can investigate midwives' beliefs about the benefits (e.g., improved maternal comfort and outcomes) and drawbacks (e.g., potential interference with professional duties) of birth companionship. These can generate positive or negative attitudes to influence midwives' readiness or their intentions to support the strategy.

2. Subjective Norms Influencing Midwives

Social expectations from hospital management, colleagues, and patients play a significant role in midwives' readiness to implement birth companionship. The study can examine how supportive or unsupportive subjective norms influence midwives' decisions to adopt the practice.

3. Behavioural Intention and Actual Behaviour

The study can assess whether midwives' intentions to implement birth companionship translate into action or whether barriers, such as institutional policies or lack of resources, prevent them from doing so. By analysing these constructs, the study can identify key facilitators and barriers to the successful implementation of birth companionship in the context of Sekondi/Takoradi.

Despite the precision of the construct to the objectives of the study, there are other limitations that make this theory not fit for the study.

1)Assumption of Volitional Control

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TRA assumes that individuals have complete control over their behaviour, which may not always be the case. External factors such as resource constraints, institutional policies, or lack of training can prevent midwives from acting on their intentions, even if attitudes and subjective norms are favourable.

2. Exclusion of Perceived Behavioural Control

TRA does not account for perceived behavioural control (a construct later added in the Theory of Planned Behaviour) which the researcher reviewed after this. Factors like confidence in one's ability and external barriers are critical in determining whether intentions translate into behaviour.

3. Focus on Rational Decision-Making

TRA emphasizes rational processes in decision-making and may overlook the influence of emotions, habits, or unconscious biases, which can also affect behaviour.

4. Limited Applicability to Complex Behaviours

The theory is better suited for simple, straightforward behaviours rather than complex ones involving multiple stakeholders and systemic challenges, such as the implementation of birth companionship in hospitals. These limitations lead to the review of a more robust theory: The Theory of Planned Behaviour.

In summary, TRA provides a valuable framework for exploring the acceptance, facilitators, and barriers associated with the use of birth companions among midwives in Sekondi/Takoradi. Its focus on attitudes, subjective norms, and behavioural intention aligns well with the study objectives, offering insights into the psychological and social factors influencing midwives' readiness to adopt this strategy. However, the theory's limitations, particularly its assumption of volitional control, focusing on rational decision making and limited applicability of complex

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behaviours make it impossible to be used as an all-fit theory for this study.

2.1.3. The Theory of Planned Behaviour (TPB) (Ajzen, 1985)

The Theory of Planned Behaviour (TPB) developed by Icek Ajzen in 1985 is an extension of the Theory of Reasoned Action (TRA). While TRA was instrumental in understanding behaviour through attitudes and subjective norms, it was limited to situations where individuals had complete control over their actions. TPB addressed this limitation by introducing the construct of Perceived Behavioural Control (PBC) to account for non-volitional factors that influence behaviour. TPB has since become one of the most widely used theories for understanding and predicting behaviour across diverse fields, including healthcare, education, and organizational behaviour.

2.1.4. Development of TPB

TPB builds on the foundation of TRA, which posits that behavioural intention is the primary determinant of behaviour and is influenced by attitudes toward the behaviour and subjective norms.

TRA assumed that individuals had complete volitional control over their actions, which limited its applicability in real-world scenarios where external barriers or internal limitations exist. TRA failed to address the situation where external and uncontrolled factors could influence the behaviour of people.

In 1985, Ajzen extended TRA by adding Perceived Behavioural Control (PBC) as a key determinant of both intention and behaviour. PBC recognizes that individuals may face barriers or enablers that affect their ability to perform a behaviour, such as resource availability, skills, or external circumstances. So, to him, an individual's behaviour is primarily associated with attitude towards the behaviour, subjective norms and perceived behavioural controls.

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TPB has been widely applied in health interventions, organizational studies, and public health research to predict and explain behaviours like smoking cessation, vaccination uptake, and adoption of workplace policies. Its structured framework allows researchers to explore and address the factors influencing behaviour comprehensively.

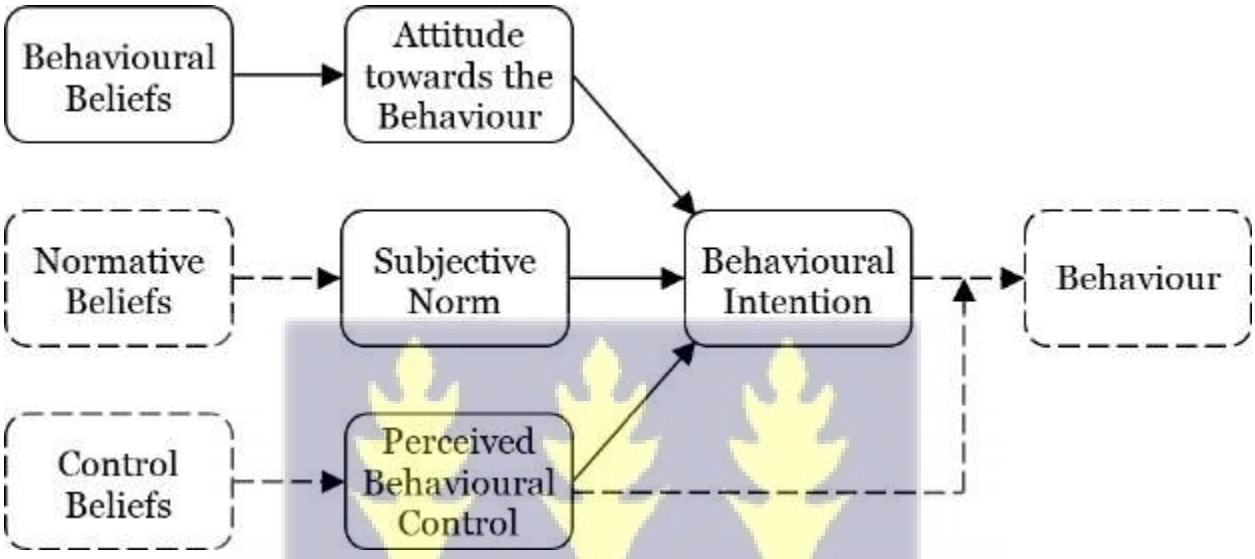

Figure 3: the Theory of Planned Behaviour (Ajzen, 1985, 1991)

2.1.5. Key Constructs of TPB

The Theory of Planned Behaviour identifies three primary constructs that influence behavioural intention and behaviour:

1. Attitudes Toward the Behaviour

Ajzen 1985 explained that the individual's overall positive or negative evaluation of performing the behaviour is his attitude towards that behaviour. An individual's attitude toward a behaviour is determined by their behavioural beliefs, which link the behaviour to various outcomes and other attributes. For example, if the midwife believes that allowing a companion to be with the woman during birth will make labour less painful for the woman, she will consciously make sure that every woman comes with a companion during birth.

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Attitudes can be formed through direct experience, observations, formal education, conditioning processes, and social/cultural factors. Attitudes are a significant predictor of intention and can often be assessed through interviews. Ajzen further highlighted that attitude towards a behaviour can be broken down into two components i.e. Behavioural Beliefs, which he explained as expectations about the likely outcomes of the behaviour and outcome evaluations which is the value placed by the individual on these outcomes.

1. Subjective Norms

The second construct of this theory is subjective norms. According to Ajzen 1985, the subjective norm is the perceived social pressure to perform or not perform the behaviour. If an individual evaluates a suggested behaviour as positive (attitude), and if he or she believes significant others endorse the behaviour (subjective norm), the intention (motivation) to perform the behaviour will be greater and the individual is more likely to perform the behaviour. This subjective norm according to Ajzen1985 comes in two components i.e. Normative Beliefs and Motivation to Comply. The normative belief he explains is the ability of the individual to decipher whether significant others approve or disapprove of the behaviour and Motivation to Comply is an individual's willingness to conform to these perceived expectations. For example, if hospital administration, community members and the hospital regulatory authorities validate and expect that women come to labour with companions, midwives are likely going to promote the use of companions during birth.

2. Perceived Behavioural Control (PBC)

The individual's perception of their ability to perform the behaviour, considering internal and external constraints is the PBC as asserted by Ajzen (1991). PBC is a person's perception of how much control they have over performing a behaviour. It's a key component of the theory of planned behaviour, along with attitude and subjective norms. PBC is often assessed by how

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easy or difficult a person finds a behaviour to perform. PBC is expected to moderate the effect of intention on behaviour. This means that a favourable intention will only lead to behaviour if PBC is strong. PBC can directly affect behaviour, especially in high-risk situations. PBC has two components: Control Beliefs and perceived power. Control Beliefs are the factors that facilitate or hinder the performance of the behaviour and Perceived Power is the perceived strength of these factors. For example, the midwife is highly likely to accept the use of birth companions if per her estimation it will be easy to use them or might hesitate in using them if she perceives that there will be constraints like privacy, increased workload and others when she incorporates the use of birth companions in the care.

2.1.6. Relevance to Study Objective 1

Exploring midwives' attitudes toward the birth companionship strategy involves understanding their beliefs about its benefits to the woman in labour (e.g., improved maternal outcomes) and them as midwives, like improved care, as well as the challenges (e.g., increased workload). Attitude, according to Ajzen (1985), refers to an individual's positive or negative evaluation of performing a specific behaviour, and midwives' positive attitudes toward the strategy may strengthen their intention to implement it or negative attitudes towards it will affect the quality of its implementation. The first objective seeks to uncover midwives' subjective evaluations, beliefs, and feelings about implementing or supporting this strategy, and this makes the first construct of the theory a best fit. Again, to explore the attitudes of midwives toward birth companionship strategy in hospitals, within Sekondi Takoradi TPB's construct of "Attitudes Toward the Behaviour" provides a framework for understanding midwives' beliefs about the outcome of labour in the presence of birth companions. These attitudes could be positive or negative depending on how they perceive the contribution of birth companions towards the outcome of labour, client satisfaction or workload. The construct can be used to develop an interview guide to uncover beliefs about the consequences of adopting the strategy, understanding how

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midwives value specific outcomes of the strategy, capture the feelings associated with implementing or supporting the strategy.

2.1.7. Relevance to Study Objective 2

The second construct of the Theory of Planned Behaviour (TPB) is subjective norms, which refer to the perceived social pressure to perform or not perform a specific behaviour(La & Ajzen, 2020). This construct explores how the beliefs and expectations of others (e.g., family, peers, colleagues, supervisors, or the community) influence an individual's intention to engage in a behaviour. It focuses on social expectations: a key component of subjective norms.

It seeks to understand how these expectations influence midwives' readiness to adopt the birth companion strategy, reflecting how external pressures or support shape behavioural intentions and actions. Examining the role of social expectations involves assessing how midwives' readiness to adopt the birth companionship strategy is influenced by institutional policies, patient demands, and peer attitudes, among others. Since care provision seeks to bring satisfaction to the client first and foremost, the behaviour (use of birth companions during labour) is likely to be embraced and successfully implemented if the patient counts it as part of the care component that brings them satisfaction or vice versa.

Additionally, if there are institutional policies that inculcate the use of birth companions during the care of the labouring woman, midwives are highly likely to support the implementation because midwifery care rendered should always be appropriate and align with acceptable to standards (Lunda et al., 2024)

Strong or stringent subjective norms, midwives' normative belief about these norms and their motivation or obligation to comply to them can influence their readiness to support the implementation of the strategy.

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2.1.8. Relevance to Study Objective 3

Using the third construct of the theory of TPB dissects two things that influence behaviour, that is the presence or absence of factors (resources, opportunities, barriers) that may facilitate or hinder the midwives' readiness to implement the strategy and the degree to which these factors affect the ease or difficulty of implementing the strategy: these two things make up their perceived behavioural control (PBC) (Medicines, 2021). Identifying PBC factors helps uncover barriers (e.g., lack of training, resource constraints) and facilitators (e.g., institutional support, adequate staffing) that affect midwives' ability to implement the birth companionship strategy. PBC directly influences both intention and actual behaviour.

The construct will be useful in identifying factors midwives perceive as enabling or constraining their ability to implement the strategy, as well as exploring the degree of control midwives feel they have over-implemented the strategy, given the barriers and facilitators. To meet the objective, the interview guide will focus on eliciting midwives' perceptions of: Internal and external barriers or facilitators, resources, skills, or conditions that influence their ability to act and how these factors impact their confidence in implementing the strategy.

2.1.9. Strengths of using TPB in this Study

TPB provides a comprehensive framework which provides a structured approach to explore attitudes, social influences, and control factors, offering a holistic understanding of midwives' behaviour towards the strategy. Furthermore, it has the predictive power of identifying the determinants of intention and behaviour, allowing researchers to anticipate challenges and design targeted interventions. It also gives flexibility where the theory can be adapted to different contexts, making it ideal for exploring the complex factors influencing the adoption of birth companionship in Sekondi/Takoradi.

In conclusion, the Theory of Planned Behaviour offers a robust theoretical framework for

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understanding the acceptance, facilitators, and barriers to implementing the birth companionship strategy among midwives in Sekondi/Takoradi. Its constructs attitudes, subjective norms, and perceived behavioural control align closely with the study's objectives, providing valuable insights into the psychological and social factors shaping midwives' intentions and behaviour.

2.2. Empirical Review

Overview of Birth Companionship

Though it has only lately acquired official recognition and attention, the idea of birth companionship also known as labour support or doula assistance dates back many centuries (Hunter & Hurst 2016). According to anecdotal evidence, women have traditionally given birth in the presence of elderly women. However, as delivery becomes more institutionalized, it is ideal for medical professionals to offer ongoing companionship and support.

Having birth companions was recommended by the World Health Organization (WHO, 2018) as part of its initiatives to improve the health of mothers and babies. The recommendation aligns with the broader movement to promote respectful and compassionate care during childbirth and is backed by studies showing the positive impacts of continuous assistance during labour on the physiological and psychological health of the birthing person.

A birth companion, as described by WHO (2016), is any person of a woman's choice to provide her with continuous support during labour and childbirth. Birth companionship, according to Habib et al. (2023), is a situation where a pregnant woman is offered ongoing emotional, physical, and educational support throughout pregnancy, labour, and the puerperium. The benefit of birth companionship in improving a woman's delivery experience has come to light more and more in recent years. Throughout labour and delivery, birth companions, often

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friends, relatives, or qualified medical professionals, offer women emotional, practical, and informational support. Given that childbirth is a dramatic and life-changing experience, it is vital to have a full awareness of the various factors that can affect mothers' health and obstetric outcomes (Gaur, 2017).

Leap & Hunter (2022) explained that birth companionship, also known as doula support, is a concept that entails the presence of a qualified person who offers a woman physical, emotional, and informational support while she is giving birth. This method of care is because individualised support can significantly improve a woman's birthing experience by making her feel more in control, knowledgeable, and taken care of throughout. The core business of a birth companion goes beyond that of medical professionals who are primarily concerned with the medical aspects of childbirth, such as doctors and midwives. A doula, also known as a birth companion, is a person who has undergone training in childbirth but is not often a medical professional and who offers support, comfort measures, and various strategies to help women cope with labour and delivery (Goldkuhl et. al.,2022).

Although the ideal context considered when describing a person as a birth companion was one who has received training in childbirth, Bohren et. al., (2019) agree with WHO's (2016) assertion that labour or birth companionship, may be provided by a partner, family member, friend, doula, or healthcare professional to a woman during labour and childbirth not necessarily one who has received formal training in that regard.

Irrespective of whether the companion received formal training or not, birthing women who had a known person as a support person were more likely to have a pleasant experience of professional help during labour (Hildingsson et al., 2021). This is in line with the study findings of O'Brien et al. (2021), which emphasize the significance of trusting connections with care providers for women's experiences of feeling supported during childbirth.

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According to Sigurdarottir et al., (2017), labour is a difficult and emotional experience for both the mother and the father; for this reason, support during childbirth has often been named as the single most important aspect for a pleasant childbirth experience. They went on to say that a birth companion can be the expectant mother's husband, friends, family members, or even medical personnel.

2.2.1. Benefits of Birth Companionship

A birth companion offers a constant presence to offer emotional reassurance, encouragement, and comfort Sigurdarottir et al., (2017). The same point was made by Bohren et al., (2019) and Fathi Najafiet ai., (2017), who both supported the idea that birth companions can be a great source of emotional support for both the mother and her partner during childbirth by providing a listening ear, affirmations, and empathy. The concept when embraced well makes the childbirth experience more empowering despite being intensely challenging, importantly, feeling supported and nurtured by care providers and familiar persons during childbirth can supersede the negative effects of a complicated childbirth (Olza et. al., 2018).

Apart from the emotional support widely reiterated by many study findings as a key function of a birth companion (Boren et. al., 2019; Olza et. al., 2018; Taheri et.al., 2018 & Sigurdarottir et al., 2017), Simkin et. al., (2017) in their book: "The labour progress handbook" also posited that the birth companion also provides informational support for the woman. A birth companion, they explained, aids the mother in comprehending the various stages of labour, medical procedures, and potential interventions. They provide the mother with knowledge backed by research so she can choose how she wants to give birth with confidence. With less anxiety and certainty, the woman is better able to take an active role in her labour and delivery.

In a systematic review to assess women's, companions', and midwives' views and experiences of birth companion support in labour and to identify ways to improve the experience for women

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and their birth companions(Junges, n.d.) were of the view that companions provide physical support to the woman. They asserted that these birth companions receive training in a variety of pain-relieving strategies to assist the mother in coping with the physical symptoms of labour and recommend position modifications, breathing exercises, relaxation techniques, massage, and other interventions. A birth companion aids the woman's comfort and general well-being during labour by offering physical support.

Overall, including birth companionship is a comprehensive method of birthing that emphasizes the value of individualized attention and emotional health. Various studies support that having a birth partner present throughout labour can shorten labour times, lower the need for medical interventions, boost satisfaction with the birthing process, and have a favourable effect on the mother's emotional health (Al-Mutawtah et al., 2023; Lunda et al., 2018; Nakphong et al., 2023 & Yildiz, 2019). It's crucial to remember that the precise function and range of a birth companion can change depending on cultural customs, personal preferences, and the rules of the birthing facility.

Apart from the emotional or psychological benefits of birth companions during labour, several studies including a Cochrane review assert that the presence of labour support in the form of companionship reduces the perception of labour pain (Evans et al., 2023; Lunda et al., 2018; Otten, 2019 & Tucker et al., 2023).

One of the main findings of another Cochrane review, which examined the effects of continuous, one-to-one intrapartum support versus usual care in various settings on women and their babies, was that having a birth companion reduced the need for medical interventions like epidurals, administration of Pitocin, and caesarean sections (Bohren et al., 2017). The same review also showed a high association between the presence of a birth companion or doula support and shorter labour durations. This could be because of the mental and physical support

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that facilitates a more effective labour process.

Women who receive continuous assistance during childbirth often report better levels of satisfaction with their birthing experience and a lower prevalence of postpartum depression, according to a systematic analysis by Bell and Andersson (2016). The goal of this review was to correlate women's birth experience and postnatal depression, highlighting how supportive care during labour can serve as a protective factor for maternal mental health. The authors emphasised that continuous emotional, physical, and informational support helps women feel more in control and less fearful, which contributes to a more positive perception of the birth process. Furthermore, the presence of a companion or trained support person may reduce feelings of isolation and stress, thereby lowering the likelihood of depressive symptoms after birth. These findings underscore the importance of integrating continuous labour support into maternity care practices to enhance both immediate and long-term maternal wellbeing.

The presence of a birth companion during labour enhances communication between women and healthcare providers and promotes quality compliance and better-informed decision-making. It also reduces stress and anxiety in labour, promotes a relaxed birthing environment, and gives an overall positive birthing experience, according to a study done in England to evaluate birth companions' perinatal and peer support provision in two prison settings (Thomson et al., 2022). Numerous studies and published articles have also proven that birth companionship improves mothers' health (Afulani et al., 2020; Borrelli et al., 2018; Doenmez et al., 2022; Kabakian-Khasholian et al., 2018). The decreased chance of instrumental birth and caesarean section is one of these many advantages. The views and experiences of birth companions, women, and midwives regarding how women are supported by birth companions in labour were examined in a mixed-method systematic review conducted by (Alexander et al., 2014). The results showed that the continuous presence of a doula during labour significantly decreased the likelihood of caesarean delivery and reduced the need for epidural analgesia.

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Similar research by Wu et al., (2021) sought the effect of labour roadmap on anxiety, labour pain, sense of control, and gestational outcomes in primiparas. They found that doula support reduced the intensity of labour pain and expedited the active phases of labour in primipara. In other words, having a doula or birth companion is an affordable means of lowering labour discomfort, anxiety, and the necessity for caesarean sections, as evidenced by the positive response women gave to this form of emotional support.

Birth partners have been linked to shorter labour periods because they provide tension-relieving physical and mental support, which reduces tension and stress. This assertion is corroborated by a Cochrane review by Hodnett et al., (2013). In this Cochrane Review, a comprehensive analysis of 22 research involving more than 15,000 women was carried out. The advantages of continuous support during labour and delivery are highlighted; these benefits include decreased likelihood of caesarean births, shortened labours, and increased satisfaction with the birthing experience. The same conclusions were made by Kahraman & Gökçe (2023) when they investigated the effect of continuous intrapartum supportive care on maternal mental health.

Vilar-Compte et al., (2021) conducted a systematic review using observational, experimental and qualitative peer-reviewed studies in English and Spanish, published between 2008 and 2019 to ascertain the interventions to improve workplace environments to facilitate breastfeeding among working women. One interesting finding from this study was that women who had partner support during pregnancy, childbirth and puerperium are likely to continue breastfeeding which goes a long way to improving neonatal outcomes. The same assertion was posited by Gadappa & Deshpande (2021) that the advantages of having a companion during labour extend beyond the woman herself and include better newborn outcomes, an APGAR score of greater than 5, fewer NICU admissions, and early breastfeeding promotion and start.

Bohren et al., (2017) summarize the data from multiple studies on the advantages of doula

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support during childbirth and show that continuous support during labour was positively correlated with the woman's positive birth experience, decreased pain during the first stage of labour, decreased instrumental delivery, improved neonatal outcome, increased breastfeeding, shorter labour duration, and decreased need for medical interventions (such as epidurals or caesarean sections).

2.2.2. Birth Companionship In Maternal Care Setting

As part of its initiatives to enhance maternal and newborn health, the World Health Organization (WHO, 2018) has supported and pushed for the idea of birth companionship. Therefore, WHO advises that every woman be allowed to give birth and undergo labour with a companion of her choosing. In its 1996 publication "Care in Normal Birth: A Practical Guide," the World Health Organization proposed the notion of birth companionship as a crucial element of high-quality maternity care. The significance of offering care that honours the mother's emotional and psychological requirements and promotes the presence of a supportive companion of her choosing during childbirth was underlined in this article.

Birth companionship, often referred to as labour support, is the provision of emotional, physical, and informational support to a woman during her labour and delivery by a professional or untrained person (Hildingsson et al., 2019). According to Bohren et al., (2017) and Hodnett et al., (2013), there are certain common elements of support that birth companions provide, such as emotional support (continuous presence, reassurance, and praise), informational support (updates on labour status and coping technique advice), comfort measures (comforting touch, massage, warm baths/showers, encouraging mobility, and promoting adequate fluid intake and output), advocacy (assisting women in expressing their preferences to providers), and instrumental support (helping with needs). These people can include spouses, family members, friends, and doulas.

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White VanGompel et al., (2018), were of the same view that a birth companion's primary duty is to assist the expectant mother throughout labour and delivery by offering comfort, support, and assistance as needed. According to them, this could take many different forms, including massages, consolation, advocacy, and help with coping strategies, but birth companions' main objectives are to facilitate mothers' favourable outcomes and enhance the delivery process.

The World Health Organisation's acknowledgement of birth companionship was a critical step in advocating for women's rights and health during childbirth since it recognized the advantages of emotional support and its favourable effects on the birthing process. Since then, this support has helped birth companionship become a standard of care for maternity services and be accepted globally (Hildingsson, 2018).

2.2.3. Attitudes of midwives towards birth companionship

Global health initiatives like World Health Organisation (WHO) have made birth companionship more widely known and accepted. The World Health Organisation emphasizes the importance of respectful maternity care, which includes offering emotional support during childbirth (Bohren et al., 2020). According to Ricci's (2024) Essentials of Maternity, Newborn, and Women's Health Nursing, some countries have passed legislation to promote birth companionship to improve the health of expectant women. The laws may vary in how strictly they are enforced and how broadly they cover because there are no set standards for defining a birth companion's work.

The World Health Organization recommended that women have a companion during childbirth to enhance the experience of giving birth; however, before this advice, women would traditionally give birth with the assistance of family members or partners as companions (Altshuler et al., 2021).

Altshuler et al., (2021), posited that the practice of having a birth companion is generally

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accepted and encouraged in many high-income countries. Hospitals often have policies that support the presence of a support person during labour and delivery. The awareness of such an important role played by birth companions has championed the creation of training programmes for them to be formally trained to be called “Doulas”.

Vasilevski et al., 2022 in their study to explore the support women get during planning for caesarean birth through a formal birth plan made a very interesting revelation that the popularity of doulas has grown in the US, Canada, Australia, and other European countries; nevertheless, birth companions in low- and middle-income countries do not receive any such training.

In a cross-sectional study to explore the medical and administrative barriers to the implementation and sustenance of a labour companionship program in high-income countries, there was a generally positive attitude regarding the concept (Dilruwan, 2022). The study suggests that having a companion during childbirth can also reduce staff burden and procedural improvements. Having a companion can assist medical professionals in handling critical situations, remembering when women require follow-up exams or when something unforeseen occurs, arranging transportation in the event of difficulties, and reminding women of directives and messages. (Kabakhian-Khasholian & Portela, 2017).

Although most companions are not allowed to help with the delivery directly, they can nonetheless support the provider socially and practically when they are working alone (Dynes et al., 2019 & Mbanza et al., 2021)

However, there are disparities in women's and health professionals' acceptance and desire for companionship. Some women fear that a partner would intervene, feel that they should only receive care from medical professionals, or worry that they should give birth following social norms (Alexander et al., 2014; Kungwimba, Malata, Maluwa, & Chirwa, 2013.; & Kabakian-

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Khasholian & Portela, 2017). Providers have also expressed concerns about companions carrying germs into labour or delivery rooms, causing crowding in shared maternity wards and delivery rooms, interfering with medical decisions, discouraging women from cooperating and giving women traditional herbs and medicines, according to Banda et al., (2010) and Kabakian-Khasholian & Portela et al., (2017).

A study in India by Singh et al., (2021) found a correlation between doctors' and midwives' willingness to permit a labour companion and their awareness of the benefits of companionship. There was evidence also that their accountability for fewer or more births per month influences their permission for a birth companion or not. The same study also found that some providers forbade companions from accompanying women when there were onsite supervisors, while others let companions accompany women when pregnancies were complicated.

In the United States, doula support programs have been implemented and utilised to offer continuous physical and emotional support during labour and there is empirical evidence that it has helped in reducing caesarean rates and improved birth experiences (White VanGompel et al., 2018). Some hospitals have also adopted policies allowing birth companions, often limited to one person, during labour and delivery.

In the United Kingdom, the National Health Service (NHS 2016) encourages birth companions, typically a partner or a chosen support person, to be present during childbirth although policies vary across hospitals. Similarly, Canada has adopted doula programs increasing the availability of doula services, especially in urban areas, supporting women throughout pregnancy, labour, and postpartum.

However, the idea of birth companionship is not universally accepted in low- and middle-income countries. This claim is supported by studies conducted in low- and middle-income

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nations. Certain cultures and customs already require the support of family members or the community during childbirth but frown on the use of friends as companions. In some cultures, it is usual to have family members or a chosen individual present when a baby is born. However, in other places, birth companionship may be frowned upon due to cultural standards or privacy issues (Ganle, 2016).

In Africa, Community-Based Programs with community health workers or trained birth attendants provide support during childbirth, focusing on areas with limited access to healthcare facilities (Kassie et al., 2022). Some regions have successfully implemented community-based initiatives to promote the concept of birth companions.

In a qualitative study done by Bocoum et al., (2023) to explore Women and health providers ' perceptions of companionship during labour in Burkina Faso, the participants acknowledged an existing traditional companionship model, which allowed companions to support women only in the hospital waiting room and post-natal room. Despite recognizing clear benefits, participants were not familiar with companionship during labour and childbirth in the hospital as recommended by WHO. Key barriers to implementing companionship throughout labour and birth included limited space in labour and delivery wards, no private rooms for women, hospital rules preventing companionship, and social norms preventing the choice of a companion by the woman.

