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Experiences of Women with the Labour and Delivery Care Received at Mzimba District Hospital, Malawi

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Abstract

Aim: *The aim of the study was to explore the perceptions of women on the care that they received during normal labour and delivery at Mzimba District Hospital, Malawi.* ***Specific Objectives:*** *To evaluate the aspects of physical care that was rendered to women during labour and delivery, evaluate the psychological care that was rendered to women throughout labour and delivery, assess the perception of women on the attitudes of midwives during the provision of labour and delivery care and review participants' files for documentation of labour and delivery care.* ***Methods:*** *The study was of explorative and descriptive design that utilized qualitative methods. The study was conducted at Mzimba District Hospital in the postnatal ward in Malawi. The sample was drawn from women who had spontaneous vertex deliveries with no complications for both the mother and baby. A purposive sampling was used to select the 15 participants for the study and included women who laboured from 4 to 5 cm and delivered without complications at the institution.* ***Data Analysis:*** *Descriptive statistics were computed for demographic data and qualitative data were analysed manually using thematic content analysis.* ***Results:*** *Results revealed that women who participated in the study received inadequate intrapartum care and the major results from the study were inadequate history taking, inadequate physical assessment, inadequate giving of information, lack of pain relief measures, lack of food and fluid intake and output, lack of use of various positions, lack of mobility during labour and delivery, lack of birth companion, poorly managed anxiety, dissatisfaction with midwives' attitudes, and inadequate documentation of labour and delivery care.*

Keywords: Labour and delivery, intrapartum care, spontaneous vertex delivery, labouring women and perception

INTRODUCTION

Labour and delivery care is very essential to improving maternal and neonatal health outcomes globally. The process of labour and delivery exert a profound physical, mental, emotional and social effect on women consequently; most women remember their birth experiences clearly and with deep emotion [1]. Traditionally, maternity services have mainly focused on reducing perinatal and infant mortality rates, whereas women's feelings and experience of the labour and delivery process have been neglected [2]. Previous experience of hospital care during labour and delivery may play a major role in a woman's decision on where to have her next delivery. As stated by Larkin et al. [3], a positive experience of labour and delivery care is associated with long lasting benefits, an affirmative relationship with the newborn, a positive attitude towards motherhood that contributes to the

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woman's self-esteem and feelings of accomplishment. Previous labour and delivery care experience can therefore positively or negatively affect the percentage of delivery by skilled birth attendants. There is an increasing documentation of neglect, verbal abuse, and intentional humiliation of women during labour and delivery in many countries which can affect access, compliance, quality and effectiveness of maternity care [4]. In Malawi there has been an outcry that midwifery care that is being provided in the public hospitals is not according to the expected standards [5] and yet there is scarce research that has been conducted to investigate the experiences of women in labour and delivery care in Malawi. Provision of standard labour and delivery care in all the three stages of labour and delivery is of paramount importance as one way of reducing maternal and neonatal complications such as postpartum haemorrhage, puerperal sepsis and obstructed labour which are contributing to the high maternal morbidity and mortality rates. Apart from that, provision of standard labour and delivery care will promote a positive experience which is the desire of every woman and can also promote maternal health.

Studies reveal that mothers are still dying due to obstetric complications despite employing several interventions. In Malawi, 675 women out of 100,000 live births are dying due to pregnancy, labour, delivery and postpartum complications and 31/1000 live births of neonates are also dying [6]. The provision of standard care during labour and delivery is believed to make the difference between life and death of mothers and neonates. It is the basic right of every woman and baby to receive the expected standard of care that enables them to survive pregnancy and childbirth in good health and depriving women of the care is denying them their basic right [7].

The expected standards of labour and delivery care also include respect for clients and women-centred care. Recently, there is growing recognition of the importance of woman centred labour and delivery care which has shifted the emphasis to incorporate views of women on care that has been rendered to them into quality improvement efforts [2]. Some studies that investigated women's experiences on their labour and delivery care found that an awareness of women's experiences will help to identify the caring behaviours as recognized by the women and that it is only when women's voices are heard that better and appropriate health services for women in labour and delivery can be rendered [8–10]. Each woman who has experienced labour and delivery care has a story to tell that may be significant to the improvement of labour and delivery care. Therefore, this study was conducted to explore experiences of women with the care they received during labour and delivery at Mzimba District Hospital. The study will give information that could be significant to the improvement of care at the facility.

METHODOLOGY

Design

The study was of explorative and descriptive design that utilised qualitative methods. It sought to get an in depth understanding of the experiences of labour and delivery care that women received at Mzimba District Hospital in Malawi.

Setting

The study was conducted at Mzimba District Hospital, which offers secondary level of health care and is in the northern region of Malawi, 270 kilometres away from the capital city, Lilongwe.

Sampling

A purposive sampling was used to recruit the participants in the study. This was a non-probability sampling method in which the researcher selected the participants based on personal judgement about who was most representative or informative in the study [11].

Sample Size

The target sample size for the study was 20 women who had uncomplicated spontaneous vertex deliveries of a live full-term baby with no complications in the past 24 hours. However, the actual sample used was 15 because data saturation was reached at that point.

Inclusion and Exclusion Criteria

Pregnant women who laboured from 4 to 5 cm and delivered without complications at the institution were recruited while those who had complications were excluded from the study.

Data Collection

A questionnaire was used to collect demographic data from the participants. In addition, qualitative data was collected using in depth interviews following an interview guide that was developed in order to ensure that all question areas are covered.

Data Analysis

Data which was collected through in-depth interviews and was analysed manually using thematic content analysis following the steps as explained by Braun and Clarke [12].