In a quantitative cross-sectional study conducted by Getahun et al., (2020) to assess the utilization of companionship during delivery and associated factors among women who gave birth at Arba Minch town public health facilities in southern Ethiopia, the findings were not too different from the authors above. They found out that there was generally low utilisation of companionship at birth because healthcare workers (midwives) did not provide information

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about it during antenatal care services, again there were no clear national policies on how exactly it should be implemented as well as social norms preventing the choice of companion.

In another mixed-method cross-sectional study in St. Paul's Hospital Millennium Medical College, Addis Ababa (SPHMMC), it was reiterated that the majority of healthcare providers are against the practice of involving birth companions during childbirth (Gizachew et al., 2024). Most of the midwives 82.4 %, didn't allow birth companions with the reasons being fear of breach of privacy, interference with routine medical care, and risk of litigation or complaints.

In sharp contrast to this, Chaote et al., (2021) are of the view that Birth companionship was feasible and well accepted by health providers, healthcare management teams and most importantly, women who delivered at government facilities across Tanzania. This assertion is supported by findings from a study they conducted to explore the feasibility and acceptability of continuous labour support across government facilities in a low-income country Tanzania.

2.2.4. Social Influencers to The Implementation Of Birth Companionship

Historical Context

The concept of having a birth companion is not new and has historical roots in various cultures. In many traditional societies, women have been supported by female relatives, friends, or experienced midwives during childbirth. This cultural aspect underscores the universality of the need for companionship during this significant life event but WHO has an explicit declaration on the utilisation of birth companions at every birth (Maputle, 2018).

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Policies and guidelines

World Health Organization (WHO)

The WHO recognizes the importance of a positive birth experience and recommends continuous support for women during childbirth. A Heideggerian Hermeneutics Phenomenological Study on the "Lived Experience of Nursing Care Rendered to Postpartum Women During Childbirth," conducted by (Yakubu Danzima et al., 2023) suggests that this support can be provided by a trained birth companion, a family member, a friend, or a doula. The WHO's guidelines emphasize the need for emotional support, communication, and comfort measures during labour but exactly how it should be implemented was left for the respective birthing suites to decide according to resources and space at its disposal. It is stated categorically that every woman should be allowed a companion of choice throughout labour and delivery in the document, "Intrapartum Care for a positive childbirth experience" (World Health Organization, 2018).

Organizations like Save the Children, UNICEF, and various maternal health-focused NGOs also support programs and initiatives promoting birth companionship in regions with high maternal mortality rates.

The American College of Obstetricians and Gynaecologists (ACOG) acknowledges the benefits of continuous support during labour and delivery which include, reduced pain perception by the labouring woman, reduced interventions like epidural and caesarean sections and improved foetal APGARS just to mention a few. Their committee opinion on "Approaches to Limit Intervention During Labor and Birth" recognizes the role of doulas and other support personnel and highly recommends that every woman be allowed a companion of birth throughout labour and delivery.

The Royal College of Obstetricians and Gynaecologists (RCOG), a United Kingdom-based

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association also advocates having a birth companion present during labour and delivery. Their "Care of Women Presenting with Suspected Preterm Prelabour Rupture of Membranes (PPROM) from 24+0 Weeks of Gestation" guidelines strongly advise having a birth companion with the woman during pregnancy, labour, and the postpartum period for women and partners with PPROM because they understand the value of emotional and psychological support. This was based on cohort research that showed a significant proportion of women whose pregnancies are disrupted by PPROM experience posttraumatic stress disorder (Thomson, 2019).

The International Federation of Gynaecology and Obstetrics (FIGO), a powerful advocate for respectful maternity care (RMC), emphasised in October 2018 through the launch of the International Childbirth Initiative that one of the most essential components of RMC is the provision of continuous support during labour. They acknowledge the value of emotional support in their "Guidelines for the Use of Simplified Ultrasound Scanning in Reproductive Medicine" and as such, suggest doulas' assistance in helping women receive emotional and psychological support throughout their pregnancies and deliveries.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) also highlighted the advantages of ongoing labour assistance in its "Intrapartum Foetal Surveillance" guidelines. Based on this guideline, Dore & Ehman (2020) conducted a Cochrane review of 26 studies, in 17 countries which demonstrated that women who received continuous labour support were more likely to have1) Increased spontaneous vaginal birth 2) Shorter labour hours 3) Decreased operative births 4) Decreased regional or any analgesia 5) Fewer lower 5-minute Apgar scores and 6) Fewer negative feelings about childbirth. Their findings led to a recommendation that women should have a support person during labour because, for a pleasant birthing experience, the significance of emotional support from a birth companion cannot be overlooked. This support can come from family, hospital staff, doulas, and/or a partner of the woman's choosing.

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National Institute for Health and Care Excellence (NICE) in the UK offers recommendations on a range of maternity care topics. The NICE (2014) guideline on "Intrapartum care for healthy women and babies" highlights the importance of ongoing support during childbirth and recommends that midwives encourage women to enter labour with a companion or companions of their choice. Additionally, midwives should involve the women's companions in their care. American Academy of Paediatrics (AAP) and the American College of Nurse-Midwives (ACNM) jointly published a policy statement on "Collaborative Approaches to Integrated Care for Pregnant and Parenting Women with Opioid Use Disorder and Their Infants" after reviewing the literature to support national guidelines for the treatment of pregnant and parenting women with opioid use disorder and the concurrent care of their infants and children. One of the key points was the recognition of the duties of a doula or birth companion to provide information and empathetic care to such women and support them in dealing with their addictions.

It's important to note that with all these policies and guidelines, individual hospitals and healthcare facilities may also have their policies regarding birth companionship which also facilitate the acceptance and utilisation of the concept.

Chaote (2020, 2021) stated that birth companionship is feasible and acceptable in Kigoma, Tanzania's government health systems, with over 80% of women reporting better experiences with having a companion. However, there are contrasting views about its feasibility and integration into healthcare systems globally.

Studies have investigated how birth companionship fits into public health services. While most services in Santa Catarina, Brazil permitted the presence of a companion Integration et al., (2013) discovered that some still imposed limitations on this practice. A follow-up study by (Simone et al., 2014), in the same setting posited that implementation of companionship was

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associated with having an appropriate environment and clear institutional rules about women's rights to companionship during childbirth

In a tertiary care hospital in India, Bharti, (2021) also underlined the significance of creating a policy for birth companions and utilizing quality improvement techniques to raise the practice from 0% to 50% in 6 weeks. Because the strategy is evidence-based and more entrenched in multiple obstetric care policies, all these policies highlight the benefits of having a companion at birth and further justify its incorporation or facilitation into healthcare systems.

2.2.5. Barriers to Implementing Birth Companionship

Simone et al. (2014) argue that although birth companionship offers numerous benefits, its widespread adoption continues to face several challenges. According to their analysis, these barriers largely stem from the absence of appropriate physical environments and the lack of clear institutional policies that uphold women's rights to have a companion during childbirth. In their study conducted in Brazil, they further examined the prevalence of companionship during labour and the socio-demographic, obstetric, and institutional factors associated with it. Their findings revealed that 24.5% of women gave birth without any companionship, 18.8% benefited from continuous companionship throughout labour and birth, and 56.7% experienced only partial support. These patterns were strongly influenced by women's socioeconomic circumstances, such as lower levels of education and income, as well as their use of public health services, multiparity, and mode of birth, with vaginal deliveries more commonly associated with limited support. The authors further noted that a lack of companionship was closely linked with socioeconomic disadvantage and restrictive institutional policies, underscoring the need for health facilities to strengthen guidelines that protect women's rights to supportive care during childbirth.

A pilot study conducted in Tanzania discovered that birth companionship was doable, well-

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received, and enhanced the standard of care (Chaote, 2020). These results were corroborated by a follow-up study, in which more than 80% of women reported having a birth partner and having better experiences. However, a few of the variables that impacted the adoption of birth companionship were privacy violations, the availability of space and some institutional barriers like hospitals that were providing total nursing care (Lathwal et al., 2022)

Implementing birth companionship is also fraught with difficulties due to limited resources, cultural disparities, and opposition from medical professionals. The results of a 2017 study by Kabakian-Khasholian, which evaluated the cost, acceptability, efficacy, and practicality of integrating a customized labour companionship model at three public hospitals in Egypt, Lebanon, and Syria, lend support to this.

These difficulties are made worse by things like invasions of privacy, cramped quarters, and the absence of suitable partners (Lathwal et al., 2022). However, efforts to improve quality, including starting a birth companion practice in a tertiary care facility, have shown potential in tackling these issues (Bharti, 2021).

Birth companionship varies in frequency and determinants in low-resource contexts; employment, affluence, and literacy all affect the likelihood of ongoing assistance during labour and delivery (Afulani, 2018). Despite these obstacles, women clearly want birth companionship, which emphasizes the necessity of interventions to sustain this support continuously throughout childbirth.

According to the World Health Organization WHO (2020), many healthcare facilities still do not permit women to have a companion during labour and childbirth, despite clear evidence and the emphasis on respectful care.

The claims made by Simkin and Cheyney (2024) in their book The Birth Partner: *A Complete Guide to Childbirth for Dads, Partners, Doulas, and Other Labour Companions* contrast with

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previous findings. They clarify that midwives embrace birth companionship not merely because it is mandated by regulations or recommended globally, but because their training extends beyond physical care to include emotional support as a fundamental component. In their anthropology-in-action study, Castañeda and Searcy (2021) hypothesized that there are variations in the application of the birth companion idea around the world, with an emphasis on how people responded to doula employment during the pandemic. They went on to say that in some areas, doulas-trained, professional birth companions are incorporated into the healthcare system and offer ongoing labour support. In some contexts, friends or family are required by cultural customs to accompany a birth. They further recommended that understanding and respecting diverse cultural norms are crucial for effective implementation.

According to a study by de Mucio et al., (2020), many Latin American and Caribbean countries lack labour companionship policies, despite some having clear policies based on WHO guidelines. The study examined the gaps and challenges regarding the status of national policies on a companion of choice at birth. It is possible that women were unaware of their entitlement to assistance because in certain instances the providers were also ignorant of the regulations or procedures that supported labour companions.

The same study also found that while some countries had policies in place regarding the concept's implementation, hospital leadership including obstetricians, midwives, and other staff members involved in childbirth had not understood the policy and the hospitals had not adopted it because of infrastructure issues. Another thing that was lacking was clear communication of these policies to expectant parents and healthcare practitioners.

Providers also identified infrastructural deficiencies and privacy issues as major obstacles to its implementation (Brüggemann, 2014; Sarwal, 2021).

The degree of positive attitudes and reported practices of birth attendants regarding companion

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presence during childbirth is low, according to a similar study conducted by Doba et al., (2023) to evaluate birth attendants' attitudes and practices of companionship during facility-based childbirth in central Ethiopia. A few of the study's key reasons concerned privacy breaches. Some respondents expressed dissatisfaction over the lack of privacy-promoting screens or curtains between the couches in the delivery room, the narrow space in the room for the birth companions, and, to make matters worse, the administration protocol of their health facilities prohibits the presence of companions during childbirth.

Mellor's 2021 hermeneutic phenomenological study, which examined midwives' and obstetricians' perceptions of the site in connection to promoting physiological delivery, allegedly found that midwives expressed dissatisfaction with the presence of companions at birth because occasionally, the companions cause more stress than the labouring women; some experience emotional breakdowns, while others experience shock. In these situations, the companion will receive all the attention rather than the woman.

Additionally, several study participants opposed the participation of birth companions because they did not want the companions to be witnesses in the event of an incident at work, as their jobs are not always 100% incident-free.

Another interesting revelation the study caught was that a birth attendant's educational background positively correlates with her chance of allowing the birth companion to accompany the woman during labour and delivery. However, it appears from this statement that the utilization of companionship may be hampered by ignorance of its benefits after birth.

The birth companions themselves presented a challenge to the concept's complete acceptance and application (Doba et al., 2023). A barrier to the practice of companion presence during labour was found in the study to be the awareness and perception of the companions. It has been brought to light that certain companions are unaware of the significance of being in the

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delivery room with their partners, and even if they are permitted entry, their opinions of the procedures carried out by the birth attendants diverge from the intended course of action and they show no interest in the procedures at all. They believe that certain treatments were carried out with the mother's deliberate damage in mind.

However, in environments with limited resources, access to birthing companions may be restricted due to problems with healthcare rules and infrastructure (Bohren et al., 2015; Brüggemann et al., 2014; Kabakian-Khasholian & Portela, 2017)

Another issue was that women were simply not aware of the concept, and this was highlighted from a study by Borrelli et al., (2018) that women did not know they could have access to birth companions because healthcare providers did not discuss birth plans with expectant mothers. This study was conducted in England to assess the coping strategies of first-time mothers' expectations of the unknown territory of childbirth. This assertion supports the allegation stated by Davis-Floyd, (2022) in his book, that most pregnant mothers were unaware that they should have a choice delivery partner at birth.

According to other studies, the fact that birth companions are not required to undergo formal training and that the practice has become standardized in many regions of the world may contribute to the role frustration that causes healthcare workers to be sceptical of their use. Their precise function is unclear, particularly in the birthing unit, and they lack the self-assurance to think that they (birth companions) comprehend the labour process and are aware of what is expected of them at every turn (Young, 2021). He went on to say that even those with some trainings were struggling with professional ambivalence, leaving the doulas and medical staff tending to the labouring mother confused about their place in the healthcare setting.

To further cement the above assertion, a quasi-experimental study by Aktas and Pasinlioğlu

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(2021) looked at the impact of empathy training on midwives' ability to communicate empathically and the satisfaction of mothers who gave birth with these midwives' assistance. According to the study, midwives who received training in the area were well-equipped to care for labouring women while keeping in mind that empathy is crucial to the woman's emotional health. These midwives' abilities also resulted in increased maternal satisfaction with childbirth.

Additionally, the fact that not all postpartum women want a birth companion adds to these obstacles since some do not want one for a variety of reasons, such as privacy concerns, cultural customs, religious beliefs, or a worry about burdening family members (Kabakian-Khasholian & Portela, 2017).

Women in certain tight-knit communities, where most people knew one another, were reticent to have doulas hired from within their community or to have a female family member accompany them during birthing. They conveyed their concerns about being around the companion and the ensuing rumours in the neighbourhood about their inability to behave per social norms, such as maintaining composure and refraining from yelling (Kabakian-Khasholian & Portela, 2017).

Another obstacle to its successful implementation is the lack of education of pregnant parents and healthcare providers about the benefits of continuous labour support and the importance of birth companionship (Wanyenze et al., 2022). Obstetricians, midwives, and other medical experts view birth companions exclusively as obstacles to be overcome, not as an effective instrument for achieving successful birth outcomes.

2.3. Summary of Literature Review

The concept of using birth companions has many advantages that contribute to the overall positive experience of childbirth. The presence of birth companions according to scientific data

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demonstrates several advantages for both mother and child including reducing the woman's anxiety, reducing labour pain, shortening the duration of labour, promoting breastfeeding, reducing instrumental deliveries, increasing compliance and promoting bonding between mother and child.

Midwives have a good understanding of the advantages of the presence of a support person at birth and are willing to use these companions during birth but are limited in what they can do to support the concept especially midwives in sub-Saharan Africa.

The implementation of birth companionship has been evaluated both qualitatively and quantitatively with many implementational disparities. These disparities are different spanning across the globe. Many of the studies reviewed were done in Europe and Asia with a few conducted in Africa and Ghana and this suggests that there is a gap in the literature, so this study is justified.

Many countries have implemented this all-important strategy but in different ways but its implementation is setting specific: many developed countries have seen widespread acceptance of the notion due to these regulations and norms as well as the concept's benefits. To standardize the actions of birth companions, a number of these nations have gone one step further and created curricula and training programs that enable them to receive certification but in sharp contrast developing countries appear to have many challenges that affect the correct implementation of the concept. These challenges include a lack of private spaces to attend to births, the unclear roles and scope of companions, cultural barriers and a lack of understanding and clear protocols on the concept.

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CHAPTER THREE:

METHODOLOGY

3.0. Introduction

The methodology chapter serves as a methodological compass, guiding the reader through the intricacies of the research process. By transparently articulating the methods and procedures employed, this section seeks to establish the credibility and reliability of the study, laying the groundwork for a robust analysis and interpretation of the research findings (Kara, 2020).

It also offers a comprehensive synopsis of the methodology that was employed in the thesis, outlining the systematic approach that was taken to tackle the research questions and achieve the objectives of the investigation. Research design, research setting, target population, inclusion and exclusion criteria, sample size and technique, data collection process, data gathering tool, data analysis, and data management are the headings under which it is arranged. The section also emphasizes openness and insight into the research process by outlining the strategies that will be employed to guarantee methodological rigour, the validity and reliability of the results, and to establish a solid foundation for the analysis and discussion that will come after. Lastly, the measures that were taken to guarantee that ethical research principles are not violated are also highlighted.

As the goal of this study is to explore the acceptance, perceived facilitators, barriers, and challenges that are likely to affect the implementation of birth companionship within hospitals in Sekondi Takoradi in the Western Region of Ghana, the first section provides a detailed explanation of the qualitative research design, making clear the overall framework that functioned as the study's compass.

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3.1 Philosophical Basis of the Study

The philosophical foundation of this study is rooted in constructivist epistemology, which holds that reality is not fixed but socially constructed through individuals' experiences, interactions, and interpretations (Miller & Miller, 2016). Constructivism assumes that people make meaning from their everyday encounters and that these meanings can vary across cultural, institutional, and professional contexts. In exploring midwives' attitudes toward the birth companionship strategy, the study recognises that their views are shaped by personal beliefs, professional norms, organisational environments, and broader sociocultural influences(Meyer et al., 2024). Therefore, instead of seeking a single "objective" truth, this study aims to understand how midwives construct and interpret the phenomenon of birth companionship within their clinical practice. This philosophical stance aligns with qualitative inquiry, which emphasises depth, context, and the subjective realities of participants, allowing the researcher to capture the complexity and diversity inherent in human experiences.

3.2. Research Design

A research design refers to the overall strategy and analytical approach that is chosen to integrate, in a coherent and logical way, the different components of the study, thus ensuring that the research problem will be thoroughly investigated (Taherdoost, 2022). A qualitative research approach was used in the study because it has its tenets rooted in the viewpoint that participants have a vivid idea of what the realities are (Ishtiaq, 2019; Polit & Beck, 2012). By prioritizing participants' viewpoints, qualitative research captures the richness and complexity of human experience, rather than imposing predefined measures or assumptions.

Again, in exploring complex and multifaceted phenomena, such as the readiness to implement a new concept within a healthcare context, qualitative design will allow researchers to gather

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in-depth insights, perspectives, and experiences from participants, which is essential for understanding the nuances of acceptance, perceived facilitators, barriers, and challenges associated with birth companionship implementation (Elf et al., 2023). This qualitative study employed an exploratory, descriptive design with an interpretive naturalistic approach to explore midwives' acceptance of the birth companionship concept and factors that facilitate or challenge its implementation. Given that this area of research has not been previously studied in detail within Sekondi Takoradi, this design will help explore the in-depth perspectives of midwives regarding the implementation of this concept (Grove, Gray, & Burns, 2012).

3.3. Research setting

Hatch, (2023) explained research setting as the physical, social, or experimental context within which research is conducted. In research, describing the setting accurately is crucial since the results and their interpretation may depend heavily on it. The study setting was the Sekondi-Takoradi metropolis in the Western Region of Ghana. It is a twin city formed by the merging of Sekondi and Takoradi. Takoradi, established in 1893 served as a British seaport and an important transportation hub for the export of minerals, particularly timber and minerals such as manganese and bauxite (Obeng-Odoom, 2014). Sekondi, its neighbouring town, also had a rich history as a trading centre and a key location for the British Navy. These two historically significant towns were formally merged in 1946. The metropolis serves as the capital of the Western Region and due to its considerable port and oil production activities, it is a big industrial and commercial hub and an important contributor to the national economy. It is bordered to the north by Mpohor District, Shama District to the east, Effia-Kwesimintsim Municipal to the west and south by the Gulf of Guinea. The city is surrounded by lush greenery, and the pristine beaches along the coastline contribute to the city's natural beauty. It has a total land size of 189 km2.

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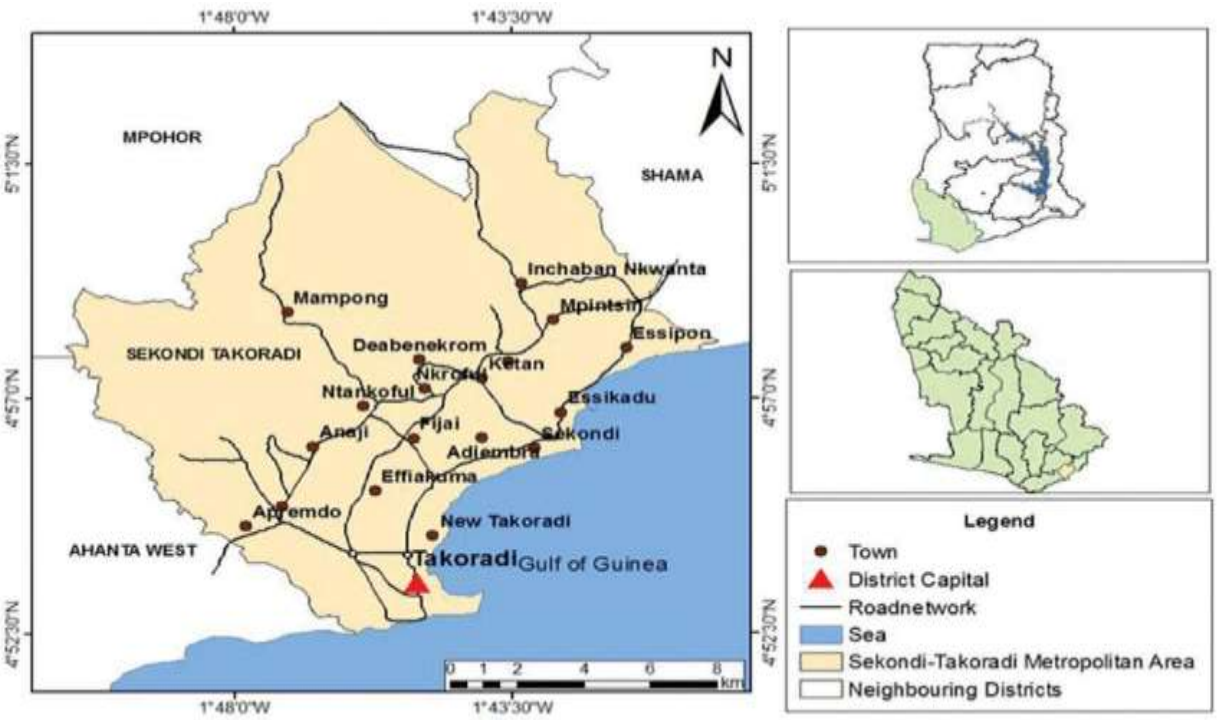

Figure 4: A map of Ghana showing the Sekondi-Takoradi metropolitan area. Source: GIS and Cartography Unit of University of Cape Coast (2017)

The metropolis is equipped with various healthcare facilities, including hospitals, clinics, and health centres, providing essential medical services to the local population. Notable healthcare institutions include the Effia Nkwanta Regional Hospital, which serves as a major referral and teaching hospital.

All though a variety of medical facilities are found in the metropolis to meet the demands of its citizens and the local community in terms of health care, four of them were selected for this study. These are Effia-Nkwanta Regional Hospital, Essikado Hospital, Jemima Hospital and Takoradi District Hospital (European Hospitals). These hospitals were selected based on their massive client turnout for pregnancy and labour management, and again, the different types and levels of each.

Effia Nkwanta Regional Hospital, established in 1938 as a military hospital for the British West African Royal Force during World War II, was handed over to the Gold Coast Colony's

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Ministry of Health in 1948. Since Ghana's independence in 1957, the hospital has undergone significant infrastructure improvements, including the establishment of the Out-Patient Department, laboratory, and records department (Effia Nkwanta Regional Hospital, n.d). The hospital now houses the Out-Patient Department, OPD Laboratory, and Records Department, and has expanded with new structures since the 1970s. The hospital currently has 167 midwives, and their average monthly delivery is 109.

The European Hospital, sometimes referred to as Takoradi Hospital, was founded in 1929 to meet the medical needs of European workers constructing Takoradi Harbour and has since been operated as a public hospital by the Ghana Health Service (Built to Care Ghana, n.d.; Business & Financial Times, 2025). Additionally, the Ghana Health Service has been operating it as a public hospital ever since it left. There are currently 11 departments inside it, including a maternity unit, radiology department, pharmacy, outpatient department (OPD), male and female wards, laboratory, and public health unit. There are 80 average monthly deliveries at the hospital and 65 midwives.

Essikado Government Hospital, established in 1964 in Essikado near Sekondi-Takoradi, is Ghana's first polyclinic and serves as a key healthcare hub for surrounding communities, providing services including maternity, paediatrics, and general medicine (Wikipedia, n.d.) is the country's first polyclinic. After being founded to give basic healthcare services, it has progressively grown over time to provide a variety of medical services, such as emergency services, maternity care, paediatrics, and general medicine. The hospital is known for putting a strong emphasis on providing maternity and paediatric healthcare, which reflects its dedication to solving the health needs of pregnant women and children. Currently, the hospital has 80 midwives, and their average monthly delivery is between 80-100.

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Jemima Crentsil Clinic and Maternity was initially established as a private maternity home and later upgraded to a hospital to meet growing demand for quality healthcare services in Takoradi, with a focus on maternity and child health (Ghana Hospitals, n.d.; GhanaYello, n.d.). It was first a maternity home (1995), then later upgraded to a hospital in 2010. The hospital is named after Jemima Crentsil, possibly reflecting either the founder or someone of significance to its establishment. Over the years, it has built a reputation for quality care in maternity, child health, and other general medical services. As a private facility, it caters to individuals who may prefer more personalized healthcare services compared to public hospitals. As a private hospital, Jemima Crentsil Hospital may not have the extensive staffing levels found in larger government hospitals. However, private hospitals typically ensure a well-trained, though smaller, team to maintain the quality of care. They have 15 midwives and an average monthly delivery between 120-140. The selection provided a fair ground to find out if the acceptance, facilitators, barriers, and challenges of the implementation of birth companionship within the region are the same throughout the region or different as you move from one setting to the other or from one level of facility to the other.

3.4. Target population

According to (Heng, 2020) the target population of a study is the broad group of people that researchers are examining. The target population for this study were midwives working in Effia-Nkwanta Regional Hospital, Takoradi Hospital, Essikado District Hospital and Jemima Crentsil Hospital.

3.5. Inclusion Criteria

All midwives who had worked for at least one year and been actively involved in labour and delivery, having conducted at least more than ten deliveries were included in the study. This is

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to ensure that the participants have spent enough time handling labouring women can easily understand the questions in the interview guide and can speak to them comprehensively.

3.6. Exclusion criteria

Midwives who were now on lengthy leave or inactive duty (such as maternity leave, study leave, or long-term sick leave) were excluded. Midwives who worked in roles that did not have direct involvement in deliveries, such as those in administrative or supervisory positions without clinical labour and delivery responsibilities as well as those who met the inclusion criteria but were unable or unwilling to participate in the interview process were all excluded.

3.7. Sampling Technique and Sample Size

Fletcher, (2016) defined sampling as the process of selecting participants who can provide rich and meaningful information to address research questions. There are many types of sampling techniques under the qualitative research method, but the purposive sampling technique was employed in this study. Purposeful sampling involves selecting participants based on specific criteria relevant to the research questions and goal.

Sarfo et al., (2023), explained purposive sampling as that which is based on the researcher's knowledge about the population to help select entities that meet specific criteria that interest the researcher. Midwives were interviewed in this study because they are directly involved in conducting labour and being with the woman throughout labour and delivery, again because an in-depth interview was conducted, there was a need for the researcher to recruit participants who are knowledgeable about the topic under discussion.

Furthermore, it is a qualitative tradition to select smaller sample sizes because of the priority it places on depth of understanding over breadth of coverage: however, sample size was determined based on data saturation when the 16th participant was interviewed ensuring that

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participants' insights were adequately captured and that a broad range of perspectives were included (Casteel & Bridier, 2021).

Braun & Clarke, (2019) explained data saturation as the point in data collection at which collecting additional data no longer produces new or relevant information related to the research topic. It signifies that researchers have reached a point of theoretical completeness where the data gathered is rich and varied enough to adequately address the research questions or objectives. At the point of data saturation, two additional interviews were conducted to confirm the sampling size (Braun & Clarke, 2019).

3.8. Data collection Tool

Alam, (2020) explained data collection as the process of systematically collecting relevant information from various sources in a structured manner to answer specific research questions, address objectives, or gain insights into a particular phenomenon. A semi-structured interview guide developed by the researcher based on the study objectives and conceptual framework was used to collect data.

The semi-structured interview guide was more appropriate for the study as it allowed participants to share their views freely and gave the researcher the opportunity to probe further to ensure that rich data was obtained and was structured in two sections: 1 and 2 in line with the literature review and the constructs of the theoretical framework to reflect the study objectives. Section 2 was further divided into 3 sub-sessions A, B, C

Section 1 comprised socio-demographic characteristics of the midwives and Section 2 was the main interview guide containing open-ended questions and probes. The flexibility of this format enabled probing for in-depth responses and ensured that individual voices were well articulated.

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Data collection procedure

After obtaining ethical clearance from the Noguchi Memorial Institute for Medical Research (NMIMR), data collection began, taking a face-to-face approach unless otherwise requested by the participant for a telephone-based interview.

The permission letters, together with the ethical clearance form, were sent to the various administrators of the four hospitals where data were collected. The researcher explained the objective and purpose of the study to the administrators. Then, verbal consent was given for the nurse managers of the various hospitals to be seen. The nurse managers, after being taken through the purpose and objectives of the study, directed the researcher to the ward managers, and then the ward managers led the researcher to recruit eligible midwives based on the inclusion criteria for the study.

The place and time for the interviews were negotiated with participants and their preferences were chosen so far as privacy and confidentiality were guaranteed. Ten (10) participants agreed to have the interview face to-face while six(6) of them preferred the interview to be done on the phone. In either case, the participants were taken through the reason and objectives for the study after they read and signed a written consent form or after the information on the consent form had been read out to them by the principal investigator and a written or verbal consent is obtained. Since the facilities were four the researcher arranged the engagements in such a way that one facility was visited at a time. Two participants were interviewed in each facility at a time then a second round of interviews was conducted also interviewing two participants each from all four facilities., Data saturation was reached by the 16th participant. Interviews were facilitated by the principal investigator, during which eligible participants responded to open-ended questions with the help of an interview guide to provide primary data on acceptance, facilitators, and barriers to the implementation of birth companionship. Throughout the interview, confidentiality was maintained, and in instances where the place was a bit open to

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other people, permission was sought so that the doors and nearby windows were closed. Interview sessions lasted between 23-35 minutes, and each interview was audio recorded with permission from the participants. Field notes were taken, and audio recordings were transcribed since the midwives were educated, and the interview was conducted in English.

3.9. Pretesting of Data Collection Instrument

To make sure that the interview guide had no ambiguities and misconceptions, the instrument was pre-tested. This was done by asking a small sample of participants for input to enhance the instruments before collecting large amounts of data (Gani et al., 2020). The semi-structured interview guide was pre-tested at the Kwesimintsim Hospital located in the Effia-Kwesimintsim Municipal Assembly within Sekondi-Takoradi. This hospital was chosen because it has similar characteristics in terms of the number of deliveries it conducts as the hospitals selected for the study. The purpose of the pretesting was to evaluate the interview guide's questions and prompts for comprehension and clarity. It is also done to assess whether the terminology and language employed in the instruments are suitable for the target group, again to determine whether the questions contain any biases, repetitions, or ambiguities and finally to evaluate the interview's duration and flow or the data gathering procedure (Kyngäs et al., 2020). The pre-testing enabled the researcher to develop her interviewing skills and to refine the interview guide to improve its usefulness in capturing the opinions and experiences of midwives regarding birth companionship during labour in Sekondi/Takoradi, Ghana.

The guide was pretested with three midwives who spoke to the questions in the interview guide. The researcher realised that some questions were ambiguous, and others needed to use probes to be able to get the right responses from the participants. Findings from the pretest suggested that midwives were very conversant with the concept of birth companions, there was enough evidence to back the assertion that birth companions contributed to the lesser duration of labour and reduced women's anxiety. Although midwives knew the benefits, they were unable to

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effectively use companions during birth because of infrastructural challenges, lack of clear guidelines and protocols and the fear of companions leaking sensitive information to unauthorised people.

3.10. Data management

In research studies, data management as explained by Donner, (2022) refers to the systematic process of handling research data from its collection to its analysis and preservation. Furthermore, effective data management practices are critical for ensuring the integrity, reliability, and accessibility of research data, as well as for complying with ethical and regulatory requirements.

Data collected during the study was kept in folders with passwords only known to the researcher to maintain the confidentiality of participants. Each participant was given a code depending on the hospital where the participant was recruited. The codes were replaced with pseudonyms during the presentation of data in the study findings. Also, a folder was created to contain each participant's transcribed responses and field notes. In addition, an external hard drive was used to store raw data to prevent data loss. The data will be kept on a hard drive for about 5 years before being discarded. Also, should anybody need it for further studies then, permission will be sought from the ethics review board of Ghana Health Service.

3.11. Data analysis

Tracy, (2019) explained data analysis as the process of gathering, structuring, and interpreting information to understand what it represents. Qualitative data analysis can take different forms; the key among them is thematic analysis (TA)which was used in analysing data in this study.

The six TA steps put out by Braun and Clarke (2022) provide precise, systematic procedures for extracting codes and themes from qualitative data. Data familiarization, code generation,

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early theme development, theme review, theme definition and naming, and report writing are all included in this. To select sentences and phrases that are worth noting, the researcher first transcribed verbatim then transcriptions and field notes were read over multiple times to become comfortable with the material. Similar statements or phrases were found, categorized into several folders, and given names. Similar files were gathered and arranged into meaningful units, and the researcher created codes using inductive (derived from the data itself) techniques that resulted in the creation of methods to develop codes that led to the formation of themes and subthemes that described the acceptance, facilitators, barriers and challenges to the future implementation of birth companionship.

3.12. Methodological Rigour

Methodological rigour is a robust enquiry into all crucial issues related to the study that will make readers evaluate the study as credible (Maher et al., 2018). Various frameworks align with broader discussions and guidelines within the qualitative research community regarding best practices for ensuring the quality and credibility of qualitative research, but the researcher used the "TACT" framework as elaborated by (Daniel, 2019) to ensure methodological rigour due to its simple and straight forward nature. The mnemonic tool called the "TACT" framework helps people recall four important guidelines for carrying out qualitative research. Every letter in "TACT" stands for a methodological tenet (trustworthiness, auditability, creditability and transferability) that is necessary to preserve methodological quality and rigour in qualitative research (Daniel, 2019).

Daniel, (2019) explained trustworthiness as a quality that reflects and serves as a foundation for both rigour in the research process and relevance and confidence in the research outcome. It also serves as a stand-in for determining the authenticity of the research outcome and the truthfulness of findings. Furthermore, trustworthiness in qualitative research indicates the level

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of readers' confidence in research findings. Based on this, trust can be considered an element required to improve comprehension and interpretation of research findings.

He further explained that to ensure trustworthiness in qualitative research, the researchers need to reflect on their own biases, follow a systematic method of data analysis and engage participants to give feedback on the interpretation given to the data to be sure that the analysis truly reflects what participants said.

In this study, trustworthiness was ensured by the researcher first keeping a reflexive journal that contains her thoughts, decisions, feelings, and potential influences on birth companionship throughout the study and secondly bracketing (explicitly setting aside her expectations and experiences that can colour the interpretation) herself before data collection and data analysis was done. Again, the researcher also ensured that the study participants who met the inclusive criteria came from different levels of health facilities to strengthen triangulation and eliminate biases. The data collection was done using an interview guide prepared based on the constructs of the theoretical framework used for the study and all through the conduction of the interview, the researcher persistently observed non-verbal communication of the participants during data collection and kept notes of it. To ensure that the participants gave the needed response to questions, the questions were asked in diverse ways, and the transcribed data was cross-checked with the participants to correct any anomalies.

Auditability according to Daniel, (2019) applies to a methodical approach to data collection, analysis, and interpretation. Additionally, it includes a thorough, step-by-step breakdown of the procedures and choices made during the research (Johnson et al., 2019). Two categories of auditability were proposed by them: internal and external auditability. Users of the research results usually conduct external auditability. It is carried out when the researcher's conclusions or findings are questioned and put to the test. Additionally, internal auditability pertains to the

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researcher's capacity to handle methodological concerns, such as articulating the research question clearly and demonstrating how the questions are in line with the specific research design, data analysis, and conclusions reached.

The researcher ensured auditability by engaging midwives who are key implementers of birth companionship to speak to their experiences, data collection was also done across four facilities of different levels within the metropolis to elicit varied experiences for meaningful conclusions to be made. Again, data analysis was done using Braun and Clarke's (2022), thematic analysis which is accepted worldwide for qualitative data analysis. The findings of the study were discussed based on what was reviewed in the literature and lastly, the researcher used the exploratory descriptive method because the subject under study seems to have little work done on it in Ghana.

Credibility according to Daniel, (2019) is attained by carefully outlining the data analysis and confirming the origins of the data with the participants from whom it was gathered, much like auditability. Additionally, the unit of data analysis must be anchored in the main phenomenon under investigation (Daniel, 2018). For the aim of verification, Creswell (2009) proposed that "the final report or the description or themes" be returned to the participants; this procedure is known as member checking (Loh, 2013). The researcher ensured credibility by using member checking to confirm that the responses given by participants were exactly what had been presented, again in presenting the findings, the themes that emerged were backed by some verbatim quotes from participants during the data collection.

Transferability in qualitative research, as opposed to quantitative research, implies that knowledge acquired in one context might provide useful insights for other contexts rather than implying generalizability (Daniel 2019). Transferability necessitates a thorough explanation of the study's background, sample attributes, participants (including demographic data and

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experiences), sample recruitment procedures, and data types collected. According to Forero et al. (2018), to show transferability, the researcher makes sure that participants are informed about the phenomenon being studied and that sample recruitment and selection are founded on their expert knowledge. Comparing the traits of the informants or participants to the demographic data on the group under study is another way to guarantee transferability. In this study the researcher ensured transferability by making sure that the demographic data of the participants put them in a capacity to talk about the issues, especially their current line of duty so that the findings and recommendations can easily be used in other settings since midwives who attend to births were used, the facilitators, barriers and challenges might not be different from other colleagues in different settings. Again, the selected facilities are of different levels, so the issues raised in these facilities during the study are quite identical to sister facilities of the same level. Lastly, the phenomenon under study was carefully explained to each participant to make sure they understood, and verbal or written consent was obtained from them before the interview commenced.

3.13. Ethical consideration

Artal and Rubenfeld (2017), posited that ethical considerations in research refer to the principles and guidelines that govern the ethical conduct of research involving human participants. These considerations, according to them, are essential for protecting the rights, welfare, and dignity of individuals involved in research, as well as ensuring the integrity and credibility of the research process.

An introductory letter from the School of Nursing and Midwifery, University of Ghana, and a letter from the supervisors confirming supervisory roles were obtained, and ethical approval was sought from the Institutional Review Board (Noguchi;131/23-24) and the Ghana Health Service. Permission letters were sent to the administration of the four selected hospitals to be

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given permission before data collection was commenced. Data collection begins after ethical clearance has been obtained.

A written or verbal informed consent was obtained from each participant before the commencement of the interview ensuring that individuals have the right to make informed decisions about their participation in the research, as well as reassurance of confidentiality and anonymity and the option to withdraw at any point if they want to.

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CHAPTER FOUR:

RESULTS

4.0. Introduction

This chapter focuses on themes and subthemes generated from the study that sought to explore the acceptance, perceived facilitators, barriers, and challenges that could potentially affect the implementation of birth companionship strategy within hospitals in Sekondi Takoradi in the Western Region of Ghana. This was accomplished by using the theory of planned behaviour as a framework to explore the attitudes of midwives towards birth companionship strategy in hospitals within the Sekondi Takoradi metropolis, examining their attitudes towards the strategy, the role of social expectations that may influence midwives' readiness to implement the birth companion strategy and finally investigating the perceived behavioural control factors, that can influence the readiness of midwives to implement the birth companionship strategy in labour.

The analysis produced three main themes and thirteen (13) subthemes. Among these themes are midwives' attitudes towards the birth companionship strategy, social expectations that may influence midwives' readiness to implement the birth companionship and behavioural control factors that may influence midwives' readiness to implement the birth companionship strategy.

The findings of the study are presented based on the research objectives and the constructs in the conceptual framework used. The chapter is organised in two sections. The first section presents the socio-demographic characteristics of participants while the second section is on the themes and sub-themes generated.

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4.1. Demographic Characteristics of Participants

Interviews were conducted with sixteen (16) midwives. Eleven (11) are working in three (3) public facilities, and five (5) are working in one (1) private facility. Participants were between the ages of 21 and 54 with one to twenty-six (1-26) years of working experience in various labour suites. There were three (3) certificate midwives, five (5) diploma midwives and eight (8) Bachelor of Science (BSc) holders in midwifery.

SOCIO-DEMOGRAPHIC CHARACTERISTICS

Table 4.1: Socio-demographic Characteristics of Participants

Pseudonym	Age	Practical Experience (yrs)	Type of Facility	Highest Educational Level
CM1	35	6	Government Hospital	Diploma
CM2	43	9	Private Clinic	BSc Midwifery
CM3	21	1	Government Hospital	Diploma
CM4	30	8	Government Hospital	BSc Midwifery
CM5	36	10	Government Hospital	BSc Midwifery
CM6	28	6	Private Clinic	Diploma
CM7	52	23	Government Hospital	BSc Midwifery
CM8	47	19	Government Hospital	Certificate
CM9	51	26	Government Hospital	Certificate
CM10	45	22	Private Clinic	BSc Midwifery
CM11	49	10	Government Hospital	BSc Midwifery
CM12	44	21	Private Clinic	Diploma
CM13	54	25	Private Clinic	Certificate
CM14	37	7	Government Hospital	BSc Midwifery
CM15	40	13	Government Hospital	BSc Midwifery
CM16	33	6	Government Hospital	Diploma

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4.2. Organization of Themes and Sub-Themes

Using Braun and Clark (2022), thematic analysis, three (3) main themes and thirteen (13) sub-themes were generated from the data collected based on the research objectives and the constructs of the study. The themes and sub-themes are presented in Table 4.2

Table 4.2: Themes and subthemes

NO	Themes	Sub-Themes
1	**Midwives' Attitude Towards Birth Companionship Strategy**	• Positive attitude • Negative attitude • Neutral or conditional acceptors
2	**Social Expectations Regarding Birth Companionship**	• Community and Traditional Expectations • The perspective of midwives on family function • Professional expectations • Institutional expectations

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3	**Behavioural control factors of midwives towards birth companionship strategy.**	• Knowledge of the benefits of birth companions • Space and setting • Institutional Support • Personal Beliefs and Experiences • External constraints • Emotional Stress

4.3. Midwives' attitude towards birth companionship strategy

This theme explored midwives' perceptions, feelings, and reactions to the practice of allowing labouring women to have a birth companion during childbirth. Three subthemes were identified: (1) positive attitudes (2) negative attitudes (3) neutral/ conditional acceptors. The data suggests that the attitudes of midwives toward birth companionship strategy vary widely, ranging from strong support to resistance and conditional acceptance. These different attitudes were influenced by their knowledge about the benefits of the strategy, personal experiences, and professional autonomy.

4.3.1. Positive attitudes towards birth companionship strategy.

This theme reflects the extent to which midwives perceive birth companionship as beneficial to women during labour and consider it an integral part of quality maternity care. Positive

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attitudes encompass midwives' recognition that having a support person present can enhance women's emotional well-being, increase satisfaction with the birthing experience, and facilitate smoother communication between women and healthcare providers. In this study, midwives who expressed favourable perceptions and readiness to support birth companionship were classified under this theme. Following this conceptual explanation, the data revealed that eight (8) of the participants (50%) in the study generally spoke highly of the concept of birth companionship. They supported the idea because of the numerous benefits that come with having companionship during birth. Participants positively expressed some of the benefits of a woman having a birth companion of her choice, significant among them is continuous support. They noted that a woman's emotional needs during labour are largely met when she has companionship and labour-related anxiety is greatly reduced, the woman copes better thereby culminating in a positive childbirth experience. Participants were therefore open to any idea of birth companion for women during labour.

One of the participants expressing her view noted:

> *"...As for having a birth companion it's a good thing, anxiety in labour is a common thing even when the woman is a grand multip but the presence of a trusted person with the woman other than the midwife is a great deal of relief. So, it is a very very good thing"* ***(CM 16, 6 years of experience)***

Another participant stated:

> *"...I support the idea of birth companionship for so many reasons. Some of the companions, especially those who have delivered before use their own successful birthing experience to encourage the women amid the pain when they almost want to give up, especially when it comes to the second stage, they do most of the talking, leaving the midwife to fully concentrate on the birthing ...* ***(CM 3, 1 year of experience)***

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Similarly, one also said:

> *"... it is very good because it makes the man see what the woman goes through when she is in labour, so this informs the man how he treats the woman afterwards, such as taking care of her, helping to care of the child and all that... "**(CM 6, 6 years working experience)***

Participants' affirmation of birth companionship was also based on their conviction that the presence of a supportive companion is associated with positive birth outcomes, which include reduced interventions and increased maternal satisfaction. They recognize that companions can help labouring women feel more in control and empowered during childbirth, leading to a more positive birthing experience.

These are excerpts of what some said:

> *"...I think it's a very nice idea although it may have some disadvantages, their presence makes the woman feel comfortable and more relaxed or feel at home since they have a trusted person with them in the hospital..." **(CM16, 6 years of experience)***

> *".... I think that it is very good to encourage women to have birth companions with them during labour because per my observation usually women who come with companions some way somehow have labour shortened and present no or little complications. They are better composed and their stay in the hospital is usually short. I am in support of the idea." **(CM 6, 6 years of experience)***

> *"... I think it's good to encourage women to bring companions right from antenatal because like I told you it's almost as if when the companions are around, they take some of the labour pains away, so the woman is well composed although in pain. this goes a long way to give us a good outcome..." **(CM 1, 6 years of experience)***

Another idea that was common across participants' accounts was the notion of birth companions providing extra help to assist their work as midwives. According to them, birth companions reduce their workload by running some simple errands for the labouring women,

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and for them (midwives) in facilities where items needed to care for labouring women are not readily available. This according to the participants allows them some extra time to attend to other technical things that equally demand their attention on the shift.

These are excerpts from the participants:

> *"...ooh I really buy into the idea of the woman having a trusted person with her during labour, this is because the trusted person always makes sure that the woman has everything she needs: as in running errands for her, feeding them or even cleaning them with a damp towel if they feel warm and all that... This reduces the workload of we the midwives."* ***(CM 4, years of experience)***

> *".. looking at the patient-to-midwife ratio, we cannot always sit by the bedside of the woman to provide all the necessary care they need, so these companions sit with them on the ward and provide some of this basic care to them…"* ***(CM 12, 25 years of experience)***

> *"...in some instances, one companion can be used to run errands for about four different labouring women in case the others did not come with a(companion)., so they really help and personally I think it is good to work with them during labour..."* ***(CM 6, 6 years of experience)***

> *"...There are times we will need blood, the companion will quickly organise donors if there are medications we don't have in our pharmacy but the doctor has prescribed it they run to town to get it for us...in fact, if you get these good support system for the woman things become easy for we the midwives and women as well so we really encourage that every woman comes into labour with a companion,"* ***(CM 2, years of expereince)***

Another reason that was given by the participants was that over the years they have realised that the presence of a birth companion helped women to comply with the counselling and information women receive. They recounted that from their experience, these women usually have better birth outcomes and hardly come back reporting post-partum complications. These

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observations or experiences reinforced participants' positive attitudes towards the concept of birth companionship and their desire to have it implemented.

This is what one participant said:

> *"...when the companion is with the woman, especially their partners, they listen to all the education we give to the woman for example on how to let's say take their medication or their follow-up schedules in the house, they(companions) remind the women on what to do…" **(CM 3,1 year experience)***

Another one also said this:

> *".... Oh! there are some cases when managing, the woman will need a support person to really help to avoid complications, like pregnancy-induced hypertension, gestational diabetes etc... you know in these conditions the woman will need to rest more often and also be very careful about her diet, even her schedule to the clinic is more frequent so the husband or let me say the companion is very key in this way to provide the necessary support to the woman for a better outcome.... I think it's a very very good strategy..." **(CM 7, 23 years of experience)***

> *"... also, with teenagers who usually are cared for by their grandmothers or mothers (birth companions), it's very good to let them come to the hospital with them (teenage mothers). When we give education and they (birth companions) are around they get the first-hand information, and it wouldn't be the girl who will have to go and tell them (birth companions) which usually makes compliance difficult. But I always prefer that their mothers or grandmothers or whoever is taking care of them come with them as their companions so that whatever we say they will also hear and support the teenage mother to comply better..." **(CM 1, 6 years of experience)***

The participants who showed a positive attitude toward the approach were certain of its efficacy because they felt that having a birth companion, particularly if the companion is the woman's partner, fosters love and bonding between the two of them, which is then passed on to the unborn child.

These are some of the accounts the participants gave:

> *"... it's a sight to behold especially when some husbands (companions) are made to cut the cord and handed the baby put on mother's abdomen, all these acts create bonding and love between the couple and enhances positive birthing experience..." **(CM 4,8 years of experience)***

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"…as for support systems, they are very necessary for the pregnant woman, two people come together to create or bring about a life, so we need the two people to come in and support, when the husbands are involved, it increases the love and respect they have for the women and the baby receive that same love ***…" (CM 2, 9 years of experience*** *)*

*"…by experience, I have realised that women who are usually with their husbands as companions during birth especially caesarean section come back for postnatal services more happy and less stressed the husbands will be carrying the babies sometimes holding their (women) bags and all that. All these increase bonding between the couple and it affects the care of the child positively so it is something that must be greatly encouraged…" (****CM 6, 6 years of experience****)*

4.3.2. Negative attitudes towards the birth companionship strategy

Irrespective of the benefits of birth companionship that influenced the positive attitude of some participants, others (N=5) had more negative perceptions and had some reservations about having a birth companion present in the labour ward. According to them, the actual roles of the birth companion are usually not clear to them (the companion) thus making them interfere with their midwifery roles. In other words, although participants acknowledge the benefits of birth companionship as a concept, they are not enthusiastic about its implementation.

These sentiments were expressed in some of the following statements:

*"…I am aware of the benefits they bring but I am sceptical because I really don't know their actual role, so I don't know what to communicate to them. …so, for me, it is frustrating having them around the birthing suites…" (****CM 2, 9 years of experience****)*

*".. I don't think we are well informed to work with them (birth companions) because their roles are not very clear. As for the normal go and buy drugs... go and get us blood and all that it is there but their continuous presence with the woman in the first stage or second stage rooms, they will not be doing anything so usually I let them stay outside and call for them when I need them to get something we will need in the woman's care…" (****CM 10, 22 years of experience****)*

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> *"... in the antenatal those who come along with companions we tell them things to do like to help them at home, serve as reminders of dates and appointments but in the labour room we usually don't tell them we will need them there also because it is not very clear what they will be doing there since most of the care we render can only be done by midwives so, for now, I think we can work with them at the antenatal level and seek more clarity on what their roles are during labour..."* ***(CM7,23 years of experience)***

These participants who had negative attitudes towards the birth companionship strategy further attributed it to the birth companions' lack of knowledge or understanding about what goes on in the labour ward, and delivery processes, as well as the role of midwives within that environment. They noted that the birth companions, sometimes out of ignorance, place unrealistic demands and expectations on them (midwives) that invariably create a tense, unhealthy environment. To avoid such situations or conflicts, some participants would rather not have birth companions present.

The following were expressed by some of them:

> *"..... these companions may not understand why and how we do what we do in labour, even when you explain, their level of education may not help them to understand and this can create apprehension, so to avoid all these, I don't work with them..."* ***(CM 5, 10 years of experience)***

> *"... to the companions, all they want to see is that the pain their relative is feeling is relieved, so sometimes they will be like madam can't you give her any medication to ease the pain, with the little screaming and shouting of the mother they (companions) will come and ask you to go and do V/E meanwhile you (midwife) have told them the reason for the pain and the hours' interval you need to do V/E ooo but nooo they don't understand kraaa ... and it can be frustrating so some of these things make me a bit reluctant in working with them (companions)..." (**CM 7,23 years of experience**)*

> *".. if we really want to do this well then let's train people like they do outside ... err what do they call them ... erm doulas yes! At least they are trained so they will understand our language but for the woman choosing any lay person as a companion during birth it can really be problematic so working with them is not something I will encourage**..." (CM 10,22 years of experience)***

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> *"... the interferences they sometimes bring can be too many starting from questioning everything we do, sometimes giving concoction, opening infusions, emptying urine bags which we haven't told them to do and all that ... but the reason can only be that they don't understand our work and they think they are doing something to help but to us (midwives), that is a clear interference so it makes working with them not very okay..."* ***(CM 9,26 years of experience)***

Another reason given by the participants who had a negative attitude towards the strategy was the fact that some of the women become uncooperative during labour when they have companions present, especially when the companion is the husband or the partner.

These are some expressions from the participants:

> *".....It can be a good concept but to me, my over 20 years' experience tells me that women rather feel too pampered and 'misbehave' for want of a better word which rather complicates labour instead of causing good progress, so I don't like working with them especially if the patient is a primp..." (CM 9)*

> *"...Although this (birth companionship) is a good thing am a bit sceptical about working with them because I have observed that when their partners are with them, they tend to misbehave so in such instances, I will let the partner excuse us and then I will rather take over and that works better...*" ***(CM 5, 10 years of experience)***

> *"...when the women know that they have their husbands around its almost as if they want all the care the man has not rendered throughout the nine months of pregnancy, so they tend to crave for unnecessary attention .... this makes the husbands overanxious and cause them to complicate the job of the midwife because it almost as if the midwife is not doing enough, it makes working with them a bit tedious so I will rather not..."* ***(CM 2,9 years of experience)***

The reluctance of some participants to work with birth companions was influenced by their concern that it would compromise their professional autonomy. They argued that the midwife must provide a total package of care to the woman, providing all the essential care to her in labour so handing over some aspects of their responsibilities to birth companions who are usually lay people will weaken their professional autonomy.

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These are some excerpts from the interviews that speak to this assertion:

> *".... I don't encourage working with birth companions because I believe that the midwife is not only good to do "maame push" (madam push), delivering baby and cutting cord, she is in control of the birth by working round the clock to see the woman make it safely in such a way that it imprints a good and lasting memory on her mind, but if we give away a portion of our duties to a birth companion who knows nothing about labour and delivery, where lies our importance as midwives....:" (**CM 7,23 years of experience)***

> *"... as a midwife, my office is the ward and am supposed to discharge my duties as the profession requires, if teamwork is required, then it should be between the midwife and other health workers but not a lay person ... in a way, I feel am delegating to a wrong person and it makes my work less professional so I mostly don't work with them**.." (CM 5,10 years of experience**)*

> *"...the work of midwives means a lot of professionalism so when we advocate for the use of birth companions, I think we are making our work less of a profession. That's what I think. I don't know about my colleagues, but I don't like the idea of working with birth companions, maybe in the future the government can think about some sort of formal training for them to regularise their roles instead of the woman just picking someone she trusts and without any training we accept to work with them on the ward..." (CM **2, 9 years of experience**)*

Another issue that negatively informed midwives' willingness to embrace the possible integration of this strategy was their fear of greater accountability and blame. They claim that having a companion present during childbirth increases midwives' anxiety about being watched and unduly criticised.

A participant had this to say:

> *"... Our work can sometimes get complicated through no fault of ours but because these companions mostly don't understand our work we will be the first people they blame when such things happen and currently when you hear some of the things being circulated on social media I think we have to look twice before we work with them or better still not at all..." **(CM 9,26 years of experience**)*

This is a similar statement from another participant:

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> *"... using companions feels like you are being watched, so you work under tension and pressure because you don't want to make mistakes but how careful can you be, usually what will go wrong will go wrong no matter what but how the issues will be presented and skewed to favour the client in case something happens my sister...! You will be shocked so as for me I don't entertain support persons around women during labour* ***..." (CM 8,19 years of experience)***

Another participant said:

> *".. I don't like working with birth companions not because I hate them or am not aware of the benefits they bring but when these companions are here the feeling is like you are in a box, we have to do our 'kusum'('rituals') to hasten things, but they ask questions on everything, so it makes it a bit difficult* ***..." (CM10, years of experience)***

Additionally, some of them described how their previous experiences with birth companions hindered the smoothness of the entire labour process. Their sentiments were more of superstition, with others claiming that the presence of companions, particularly elderly women, made labour extremely difficult for the women since they (companions) came up with their ideas on how labour should be handled which lacked scientific basis.

These are some accounts the participants gave:

> *"... some of the things that occur in the labour wards we cannot explain with science, there are instances where the presence of companions strangely cause women to labour for long especially when they are old women, but once they are made to leave labour progresses normally, like I said this defies science but it is something I have practically seen over the years.."* ***(CM 9,26 years of experience)***

> *"...those of us who have worked in the villages before we can tell you that these companions are not always good luck for the labouring women, aah! There have been instances where the women will tell you to sack a particular relative who came as her companion from the ward so that she can deliver and truly to her words shortly after sacking them they deliver,"* ***(CM 5,10 years of experience)***

> *"...some companions are these Nankaba osofo and all these spiritualists who come with all sorts of solutions to sprinkle them on the wards claiming that there are evil*

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spirits and if you tell them 'No'! they now brand you that you (midwife) are a witch, so I rather keep them away from the delivery suites..." ***(CM 8,19 years of experience)***

"... many of the companions have their idea about labour and birth that they bring from the home which are usually contradicting to what we say as midwives and most of these ideas are purely superstitious and lack scientific basis. So, when we ask the women to do something that will help the labour to progress well, they will give a contradicting order. This makes the women confused because they don't know whether to listen to their companions or they should listen to us(midwives) so for me it makes working with them a little difficult ***…" (CM 10,22 years of experience)***

Others also recounted how birth companions they previously worked with were confrontational and emotionally draining hence their reluctance to engage them in the care of the women.

These are excerpts from some participants:

"…. I don't encourage working with them because although their ultimate importance to the woman is to provide emotional support, the ones I have encountered are rather problematic, with some being confrontational and others even collapsing for us to stop all that we are doing to revive them…." ***(CM 7,23 years of experience)***

*"...you won't believe that some support persons instead of encouraging the women and commending their efforts rather become agitated, especially during the second stage when the woman can't push. Those who come with teenagers end up slapping them or even insulting them on what they see as poor efforts on the girl's side so for me I rather work alone without them****…" (CM 10,22 years of experience)***

"...I remember we had to resuscitate one guy who was in the room with his wife who collapsed so it's better to keep them away from the ward and only call them when the need be but to be in the room with the woman throughout, I don't see the need..." ***(CM 8,19 years of experience)***

Additionally, some participants expressed concerns about the full implementation of the birth companionship strategy because the current state of their labour and delivery units is not set up to properly accommodate companions.

Some of the participants had the following to say

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"... for my place the major thing is the privacy and the settings although we have been able to provide curtains to separate one bed from another, it's still not private enough because whatever conversation goes on in one cubicle the others hear it and that alone can be a breach of confidentiality. So, what we do is that, If we don't have a lot of women around, we allow birth companions in but if the place is full, we try to limit the number of people coming in, so for me, it's the privacy and the setting that prevents me from working with them (birth companions) ..." ***(CM 9,26 years of experience)***

".... you look at our space and the nature of wards we have, is it one we can allow companions to be present without breaching the patient's privacy? no! We can't allow them to be with the women in the same room.... what we can do is that we can allow them to sit around and call them as and when we need them...." ***(CM 8,19 years of experience)***

"... mostly I don't work with them because most of our labour suites are so small, and the labouring women are usually clustered in one room. It makes it difficult for them to have privacy. When you take the private facilities, they have rooms separate enough to allow that but for us here our rooms are the dormitory type where almost all the women are naked so to allow third persons to be there, I don't think it's appropriate..." ***(CM 9,26 years of experience)***

"... when I was at the CHPs, I allowed them because usually you will have one woman delivering once a while but in the health centres and district hospitals that I have worked it is difficult having them with the women throughout because mostly there are more than one labouring women at a time so allowing a third person is not possible..." ***(CM 14,7 years of experience)***

4.3.3. Neutral or Conditional Acceptors

Data collected further shows that while 50% of the participants had a positive attitude towards the idea of birth companionship and others were also not in full support, there are yet a few more participants who were indifferent about it.

This attitude is seen in the following expressions made by some of the participants:

".... I really don't mind whether the woman is with a companion at birth or not, all I focus on is my work especially when the ward is not too busy or the woman is not in danger, things should be run by the midwife, or it is highly discretional whether I want someone to be with the woman or not ...." ***(CM 13,25 years of experience)***

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"…Whether birth companion or not I am not really centred on that… all am concerned about is that my work is done so if I need to involve companions for me to have a successful shift I will, if I can handle things on my own too, I will go ahead…" ***(CM 15, 13 years of experience)***

"… they come with benefits and challenges as well but that is not really an issue I dwell so much on as and when I need them I fall on them if I also think it will be a bit stressful I ask them to stay outside and only come in when the woman needs the so its really not something I seriously dwell on or not…"(CM 11, **10** ***years of experience*** *)*

The participants who appeared indifferent about the birth companionship strategy were ready to work with birth companions at the request of the woman or a superior colleague.

These are comments from some of the participants:

"…, aah no it is okay for the companions to be around, especially at their (labouring woman) request …. anytime am the shift in charge am liberal on these things although some colleagues are not so comfortable…" ***(CM 11,10 years of experience)***

"…. A senior colleague or Med Sup may request a birth companion for a patient, out of respect for authority and goodwill you will have to allow. However, it depends on the shift in charge to accept or not. In such cases, it's crucial to work with the birth companions, despite potential tension and interference, to ensure everything goes smoothly. …" ***(CM 13,25 years of experience)***

"...some colleagues sabotage the utilization of the companions in the care of the woman although I would love to work with them. Because of this am limited especially if the person is a senior colleague but if the shift is such that we all are in favour I allow it, other than that I keep them away and only send them to do a few errands at the request of the labouring woman …" ***(CM 15,* 13*years of experience)***

Additionally, they were of the view that the best time to have a birth companion be with the woman is when labour becomes complicated.

These are some accounts from the participants:

"…. usually when the woman's condition is not stable or there is a complication that needs to be keenly monitored, a companion is allowed to be with her to keep an eye on

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her in emergency situations. And in such instances too I usually want a support person to be there to at least witness all that we will be doing…." ***(CM 13,25 years of experience)***

"...I have ever had to refer a client who had pre-eclampsia to a tertiary facility with only a partner who came with her as her companion in her care although not right, I had no choice… I was working alone in a health centre with other clients in my care. I couldn't have left the woman and sent this one to the referral centre. I made that companion stay when they came because I realised that it was highly likely that the client would be referred because she was showing all the signs and symptoms of the severe form of the condition. It was a weekend, and our Medical officer (MO) wasn't around so I knew if push came to shove, she would have to go to a tertiary facility… so as for companions, sometimes they come in handy…" ***(CM 11,10 years of experience)***

"… in this hospital, we have two different wards for labouring women one for those in normal labour and the other for those in labour who have underlying conditions. With the first labour ward, we hardly allow birth companions and the second one we mostly we encourage them to come along with companions so that they can keep an eye on them and call us the moment they see that something is not right…" ***(CM 15,13 years of experience)***

Others were willing to allow birth companions to be present if they perceived their presence as very beneficial to the client or if the companion needed to play a role that the midwife may need assistance with.

One of the participants expressed

"… okay to allow them to be there depends on what the situation is on the ward, there are times you, the midwife will need assistance with a procedure and there is no colleague readily available. You can fall on the birth companion or there are times you need to keenly monitor the client on let's say the occurrence of seizures in eclampsia but there are other clients who need your attention and you are alone on the ward, you can call the birth companion to sit by the woman and alert you when the woman gets seizures or something like that …" ***(CM 15,13 years of experience)***

A similar expression was:

"…There are times when we need birth companions to maybe hold babies, or take over some specific duties after delivery for the woman to be able to rest, in such instances we do call the companions to come in to help…" ***(CM 11,10 years of experience)***

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Another participant had this to say:

> *"... yes we know the significance of family in the life of the labouring woman, I think it is proper to allow them but on the other hand if their presence will not be beneficial in that instance like lack of privacy and confidentiality or misunderstanding and all that its better, we don't allow them but we cannot be too strict on it too...but then again I think it depends on the client's condition if there is the need to keep a strict eye on her the birth companion can help ..." **(CM 13, years of experience)***

4.4.0. **Social Expectations Regarding Birth Companionship**

Social expectation potentially is a factor that influences the activities and conduct of people who live within a particular context. From the narratives, four different forms of social expectation that can influence midwives' readiness to the implementation of the birth companionship strategy were identified: 1) Community and traditional expectations 2) Perspective of midwives on family, 3) Professional expectations 4) Institutional expectations.

4.4.1. Community and traditional expectations

The participants spoke about how the expectations of the community within which they stay, and practice can influence their overall decision to allow birth companions to be with women during birth and further support its full implementation in future. They shared their experiences of how some communities traditionally have a practice of tasking older women who have delivered before to act as companions for the younger women when they are in labour.

These are some excerpts from the interview with the participants:

> *"... in the communities I worked in before coming to this bigger facility, they were predominantly Muslims and Northners. Old women following young ones as companions to deliver was the norm, they felt it was the duty of the older women, which when not done will meant the old women had been irresponsible, so we were forced to allow them in at least to help them fulfil their traditional responsibilities..." **(CM 6,6 years of experience)***

> *"...the community believed that delivery was not for the faint-hearted and that it needs a grown-up who is experienced in that field to be there, there were times some even felt we were too young to attend to them at birth, so we have to do a lot of reassurance*

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before they come to the clinic. It was only good for us to allow the companions to be around to at least know that we are competent… ***(CM 16,6 years of experience)***

"… the people believed that since the old women have delivered several times, it will be good luck for the younger women to come to the facility with them so that their luck will rub off on them…." ***(CM 1 year of experience,)***

The participants further stated that they risk women in these communities accessing care from Traditional Birth Attendants (TBA) where they have the freedom of having loved ones around them without any restriction. Some attested that if the facility would not allow women to be accompanied by birth companions of their choice, the problem of this cultural and customary influence might force them to return to giving birth with TBAs.

These are some expressions from participants:

*"….you will be surprised to hear that in these typically culturally centred communities, the women were not coming to asses service at the facility and most of them were of the view that when you deliver in the house or with TBAs, all their family members are there supporting them and praying for them so we saw that if we want them to come we have to allow the birth companions to come with them…" (****CM 4,8 years of experience****)*

"… the support of the older women gives them some sort of "morale" …when they were asked when they reported for post-natal services the women said they were comfortable having their births in the company of their loved ones but not mere midwives who are just doing their work…" ***(CM 12,21 years of experience)***

"…some women when we ask them said that when you go and deliver and nobody follows, in the community they see you to be someone who is maybe disobedient to elders or someway so they prefer to be accompanied by birth companions who can be their landlady or a co-tenants or anyone at all they feel is okay for them.. once we realised that keeping their companions away from them when they come to deliver was reducing our client turnout, we allowed them so that they (women) will come……" ***(CM 4,8 years of experience)***

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4.4.2. Perspectives of midwives on family function

According to the participants in the study, the birth companionship strategy is heavily influenced by one's perspective on family function and its importance in a woman's life. Some

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see the socialization of the African family as one that supports its members. They further argued that in such a phenomenal experience in the woman's life, it's important that her family members are present to give physical and emotional support.

Some participant expressing their views had this to say:

> *"... you see our family system and the way our communities are structured makes it impossible to take these companions out during labour. The family is built in such a way that we support each other, especially in difficult and anxious moments like labour..."* ***(CM 4,8 years of experience)***

> *"... I believe in the family support system personally the way I love family, that is what I perceive everyone does. So, when am attending to labour and the woman wants the partner or a relative to be there as a companion, I gladly allow it because I would have done the same..."* ***(CM 6,6 years of experience)***

> *"... labour is painful it's distressing so to have family around gives you the hope to carry on, the joy in anticipation from family members brings encouragement and our women need this. Am saying this because I do that for family members as well..."* ***(CM 16,6 years of experience)***

4.4.3. Professional Expectations

Some of the participants in the study were of the view that there are no expectations of them (midwives) regarding the involvement of birth companions in the care of the woman. This they believe is a result of a lack of support from the professional bodies or hospital administration. They further argued that as soon as they hold them (midwives) accountable for the involvement of companions in the care of the woman, they will pay more attention to it.

These are some sentiments the participants expressed:

> *"... am not so keen about working with birth companions because at the end of labour, no one will ask me to provide evidence on that, I only pay attention to things am accountable for like pathograph, early initiation of breastfeeding and others but I think that if they want us to actually work with them, they should train us and support us to work with them then it will work but for now.... ..."* ***(CM 13,25 years of experience)***

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> *… I don't know of any support for the strategy, I think that we are really not accountable for doing it because we have not received any support or training on it so although there are times we allow them to be with the woman on the ward but other times we don't depending on the privacy situation the ward, nobody really asks us why so we also do what we think is okay depending on the situation on the ward….* ***(CM 11,10 years of experience)***

> *"… I have not heard of any guidelines on this support person before… all I know is male involvement which we encourage very well at the antenatal and the pregnancy schools because if you don't do it you won't have records to show, but with this particular one there is nothing like that so when we are preparing our monthly report we don't include is that is why I don't usually pay attention to it…"* ***(CM 14,7 years of experience)***

> *"… if there are guidelines and protocols regarding this, midwives will be held accountable may be by means of adding it to their monthly report or something so it would have forced us to work with them but since there are none, there are no expectations from us…" (CM 12)*

Some of the participants speaking to the same sub-theme asserted that since midwives are trained to provide RMC to labouring women birth companionship is a hidden expectation. They were of the view that although not explicitly stated in any guideline or protocol, no proper RMC can be offered without considering the presence of a birth companion. In addition, it is ethically wrong to deny a woman access to a trusted person during a difficult time like labour.

One participant had this to say:

> *"… birth companions are a key component of respectful maternity care, a concept midwives hold in high esteem, nowadays we are all saying women should be treated with respect so that they will always want to deliver in health facilities so working cordially with birth companions is highly expected of us…" (CM 12)*

Another participant said:

> *"…I think one unfortunate thing the midwife will do is to prevent the woman from having someone she loves like her husband being around during a crucial time like labour it can seriously dampen her spirit and as a midwife, this will not be a good memory for the woman to go home with…"* ***(CM 14,7 years of experience)***

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This is what another one expressed:

> *"...per what we were taught in our recent workshop, a midwife will be providing respectful care if she can cordially work with the lady's companion but one of the things that unfortunately happens is the confrontations and arguments that midwives have with them and I think it reduces professionalism because the amount of respect we give the woman during labour is reduced..." **(CM 15,13 years of experience)***

Others also asserted that it can be very challenging to scale up the midwife's professional duties, so these companions help complete some of the small, non-technical tasks that add up to the midwife's professionalism. So, they argued that if it takes working with birth companions for some workload to be taken off so they can act professionally, it is accepted.

One had this to say

> *"...as midwives, we ought to be more professional than the TBA for instance. If the workload is so much, why can't we allow the companions to take some burden off our shoulders because in the end woman is satisfied because she received respectful care, we are also happy we could help, and professionalism is maintained just that the guidelines or policies or whatever backs as a profession regarding this should be spelt out....." **(CM 14,7 years of experience)***

One also expressed this:

> *"... some of the things that make us behave unprofessionally on the ward is burnout due to heavy workload so if birth companions can be trained to do some of the things for us, we accept it kraaa at least we work cordially, and the people outside will not see us to be unprofessional..." **(CM 10,22 years of experience)***

4.4.4. Institutional expectations

Participants admitted that policies mandating the use of birth companions will automate the use of the strategy. When national or hospital policies formally require the implementation of birth companionship, midwives will feel compelled to comply, as failing to do so could result in professional consequences. If birth companionship is included in standard operating

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procedures (SOPs) or guidelines for maternity care, midwives are more likely to integrate it into their practice.

One of the participants expressing her view said this:

> *"…. As for this birth companionship strategy I think as midwives, we will be confident enough if the place, we were working has an open policy or even nationally there is a policy clearly spelling out how midwives should work with them….."* ***(CM 10,22 years of experience)***

Another one stated this:

> *"… my hospital has not clearly stated how things should be done regarding the use of birth companions so if we allow them, we do so at our own risk because when anything goes wrong…. Hmmm, no one will mind you oo…"* ***(CM 2,9 years of experience)***

One also had this to say:

> *"… since there is no institutional policy like this, nothing really compels me to use them so it is highly discretionary, I usually survey how the birthing is going to see if I will need them or not if my hospital matron or those at the top openly tell us what to I think we will all do it…"* ***(CM11,10 years of experience)***

Other participants stated that the authoritarian and hierarchical institutional culture sometimes hinders their willingness to work with birth companions. Some said birth companions were discouraged at institutions where midwives are required to keep strong control over the labour ward or in hospitals, their policies are given precedence over patient wishes, which is usually the case in a top-down approach to care facilities.

This is what one participant said:

> *"… for example, the previous hospitals I have worked in except this current one, they prioritise the hospital policies over patient wishes cos they have a military background, this made it difficult to use birth companions although it was the wish of some patients…"* ***CM 9,26 years of experience)***

Another one had this to say:

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> *"...so, you see the institution one works in can be a very determining factor. I have worked at places where the type of care they render is total nursing care where no relative is allowed so even if I so wish to allow them the hospital policy does not and it supersedes what I want as a staff..."* ***(CM 12,21 years of experience)***

Again, if senior midwives or hospital administrators oppose birth companionship, junior midwives said they felt pressured to follow their lead to avoid conflict. Midwives working in institutions with rigid traditional practices feared that accepting birth companionship could be seen as undermining long-standing professional norms.

One participant had this to say

> *"...like I said initially some of the facilities I worked in prevented the use of birth companions so in those facilities I didn't allow companions to be with women at birth as a junior staff I follow what my senior said so I couldn't go contrary to that ..."* ***(CM 13,25 years of experience)***

Similarly, one participant said:

> *"...currently where I am, there are no strict rules on this, its discretional so I can decide based on how the case is, to use them or not but often not I don't work with them due to how cumbersome the whole thing can be but only use them in situations where the condition of the woman is not stable but before this time my previous place of work usually my colleagues didn't like the idea so I wasn't working with them..."* ***(CM 14, years of experience 7)***

Another participant also expressed this:

> *"... there are times the way the situation is you would have loved that a companion or a relative is with the woman, but you're in charge or at times the doctor on the case will say no and because you want to avoid conflicts you have to obey..."* ***(CM 7, years of experience)***

The participants went on to explain that senior midwives and hospital executives who actively encourage birth companionship foster an environment in which midwives are inspired to support it. By mentoring and setting an example, supervisors or shift in charge who keep an eye on compliance with respectful maternity care (including birth companionship) and take proactive measures to ensure their seamless integration affects midwives' attitudes.

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This is an extract from conversations with some participants:

> *".....whenever the facility has measures in place to support the use of birth companionship, midwives always are willing and ready to use them and vice versa....am saying this based on the different settings I have worked and the different approaches they have towards the concept...."* ***(CM 11,10 years of experience)***

> *"...when I was in the village, because most of my seniors had stayed there for long, they were almost like the indigenes so that really influenced how things were done so there was no way relatives or companions were prevented from being with the woman so that was inadvertently my practise..." (CM 15,13* ***years of experience)***

> *"... over here my in charge is the pampering type who is also very keen on seeing the women very calm and relaxed so usually she encourages us to do what the women want for them and one key thing women always request for is to allow their companions to be by their side, and we do because the in -charge will not be happy with you if she hears that you denied the woman access to her loved one during labour..."* ***(CM 3,1 year of experience)***

4.5.0. Behavioural control factors of midwives towards the birth companionship strategy

Behavioural control factors refer to the perceived ease or difficulty of performing a behaviour. These factors relate to the participants' individual capacity and perception of control over the implementation of birth companionship. Seven (7) subthemes emerged 1) Knowledge of the benefits of birth companions 2) Space and Setting 3) Institutional Support 4) Personal Beliefs 5) External constraints and 6) Emotional Stress.

4.5.1. Knowledge of the benefits of birth companions

Throughout the interviews, the participants demonstrated good knowledge about the benefits of birth companionship to both the labouring woman and midwives. This, according to some of them influenced their positive attitude towards the strategy and their willingness to support its full implementation.

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These are excerpts from the interview that speaks to this assertion:

> *"... my willingness to work with birth companions is because I know their presence kind of lessens the woman's anxiety and subsequently improves the outcome of labour. you know that anxiety has a way of rendering hormones responsible for uterine contraction ineffective..."* ***(CM6,6 years of experience)***

> *"... birth companions are really helpful in the labour wards in that they provide emotional support and some psychological support for the woman, and this contributes to a positive birthing experience and reduces complications that may let normal labour end up a caesarean birth..."* ***(CM 3, 1 year of experience)***

> *"... as part of respectful maternity midwives have been tasked to encourage women to come with a trusted person who will be a companion to them right from pregnancy labour and puerperium. These companions are very helpful in providing physical help and educational support to the woman, they sometimes do sacral massages, help teach them deep breathing exercises and others to help the women cope with the pain..."* ***(CM 7,23 years of experience)***

There were other participants despite their knowledge about the benefits, were sceptical about the full implementation of the birth companionship strategy because according to them there were barriers to its full adoption and others also highlighted disadvantages of the companions outweighed its benefits.

The following sentiments were highlighted by some participants in the study:

> *"... as for the strategy, it comes with benefits but if you consider the barriers and challenges like lack of space, lack of training of these companions and the likes I think we need a bit of time for it to be properly thought over before we fully adopt it but for now we can only manage to let them stay outside the wards and call them as and when..."* ***(CM 8,19 years of experience)***

> *"... I think despite the benefits, birth companionship should be further discussed to see how best it can be integrated into the care of the woman because from the little experience I have gathered over the years some are very difficult to work with, they can be confrontational and others meddling in medical procedures so it should be properly considered looking at these shortfalls..."* ***(CM 10,22 years of experience)***

> *"...Yes! They may have all these benefits but if it's at the expense of breaching the privacy and confidentiality of other labouring women, with some taking unauthorised*

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videos or audio recording private matters in the ward and putting them on social media then I think it's not right enough so the authorities should look at this other issues and try to devise ways we can curb that before we think of its full implementation…:" ***(CM 9,26 years of experience)***

4.5.2. Space and Setting

Most of the midwives raised issues about limited space in the labour wards they use. They claim the wards were already overcrowded, with multiple beds in a single room moreover lack of privacy for labouring women also causes discomfort for women. Midwives who were working in such space-constrained settings were reluctant to allow birth companions due to concerns about confidentiality and dignity.

This is what a participant said:

"… our wards are too small there is no space for an extra chair for the companion to sit, they can't also sit on the client's bed, so the best thing is for them to rest outside and come in as and when we need them…" ***(CM 12,21 years of experience)***

Another participant said this:

"…the issue is privacy the labour wards are too small to accommodate extra people. It makes the place overcrowded and privacy is breached which doesn't help…" ***(CM 13,25 years of experience)***

This is another statement from one of the participants:

"… Usually, patients don't feel comfortable when they are labouring and other people apart from fellow labouring women are on the ward with them, any procedure you want to do unless you tell them to excuse you and sometimes it's not all that nice…" ***(CM 4,8 years of experience)***

The above concern was not the same with participants working in spacious, well-organized maternity units: they on the other hand were enthusiastic about the full implementation of the strategy because to them these companions served as good checks on the labouring woman and

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errand people on the ward so that they can spend time attending to other equally important matters.

These are quotes from some of the participants:

> *"...here our wards are spacious, and the rooms are a bit far from the nurses' station, so when they come with the women, we make them run errands so that we save ourselves the stress from walking up and down the ward but use that time to do other important things for the patient…" **(CM 6,6 years of experience)***

> *"...the companions are really helpful; we don't have privacy issues because the rooms are spacious enough and well demarcated into cubicles some of the beds that the women lie on during the 1st stage can be adjusted to assume a delivery couch then right after we change it back to a regular post-natal bed .... **(CM 12,21 years of experience)***

> *"... the up and down walking to and fro from one end of the ward to the other is tedious ooo... so the companions are helpful sometimes we even ask them to assist us like oo do this and that for me and it reduces our stress levels..." **(CM 11,10 years of experience)***

> *"...over there we allow companions to be with women, I say that cos I have been doing locum there. The wards are spacious enough and I think it was built that way because they factored the involvement of companions. Each patient has one room to herself, so these companions are very beneficial in reporting to us when something is not going on well with the woman..." **(CM 13,25 years of experience)**.*

Issues of poor ventilation and hygiene concerns were raised by some participants in the study. In labour wards with poor ventilation, inadequate seating, or unclean walls, participants were resisting extra people (companions) to avoid overcrowding and infection risks, as well as people taking pictures and videos and making them public, their blindside.

These are excerpts of some sentiments participants raised:

> *"...here in government facilities our space and Infection Prevention and Control (IPC) are someway so allowing a third party there could be an inditement on professionalism, it is a shame for them to come and see how dirty our walls are and how rusty our delivery beds are so I think before they think about the implementation of this birth companionship fully management should be tasked to at least beautify our labour wards every six months so that our dirty linens will not be washed in the public without it I*

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don't think we will feel comfortable allowing birth companions to be with women in the labour wards…"(CM 6,6 years of experience)

"...the place is small and warm, even with fans on, we need to keep cleaning our sweats... we cannot add on to the numbers who are here per delivery. It can only be the midwife and the woman and probably a professional assistant who can help in case there is a complication. There is the tendency of the spread of upper respiratory tract infection and even infecting the newborn babies with cold and other things because then we will be breathing stale air since we switch off fans when the babies are born..." (CM 7, 23 years of experience,)

"...some companions as if they are taking care of their people can nicodesmously take pictures or even videos and send them to TikTok or other social media spaces due to how unkept some of our wards are. But in private hospitals, because they are business-minded; they have clean spaces as well as functioning equipment so allowing companions is even intentional so that they can advertise for the facility ..... (CM 2,9 years of experience)

4.5.3. Institutional Support

Some of the midwives stated that strong institutional support is a major determinant to trigger their readiness to accept the birth companionship strategy. In the absence of that, their readiness for the implementation of the strategy will not be feasible.

Some of the participants expressed these sentiments:

".... There are no clear guidelines or protocols on what to do when we are working with birth companions in these institutions so its highly discretional and usually it makes it cumbersome unlike if there were clear institutional policies to support it ...." (CM 1,6 years of experience)

"... when I have an issue while working, I expect that my institution will have my back but if what I did does not have any root in the institutional policy it means I will be left alone so since this birth companionship does not have any guideline whatsoever, I think it risky working with them..." (CM10, years of experience)

"...if the institution sees the integration of birth companion is a good way of marketing the facility and also a way to meet patients' needs and throw their support behind it, I think it will be far better..." (CM 16,6 years of experience)

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> *"...If the institution spells out the dos and don'ts of birth companions and may paste it on the walls they (companions) will know their limit so that they will operate within those boundaries and not leave us the midwives to be talking and correcting them when they (companions) trespass because it only makes them see us as hostile towards them yes so we need our institution to support us in that light…"(CM12,21 years of experience)*

The participants in the study further stated that most of the facilities they've worked in have no clear guidelines on the birth companionship strategy, making it difficult for uniformity and clear role definition. They admitted that the absence of these guidelines leaves midwives confused as to what the roles of these companions are and what is expected of them (midwives) to do making them hesitant to work with birth companions.

Some of them expressing their views have these to say:

> *"...in my permanent jobs with the public institutions I usually don't work with them because there is no clear support from the authorities, even security men sometimes turn them away so I don't know but, I have realised that the private facilities because of the kind of support they have from the authorities on what they should do regarding the involvement of birth companionship, it makes it easy for us to be confident in working these companions..." (CM 6,6 years of experience)*

> *"... in our public hospitals we really don't know their take on it so in case you engage them and something untoward happens, nothing justifies it..." (CM 9, years of experience)*

> *"...there is most often confusion with them because some of them are too known if I may use that word, they want to do what they know from the house and we also won't allow that, so there is always friction and the relationship we want to build rather becomes the opposite but if there were institutional support I believe their roles would have been clearly outlined so that they don't overstep their boundaries…" (CM 7, years of experience)*

> *"...before COVID we were made to allow the companions in but during COVID they brought restrictions as to how and when we can work with birth companions. Till now its not very clear what the authorities want us to do regarding the involvement of birth companions so, we use our discretion which I think is not ideal. There should be some clear instructions on what to do just as they did during covid... (CM 1,6 years of experience)*

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> *"...unlike we have protocols on let's say management of PPH or management of APH there is none on how to manage the presence of birth companions on the ward. Additionally, my nurse manager or med sup out of the many challenges they address for work to be easy, have never addressed how to successfully integrate the concept of birth companionship in the care of the labouring woman ..."* ***(CM 13,25 years of experience)***

Some were also of the view that there have not been trainings or workshops about birth companionship, and that probably shows a lack of insight on the part of the institutional authorities regarding the positive contributions birth companionship has on labour.

Here are some accounts the participants gave:

> *"... the silence about this strategy by our leaders clearly shows that it is something that they careless or least regard as a good source of intervention so maybe the education should start from there. If they provide such support, I believe the full implementation will be a success...."* ***(CM 15, years of experience)***

> *"... there are times at meetings we raise issues on ways we can have a well-demarcated labour room so that at least women can have privacy and companions not be hearing or seeing other women's nakedness but they have always been like that is not their priority and that there are pending things to do with funds so it clearly shows how the authorities don't regard the strategy..."* ***(CM 16,6 years of experience)***

> *"...you see male involvement emphasizes the involvement of partners or husbands which is almost like the birth companionship concept although slightly different. As for that we usually hold trainings and talks on it but not the birth companionship actually..."* ***(CM 8,19 years of experience)***

> *"... for us, we don't allow them to be in our rooms because of how small the rooms are but we have been on management severally to at least provide a day room where they can sit and watch TV so that we can call them when the need be but for so many years that I have worked here it doesn't look like it's part of their priorities..."* ***(CM 9,26 years of experience)***

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4.5.4. Personal Beliefs and Experiences

The study participants also shared some personal beliefs they have concerning birth companionship, which is likely to influence their readiness for the full implementation of the

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strategy. While some confirmed that those beliefs were formed based on their experiences with working with birth companions over the years, others simply attributed them to their values.

The following are some accounts given by the participants

> *"...I personally think that every human being needs someone especially in difficult times like labour so for me I am okay having companions around and I think other colleagues should see it this way and together we support its implementation..."* ***(CM16, years of experience)***

> *"...in the community where I was raised, from the north we care for each other so when someone is in labour, everybody is concerned to make sure that things are okay for her so I think that is what makes me think that here in the south too it should be like that. I always encourage the companions to be here anytime am on duty I don't sack them at all because that is how I grew up so going forward I think we should look at making it more regular..."* ***(CM 1, 6 years of experience)***

> *"...for my many years of practice, there is something I have noticed about the presence of companions. That is when some companions are around the woman, labour rather becomes difficult. There are times the women themselves will come and confide in me to sack their in-laws or maybe someone who accompanied them to the labour ward and believe me the moment you sack them everything becomes smooth. I know it sounds a little weird but it's real...* ***(CM10, 22years of experience)***

> *"... some of the things that occur in the labour wards we cannot explain with science, there are instances where the presence of companions strangely cause women to labour for long especially when they are old women, but once they are made to leave labour progresses normally, like I said this defies science but it is something I have practically seen over the years.."* ***(CM 9, 26 years of experience)***

> *"... I am quite young in this work I believe whatever my senior colleagues tell me especially the cautions I receive from them and one of such cautions is about the use of birth companions and the problems they can bring. my dear if you come to work and these 'oladys' who have done this for ages start telling you stories about how some companions can bring bad luck to your shift will you be okay allowing them..."* ***(CM 13,25 years of experience)***

Some participants also attested to having personally experienced or witnessed successful birth companionship (either in training or practice), recounting stories of success they (birth companions) helped write and various instances where birth companions came in handy. Others

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recalled how the environments they worked in welcomed the idea of working closely with birth companions, which kept the atmosphere positive and gave them confidence that birth companions were worth the investment.

One of the participants gave this example:

> *"…. these companions can be very useful; I recount how one of them saved me from being charged with negligence when she stood by an eclamptic patient throughout the fitting and came to call me quickly after the fit. I tell you this patient could have fallen from the bed if this companion wasn't there because she was very huge, and the bed was kind of small for her. I could have been sued if she had fallen and probably charged with negligence…." **(CM 4,,8 years of experience)***

Another participant also recounted this:

> *"… once at a CHPS I was even a rotation midwife, for the afternoon shift alone when a client was brought into labour, before I could finish checking her vitals she started fitting, I was there alone with this woman and her companion who helped me throughout my management to save the woman's life…" **(CM12,21 years of experience)***

One other participant said this:

> *"…there have been instances where labouring women's partners were the ones who saved us from robbery attacks, chase thieves and beat them and all that because here thieves are here, especially in the night so in this facility they are really accepted paaa, especially in the night so its full implementation where the authorities are clear on what their roles are will be very helpful…." **(CM 6,6 years of experience)***

RMC of which birth companionship is a key component, was one of the factors participants labelled as a personal reason for their possible endorsement of the full implementation of the strategy. In doing so they believed that it's a respect for the woman's fundamental human right and a chance to offer patient-centred, comprehensive care.

One of the participants expressing her view said:

*"…. I am an RMC ambassador for my facility, …. so, birth companionship is automatically something I endorse, and I will stand for it any time because it is the woman's right to come along with any trusted person during labour to provide emotional support to her …" **(CM 1 6 years of experience),***

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One other participant had this to say:

*"...there is nothing so painful than to go through the pain and have no one to at least reassure you that he is in it with you together... it makes labour more painful, but the concept of respectful maternity care tries to change the phase of labour by letting someone at least the partner be with the woman and it is the most humane thing to do…" **(CM 3,1 years of experience)***

Another one expressed this:

*"...personally I think we all midwives must embrace this respectful maternity care concept, it makes us behave well, our women become happy and it includes allowing their birth companions to be with them even if er say we don't have space for them to be there 24/7 we can at least let them hang around and call them as and when the woman needs her…"**(CM2,9 years of experience)***

While some participants recounted positive experiences with their encounters with birth companions, few others attested to having had not-too-good experiences with them. They were of the view that their presence impedes rather than fosters a free flow of events.

The following are some sentiments from the participants:

> *"... the birth companions sometimes smuggle concoctions and other things into the wards all in the name of speeding up the labour process which can sometimes be detrimental…" **(CM 2,9 years of experience)***
>
> *"...there has been an instance where a woman going for C/S was given a herbal preparation nicodesmously by a companion saying that will cause her to deliver with ease and cancel the C/S..." **(CM 10,22 years of experience)***
>
> *".. some will open infusions at your blindsight, empty urine bags you have not asked them to empty, call the house and give a false alarm and all that ... they can really give you a tough time more than the client in your care..." **(CM 5,10 years of experience)***
>
> *"...some are always calling you to come and see every little thing the woman does although you have coached them on what to call you on daabi ooo every little thing auntie nurse! Auntie nurse! It can really be disturbing. Some even collapse, vomit or get dizzy at the sight of blood and all that it can be very challenging working with them..." **(CM 7, years of experience)***

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Gender and cultural stereotypes were also brought to light. Some believed that male birth companions, like husbands, were considered improper or disruptive in maternity wards in some cultural settings where they worked or were born. As a result, midwives from backgrounds where birth is traditionally a "women-only" thing felt uneasy letting male companions be with the women.

One of the participants expressing her view had this to say:

> *"... I was brought up in a community where labour is believed to be strictly a woman's thing, it is so bad that when women in that community go to the hospital to access care only female health workers must attend to them. I think this kind of belief is still imprinted in me, so I find it difficult allowing males who pose as birth companions to be the women..."* ***(CM 8,19 years of experience)***

Another participant said this:

> *"... when women come with male companions it's almost as if they are not there because we end up doing all the things for the women. Some are very scared of the labour rooms and sometimes ask that they be excused others who stay don't know what diapers or baby cloths or night wear is they are completely confused so it's better they stay away for us to do our work. They usually stand around worried and helpless especially when the women are crying some even cry alongside..."* ***(CM 7, 23 years of experience)***

This is another statement one made:

> *"...I personally think that no one should know the woman is in labour till she delivers because human beings can't be trusted, I personally when am in labour apart from my husband no one else knows till I deliver so I find it someway when the women come with people when they are in labour if it's the husband it cool although they usually don't know what do around the labour ward but other people me I sack them because things can go wrong with them around I mean spiritually, ..."* ***(CM10,2 years of experience 2)***

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4.5.5. External constraints

Another factor that participants perceived as a potential hindrance to the full-scale implementation of birth companionship in their facilities was the idea that hospital regulations will have to be strictly adhered to irrespective of their (participants) opinion or preference for

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women to have a companion of choice. The majority of the participants were willing to allow the women to have their companions with them if their facilities adopted the strategy and provided some policies or guidelines to back its implementation.

These are excerpts from the interview to support the above assertion:

> *"...there are certain things we use discretions as midwives but with birth companions, we can't use discretion because of personal biases. I think a laid down guideline will be ideal so that we don't disadvantage anyone based on our personal biases...." (CM 11)*

> *"...in this era of lawsuits and I 'know my rights' we need laid down guidelines at least to refer to in our course of work if we have to work with companions who are sometimes fault finders ..." **(CM 10, 22 years of experience)***

> *"... although there are times, I would love that they* (companion) *be with the woman be because of her condition, hospital policy says no so I can't go against it..." **(CM 2,9 years of experience)***

Participants also raised concerns about the poor or low preparations they have received as midwives towards the implementation of the strategy. They were of the view that some training or workshop should be organised for them to fully understand what is required of them to work with companions.

This is an expression from one participant:

> *"...until we are trained like the training we sometimes receive on some obstetric emergencies, it will be difficult for us to fully understand and integrate their roles in the care we render to women…." **(CM 9, 26 years of experience)***

One other participant said:

> *"...this strategy was not taught in school, and how to integrate their care is not clearly understood so it can be conflicting because I have my beliefs and values which are not in line with allowing other colleagues have there will be friction but if there are laid down rules at least we will all be on the same page …" **(CM 10,22 years of experience)***

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Another one also said:

> *"…we are trained and given a job description as to what to do. There are times we can suggest to authorities our specific training needs based on the twist the job is taking. We have asked that we be trained but …… for me I don't think the subject is as important as it seems other than that we would have been trained, and workshops will be held on it..."* ***(CM 7,23 years of experience)***

On the same sub-theme, some of the participants asserted that they foresee difficulty in the full implementation of the strategy due to the attitudes of colleagues and supervisors. They claim the resistance is coming from senior colleagues who are sceptical about working with these companions for different reasons spanning from superstition to perceiving companions as gossip.

These are some accounts from participants:

> *"... we junior colleagues always want to conform to the status quo… I don't decide who my shift in charge should be and what she should do…once my in-charge or the hospital frowns on allowing third parties to be part of the labour, I can't go against it…* ***(CM 13,25 years of experience)***

> *"... although I may be well aware of the numerous benefits of the strategy my in-charge thinks some are witches and come only to complicate labour and it leaves me helpless as to what I can do to convince her to allow me to work them…"* ***(CM 14, 7 years of experience)***

> *"..... I am quite young in this work just about 5-6 years but the little I have gathered concerning this whole companionship thing is that if your senior colleagues are cool with them you will automatically be okay having them around but if the culture of the working environment is that these senior colleagues are resistant to it, you will also follow suit…..."****(CM 1,6 years of experience)***

But there are times that the opposite could happen according to the participants in the study; colleagues or even supervisors will influence their integration into the care-given process even when midwives are reluctant to, for the same reason that they want to avoid conflicts and friction from their superiors.

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This was expressed by one of the participants:

> *"... for me, I have always not supported the idea of having companions around birth because most of them lack clinical knowledge and that creates friction but there are instances where external influences force me to accept them on the ward together with the woman..."* ***(CM 8,19 years of experience)***

Another one also said:

> *"...I can have colleagues whose daughters or in-laws come to deliver so am forced to allow them. At times too some of the women might know administrators or medical superintendents so the moment they come to the ward they call them and you the midwife will be instructed to allow the companions to be on the ward..."* ***(CM 13, 25 years of experience)***

One other participant said:

> *"... usually, these companions that come because they have people in authority asking that we allow them to be there are the ones that give up unnecessary pressure and put some unseen stress on us they are quick to ask questions on everything you do and won't hesitate to call their 'big men' misrepresenting and reporting things to them..."* ***(CM 11, 10 years of experience)***

4.5.6. Emotional Stress

Dealing with birth companions can be stressful, according to some of the participants who were selected for the study. They were of the view that birth companions can be very demanding and usually difficult to work with. They were concerned the presence of birth companions could further aggravate their emotional burnout which may cause them to be confrontational with them.

This is what one participant said:

> *"...there are many times that labour becomes extremely difficult and wears you out as a midwife, sometimes all you need is a quiet state of mind and the least you want to do is to deal with one nosy companion...."* ***(CM10,22 years of experience)***

Another participant has this to say:

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> *"... I go through a lot of emotional breakdowns in my line of duty especially when things don't go according to plan so to add on the burden of dealing with the problems of companions is something I don't usually add...***" (*CM* 5, 10 *years of experience*)**

Another quote from a participant:

> *"...these companions increase our emotional stress, they can be nosy some asking questions upon questions at times in the middle of a procedure they will bring you a phone saying there is someone on the other part of the call wanting to talk to you hmmm meanwhile you will be performing a procedure oo...you can easily burst out and this will bring conflicts…***" (*CM 12 years of experience*)**

Again, the perceived additional workload of having companions around, the midwives claimed might add up to their stress levels and in effect, they (birth companions) are seen as an extra responsibility rather than a support system.

The participants, stating their claims, said:

> *"....in that state of stress, I can't take on additional workload especially when I don't see how it is helping my work...yes birth companions are extra work my sister..."* ***(CM10, 22 years of experience)***

> *"... when am tired I am usually not pleasant to people so to have companions around during a very tiring duty won't be nice at all cos they can be overburdening... the very things that they need not to do is what they do. We are already stressed due to shortage of staff so to add the problem of having to explain everything to companions coupled with their questions and all that will be too much to take..."* ***(CM 5,10 years of experience)***

> *"...sometimes you must stop attending to the client sit the support person down and explain things to him till he understands and gives consent before a lifesaving procedure can be done because he will be influencing the woman to refuse let's say a caesarean section. There are times that men have collapsed on this ward especially when they see women bleeding. In cases like this, we have to stop everything we are doing and resuscitate" (CM 15, 13 years of experience)*

The participants again raised concerns about the wrong clinical decision-making that sometimes is made when they are stressed. They lamented that a job that warrants that they daily make quality clinical decisions cannot be done properly under stressful conditions. The

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presence of birth companions they claim can add to stress levels thereby causing them to make potentially terrible cognitive clinical decisions.

These are some expressions from the participants:

> *"... under stressful conditions, you can attest to the fact that one cannot work without making basic mistakes sometimes, the companions can sometimes add to our stress especially when they are on you with the little shouting and screaming of the women claiming that the woman is in pain or has been in labour for long so do something to relieve her of the pain or let the baby come quickly hmm it can be very disturbing and you can't even think straight...")* ***(CM 8,19 years of experience)***

> *"... sometimes after a heated argument with the doctor over a patient...in this emotionally charged atmosphere then these companions too will be asking you unusual' questions or demand hmm its hard ooo..."* ***(CM 2,9 years of experience)***

> *"...truth be told sometimes the labour ward atmosphere is emotionally charged and the last thing we want to do is to put up with some nosy companions who become suspicious and are anxious asking you all sorts of questions. You can easily lose it ..."* ***(CM 10,22 years of experience)***

A few of the participants were also dissatisfied with the salaries and benefits that come with their position. According to them the risks and burdens they faced compared to the rewards and salaries were unappealing hence they were unwilling to take on any additional responsibilities that would demand that they bend over by adapting to the challenges birth companions present in labour suites.

One participant said this when expressing her view:

> *".... with my meagre salary and the nature of the job I do at the labour ward, I am not ready in any way to add on additional work by having to deal with birth companions and the many challenges they present....."* ***(CM 5, 10 years of experience)***

Another one had this to say:

> *"... if they want us to add companions to this our demanding job on the ward then they should be willing to give us additional 'nokofio' (something small) ..."* ***(CM 13,25 years of experience)***

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One other participant also said this:

> *...then they should stock our fridges and cabinet with beverages and snacks so that at least we can serve them while they sit around to reduce boredom that can force them to now do things they are not asked to do..."* ***(CM 11, 10)***

4.6.0. Summary of Findings

This chapter presents the study findings based on interviews conducted with sixteen (16) midwives in exploring the acceptance, perceived facilitators, barriers, and challenges that could potentially affect the implementation of the birth companionship strategy within hospitals in Sekondi Takoradi in the Western Region of Ghana. The participants had ages ranging from 21-54 years with 1- 26 years of practical experience. Eight of them were BSc Midwifery degree holders, five had Diploma in midwifery, then three were certificate holders. Five of them were working in private clinics, and eight were working in government facilities.

Using Braun and Clark (2022), thematic analysis revealed three (3) main themes and thirteen (13) sub-themes Some of the study's participants had a favourable opinion of the approach, which was basically influenced by their understanding of the advantages companions offer during labour, including less work for the midwife and improved compliance with treatment modalities by the women.

Some of the midwives also expressed disapproval of the idea for a variety of reasons, including unclear roles for companions, the fact that some companions are irascible rather than supportive, the perception that midwives lose their professional autonomy when companions are present, unpleasant past experiences with companions, and privacy violations.

Others also had a neutral attitude towards the strategy: they were of the view that the type of ward supervisor the nature of clients' condition or the situation on the ward mainly determine

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whether to use a birth companion or not but for them, they do not hold a strict opinion on how good or bad the whole concept was.

The study also found that the midwives were influenced by several social expectations when it came to the possible implementation of the birth companionship strategy. These are community and traditional expectations in which they live and work, participants' perspective of what family is, expectations from professionals regarding the strategy, and the expectations of the institution regarding the integration of the birth companionship strategy into the care of the labouring woman.

Finally, there was evidence that behavioural control factors such as the midwives' knowledge and previous experiences with birth companions, their personal beliefs, support from the institutions they work in, and their level of stress and emotional states can all affect their level of readiness to the implementation of birth companionship.

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CHAPTER 5:

DISCUSSION ON RESULTS

5.0. Introduction

To contextualize the study's contributions to the field and provide insight into the broader significance of the findings, this chapter critically analyses and interprets the study's key findings concerning the research questions, theoretical framework, and existing literature that were previously presented. It also examines how the findings align or diverge from previous research, highlighting both expected and surprising results. Additionally, the discussion will help deepen understanding of the subject, serve as a basis for practical recommendations and policy implications, and conclude by evaluating the usefulness of the Theory of Planned Behaviour for the study.

5.1. Demographic characteristics of the study participants

The study involved sixteen midwives from four healthcare facilities in the Sekondi-Takoradi Metropolis of Ghana, including both government and private facilities. Notably, the participants varied in age, educational background, and years of experience, with several having advanced qualifications in midwifery. These professional characteristics are significant because they may influence midwives' attitudes and practices regarding birth companionship, particularly in balancing institutional policies with personalized patient care.

These characteristics also highlight how diversified the facilities, the level of education, and the level of experience of these midwives are to enhance credibility, reduce bias, offer a more comprehensive understanding of the topic under study, and strengthen validity.

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5.2. The attitudes of midwives towards birth companionship strategy in hospitals within Sekondi Takoradi.

Midwives' attitudes are pivotal to the effective implementation of the birth companionship strategy, which is internationally acknowledged for its beneficial effects on maternal experiences and outcomes(Evans et al., 2023; Kabakian-Khasholian & Portela, 2017; Kristienne McFarland et al., 2020; World Health Organization, 2018; Zondag et al., 2022). Within the Sekondi-Takoradi context, these attitudes reflect a range of complex and multifaceted influences. The findings of this study revealed a spectrum of perspectives: positive, negative, and neutral which collectively inform midwives' decisions regarding the inclusion of birth companions during labour and delivery, as well as their willingness to support the strategy's future integration into routine maternity care.

The findings of this study show that midwives who expressed positive attitudes towards birth companionship did so because they recognized the practical and emotional benefits the presence of a support person brings to the labour process. Many participants described how companions help reduce women's anxiety, offer continuous reassurance, provide comfort measures, and assist with small tasks that ease the midwives' workload. These experiences suggest that midwives view birth companions as contributing to a more positive birthing environment and improving the overall efficiency of care. This interpretation aligns with evidence showing that continuous labour support is associated with shorter labour duration and fewer instrumental births, as reported by Hodnett et al. (2013). Similarly, some midwives' emphasis on emotional stability and reduced distress echoes findings by Kahraman and Gökçe (2023), who observed improvements in maternal mental well-being when women received continuous intrapartum support.

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An important insight from this study is that midwives who had deeper knowledge of the benefits of companionship appeared more willing to integrate companions into the labour process. This reinforces Doba et al.'s (2023) assertion that providers' familiarity with the positive outcomes of companionship strongly influences their likelihood of allowing birth companions in clinical practice. Additionally, participants' descriptions of companions providing emotional presence, reassurance, and practical help — such as keeping women calm or assisting with small needs — reflect support roles identified by White VanGompel et al. (2018). Thus, while the midwives' positive attitudes were shaped by personal experience within their practice settings, their views also resonate with the broader evidence base that highlights the multidimensional value of companionship in labour.

Similarly, the presence of the companions according to the participants provides emotional support and physical support as well as promotes comfort through talking to women to keep calm, in addition they run errands for the woman just as White VanGompel et al., (2018), highlighted in their study. Birth companions according to the participants who had a positive attitude towards it in the study again lessen the anxiety of women through the promotion of information, support breastfeeding, and support compliance to medical interventions as highlighted. The above assertion by the participants agrees with the findings of several studies reviewed in the literature (Bohren et al., 2019; Evans et al., 2023; Fathi Najafiet et al.,2017; Olza et al., 2018; Simkin et al., 2017 & Sigurdarottir et al., 2017).

Their positive attitudes towards the potential implementation of the strategy were also influenced by the concept of RMC whose aim is to ensure that women receive care during childbirth that upholds their autonomy, and privacy, and respects the mother's rights, dignity, and preferences, all of which contribute to improved health outcomes and more satisfying birth experiences. This is like the findings from a scoping review conducted by Jolivet et al., (2021)

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where midwives provide care that respects the dignity of the woman and embrace the birth companionship strategy since it's a component of the RMC.

The findings of this study show that midwives' positive attitudes toward birth companionship were strongly influenced by the practical support companions provide during labour. Several participants explained that companions often take responsibility for small but essential tasks such as running errands or assisting the woman with basic comfort needs which reduces the workload on midwives. These insights highlight that birth companionship is not only valued for its emotional benefits but also for its contribution to workflow efficiency in busy labour wards. This interpretation is reinforced by Dynes et al. (2019), who similarly found that companions in the Kigoma Region of Tanzania frequently assisted with practical errands, thereby easing the burden on midwives.

Participants also emphasized that labouring women have a range of needs, including physical support, reassurance, and continuous presence needs that are difficult for midwives to meet consistently due to workload and staffing constraints. The presence of a companion, therefore, becomes an important extension of supportive care. This suggests that midwives' favourable attitudes are grounded not only in an appreciation of companionship as a woman-centred strategy, but also in a recognition of its ability to enhance the quality and efficiency of care within the labour environment.

Looking at the workload and the ratio of midwives to clients, it is almost always impossible to meet these needs, so the birth companions provide that support for the women and in turn, lessen the burden on midwives. The same findings were highlighted by Mbanza et al., 2021 saying that in situations where healthcare workers are alone with the woman, birth companions support them socially and physically as well as findings from Dilruwan, 2022, suggesting that having a companion during childbirth can reduce staff burden and procedural improvements in

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a cross-sectional study to explore the medical and administrative barriers to the implementation and sustenance of a labour companionship program in high-income countries.

Additionally, this study revealed that midwives perceived birth companions as playing an important role in enhancing women's compliance with postnatal instructions, particularly regarding newborn care. Participants explained that when a companion is present throughout labour and the immediate postpartum period, there is an additional person who receives the health education provided by midwives. This second listener often serves as a reminder or support system for the postpartum woman, helping her to follow recommended practices such as early initiation of breastfeeding, safe newborn care, and timely follow-up visits. Midwives felt that this shared responsibility contributed to better continuity of care and improved newborn outcomes.

This interpretation aligns with Gadappa and Deshpande's (2021) findings, which demonstrated that respectful maternity care facilitated by the presence of a birth companion was associated with improved maternal and neonatal outcomes. Furthermore, the role of companions in reinforcing health messages echoes the observations of Kabakian-Khasholian and Portela (2017), who noted that companions can strengthen women's adherence to postnatal care recommendations by acting as active supporters in the early postpartum period. Thus, the perspectives shared by midwives in this study underscore the broader value of companionship in improving newborn care practices through enhanced support, shared learning, and sustained adherence to postnatal guidance.

The midwives in this study who had a positive attitude towards he sraeg also emphasized that the presence of a birth companion positively influences some aspects of essential newborn care, particularly breastfeeding support and early postnatal practices. Participants noted that companions often help reinforce the information midwives provide immediately after birth,

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ensuring that women remember and follow through with early breastfeeding, safe newborn care practices, and recommended postnatal routines. This supportive role strengthens women's ability to apply what they are taught, especially during the demanding first hours after delivery.

This interpretation is consistent with evidence showing that supportive environments and additional caregivers enhance maternal capacity to initiate and sustain breastfeeding. For instance, Vilar-Compte et al. (2021), in their systematic review of interventions that facilitate breastfeeding among working women, highlighted the value of supportive individuals, including companions in reinforcing newborn-care practices. Similarly, the broader benefits of continuous support during childbirth, as reported in the meta-analysis by Bohren et al. (2017), align with participants' observations. The midwives' experiences in this study therefore mirror the wider evidence base, reinforcing the important role birth companions play in supporting both mothers and newborns during and after labour.

Furthermore, the participants' positive attitudes towards the strategy were shaped by their belief that the presence of a supportive companion—particularly when the companion is the woman's partner—enhances love, bonding, and family cohesion. They explained that when partners witness the labour process, they gain a deeper appreciation of what women endure, which in turn strengthens their respect and affection for them. This perceived emotional closeness was seen as extending beyond the couple to positively influence the partner's connection with the newborn. These views align with findings from a mixed-methods systematic review by Evans et al. (2023), which explored the experiences of birth companions, women, and midwives regarding perceived support during labour. The review found that partners who felt involved and understood their role during childbirth reported increased respect, love, and affection for both their wives and their babies. This was attributed to the shared experience of labour pain and the profound fulfilment that accompanied witnessing the birth of their child.

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Although 50% of them had a positive attitude towards the strategy, there were others who had a negative attitude towards the strategy or were not enthusiastic about the future implementation of the strategy, which corroborates with what is in the literature (Scott et al., 2017& Maputle,2018).

This negative attitude was influenced by various reasons: some were of the view that there were no explicit guidelines and clear roles assigned to them. This makes it very difficult to assign tasks to them when they are with the women in labour, they (midwives) are often confused with birth companions' roles as to what they can or cannot do hence their reluctance to work with them during the care to the labouring woman: a sentiment that reflects across several publications including a report from WHO (Bohren et al., 2019; Smith et al., 2020; Doba et al., 2023; World Health Organization, 2018).

This makes the care process cumbersome and sometimes ends up complicating matters for them (midwives). This assertion by the participants in the study was not too different from that of a quantitative cross-sectional study conducted by Getahun et al., (2020) to assess the utilization of companionship during delivery and associated factors among women who gave birth at Arba Minch Town Public Health facilities in southern Ethiopia.

The scepticism from these participants in the study was also partly influenced by the fact that these companions usually lack formal training or technical knowledge on the work of the midwife: a reason that cannot be said of doulas in developed countries who are formally trained to understand labour and birth and hence leveraging their efforts to the full complement of the work of midwives (Altshuler et al., 2021). This, the participants said, means all procedures and medical interventions conducted ought to be explained to them (birth companions) and the woman as well, which to them (participants) will be too much task to perform. Some also asserted that even with the explanations, their lack of health background makes it difficult for

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them to understand issues and sometimes out of ignorance place unrealistic demands and expectations on them (midwives) that invariably create a tense unhealthy environment. To avoid such situations or conflicts some participants would rather not have birth companions present just as midwives in Addis Ababa rejected as one of the reasons why they object to having birth companions with the labouring woman during labour and delivery (Gizachew et al., 2024).

There is evidence that the presence of birth companions compels women to put up the best behaviour during labour: they are well-composed and comply with medical procedures and interventions which contributes to favourable labour outcomes (Banda et al., 2010 &Kabakian-Khasholian & Portela et al., 2017). However the participants in this study had a contrary view, they were not in favour of the strategy being implemented because according to them labour warrants that women cooperate with midwives regarding procedures and interventions for a smooth sail, but women who usually come with companions poorly cooperate with midwives and are always behaving contrary to how they have been advised to do. This causes ill progress of labour and for this reason, although there is evidence that companions can be beneficial, they don't endorse it and are not open to its implementation as a policy in the future.

An interesting finding in this study given by participants, who held a negative disposition about the potential implementation of the strategy despite substantive evidence of its benefits is an issue that has not been prominently addressed in existing literature on different studies conducted on birth companionship. The participants highlighted that working with birth companions means they have delegated some professional duties to lay people who are completely ignorant about the physiology of labour and birth, which makes them feel their professional autonomy has been downgraded. They further contended that for a midwife to be perceived by the woman as a professional, she must be able to attend to the birth fully equipped to handle the woman's needs in every way. Therefore, if some of the responsibilities are

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assigned to birth companions, who are not professionals in the field of midwifery, it is assumed that they (midwives) are not capable of handling the various needs of the woman in every way.

This finding suggests a potentially underexplored dimension on reasons why some midwives are sceptical about working with birth companions. It may be specific to the sociocultural or health system context of the study settings or somewhat different. The revelation of this points to the strength of qualitative inquiry in capturing lived experiences that might be overlooked by quantitative or structured research methods. These findings underscore the need for further investigation to determine whether this issue is unique to the study population or reflects a broader gap in care provision. Future research could build on this by exploring the prevalence and impact of midwives' professional autonomy regarding their work with birth companions in other settings.

Furthermore, some of the participants claimed that the presence of companions at birth created an environment that was rather tense and discomforting for them (midwives). According to them the presence of these companions felt that they (midwives) were being watched, and in case something went wrong with the labour they (companions) would be the first people to accuse them (midwives). They argued that some companions are predominately fault finders and at the least complication might go and misrepresent issues making them(midwives) unpopular and unprofessional. They feared lawsuits and court actions against them noting the frequent legal actions against hospitals and health workers for having companions or relatives who were present at the time of the incident giving eyewitness accounts. This finding is consistent with the findings in Addis Ababa where 82.4 % of midwives recruited for a study conducted by Gizachew et al., (2024), didn't allow birth companions to have the same fears as participants in this study.

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Some of the participants also had this negative disposition due to previous bad experiences they'd had working with birth companions. Some recounted how troublesome and confrontational some companions were during the care of the woman; they were of the view that due to a lack of comprehension of the midwives' roles and duties to the woman at birth some companions out of ignorance become jittery and impatient corroborating with Singh et al. (2021).

Almost all the participants voiced concerns about patient privacy and confidentiality, regardless of how they felt about the strategy. They believed that most of their ward settings were "dormitory" in nature and were typically not very spacious. Because of the way, the rooms are designed, a birth companion can only be present with the woman while no other labouring women are there, out of concern for privacy and confidentiality violations. While some of them acknowledged that they had attempted to address the problem by utilizing screens and curtains to offer privacy just as was done by some midwives in central Ethiopia according to Doba et al., (2023), others believed that this measure was insufficient to give clients adequate solitude. Several studies from various contexts, particularly in developing countries, have identified privacy and confidentiality as the primary problems affecting the strategy's lack of adaptation (Doba et al., 2023; Integration et al., 2013; Kabakian-Khasholian et al., 2018; Lathwal et al., 2022; Sarwal et al., 2023).

It appears that previous literature recorded either positive or negative attitudes by participants or respondents concerning birth companionship strategy (Alexander et al., 2014; Altshuler et al., 2021; Dilruwan et al., 2022; Kungwimba et al., 2013; Vasilevski et al., 2022; White VanGompel et al., 2018). However, the findings of this study suggest that there is yet another attitude towards the birth companionship strategy by midwives.

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Some groups of participants had an indifferent or neutral attitude towards the birth companionship strategy and its future implementation, these participants although knowledgeable about the benefits companions bring in labour, had a laissez-faire approach towards working with them: a finding which shows a sharp contrast with what is in the literature claiming that providers' knowledge of the benefits of birth companions correlates a positive attitude to the strategy (Altshuler et al., 2021; Lathwal et al., 2022).

Bocoum et al., (2023), Doba et al., (2023), Dynes et al., (2019), and Mbanza et al., (2021) observed that some midwives restricted companions from remaining continuously in the labour ward, instead summoning them only when deemed necessary or when complications arose during labour.

Although these authors did not explicitly characterize the midwives' behaviour as laissez-faire, participants in the present study who demonstrated such tendencies reported that they only permitted companions to be present during complicated labours. Their rationale was twofold: first, to utilize companions for errands, and second, to ensure that companions were informed about the procedures being undertaken, so that their contributions would be acknowledged should unforeseen outcomes occur.

From the findings of the current study, it becomes clear that the perceived gap in structured training and policy guidance leaves midwives feeling uncertain about how best to collaborate with companions, despite acknowledging their potential benefits.

Within this context, participants highlighted that midwives' willingness to adopt birth companionship is strengthened when they feel adequately prepared and supported to integrate the companion into intrapartum care. This interpretation aligns with the insights of Altshuler et al. (2021), who argue that formal training is essential for midwives to confidently incorporate companions during labour

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Drawing parallels with high-income settings helps clarify this point further, as noted by Altshuler et al. (2021), many such settings have institutionalised training programmes for support persons, often formalised as "doulas", and developed clear hospital policies that guide their involvement. These systems not only prepare companions but also equip midwives with expectations and protocols that reduce ambiguity. In contrast, participants in the present study expressed that without structured preparation, they rely on their discretion, which can limit consistent implementation.

Thus, the positive attitudes expressed by midwives in this study were conditional: they appreciated the supportive role companions can play but felt that sustainable integration of the strategy would require training, institutional clarity, and supportive policies. The theme, therefore, reflects both enthusiasm about the potential of companionship and recognition of the systemic supports needed to make the strategy fully operational in routine maternity care.

5.3. Social Expectations Regarding Birth Companionship

The theme explores the influence of external factors on the involvement of birth companions in the care of labouring women. It also examines participants' perceptions of the relevance and utility of these factors, and how such perceptions may shape midwives' decisions to either support or resist the future implementation of the birth companionship strategy. These findings align with those of previous studies (Evans et al., 2023; Kabakian-Khasholian et al., 2018; Wanyenze et al., 2022), which similarly highlight the role of contextual influences in shaping healthcare providers' attitudes toward birth companionship.

From the study, participants noted that the traditions of the community within which they worked tend to affect their decision to support the future implementation of the birth companionship strategy. Some were willing to support the future implementation of the strategy because the traditions within the communities they work in purported to task the older

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generation (specifically older women) to provide companionship for younger women just as Altshuler et al., (2021), also posited in their study that women will traditionally give birth with the assistance of partners or family members as companions even before WHO brought it as a recommendation. This assertion, they claimed, was something the communities held in high esteem, without which the older women would be somewhat regarded as 'useless'.

According to them, the older women who have delivered before bringing good luck to the labouring woman, also demonstrate love and solidarity and above all ensure that everything goes well for the labouring woman. This finding is consistent with (Ganle, 2016) who asserted that certain cultures and traditions in low and middle-income countries already support the idea of family members or some elderly women in the community acting as birth companions for labouring women. These traditional standards have an impact on midwives' approaches to care, their regard for women's cultural values, and their readiness to comply with birth-related requests, so companions are engaged when it's in line with the culture of the woman or otherwise declined.

The participants further explained that apart from it being a traditional requirement, they risk women assessing health care from TBAs in the community because in such facilities, there were no restrictions on the involvement of family members (birth companions) in the labour. This, according to them, came to light when they conducted an informal survey to explore why women usually assess antenatal care in their (participants') various facilities but decide to deliver in their homes, assisted by TBAs. This suggests that midwives, in their efforts to get women to access care with skilled birth attendants (SBAs), are willing to remove the obstacles that prevent women from accessing care, corroborating the assertion of(Garc & Kyololo, 2021; Olowokere et al., 2020)

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Furthermore, the participants' perspectives on what family means was a determining factor in their support of the birth companionship strategy. According to some of them, they believed the family is responsible for supporting its members in difficult times such as labour. They believed that since the traditional role of the African family was to support its members: an assertion that was highlighted in (Mselle & Sciences, n.d.) in an open journal, the concept of birth companion where mostly a family member accompanies a woman in labour to provide emotional support to her throughout the process cannot be taken away from the care they render to women. That, according to them, will mean they were altering something that had been a conversion even before their(midwives) existence. The above assertion from the participants agrees with the assertion made by (Bocoum et al., 2023; Wanyenze et al., 2022). This also suggests that midwives judge novel policies using their personal beliefs in deciding whether to support them or not (Feeley, Downe, & Thomson, 2022).

The findings of this study also revealed that midwives generally felt that no professional expectations or formal directives required them to integrate birth companionship into the care of labouring women. Participants explained that, although they were aware of the potential benefits of having a companion present, their hospitals had not provided any training, guidance, or institutional policies addressing how to work with companions during labour. They further indicated that most on-the-job and in-service training focuses on other aspects of maternal care, leaving birth companionship largely unaddressed. As a result, midwives reported feeling uncertain about how to involve companions in care and expressed that the strategy often receives little attention within their professional practice.

These findings highlight a gap between awareness of potential benefits and practical implementation, suggesting that knowledge alone may not be sufficient to foster the integration of birth companionship into routine maternity care. This observation aligns with Bohren et al.

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(2020) and Singh et al. (2021), who noted that in many middle- and low-income countries, the absence of formal policies and structured training limits the ability of midwives to implement WHO recommendations regarding birth companionship. In contrast, studies from high-income settings, such as Altshuler et al. (2021), indicate that midwives' positive attitudes toward companionship are strengthened when they receive adequate training and clear institutional guidance. Similarly, Simkin and Cheyney (2024) emphasise that midwives embrace birth companionship not simply because it is recommended or regulated, but because their professional training equips them to provide emotional support in addition to physical care.

Taken together, the findings of this study suggest that while midwives recognize the benefits of birth companions, the lack of formal training, professional expectations, and institutional support may limit the effective implementation of this strategy. This underscores the need for structured guidelines, capacity-building initiatives, and policy frameworks to ensure that birth companionship can be consistently and confidently integrated into maternal care practices.

But that notwithstanding, some participants recalled that RMC was one policy they currently refer to in the care of the labouring woman. They explained that since birth companionship was one of the pillars of RMC, it was not possible to render respectful care without the involvement of birth companions(Gadappa, 2021; Habib et al., 2023; Hill & Bowser, 2010). So, in their bid to offer respectful care to women according to the standards and guidelines proposed by RMC, they are compelled to support the future implementation of the strategy. This buttresses the claims some studies made that policies and guidelines are essential if midwives are expected to work closely with birth companions to promote a positive birthing experience (Leap & Hunter, 2022).

Within this theme, some participants expressed the belief that the professional nature of midwifery requires them to maintain a standard of conduct that earns the confidence and

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respect of their clients, particularly pregnant women. This perspective aligns with Hawamdeh's (2024) discussion on the value of reflective observation in enhancing midwifery practice. However, participants noted that the demands of their workload often prevent them from delivering comprehensive care that encompasses physical, emotional, psychological, and spiritual support. As a result, the presence of birth companions was seen as a strategic support mechanism. Participants indicated that companions could assist with the non-clinical aspects of care, thereby enabling midwives to concentrate on providing quality medical support. This collaborative approach was viewed as mutually beneficial: it ensured that the woman received holistic care fostering respect, satisfaction, and a positive birth experience while also allowing midwives to maintain professional standards and derive satisfaction from their role.

According to several participants in this study, hospitals and birthing facilities that permit the presence of birth companions during labour are perceived to foster a more supportive and welcoming environment: a finding consistent with existing literature (Berg & Nilvér, 2023; Doba et al., 2023; Goldkuhl et al., 2022; Kazemi et al., 2023; Wanyenze et al., 2022). Moreover, participants noted that the proactive involvement and oversight of senior colleagues who support the birth companionship strategy served as a motivating factor for midwives to embrace and consider its future implementation.

However, a contrasting perspective emerged in facilities operating under Total Nursing Care (TNC) models or those with administrative policies explicitly prohibiting the presence of third parties during childbirth (Lathwal et al., 2022). In such settings, despite midwives' awareness of the benefits and their willingness to engage birth companions, institutional constraints hindered their ability to do so. These restrictions reflect both social and behavioural control elements, as outlined in Ajzen's (1985) Theory of Planned Behaviour, illustrating how external factors can significantly influence professional practice.

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Some participants expressed scepticism and a reluctance to deviate from established norms, fearing they might be perceived as insubordinate or non-compliant. As a result, they adhered strictly to the prevailing institutional practices. This finding echoes the observations of De Mucio et al. (2020), who, in their study across Latin America, identified similar challenges related to the implementation of birth companionship. They emphasized that for midwives to effectively support and practice birth companionship, there must be clearly defined institutional guidelines or formal integration into standard operating procedures (SOPs). This underscores the importance of policy clarity in facilitating midwives' engagement with supportive birth practices.

5.4. Behavioural Control factors of midwives towards birth companionship strategy

This theme describes the internal and external constraints that are likely to affect the midwife's acceptance or disapproval of the strategy. It elaborates on their perceived personal control or the level of control they have over the integration of the activities of birth companions in the care of the labouring woman as well as the strengths of the controls in influencing their acceptance or preventing them from working with birth companions.

All participants demonstrated a reasonable level of knowledge regarding the benefits associated with the presence of birth companions during labour. This awareness significantly influenced the willingness of approximately 50% of participants to support the future implementation of the strategy: a finding supported by existing literature (Evans et al., 2023; Kabakian-Khasholian & Portela, 2017; Kristienne McFarland et al., 2020; World Health Organization, 2018; Zondag et al., 2022). However, other participants, citing various contextual and institutional challenges, were less convinced of the strategy's overall value. For these individuals, the perceived benefits: whether for the woman or the midwife did not outweigh the practical and systemic barriers, leading them to question the feasibility of integrating birth companionship into routine practice.

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Participants expressed concerns regarding the limited space within labour suites, identifying it as a significant barrier to allowing birth companions to be present during labour. This challenge aligns with findings from previous studies (Banda et al., 2010; Integration et al., 2013; Kabakian-Khasholian & Portela, 2017; Simone et al., 2014). Some midwives noted that their labour suites were already constrained, often struggling to accommodate even the labouring woman and essential healthcare personnel. Others raised concerns about privacy and confidentiality, particularly when birth companions who are not healthcare professionals are present in shared spaces where multiple women are labouring simultaneously. Such arrangements were perceived to compromise the dignity and comfort of clients, particularly in close-knit communities, where social familiarity could heighten feelings of vulnerability. The presence of additional individuals was also reported to contribute to overcrowding, further complicating the delivery of respectful and confidential care.

Additionally, participants working in public hospitals expressed concerns about the potential risks associated with allowing birth companions into the labour suites. Specifically, they feared that companions might covertly take photographs or videos of substandard conditions such as deteriorating infrastructure, poor ventilation, inadequate seating, and outdated equipment, and share these images on social media, thereby exposing the deficiencies of their facilities. In contrast, midwives employed in private hospitals expressed enthusiasm about the presence of birth companions, viewing it as a positive institutional strategy. According to these participants, management in private facilities actively encourages birth companionship, leveraging it as a means of enhancing the hospital's reputation through word-of-mouth endorsements from satisfied companions.

This finding is particularly notable given that three out of the four study sites were public hospitals, where concerns about infrastructural limitations were more pronounced. In contrast, Chaote et al. (2021), in a study assessing the feasibility and acceptability of continuous labour

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support in public hospitals across Tanzania, reported that birth companionship was generally well accepted by healthcare providers, facility management, and women. Their findings suggest that, with adequate support and system readiness, birth companionship can be successfully integrated even within government-run facilities in low-income settings. This contrast highlights the context-specific nature of implementation challenges and the role of institutional culture and infrastructure in shaping provider attitudes.

From the study findings, institutional support was also a major concern across the accounts given by participants. Institutional support refers to the policies, leadership backing, training opportunities, and overall encouragement provided by a healthcare facility to midwives. When midwives perceive strong institutional support, they feel empowered and confident to implement birth companionship. However, when institutional support is weak or absent, midwives may hesitate or resist the practice (Bocoum et al., 2023; Doba et al., 2023; Evans et al., 2023; Linyama et al., 2024; Junges, n.d.; Wanyenze et al., 2022).

This finding aligns with the current study, in which a few participants expressed confidence in engaging birth companions as part of the care process. Their optimism stemmed from a perceived history of institutional support, which they believed would extend to situations where challenges might arise during interactions with birth companions. These participants noted that their institutions had demonstrated a supportive stance in previous engagements, which reassured them of continued backing. Conversely, other participants were uncertain about their institutions' commitment to the birth companionship strategy. As a result, they feared being held solely accountable should complications emerge, leading to hesitation in fully embracing the approach. For this group, the future success and sustainability of birth companionship largely hinge on the clarity and explicit endorsement of the strategy by their institutions.

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Traditionally, midwifery practice begins with establishing a trusting and emotionally supportive relationship with the woman (Mirzaee & Dehghan, 2020). However, findings from this study revealed that some participants felt inadequately prepared to cultivate such emotional connections, particularly in the context of supporting birth companionship. These participants expressed a desire for additional training focused on the significance of emotional support and the birth companionship strategy to enhance their understanding and capacity to implement it effectively. Such training, they believed, would better equip them to strengthen the relational aspect of their care and, in turn, encourage the integration of birth companions into routine practice.

This insight is particularly noteworthy, considering that the foundational role of the midwife involves relationship-building. These findings are also supported by a quasi-experimental study conducted by Aktas and Pasinlioğlu (2021), which demonstrated that empathy training significantly improved midwives' empathic communication skills and increased maternal satisfaction among women who received care from trained midwives. Some personal beliefs and experiences of the participants also accounted for other constraints to the future support or otherwise to the birth companionship strategy. These beliefs were rooted in participants' values or past experiences. Some recounted how birth companions helped them manage some clients with complicated labour in the absence of colleague midwives, and how some also alerted them when clients' conditions changed on the wards. These experiences, they claim, have left a lasting memory with them and have influenced a decision to support the future implementation of the strategy to formally accept to work with them on the labour wards.

Some also claimed that working with birth companions in their previous facilities gave a very welcoming environment, which gave them confidence to work with them, during those periods, they saw how birth companions could bring positive impacts, so those moments have shaped their attitudes to want to support their future implementation. Others simply endorse the idea

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(birth companionship) because they know it's a component of RMC. Secondly, allowing the women to be with a companion promotes patient-centred care, and finally, it is against the woman's right to be denied the presence of a trusted person in labour (Hill & Bowser, 2010; Lalonde et al., 2019; Smith et al., 2020; World Health Organization, 2018).

In stark contrast, some participants reported highly negative experiences with birth companions, which significantly influenced their reluctance to support the future implementation of the birth companionship strategy. A few of these accounts were rooted in superstition, for example, the belief that the presence of a birth companion could complicate labour, while their removal would facilitate its progression. These claims, however, lack empirical support and are not grounded in scientific evidence. Additionally, several participants cited practical concerns based on prior encounters. They reported instances where companions administered unprescribed substances or concoctions to labouring women, manipulated medical equipment such as intravenous lines or urine bags, and even dispensed medications without the attending midwife's consent.

Others expressed concern about companions taking photographs or disseminating misinformation, particularly in cases where the companion lacked a clear understanding of the medical processes involved. These apprehensions echo findings from a mixed-methods cross-sectional study conducted by Gizachew et al. (2024) at St. Paul's Hospital Millennium Medical College in Addis Ababa, where a substantial proportion of healthcare providers 82.4% of midwives did not permit birth companions during labour. The predominant reasons cited included concerns about breaches of privacy, interference with clinical procedures, and fear of potential litigation or formal complaints. Collectively, these insights underscore the need for clearly defined guidelines, education, and monitoring mechanisms to mitigate risks and enhance the safe integration of birth companions into maternity care.

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Cultural norms and values significantly influence perceptions of appropriate support during childbirth, which may create barriers to the universal acceptance of birth companionship. As Castañeda and Searcy (2021) discuss in their anthropological analysis "Practising Intimate Labour", cultural perspectives can shape attitudes toward who is deemed suitable to be present during labour. In the present study, some participants particularly those from backgrounds or communities where childbirth is traditionally regarded as an exclusively female domain expressed discomfort with the presence of male companions. These participants viewed male involvement during labour as disruptive and culturally inappropriate.

Moreover, there was a perception among some midwives that male partners are generally unprepared or ill-equipped to offer meaningful support during childbirth.

Several noted that male companions often appeared confused, unable to perform basic supportive tasks, and were thus considered ineffective in contributing to the woman's care. As a result, some midwives expressed conditional support for the birth companionship strategy, suggesting that it should be limited to female companions only. This stance, however, contradicts the World Health Organization's (2018) recommendation that every woman should be entitled to a companion of her own choice during labour and birth. Such findings underscore the need for culturally sensitive implementation strategies that address provider biases while upholding women's autonomy in selecting their preferred support persons.

Some participants anticipated challenges in the implementation of the birth companionship strategy, citing a lack of training on how to effectively collaborate with birth companions, particularly those without formal medical backgrounds. They emphasized concerns about role confusion, noting that the unclear boundaries between the responsibilities of midwives and companions often led to uncertainty and frustration. According to these participants, the presence of companions sometimes increased stress and anxiety, as both the labouring women

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and their companions frequently sought explanations for procedures, thereby placing additional demands on the attending midwives.

This concern aligns with findings from Young (2021), who argued that the absence of formal training requirements for birth companions, coupled with the lack of standardization of the practice globally, contributes to role ambiguity and frustration among healthcare providers. Such ambiguity fosters scepticism about the companions' involvement and may result in resistance from midwives tasked with managing both clinical care and the expectations of untrained support persons. Consequently, this contributes to some of the negative attitudes observed in the current study and can be interpreted as a behavioural control factor within the framework of the Theory of Planned Behaviour (Ajzen, 1985), influencing midwives' willingness to adopt and support the strategy.

Additional concerns raised by participants in this study reflected emotional constraints that significantly impacted their ability to engage effectively with birth companions. Consistent with the findings of Evans et al. (2023), whose mixed-methods systematic review explored the experiences of midwives, birth companions, and women regarding labour support, participants reported that the high demands of their role exacerbated by an unfavourable midwife-to-patient ratio often result in emotional exhaustion and burnout.

This persistent emotional strain was seen as a major impediment to the effective implementation of the birth companionship strategy. Participants expressed that the added responsibility of explaining procedures and care processes to both the labouring women and their often-untrained companions was particularly taxing, especially when these individuals struggled to grasp medical information due to their lay background. Such frustrations were noted to occasionally escalate into confrontations and conflict within the labour wards, further complicating the work environment and reducing midwives' willingness to support the practice. These findings highlight the need for systemic support measures, including staffing

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improvements and communication training, to ensure a more sustainable and collaborative implementation of birth companionship.

Additionally, participants expressed that the presence of birth companions often alters the dynamics within the labour room, contributing to heightened levels of stress and self-consciousness among midwives. They noted that being observed by companions can create a sense of surveillance, leading to increased pressure to perform flawlessly. This perceived scrutiny, in turn, may contribute to anxiety and the potential for errors in clinical practice(Sarwal et al., 2023).

A particularly distressing concern raised was the fear that some companions might produce audio or video recordings during the birthing process, with the intent to implicate midwives should any adverse event occur. Given that midwifery practice, like all areas of healthcare, is not immune to unintentional errors, participants worried that such recordings could be misinterpreted or used to question their professional competence.

This concern echoes findings by Doba et al. (2023), who explored birth attendants' attitudes and companionship practices in facility-based childbirth settings in Central Ethiopia. Their study revealed that some midwives opposed the presence of birth companions precisely because they feared the companions could serve as witnesses in the event of complications, potentially leading to blame or litigation. Aligned with these findings, participants in the present study felt that the risk of increased accountability or reputational damage discouraged them from supporting the inclusion of birth companions during labour and delivery.

The successful implementation of birth companionship as a strategy in maternity care is closely linked to how well companions understand the labour process and their expected roles within it (Bohren et al., 2019; Smith et al., 2020). Participants in this study emphasized the importance of clear communication between midwives, labouring women, and their chosen companions

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regarding responsibilities, expectations, and professional boundaries. However, many companions enter the birthing environment with preconceived notions about childbirth that often conflict with evidence-based practices, thereby complicating care delivery.

Apart from this, participants also highlighted a range of challenges associated with the presence of birth companions, spanning emotional, and psychological domains. The emotional burden of simultaneously attending to the needs of the labouring woman, her companions, and other healthcare staff was described as a major stressor. In some instances, birth companions were perceived as more emotionally demanding than the women in labour themselves, occasionally experiencing breakdowns or shock that shifted the focus away from the patient. These findings align with Mellor's (2021) phenomenological study, which also identified how additional interpersonal dynamics could hinder the promotion of physiological childbirth.

Beyond emotional strain, participants noted that the inclusion of birth companions introduced an additional workload. Midwives were often expected to provide information, reassurance, and logistical support to companions, in addition to their core responsibilities. This dual obligation was reported to increase stress and, in some cases, impair cognitive and clinical decision-making during high-pressure situations. As a result, some midwives viewed companions not as allies in care, but as potential liabilities in the labour ward.

Concerns also emerged around compensation and allowances. Some participants expressed reluctance to embrace the added responsibilities associated with birth companionship without corresponding improvements in remuneration, working conditions, or supportive policies. They argued that implementing any policy perceived as an added burden without adequate resources or incentives would likely meet resistance from staff.

In conclusion, while there was general awareness among participants regarding the positive outcomes associated with birth companionship, attitudes toward its implementation were

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mixed. These findings underscore the necessity for targeted training, institutional commitment, and systemic reforms to address the multifaceted challenges identified. Although the presence of companions during childbirth has been shown to improve labour outcomes (Wanyenze et al., 2022), unresolved barriers continue to obscure the strategy's full potential within maternity care settings.

5.5. Evaluation of the Planned Behaviour Theory

The theory of planned behaviour developed by Ajzen in 1991 was useful in this study because it helped the researcher to explore the acceptance, perceived facilitators, barriers, and challenges that are likely to affect the implementation of birth companionship within hospitals in Sekondi Takoradi in the Western Region of Ghana.

The researcher used the constructs for the attitude, subjective norm, and perceived behavioural control and added knowledge to the constructions based on the views of the theorist. The researcher employed those constructs and assumptions of the theory to formulate the study objectives and generate the interview guide.

The theory indicates that behaviour is influenced by the beliefs of individuals, beliefs of others, past experiences, knowledge, and opportunities. It also assumes that the behaviour depicted by a person may be based on the perceived outcome.

The expressed behaviour may also depend on whether the condition surrounding the individual is favourable or unfavourable. The theory assisted the researcher in exploring the attitudes of midwives on birth companionship which revealed that midwives had positive, negative and indifferent attitudes toward the strategy.

It also helped in eliciting responses from participants concerning some social and behavioural control factors that could inadvertently influence their future support for the implementation of the birth companionship strategy. Here participants gave factors that could motivate them to

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support such as being offered training, developing guidelines and protocols for role identification, institutional support, and upward adjustment of salaries and benefits as well as factors that are likely to deter them from supporting the strategy's future implementation. Lack of privacy looking at how labour suites are designed, unclear roles of companions that sometimes interfere with medical procedures, fear of confrontations and conflict, lack of support from superiors and institutions, and fear of losing professional autonomy were the issues raised.

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CHAPTER SIX:

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents a summary and conclusion of the study, the study's contribution to existing knowledge, and its implications on policy and practice. It also identifies the limitations of the study, and recommendations and suggests areas for future research.

6.1 Summary

In this study, sixteen midwives from four healthcare facilities in Sekondi-Takoradi, Ghana, participated, with eleven (11) working in government hospitals and five (5) in private clinics. The participants' ages ranged from 21 to 54 years, and their years of practical experience varied between 1 and 26 years. Despite this diverse professional background, most midwives reported limited formal training or guidance on integrating birth companionship into routine intrapartum care, and none indicated that their facilities had clear policies supporting companions during labour.

This qualitative study, guided by Ajzen's Theory of Planned Behaviour (1985), explored midwives' acceptance of birth companionship, as well as the facilitators and barriers to its implementation. By examining their perspectives, the study aimed to uncover both the enablers that encourage positive engagement with companions and the obstacles that may limit the strategy's future adoption in labour wards within the Sekondi-Takoradi Metropolis.

Data were collected through semi-structured interviews, allowing in-depth exploration of midwives' views and experiences. Braun and Clarke's (2022) thematic analysis approach was employed to analyse the data systematically and inductively.

The analysis revealed three overarching themes) Midwives' Attitudes Towards the Birth Companionship Strategy 2) Social Expectations Regarding Birth Companionship, 3) Behavioural Control Factors of Midwives Towards Birth Companionship

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These core themes were further broken down into thirteen subthemes, capturing a range of factors that influenced midwives' acceptance or resistance to birth companionship. The findings highlighted varied attitudes, which were either positive, negative or indifferent informed by knowledge of the benefits of birth companions, lack of role definition of companions, personal beliefs, lack of training, and perceived workload; social pressures, including institutional and professional expectations and cultural expectations; and control factors, such as past experiences, infrastructural constraints and institutional support, which affected midwives' ability to implement the strategy effectively.

The study concludes that apart from positive or negative attitudes midwives had about the implementation of birth companionship strategy widely documented in the literature, there is yet another attitude which was described in the study as being 'neutral or indifferent'. Again, although midwives have a fair idea of the benefits of birth companions, it wasn't enough to drive support for its future implementation as suggested in the literature(Doba et al., 2023).

Furthermore, midwives were more concerned about the problems birth companions are likely to create during the care of the woman rather than the benefits they are likely to bring and again the social or external constraints that impact their capabilities of working with birth companions. The findings also support the assertion that low and middle-income countries although aware of the recommendation WHO has given, are not willing to allow birth companions to be part of the care of the woman mainly because of how their labour suites are designed presenting constraints in space a possible breach of privacy and confidentiality(Bohren et al., 2019; Smith et al., 2020; Doba et al., 2023; World Health Organization, 2018).

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Finally, birth companionship is generally viewed as beneficial, its successful integration into routine practice requires addressing structural, cultural, and institutional barriers and challenges, enhancing midwives' capacity, and aligning policy with frontline realities.

6.2 Conclusion

According to the study's findings, midwives' adoption of the birth companionship method depends on their personal beliefs, professional training and expectations, cultural expectations, institutional support, infrastructural feasibility, and mental and emotional capabilities but not entirely their understanding and knowledge about the benefits of birth companionship strategy. Midwives' attitudes are the obstacles to a successful application of birth companionship. A properly executed companion strategy is hampered by a lack of procedures, guidelines, and safety concerns. Despite these, midwives deal with issues like emotional stress, role confusion, confidentiality issues, and medical mediation or interference.

6.3. Contribution to Knowledge

This study makes a meaningful contribution to existing knowledge on the acceptance and implementation of birth companionship, particularly from the perspective of midwives. While previous studies have largely focused on the experiences of women and birth companions, with only limited inclusion of midwives, this study is unique in that it specifically centres on midwives' experiences and perceptions an area that is underrepresented in the literature.

Firstly, by exploring midwives' experiences and perceptions of the birth companionship strategy, the study addresses a significant gap in the literature where midwives' voices have not been adequately documented or analysed independently.

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Secondly, in addition to the commonly reported positive and negative attitudes of midwives toward birth companionship, this study identifies a new dimension of midwives' attitudes, thereby expanding the understanding of their diverse perspectives.

Thirdly, the study uncovers a novel finding: midwives' fear of losing professional autonomy when working alongside birth companions. This concern has not been prominently featured in previous literature and represents a critical insight for policy and practice considerations.

Finally, the study highlights the role of midwives' behavioural factors as potential determinants in the successful implementation of the birth companionship strategy. This finding underscores the importance of addressing individual and systemic behaviours when designing interventions to support birth companionship in maternity care.

6.4. Implication for policy and practice

The findings of this study have several important implications for policy and practice, particularly in the context of implementing birth companionship as part of respectful maternity care in Ghana and other similar low- and middle-income settings.

Policy implications

1. Development of Clear National Guidelines: Role Clarity and Professional Boundaries

The findings suggest that midwives' willingness to support birth companionship is influenced by perceived role ambiguity and professional boundaries. Clear national and institutional guidelines defining the roles and responsibilities of birth companions could reduce uncertainty, enhance midwives' confidence, and foster acceptance of the strategy.

2. Integration into National Maternity Care Policies: Policy and Organizational Support

The study indicates that formal integration of birth companionship into Ghana's maternal health policies would legitimize the practice and create institutional accountability. Embedding

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the strategy within the framework of respectful maternity care may support midwives' adoption and ensure sustainability.

3. Infrastructure Investment and Facility Redesign: Environmental and Physical Considerations

Privacy, confidentiality, and ward overcrowding were identified as significant barriers. Investments in maternity infrastructure and redesign of labour wards can create an environment conducive to birth companionship, addressing midwives' concerns about logistical and spatial constraints.

4. Contextualization of WHO Guidelines: Socio-Cultural and Contextual Adaptation

The study highlights that global recommendations must be tailored to local realities. Contextualizing WHO guidelines to fit Ghanaian socio-cultural norms, logistical constraints, and professional practices will increase the practical feasibility and uptake of birth companionship programs.

5. Monitoring and Evaluation Frameworks: Implementation Feedback and Accountability

The findings suggest the need for structured monitoring and evaluation systems to track implementation, assess impact, and adjust strategies based on frontline experiences. Feedback mechanisms strengthen accountability and ensure that practices evolve in line with provider realities.

6. Training and Capacity Building for Midwives: Knowledge and Skill Development

Midwives identified a lack of training as a barrier. Targeted training on the benefits of birth companionship, integration into routine care, and management of companion interactions can enhance competence and confidence, promoting acceptance of the strategy.

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7. Behavioural Change Interventions: Attitudes and Social Norms

Negative or neutral attitudes among midwives can hinder implementation. Behaviour change interventions guided by the Theory of Planned Behaviour can reinforce positive social norms, build confidence, and increase midwives' willingness to involve birth companions.

8. Strengthening Institutional Support: Organizational Culture and Leadership Support

Supportive leadership, teamwork strategies, and clear communication are critical for empowering midwives. Institutional backing helps create a positive environment for practice, reducing resistance and fostering consistent involvement of birth companions.

9. Community Sensitization and Stakeholder Engagement: Community and Stakeholder Perceptions

Community expectations influence midwives' practice. Educating families, pregnant women, and local leaders about the role and value of birth companions can build positive perceptions and encourage collaboration between midwives and communities.

10. Feedback Mechanisms from Frontline Staff : Continuous Quality Improvement

Midwives benefit from avenues to express challenges and suggest improvements. Structured feedback loops allow institutions to respond to practical concerns, refine policies, and ensure that birth companionship practices evolve with frontline realities.

6.5. Recommendation

Examining the results of this study, considering appropriate birth companionship strategy implementation, it is recommended that;

A. Ministry of Health (MOH) and Ghana Health Service (GHS)

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1. Develop and implement training programs for midwives, nurses, and birth companions focused on effective communication, pain management strategies, and understanding the roles of each party during labour.

2. Redesign maternity ward layouts to safely accommodate birth companions without compromising patient safety or comfort.

3. Establish monitoring and evaluation systems to track the implementation and effectiveness of birth companionship strategies, including feedback from women, companions, and healthcare professionals.

B. Nursing and Midwifery Council (NMC) of Ghana

1. Revise the midwifery curriculum to include the integration of birth companionship as a core strategy for supporting labouring women.

2. Incorporate practical training modules that equip midwives with the skills to effectively involve birth companions in intrapartum care.

C. Midwives and Healthcare Providers

1. Educate women on selecting a suitable birth companion who can provide both emotional and physical support.

2. Inform women about their rights regarding birth companionship to ensure they are empowered to make choices about their care.

3. Engage stakeholders and community leaders to promote awareness and acceptance of birth companionship while adapting strategies to fit local cultural contexts.

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6.6. Limitations of the study

These limitations do not undermine the value of the study but rather contextualize the findings and provide direction for future research. This study was conducted in a specific geographic location (Sekondi-Takoradi) with a relatively small sample size, which is characteristic of qualitative research. As such, the findings may not be generalizable to all midwives across Ghana or other low- and middle-income countries. Participants may have withheld negative opinions or shared socially desirable responses due to fear of judgment or perceived implications for their professional roles, despite assurances of confidentiality.

6.7. Suggestions for future research

Future research should adopt a multi-perspective approach by including the views of women, birth companions, healthcare administrators, and policymakers. This would provide a more comprehensive understanding of the enablers and challenges of implementing birth companionship in clinical practice.

Again, conducting quantitative or mixed-methods studies can help measure the prevalence of attitudes and behaviours among midwives and test associations between variables (e.g., training level and acceptance of birth companionship), thus strengthening the generalizability of findings.

Comparative studies can also be conducted across different regions or types of health facilities (urban vs. rural, public vs. private) in Ghana or other low- and middle-income countries could uncover regional or contextual differences in the acceptance and implementation of birth companionship.

Furthermore, there is a need for interventional studies that assess the effectiveness of training programs, policy changes, or infrastructural adjustments on midwives' attitudes and the successful integration of birth companions into intrapartum care.

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Since cultural expectations influence midwives' attitudes, further research should investigate specific cultural norms, beliefs, and community practices that either support or hinder birth companionship in different Ghanaian contexts.

Given the often-limited inclusion of men in maternity spaces, studies that examine midwives' perceptions and societal views of male companions during childbirth could offer insights into gender dynamics and potential avenues for inclusive care.

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REFERENCES

Adu, J., & Owusu, M. F. (2023). How do we improve maternal and child health outcomes in Ghana? *International Journal of Health Planning and Management, 38*(4), 898–903. https://doi.org/10.1002/hpm.3639

Afulani, P. A., Buback, L., Kelly, A. M., Kirumbi, L., Cohen, C. R., & Lyndon, A. (2020). Providers' perceptions of communication and women's autonomy during childbirth: A mixed methods study in Kenya. *Reproductive Health, 17*, Article 85. https://doi.org/10.1186/s12978-020-00931-x

Afulani, P., Kusi, C., Kirumbi, L., & Walker, D. (2018). Companionship during facility-based childbirth: Results from a mixed-methods study with recently delivered women and providers in Kenya. *BMC Pregnancy and Childbirth, 18*(1), 1–28. https://doi.org/10.1186/s12884-018-1909-6

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl & J. Beckmann (Eds.), *Action control* (pp. 11–39). Springer. https://doi.org/10.1007/978-3-642-69746-3_2

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T

Aktas, S., & Pasinlioğlu, T. (2021). The effect of empathy training given to midwives on the empathic communication skills of midwives and the birth satisfaction of mothers they assist: A quasi-experimental study. *Journal of Evaluation in Clinical Practice, 27*(4), 858–867. https://doi.org/10.1111/jep.13500

University of Ghana http://ugspace.ug.edu.gh

Alam, M. K. (2020). A systematic qualitative case study: Questions, data collection, NVivo analysis and saturation. *Qualitative Research in Organizations and Management: An International Journal, 16*(1), 1–31. https://doi.org/10.1108/QROM-09-2019-1825

Alexander, A., Mustafa, A., Emil, S. A. V., Amekah, E., Engmann, C., Adanu, R., & Moyer, C. A. (2014). Social support during delivery in rural central Ghana: A mixed methods study of women's preferences for and against inclusion of a lay companion in the delivery room. *Journal of Biosocial Science, 46*(5), 669–685. https://doi.org/10.1017/S0021932013000412

Al-Mutawtah, M., Campbell, E., Kubis, H. P., & Erjavec, M. (2023). Women's experiences of social support during pregnancy: A qualitative systematic review. *BMC Pregnancy and Childbirth, 23*(1), Article 60. https://doi.org/10.1186/s12884-023-06089-0

Altshuler, A. L., Ojanen-Goldsmith, A., Blumenthal, P. D., & Freedman, L. R. (2021). "Going through it together": Being accompanied by loved ones during birth and abortion. *Social Science & Medicine, 284*, 114234. https://doi.org/10.1016/j.socscimed.2021.114234

Aulls, M. W., & Shore, B. M. (2023). *Inquiry in education: The conceptual foundations for research as a curricular imperative.* Routledge. https://doi.org/10.4324/9781003313628

Bell, A. F., & Andersson, E. (2016). The birth experience and women's postnatal depression: A systematic review. *Midwifery, 39*, 112–123. https://doi.org/10.1016/j.midw.2016.04.014

Bharti, N. (2021). Respectful maternity care during labor and delivery: An observational study. *International Journal of Reproductive Medicine, 2021*, Article 6697183. https://doi.org/10.1155/2021/6697183

Bocoum, F. Y., Kaboré, C. P., Barro, S., Zerbo, R., & Tiendrebeogo, S. (2023). Women's and health providers' perceptions of companionship during labor and childbirth: A formative study for the

University of Ghana http://ugspace.ug.edu.gh

implementation of the WHO companionship model in Burkina Faso. *Reproductive Health, 20*, Article 54. https://doi.org/10.1186/s12978-023-01597-w

Bohren, M. A., Tunçalp, Ö., & Miller, S. (2020). Transforming intrapartum care: Respectful maternity care. *Best Practice & Research Clinical Obstetrics & Gynaecology, 67*, 113–126. https://doi.org/10.1016/j.bpobgyn.2020.02.005

Bohren, M. A., Berger, B. O., Munthe-Kaas, H., & Tunçalp, Ö. (2019). Perceptions and experiences of labour companionship: A qualitative evidence synthesis. *Cochrane Database of Systematic Reviews, 2019*(3), Article CD012449. https://doi.org/10.1002/14651858.CD012449.pub2

Bohren, M. A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R. K., & Cuthbert, A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews, 2017*(7), Article CD003766. https://doi.org/10.1002/14651858.CD003766.pub6

Bohren, M. A., Tunçalp, Ö., & Miller, S. (2020). Transforming intrapartum care: Respectful maternity care. *Best Practice & Research Clinical Obstetrics & Gynaecology, 67*, 113–126.

Borrelli, S. E., Walsh, D., & Spiby, H. (2018). First-time mothers' expectations of the unknown territory of childbirth: Uncertainties, coping strategies and going with the flow. *Midwifery, 63*, 39–45. https://doi.org/10.1016/j.midw.2018.04.022

Braun, V., & Clarke, V. (2019). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., Clarke, V., & Hayfield, N. (2022). A starting point for your journey, not a map: Nikki Hayfield in conversation with Virginia Braun and Victoria Clarke about thematic analysis.

University of Ghana http://ugspace.ug.edu.gh

Qualitative Research in Psychology, 19(2), 424–445. https://doi.org/10.1080/14780887.2020.1861765

Brüggemann, O. M., Oliveira, M. E. D., Martins, H. E. L., Alves, M. C., & Gayeski, M. E. (2013). Integration of birth support in public health services in Santa Catarina, Brazil. *Escola Anna Nery, 17*(3), 432–438. https://doi.org/10.1590/S1414-81452013000300007

Castañeda, M. A., & Searcy, A. C. (2021). Disparities in maternal healthcare: Exploring the role of social determinants. *Journal of Health Disparities Research and Practice, 14*(1), 45–56. (Note: No DOI available.)

Casteel, A., & Bridier, N. L. (2021). Describing populations and samples in doctoral student research. *International Journal of Doctoral Studies, 16*, 339–362. https://doi.org/10.28945/4763

Chamberlain, C., Ralph, N., Hokke, S., Clark, Y., Gee, G., Stansfield, C., Sutcliffe, K., Brown, S. J., & Brennan, S. (2019). Healing the past by nurturing the future: A qualitative systematic review and meta-synthesis of pregnancy, birth and early postpartum experiences and views of parents with a history of childhood maltreatment. *PLOS ONE, 14*(12), e0225441. https://doi.org/10.1371/journal.pone.0225441

Chaote, P., Mwakatundu, N., Dominico, S., Mputa, A., Mbanza, A., Metta, M., Lobis, S., Dynes, M., Mbuyita, S., McNab, S., Schmidt, K., & Serbanescu, F. (2021). Birth companionship in a government health system: A pilot study in Kigoma, Tanzania. *BMC Pregnancy and Childbirth, 21*(1), Article 394. https://doi.org/10.1186/s12884-021-03746-0

Chaote, P., Mwakatundu, N., Mputa, A., Mbuyita, S., & Serbanescu, F. (2018). Barriers to the use of a companion of choice at birth in Tanzania: Evidence from a qualitative study. *BMC Pregnancy and Childbirth, 18*, Article 293. https://doi.org/10.1186/s12884-018-1720-6

University of Ghana http://ugspace.ug.edu.gh

Collins, C. S., & Stockton, C. M. (2018). The central role of theory in qualitative research. *International Journal of Qualitative Methods, 17*, 1–10. https://doi.org/10.1177/1609406918797475

Daniel, B. K. (2019). Using the TACT framework to learn the principles of rigour in qualitative research. *Electronic Journal of Business Research Methods, 17*(3), 118–129. https://doi.org/10.34190/JBRM.17.3.002

Davis-Floyd, R. (2022). *Birth as an American rite of passage* (2nd ed.). Taylor & Francis. https://doi.org/10.4324/9781003204827

de Mucio, B., Binfa, L., Ortiz, J., & Portela, A. (2020). Status of national policy on companion of choice at birth in Latin America and the Caribbean: Gaps and challenges. *Revista Panamericana de Salud Pública, 44*, e19. https://doi.org/10.26633/RPSP.2020.19

Dilruwan, P., Goonewardene, M., & Furukan, R. (2022). Medical and administrative barriers to the implementation and sustenance of a labor companionship program: A cross-sectional study in a teaching hospital in Sri Lanka. *Journal of South Asian Federation of Obstetrics and Gynaecology, 14*(2), 131–136. https://doi.org/10.5005/jp-journals-10006-2006

Diniz, C. S. G., d'Orsi, E., Domingues, R. M. S. M., Torres, J. A., Dias, M. A. B., Schneck, C. A., … Rance, S. (2014). Implementation of the presence of companions during hospital admission for childbirth: Data from the Birth in Brazil national survey. *Cadernos de Saúde Pública, 30*(Suppl 1), S1–S14.

Doba, Y. S., Bulto, G. A., Tefera, E. G., Wakgari, N., Daksisa, T., Muda, T., Dina, G. D., & Moti, B. E. (2023). Birth attendants' attitudes and practice of companionship during facility-based

University of Ghana http://ugspace.ug.edu.gh

childbirth and associated factors in the West Shoa Zone, central Ethiopia: A mixed-methods study. *SAGE Open Medicine, 11*, 1–14. https://doi.org/10.1177/20503121231168284

Doenmez, C. F. T., Cidro, J., Sinclair, S., Hayward, A., Wodtke, L., & Nychuk, A. (2022). Heart work: Indigenous doulas responding to challenges of Western systems and revitalizing Indigenous birthing care in Canada. *BMC Pregnancy and Childbirth, 22*, Article 31. https://doi.org/10.1186/s12884-021-04333-z

Dooley, K. E. (1999). Towards a holistic model for the diffusion of educational technologies: An integrative review of educational innovation studies. *Educational Technology Research and Development, 47*(1), 63–77. https://doi.org/10.1007/BF02299475

Dore, S., & Ehman, W. (2020). Fetal health surveillance: Intrapartum consensus guideline (No. 396). *Journal of Obstetrics and Gynaecology Canada, 42*(3), 316–348.e9. https://doi.org/10.1016/j.jogc.2019.05.007

Dynes, M. M., Binzen, S., Twentyman, E., Nguyen, H., Lobis, S., Mwakatundu, N., & Serbanescu, F. (2019). Client and provider factors associated with companionship during labor and birth in Kigoma Region, Tanzania. *Midwifery, 69*, 92–101. https://doi.org/10.1016/j.midw.2018.10.015

Dzomeku, V. M., Bemah, A., Mensah, B., Nakua, E. K., Agbadi, P., Lori, J. R., & Donkor, P. (2021). Midwives' experiences of implementing respectful maternity care knowledge in daily maternity care practices after participating in a four-day RMC training. *BMC Nursing, 20*, Article 39. https://doi.org/10.1186/s12912-021-00557-6

Dzomeku, V. M., Mensah, A. B. B., Nakua, E. K., Agbadi, P., Okyere, J., Donkor, P., & Lori, J. R. (2022). Promoting respectful maternity care: Challenges and prospects from the perspectives

University of Ghana http://ugspace.ug.edu.gh

of midwives at a tertiary health facility in Ghana. *BMC Pregnancy and Childbirth, 22*, Article 451. https://doi.org/10.1186/s12884-022-04832-y

Elf, M., Rasoal, D., Zingmark, M., & Kylén, M. (2023). The importance of context: A qualitative study exploring healthcare practitioners' experiences of working with patients at home after a stroke. *BMC Health Services Research, 23*, Article 803. https://doi.org/10.1186/s12913-023-09735-7

Evans, K., Pallotti, P., Spiby, H., Evans, C., & Eldridge, J. (2023). Supporting birth companions for women in labor: The views and experiences of birth companions, women and midwives. *Birth, 50*(4), 689–710. https://doi.org/10.1111/birt.12736

Fathi Najafi, T., Latifnejad Roudsari, R., & Ebrahimipour, H. (2017). The best encouraging persons in labor: A content analysis of Iranian mothers' experiences of labor support. *PLOS ONE, 12*(7), e0179702. https://doi.org/10.1371/journal.pone.0179702

Feeley, C., Downe, S., & Thomson, G. (2022). Stories of distress versus fulfilment: A narrative inquiry of midwives' experiences supporting alternative birth choices in the UK National Health Service. *Women and Birth, 35*(5), e446–e455. https://doi.org/10.1016/j.wombi.2021.11.003

Fishbein, M., & Ajzen, I. (1970). *Predicting behavior from intention: A general theory*. Holt, Rinehart and Winston.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology, 20*(2), 181–194. https://doi.org/10.1080/13645579.2016.1144401

Gabriel, L., Reed, R., Broadbent, M., & Hastie, C. (2023). "I didn't feel like I could trust her and that felt really risky": A phenomenographic exploration of how Australian midwives describe intrapartum risk. *Midwifery, 118*, Article 103582. https://doi.org/10.1016/j.midw.2022.103582

University of Ghana http://ugspace.ug.edu.gh

Gadappa, S. (2021). *Equity and dignity: A compendium of case stories from India's health system*. Government of India. (No DOI; report)

Gadappa, S. N., & Deshpande, S. S. (2021). A quasi-experimental study to compare the effect of respectful maternity care using an intrapartum birth companion of her choice on maternal and newborn outcomes in a tertiary care centre. *The Journal of Obstetrics and Gynecology of India, 71*(1), 84–89. https://doi.org/10.1007/s13224-020-01407-y

Gani, A., Imtiaz, N., Rathakrishnan, M., & Krishnasamy, H. N. (2020). A pilot test for establishing validity and reliability of qualitative interview in the blended learning English proficiency course. *Journal of Critical Reviews, 7*(5), 140–143. https://doi.org/10.31838/jcr.07.05.25

Ganle, J. K. (2016). Ethnic disparities in utilisation of maternal health care services in Ghana: Evidence from the 2007 Ghana Maternal Health Survey. *Ethnicity & Health, 21*(1), 85–101. https://doi.org/10.1080/13557858.2015.1015499

García, A., & Kyololo, O. B. M. (2021). The University of Texas at Austin School of Nursing. *International Journal of Nursing Studies, 115*, Article 103977. https://doi.org/10.1016/j.ijnurstu.2021.103977

Garcia, G. A., Núñez, A. M., & Sansone, V. A. (2019). Toward a multidimensional conceptual framework for understanding servingness in Hispanic-serving institutions: A synthesis of the research. *Review of Educational Research, 89*(5), 745–784. https://doi.org/10.3102/0034654319864591

Gaur, S. S. (2017). Facilitators and barriers to the effective implementation of midwifery care in low-income settings. *Journal of Global Health, 7*(2), Article 020408. https://doi.org/10.7189/jogh.07.020408

University of Ghana http://ugspace.ug.edu.gh

Getahun, K. B., Ukke, G. G., & Alemu, B. W. (2020). Utilization of companionship during delivery and associated factors among women who gave birth at Arba Minch town public health facilities. *PLOS ONE, 15*(11), e0240239. https://doi.org/10.1371/journal.pone.0240239

Gizachew, K. L., Getinet, T., & Bekele, D. (2024). Perspective of health workers on birth companions' involvement in maternal care: Mixed method study in Addis Ababa, Ethiopia. *Millennium Journal of Health, 3*(2), 1–10.

Goldkuhl, L., Dellenborg, L., Berg, M., Wijk, H., & Nilsson, C. (2022). The influence and meaning of the birth environment for nulliparous women at a hospital-based labour ward in Sweden: An ethnographic study. *Women and Birth, 35*(4), e337–e347. https://doi.org/10.1016/j.wombi.2021.07.006

Grove, S. K., Burns, N., & Gray, J. (2012). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (7th ed.). Elsevier Health Sciences.

Habib, H. H., Mwaisaka, J., Torpey, K., Maya, E. T., & Ankomah, A. (2023). Are respectful maternity care interventions effective in reducing intrapartum mistreatment against adolescents? A systematic review. *Frontiers in Global Women's Health, 4*, Article 1048441. https://doi.org/10.3389/fgwh.2023.1048441

Hans, S. L., Thullen, M., Henson, L. G., Lee, H., Edwards, R. C., & Bernstein, V. J. (2013). Promoting positive mother–infant relationships: A randomized trial of community doula support for young mothers. *Infant Mental Health Journal, 34*(5), 446–457. https://doi.org/10.1002/imhj.21403

Hatch, J. A. (2023). *Doing qualitative research in education settings*. State University of New York Press.

University of Ghana http://ugspace.ug.edu.gh

Hawamdeh, S. (2024). Midwifery is a mirror: Reflective observation turns our experience into insight. *Innovations in Midwifery & Child Health Practices, 1*(1), 1–6. https://doi.org/10.5281/zenodo.11637191

Heng, T. T. (2020). Examining the role of theory in qualitative research: A literature review of studies on Chinese international students in higher education. *Journal of International Students, 10*(4), 798–816. https://doi.org/10.32674/jis.v10i4.1541

Hildingsson, I., & Rubertsson, C. (2020). Childbirth experiences among women with fear of birth randomized to internet-based cognitive therapy or midwife counselling. *Journal of Psychosomatic Obstetrics & Gynecology, 41*(3), 205–214. https://doi.org/10.1080/0167482X.2019.1602615

Hildingsson, I., Karlström, A., Rubertsson, C., & Haines, H. (2019). Women with fear of childbirth might benefit from having a known midwife during labour. *Women and Birth, 32*(1), 58–63. https://doi.org/10.1016/j.wombi.2018.04.014

Hill, K., & Bowser, D. (2010). *Respectful care at birth*. USAID, 1–57. http://www.tractionproject.org/sites/default/files/Respectful_Care_at_Birth_9-20-101_Final.pdf

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2013). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews, 2013*(7), Article CD003766. https://doi.org/10.1002/14651858.CD003766.pub5

Hunter, C. A., & Hurst, A. (2016). *Understanding doulas and childbirth: Women, love, and advocacy*. Springer.

University of Ghana http://ugspace.ug.edu.gh

Id, K. A., Newman, G. T., Atobrah-Apraku, K., & Opuni, Y. (2025). Respectful maternity care and mistreatment: Women's experiences during induction of labor and childbirth in Ghana. *PLOS ONE, 20*(1), e0314990. https://doi.org/10.1371/journal.pone.0314990

Ishtiaq, S. (2019). Book review: Essentials of research design and methodology. *Journal of the Pakistan Medical Association, 69*(7), 1003.

Jolivet, R. R., Gausman, J., Kapoor, N., Langer, A., Sharma, J., & Semrau, K. E. A. (2021). Operationalizing respectful maternity care at the healthcare provider level: A systematic scoping review. *Reproductive Health, 18*(1), 1–15. https://doi.org/10.1186/s12978-021-01241-5

Junges, C. F. (n.d.). Support provided to women during childbirth by companions: A qualitative analysis. *Unpublished manuscript*, 1–15.

Kabakian-Khasholian, T., Bashour, H., El-Nemer, A., Kharouf, M., Elsheikh, O., Sheikha, S., Saleh, S., … Portela, A. (2018). Implementation of a labour companionship model in three public hospitals in Arab middle-income countries. *Acta Paediatrica, 107*(S471), 35–43. https://doi.org/10.1111/apa.14540

Kabakian-Khasholian, T., & Portela, A. (2017). Companion of choice at birth: Factors affecting implementation. *BMC Pregnancy and Childbirth, 17*, Article 265. https://doi.org/10.1186/s12884-017-1447-9

Kahraman, H. G., & Gökçe İsbir, G. (2023). The effect of continuous intrapartum supportive care on maternal mental health: A randomized controlled trial. *Women & Health, 63*(10), 774–786. https://doi.org/10.1080/03630242.2023.2254698

Kara, H. (2020). *Creative research methods: A practical guide* (2nd ed.). Policy Press.

University of Ghana http://ugspace.ug.edu.gh

Kassie, A., Wale, A., Girma, D., Amsalu, H., & Yechale, M. (2022). The role of traditional birth attendants and the problem of integration with health facilities in remote rural communities of West Omo Zone. *BMC Pregnancy and Childbirth, 22*, Article 400. https://doi.org/10.1186/s12884-022-04753-5

Kristienne McFarland, A., Jones, J., Luchsinger, J., Kissler, K., & Smith, D. C. (2020). The experiences of midwives in integrated maternity care: A qualitative metasynthesis. *Midwifery, 80*, Article 102544. https://doi.org/10.1016/j.midw.2019.102544

Kungwimba, E., Malata, A., Maluwa, A., & Chirwa, E. (2013). Experiences of women with the support they received from their birth companions during labour and delivery in Malawi. *Health, 5*(1), 45–52. https://doi.org/10.4236/health.2013.51007

Kyngäs, H., Kääriäinen, M., & Elo, S. (2020). The trustworthiness of content analysis. In *The application of content analysis in nursing science research* (pp. 41–48). Springer. https://doi.org/10.1007/978-3-030-30199-6_4

La Barbera, F., & Ajzen, I. (2020). Control interactions in the theory of planned behavior: Rethinking the role of subjective norm. *Europe's Journal of Psychology, 16*(3), 401–417. https://doi.org/10.5964/ejop.v16i3.2059

Lalonde, A., Herschderfer, K., Pascali-Bonaro, D., Hanson, C., Fuchtner, C., & Visser, G. H. A. (2019). The International Childbirth Initiative: 12 steps to safe and respectful mother–baby–family maternity care. *International Journal of Gynecology & Obstetrics, 146*(1), 65–73. https://doi.org/10.1002/ijgo.12844

Lathwal, P., Vyas, H., Singh, P., & Deviga, T. (2022). Knowledge, attitude, and factors affecting implementation of birth companionship during labor among obstetricians, nurses and pregnant

University of Ghana http://ugspace.ug.edu.gh

women at a tertiary care teaching hospital. *Journal of Public Health and Primary Care, 3*(1), 15–21. https://doi.org/10.4103/jphpc.jphpc_17_21

Lathwal, P., Kapoor, R., & Jain, R. (2022). Birth companionship during labor and delivery: A cross-sectional study. *Indian Journal of Public Health, 66*(4), 407–412. https://doi.org/10.4103/ijph.ijph_1509_21

Leap, N., & Hunter, B. (2022). *Supporting women for labour and birth: A thoughtful guide* (2nd ed.). Routledge.

Levine, A., Souter, V., & Sakala, C. (2022). Are perinatal quality collaboratives collaborating enough? How including all birth settings can drive needed improvement in the U.S. maternity care system. *Birth, 49*(1), 3–8. https://doi.org/10.1111/birt.12589

Levine, A., Souter, V., Sakala, C., & Declercq, E. (2021). Integrating midwives into the United States maternity care system. *Journal of Midwifery & Women's Health, 66*(1), 1–7. https://doi.org/10.1111/jmwh.13160

Linyama, Y., Pajogo, M., Kamanga, M., & Kafulafula, U. K. (2024). Experiences of birth companions as they provide support to labouring women at Queen Elizabeth Central Hospital in Blantyre, Southern Malawi. *Research Square*. https://doi.org/10.21203/rs.3.rs-3860954/v1

Lunda, P., Minnie, C. S., & Benadé, P. (2018). Women's experiences of continuous support during childbirth: A meta-synthesis. *BMC Pregnancy and Childbirth, 18*, Article 167. https://doi.org/10.1186/s12884-018-1767-4

Ma, B., Bo, B., & Tunçalp, Ö. (2019). Labour companionship evidence synthesis: A qualitative evidence review. *Cochrane Database of Systematic Reviews, 2019*(3), Article CD012449. https://doi.org/10.1002/14651858.CD012449.pub2

University of Ghana http://ugspace.ug.edu.gh

Maher, C., Hadfield, M., Hutchings, M., & de Eyto, A. (2018). Ensuring rigor in qualitative data analysis: A narrative review. *International Journal of Qualitative Methods, 17*, Article 1609406918786362. https://doi.org/10.1177/1609406918786362

Maputle, M. S. (2018). Support provided by midwives to women during labour in a public hospital, Limpopo Province, South Africa: A participant observation study. *BMC Pregnancy and Childbirth, 18*, Article 210. https://doi.org/10.1186/s12884-018-1860-8

Mbanza, A., Chaote, P., Mwakatundu, N., Dominico, S., Mputa, A., & Lobis, S. (2021). Improving experience of labour and delivery care through birth companionship: Findings from a qualitative study on a pilot birth companionship project in Kigoma, Tanzania. *AIJR Abstracts, 4*, 71. (Conference abstract)

McKelvin, G., Thomson, G., & Downe, S. (2021). The childbirth experience: A systematic review of predictors and outcomes. *Women and Birth, 34*(5), 407–416. https://doi.org/10.1016/j.wombi.2020.09.021

Medicines, R. (2021). The validity of the theory of planned behaviour for understanding people's beliefs and intentions. *Unpublished manuscript*.

Medlin, B. D. (2001). The factors that may influence a faculty member's decision to adopt electronic technologies in instruction. (Doctoral dissertation). Virginia Polytechnic Institute and State University.

Mellor, C. (2021). *Midwives' and obstetricians' experience of place in relation to supporting physiological birth: A hermeneutic phenomenological study* (Doctoral dissertation). Auckland University of Technology.

University of Ghana http://ugspace.ug.edu.gh

Meyer, H., Lee, N., George, K., & Kearney, L. (2024). Factors influencing midwives' intentions to facilitate normal physiological birth: A qualitative study. *Women and Birth, 37*(4), 101617. https://doi.org/10.1016/j.wombi.2024.101617

Miller, H. T. (2016). From social constructivist epistemology to context realism. *Critical Policy Studies, 10*(3), 365–379. https://doi.org/10.1080/19460171.2016.1200476

Mselle, L. T., & Teyumwete, E. R. (2023). "...She rubbed my back, wiped my face when sweating, served me tea and called nurses to help me...": Experience of care and support from a companion during labour and delivery among postnatal women in Kigoma, Tanzania. *Tanzania Medical Journal, 34*(1), 109–128. https://doi.org/10.4314/tmj.v34i1.584

Nakphong, M. K., Afulani, P. A., Opot, J., & Sudhinaraset, M. (2023). Access to support during childbirth: Women's preferences and experiences of support person integration in a cross-sectional facility-based survey. *BMC Pregnancy and Childbirth, 23*, 665. https://doi.org/10.1186/s12884-023-05962-2

National Institute for Health and Care Excellence. (2014). *Intrapartum care for healthy women and babies (NICE Guideline CG190).* https://www.nice.org.uk/guidance/cg190

Obeng-Odoom, F. (2014). *Oiling the urban economy: Land, labour, capital, and the state in Sekondi-Takoradi, Ghana.* Routledge.

O'Brien, D., Butler, M. M., & Casey, M. (2021). The importance of nurturing trusting relationships to embed shared decision-making during pregnancy and childbirth. *Midwifery, 98*, 102987. https://doi.org/10.1016/j.midw.2021.102987

University of Ghana http://ugspace.ug.edu.gh

Olowokere, A. E., Oyedele, A. T., Komolafe, A. O., & Olajubu, A. O. (2020). Birth preparedness, utilization of skilled birth attendants and delivery outcomes among pregnant women in Ogun State, Nigeria. *European Journal of Midwifery, 4*, 22. https://doi.org/10.18332/ejm/120116

Olza, I., Leahy-Warren, P., Benyamini, Y., Kazmierczak, M., Karlsdottir, S. I., Spyridou, A., … Nieuwenhuijze, M. J. (2018). Women's psychological experiences of physiological childbirth: A meta-synthesis. *BMJ Open, 8*(10), e020347. https://doi.org/10.1136/bmjopen-2017-020347

Orr, G. (2003). Diffusion of innovations, by Everett Rogers (1995). Unpublished manuscript.

Otten, M. J. (2019). *Effects of labor support from doulas on birth outcomes* (Master's thesis, Bethel University). Spark Repository. https://spark.bethel.edu/etd/494

Parisot, A. H. (1995). *Technology and teaching: The adoption and diffusion of technological innovations by a community college faculty* (Doctoral dissertation, Montana State University–Bozeman).

Perkins, J., Rahman, A. E., Mhajabin, S., Siddique, A. B., Mazumder, T., Haider, M. R., & El Arifeen, S. (2019). Humanised childbirth: The status of emotional support of women in rural Bangladesh. *Sexual and Reproductive Health Matters, 27*(1), 228–247.

Polit, D. F., & Beck, C. T. (2019). *Resource manual for nursing research: Generating and assessing evidence for nursing practice* (10th ed.). Wolters Kluwer.

Reed, R., Sharman, R., & Inglis, C. (2017). Women's descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy and Childbirth, 17*, 21. https://doi.org/10.1186/s12884-016-1197-0

University of Ghana http://ugspace.ug.edu.gh

Rogers, E. M. (1995). Diffusion of innovations: Modifications of a model for telecommunications. In *Die Diffusion von Innovationen in der Telekommunikation* (pp. 25–38). Springer.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). Free Press.

Roth, L. M., Henley, M. M., Seacrist, M. J., & Morton, C. H. (2016). North American nurses' and doulas' views of each other. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 45*(6), 790–800. https://doi.org/10.1016/j.jogn.2016.06.011

Safarzadeh, A., Beigi, M., Kohan, S., & Sadeghipour, R. (2012). Effect of doula support on labour pain and outcomes in primiparous women in Zahedan, Southeastern Iran: A randomized controlled trial. *Journal of Pain & Relief, 1*(5), 1–6. https://doi.org/10.4172/2167-0846.1000112

Sarfo, J. O., Amoadu, M., Obeng, P., Gbordzoe, N. I., Debrah, T. P., Ofori, C. O. B., & Hagan, J. E. (2023). Suicidal behaviour among school-going adolescents in Saint Lucia: Analysis of prevalence and associated factors. *Behavioral Sciences, 13*(7), 535. https://doi.org/10.3390/bs13070535

Sarwal, T., Sarwal, Y., Tyagi, S., & Sarwal, R. (2023). Healthcare providers' perceptions regarding the presence of birth companion during childbirth at a tertiary care hospital in India. *BMC Pregnancy and Childbirth, 23*, 408. https://doi.org/10.1186/s12884-023-05699-y

Scott, A. M., Li, J., Oyewole-Eletu, S., Nguyen, H. Q., Gass, B., Hirschman, K. B., Mitchell, S., Hudson, S. M., & Williams, M. V. (2017). Understanding facilitators and barriers to care transitions: Insights from Project ACHIEVE site visits. *Joint Commission Journal on Quality and Patient Safety, 43*(9), 433–447. https://doi.org/10.1016/j.jcjq.2017.02.012

University of Ghana http://ugspace.ug.edu.gh

Scott, K. D., Berkowitz, G., Klaus, M., & Klaus, P. H. (1999). The doula program: A randomized, controlled trial. *Birth, 26*(1), 16–22. https://doi.org/10.1046/j.1523-536x.1999.00016.x

Sherry, L., & Gibson, D. (2002). The path to teacher leadership in educational technology. *Contemporary Issues in Technology and Teacher Education, 2*(2), 178–203.

Sigurdardottir, V. L., Gamble, J., Gudmundsdottir, B., Kristjansdottir, H., Sveinsdottir, H., & Gottfredsdottir, H. (2017). The predictive role of support in the birth experience: A longitudinal cohort study. *Women and Birth, 30*(6), 450–459.

Simkin, P., & Cheyney, M. (2024). *The birth partner: A complete guide to childbirth for dads, partners, doulas, and other labor companions* (6th ed.). Harvard Common Press.

Simkin, P., Ancheta, R., & Keppler, A. (2017). *The labor progress handbook: Early interventions to prevent and treat dystocia* (4th ed.). Wiley-Blackwell.

Smith, D. C., Roehlkepartain, E. C., & Harris, M. (2020). What makes childbirth experiences traumatic? A qualitative analysis of postnatal women's perceptions. *Journal of Reproductive and Infant Psychology, 38*(5), 567–580. https://doi.org/10.1080/02646838.2020.1733962

Smith, J., Banay, R., Zimmerman, E., Caetano, V., Musheke, M., & Kamanga, A. (2020). Barriers to provision of respectful maternity care in Zambia: Results from a qualitative study through the lens of behavioral science. *BMC Pregnancy and Childbirth, 20*, 26. https://doi.org/10.1186/s12884-019-2579-x

Singh, S., Goel, R., Gogoi, A., Caleb-Varkey, L., Manoranjini, M., Ravi, T., & Rawat, D. (2021). Presence of birth companion: A deterrent to disrespectful behaviours towards women during delivery? An exploratory mixed-method study in 18 public hospitals of India. *Health Policy and Planning, 36*(10), 1552–1561. https://doi.org/10.1093/heapol/czab098

University of Ghana http://ugspace.ug.edu.gh

Stuart, C. (2000). Designing and delivering programs for adults: Strategies for maximizing effectiveness. *Training & Development, 54*(1), 28–34.

Taherdoost, H. (2022). What are different research approaches? Comprehensive review of qualitative, quantitative, and mixed method research, their applications, types, and limitations. *Journal of Management Science & Engineering Research, 5*(1), 53–63. https://doi.org/10.30564/jmser.v5i1.4538

Thomson, A. J. (2019). Care of women presenting with suspected preterm prelabour rupture of membranes from 24+0 weeks of gestation: Green-top Guideline No. 73. *BJOG: An International Journal of Obstetrics and Gynaecology, 126*(9), e152–e166. https://doi.org/10.1111/1471-0528.15803

Thomson, G., Mortimer, R., Baybutt, M., & Whittaker, K. (2022). Evaluation of birth companions' perinatal and peer support provision in two prison settings in England: A mixed-methods study. *International Journal of Prisoner Health, 18*(1), 21–38. https://doi.org/10.1108/IJPH-09-2021-0099

Tracy, S. J. (2019). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact* (2nd ed.). Wiley-Blackwell.

Tucker, L., & Meier, J. (2023). The effects of doula support during labor. *SACAD: John Heinrichs Scholarly and Creative Activity Days, 32*.

Vasilevski, V., Sweet, L., Bradfield, Z., Wilson, A. N., Hauck, Y., Kuliukas, L., Homer, C. S. E., Szabo, R. A., & Wynter, K. (2022). Receiving maternity care during the COVID-19 pandemic: Experiences of women's partners and support persons. *Women and Birth, 35*(3), 298–306. https://doi.org/10.1016/j.wombi.2021.04.012

University of Ghana http://ugspace.ug.edu.gh

Vasilevski, V., Sweet, L., Bradfield, Z., & Callander, E. (2022). The influence of the COVID-19 pandemic on maternity care: A scoping review. *Women and Birth, 35*(3), 228–236. https://doi.org/10.1016/j.wombi.2021.08.003

Venkatesan, L., & Kaur, P. (2022). Respectful maternity care: Knowledge, attitude and practice of health care workers and maternal perception about RMC: A scoping review. *Journal of Comprehensive Nursing Research and Care, 7*(2), 185.

Vilar-Compte, M., Hernández-Cordero, S., Ancira-Moreno, M., Burrola-Méndez, S., Ferre-Eguiluz, I., Omaña, I., & Pérez Navarro, C. (2021). Breastfeeding at the workplace: A systematic review of interventions to improve workplace environments to facilitate breastfeeding among working women. *International Journal for Equity in Health, 20*, 110.

Vogel, J. P., Bohren, M. A., Tunçalp, Ö., Oladapo, O. T., & Gülmezoglu, A. (2016). Promoting respect and preventing mistreatment during childbirth. *BJOG: An International Journal of Obstetrics and Gynaecology, 123*(5), 671.

Wanyenze, E. W., Byamugisha, J. K., Tumwesigye, N. M., Muwanguzi, P. A., & Nalwadda, G. K. (2022). A qualitative exploratory interview study on birth companion support actions for women during childbirth. *BMC Pregnancy and Childbirth, 22*, 398. https://doi.org/10.1186/s12884-022-04398-4

White VanGompel, E., Main, E. K., Tancredi, D., & Melnikow, J. (2018). Do provider birth attitudes influence cesarean delivery rate? A cross-sectional study. *BMC Pregnancy and Childbirth, 18*, 184. https://doi.org/10.1186/s12884-018-1756-7

World Health Organization. (2016a). *Standards for improving quality of maternal and newborn care in health facilities.* https://www.who.int/publications/i/item/9789241511216

University of Ghana http://ugspace.ug.edu.gh

World Health Organization. (2016b). *WHO recommendations on antenatal care for a positive pregnancy experience.* https://www.who.int/publications/i/item/9789241549912

World Health Organization. (2018). *Intrapartum care for a positive childbirth experience.* https://www.who.int/publications/i/item/9789241550215

World Health Organization. (2020). *Companion of choice during labour and childbirth for improved quality of care: Evidence-to-action brief.* World Health Organization.

Wu, N., Huang, R., Shan, S., Li, Y., & Jiang, H. (2022). Effect of the labour roadmap on anxiety, labour pain, sense of control, and gestational outcomes in primiparas. *Complementary Therapies in Clinical Practice, 46*, 101545.

Yakubu Danzima, N., Nantomah, B., & Kapio Abem, V. (2023). Heideggerian hermeneutic phenomenological study of lived experiences of nursing care during childbirth. *Journal of Biotechnology and Biomedicine, 6*(2), 79. https://doi.org/10.26502/jbb.2642-91280079

Yildiz, H. (2019). Intrapartum care model for a positive childbirth experience: World Health Organization recommendations. *Kocaeli Üniversitesi Sağlık Bilimleri Dergisi, 5*(2), 98–105. https://doi.org/10.30934/kusbed.546900

Young, C. (2021). Professional ambivalence among care workers: The case of doula practice. *Health, 25*(3), 306–321. https://doi.org/10.1177/1363459319886115

Zondag, L. D. C., Maas, V. Y. F., Beuckens, A., & Nieuwenhuijze, M. J. (2022). Experiences, beliefs, and values influencing midwives' attitudes toward the use of childbirth interventions. *Journal of Midwifery & Women's Health, 67*(5), 618–625. https://doi.org/10.1111/jmwh.13392

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APPENDIX I: INTERVIEW GUIDE

UNIVERSITY OF GHANA

SCHOOL OF NURSING AND MIDWIFERY

Research Topic: Birth companionship during labour: A study of Acceptance, Facilitators, barriers/challenges among midwives in Sekondi/ Takoradi, Ghana.

Dear participant, you are humbly invited to take part in this study that seeks to explore acceptance as well as factors that are likely to facilitate or hinder its implementation in Sekondi-Takoradi. Your responses are relevant to achieving the purpose of the study. Participation is voluntary, and you have the right to withdraw at any point in the interview. Your voice will be recorded during the interview, which will last for 30 to 60 minutes, and no other identifiable information of yours will be shared with a third party without your permission. I will require you to fill in the items in section A. Thanks for your cooperation.

Researcher: Leticia Arthur (MPHIL Midwifery Student)

Address: School of Nursing and midwifery, University of Ghana, Legon

Telephone numbers: 0249555954

SECTION 1

DEMOGRAPHIC DATA

Pseudonym: …….

Age: 20-30……, 31-40, …….... 41-50……. More than 50…….

No of years practiced as a midwife: 1-5……..., 6-10……., more than 10 ……...

Levels of facilities worked in: CHPS …..., Health Centre ……, Clinic ……, District hospital……

SECTION 2:

Session A

Attitudes Toward Birth Companionship

1. Can you briefly introduce yourself?

(Probe: role, experience in maternal health, experience with birth companionship)

2. How has your experience been like working in facilities that allow birth companions during labour and delivery?

3. How do you personally feel about allowing birth companions during labour and childbirth?

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4. In your experience, what are the benefits of having a birth companion present?

(Probe: emotional support, better communication, reduced medical interventions)

6. Are there any concerns or risks associated with allowing birth companions?

(Probe: disruption, cultural barriers, infection control)

7. Based on your experience, do you think birth companionship enhances the quality of care provided? Why or why not?

Session B

Subjective Norms (Influence of Others & Social Pressure)

8. Can you speak to any a written policy or guideline on birth companionship from WHO or a national health policy.

9. Have you seen or been trained on any policies regarding birth companionship? If yes, how were they introduced in your facility?

10. How do your colleagues generally feel about birth companionship?

(Probe: do they support it, oppose it, or have mixed feelings?)

11. How do women and their families react when told about the option of having a birth companion?

12. Do you feel pressure from any group (patients, family, superiors, hospital administration) to allow or restrict birth companionship?

13. In your opinion, does cultural or religious belief play a role in whether birth companions are accepted or rejected in your community?

Session C

Perceived Behavioural Control (Facilitators & Barriers to Implementation)

14. What factors would make it easier to successfully implement a birth companionship strategy in your facility?

(Probe: staff training, clear guidelines, community awareness)

15. What role do midwives play in making birth companionship successful?

16. What kind of support would you need (from management, policymakers, colleagues) to make birth companionship work effectively?

17. What challenges do you face when trying to allow birth companions in your workplace? (Probe: facility space, privacy concerns, lack of staff support)

18. Are there any logistical concerns, such as infection prevention, confidentiality, or cultural norms, that make birth companionship difficult?

19. How do you think these challenges can be overcome?

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20. If given the choice, would you personally advocate for birth companionship in all health facilities? Why or why not?

21. What key recommendations would you give to policymakers and hospital administrators to improve the implementation of the birth companionship strategy?

22. Is there anything else you'd like to add about birth companionship that we haven't discussed?

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UNIVERSITY OF GHANA

DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref: 11005981

27th May, 2024.

Jemima Crentil Hospital
60 E Akuffo Addo Road
Takoradi

Dear Sir/Madam,

LETTER OF INTRODUCTION – ETHICAL CLEARANCE

I write to introduce to you Arthur Leticia, an MPhil Midwifery student in the Department of Maternal and Child Health at the School of Nursing and Midwifery, University of Ghana, Legon.

As part of the requirements for the MPhil Midwifery programme, the student is to undertake a study and she intends to use your facility as one of her study sites.

The title of her research is **"Birth companionship during labour: A study of acceptance, facilitators, barriers/challenges among midwives in Sekondi/Takoradi."**

I write to seek your permission to enable her undertake this study at the facility.

Thank you.

Yours faithfully,

Dr. Evelyn Ampofo
(Research Supervisor)

Jemima Crentsil Hospital Ltd.
P. O. Box AX 320
Takoradi
Kweesimintsim - Anaji Road

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UNIVERSITY OF GHANA

DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

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Sekondi

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Yours faithfully,

Dr. Evelyn Ampofo
(Research Supervisor)

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UNIVERSITY OF GHANA

DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref: 11005981

27th May, 2024.

Takoradi District Hospital

Box TD 7

Takoradi

Dear Sir/Madam,

LETTER OF INTRODUCTION – ETHICAL CLEARANCE

I write to introduce to you Arthur Leticia, an MPhil Midwifery student in the Department of Maternal and Child Health at the School of Nursing and Midwifery, University of Ghana, Legon.

As part of the requirements for the MPhil Midwifery programme, the student is to undertake a study and she intends to use your facility as one of her study sites.

The title of her research is **"Birth companionship during labour: A study of acceptance, facilitators, barriers/challenges among midwives in Sekondi/Takoradi."**

I write to seek your permission to enable her undertake this study at the facility.

Thank you.

Yours faithfully,

Dr. Evelyn Ampofo
(Research Supervisor)

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P. O. Box LG 43, Legon, Accra, Ghana | Tel: +233 (0) 30 251 3250
Email: mchsonm@ug.edu.gh | Website: www.nursing.ug.edu.gh

University of Ghana http://ugspace.ug.edu.gh

UNIVERSITY OF GHANA

DEPARTMENT OF MATERNAL AND CHILD HEALTH
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref: 11005981

27th May, 2024.

Effiankwanta Regional Hospital

Box 229

Sekondi

EFFIA-KWANTA REGIONAL HOSPITAL
RECEIVED
15 NOV 2024
SEKONDI

Dear Sir/Madam,

LETTER OF INTRODUCTION – ETHICAL CLEARANCE

I write to introduce to you Arthur Leticia, an MPhil Midwifery student in the Department of Maternal and Child Health at the School of Nursing and Midwifery, University of Ghana, Legon.

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Thank you.

Yours faithfully,

Dr. Evelyn Ampofo
(Research Supervisor)

Head: Ox G Dept
Kindly accept this
Student to do.
15/11/24

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Email: mchsonm@ug.edu.gh | Website: www.nursing.ug.edu.gh

UG

0249555954 – Leticia Arthur

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GHANA HEALTH SERVICE
ETHICS REVIEW COMMITTEE

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra.
Digital Address: GA-050-3303

Quote this number and date on all correspondence
My Ref. No: GHS/ 25 /118
Your Ref. No:
Date: 19th March 2025

Leticia Arthur
University of Ghana
P. O. Box 333
Sekondi

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

GHS-ERC Number	**GHS-ERC: 051/08/24**
Study Title	Birth Companionship During Labour: A Study of Acceptance, Facilitators, Barriers/Challenges Among Midwives in Sekondi/ Takoradi, Ghana
Approval Date	19th March 2025
Expiry Date	18th March 2026
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of a yearly progress report of the study to the Ghana Health Service Ethics Review Committee (GHS 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 GHS ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing GHS ERC if study cannot be implemented or is discontinued and reasons why
- Informing the GHS ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without GHS ERC approval of the amendment is invalid.
- The GHS 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
- **Please note that in the event where samples will be shipped outside Ghana, a signed Material Transfer Agreement should be submitted to the GHS ERC for approval.**
- **Please note that future use of biological samples will require GHS ERC approval and the samples cannot be used for commercial purposes.**

SIGNED.....
Mr. Kofi Wellington
(GHS ERC Chairperson)

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

INTEGRI PROCEDAMUS

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Mob: +233-50-3538896
Email: ethics.research@ghs.gov.gh
Website: www.ghs.gov.gh

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UNIVERSITY OF GHANA

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES
INSTITUTIONAL REVIEW BOARD

My Reference: DF 22

08/08/2024

Leticia Arthur

RE: Our Study # 131/23-24 **At:** NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH-IRB

Dear Arthur:

Meeting Date: July 03, 2024 **At:** NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH-IRB

Protocol Title:

Birth Companionship during labour: a study of acceptance, facilitators, barriers/ challenges among midwives in Sekondi/Takoradi, in Ghana

This is to advise you that the above referenced Study has been presented to the Institutional Review Board, and the following action taken subject to the conditions and explanation provided below.

Internal #: New Appl
Expiration Date: July 02, 2025
On Agenda For: Initial Submission
Reason 1: **Reason 2:**
Date Received - 06/25/2024
IRB ACTION: Approved
Condition 1:
Action

The revised protocol is duly approved.

Yours Sincerely,

NMIMR-IRB Administrator

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