Ethical Considerations

The rights of participants were respected throughout the period of study. A research proposal was sent to the College of Medicine Research Committee (COMREC) for approval. An approval was also obtained from the Mzimba District Health Officer (DHO). Permission was sought from the participants before data collection. A consent form was used for the women to sign if they were willing to participate in the study before data collection. In addition, their names were not indicated on the data collection forms and results. The names were replaced by number codes to ensure anonymity.

RESULTS

The ages of the 15 participants who were recruited in the study ranged from 13 to 35 years and most of them were within age range of 20 to 25 years. It is important to note that four of the participants were teenagers who were aged between 16 and 19 years. All the women who were recruited in the study were married and belonged to Christian denominations. All the participants had some form of education, but the majority had primary education with only one who had secondary education. The results from demographic data are summarized in Table 1.

Table 1. Demographic characteristics of participants.

Characteristic		Total
Age of participants	13–19 years 20–25 years 26–35 years	4 6 5
Marital status	Married	15
Denomination	Other denominations C.C.A.P R/C	9 4 2
Level of education	Primary Secondary	14 1
Occupation	Not employed Subsistence farmers	11 4
No. of children	One child Two children Three children Four children Five children	5 4 2 2 2
Place of delivery	Hospital Home TBA	13 1 1
Economic status	Less than K 5,000 K 5,000 K 10,000 More than K 20,000	8 3 2 2

CCAP, Church of Central Africa Presbyterian; R/C, Roman Catholic; TBA, traditional birth attendant.

Two major themes identified from the qualitative data were inappropriate admission process and inadequate intrapartum care. Results revealed that although some few women appreciated the care which they received during labour and delivery, it was found that most women received inadequate intrapartum care and the following subthemes emerged from the data: inadequate history taking, inadequate physical assessment, inadequate giving of information, lack of pain relief measures, lack of food and fluid intake and output, lack of use of various positions, lack of mobility during labour and delivery, lack of birth companion, poorly managed anxiety, dissatisfaction with midwives' attitudes and there was inadequate documentation of labour and delivery care.

Inappropriate Admission Process

It was noted that there was incomplete history taking and the clients were not physically comprehensively managed. In addition, majority of the participants had no information on danger signs and labour and delivery process.

Inadequate Intrapartum Care

Lack of Pain Relief Measures

All the participants did not receive any pharmacological or non-pharmacological pain relief measures during labour and delivery. One of the participants a 16-year-old teenager who had delivered her first baby said: *I just complained that I had severe pains and yet the midwives said it cannot stop being painful because it is on a human body (meaning that she was supposed to feel pain) but they did not give her any pain killer*. Woman #14.

Lack of Food and Fluid Intake and Output

The results showed that most participants did not take food or fluid during labour. Some explained that they were thirsty but were afraid to take water because they were not sure whether to take it or not. Others also had misconceptions that if they drink water the labour pains will cease. Although some participants reported that they were told to urinate in order to promote descent of the baby, it was noted that they were doing this without midwives' assistance.

Psychological Support

The study revealed that most participants did not receive adequate psychological support from midwives. It was found that for some participants, anxiety was not well cared for. Few of the participants (n = 3) delivered alone without midwifery assistance and this scared them. Apart from that, some participants received threatening responses which caused fear in the participants. One of the participants said: *They (midwives) said you should listen to what we will be saying without which you will die or you will go home alone (meaning that the baby will die) or you will have a caeserian section.*" Woman #12.

Lack of Birth Companion in the Labour and Delivery Room

The results showed that majority of participants (n = 14) were accompanied by birth companions to the hospital but none of them were allowed in the labour and delivery room.

Maintaining Privacy

It was noted that there was inconsistency in the participants' experience of privacy. To some participants' visual privacy was ensured by closing the curtains around the beds while for others nothing was done as a result, participants were seeing each other's' private parts since they were just exposed.

Attitudes from Midwives

The findings revealed that majority of participants were satisfied with the attitude that midwives portrayed during labour and delivery. However, few participants (n = 2) expressed dissatisfaction and contributed it to lack of attention from midwives which led to self-delivery of babies.

Findings on Review of Participants Records on Labour and Delivery

It was generally noted that documentation was below standards. A lot of information that is critical to midwifery care was not documented reflecting substandard care.

DISCUSSION

The results showed that most of the participants were within a good age range for childbearing which is 20 to 35 years. However, few (n = 4) participants in the study were teenagers aged within 16 to 19 years. This age range is critical in midwifery in that the reproductive body organs are still developing so the participants were at high risk of developing obstetric complications. As such they needed to be closely monitored for development of the complications and comprehensively managed to prevent the complications, but this was not done, and they received inadequate care during labour and delivery. All women who were recruited in the study were married. This was good because it meant that ideally all the participants had an opportunity to be supported by their husbands (male involvement) during labour and delivery. However, the results showed that none of them had a husband or other birth companion in labour ward. This is contrary to the findings from a study which was conducted by Kululanga et al. [13] which found that male involvement at childbirth, increased men's knowledge of childbirth process and this knowledge helped them to provide psychological and emotional support to their wives. The study also revealed that presence of their male partners made labouring women feel valued, cared for and appreciated. This means that these participants were denied the opportunity to receive care which could be provided by their male partners during labour and delivery. Although the structure of the facility does not accommodate male involvement yet, female companions could have been used in this case, but this was not done. It is documented that lack of support during labour and delivery could lead to stress which can trigger catecholamine release that in turn can slow down the progress of labour.

Physical Care Received During Labour and Delivery

Inadequate History Taking

History taking is very important for correct diagnosis and management of midwifery clients. It consists of systematic and orderly collection and analysis of data about the health status of a client. The purpose is to identify needs or problems for proper management [14]. However, the findings revealed that none of the participants had complete histories collected from them and yet incorrect assessment can lead to wrong diagnosis and wrong implementation of care.

Inadequate Physical Assessment

Physical assessment of a labouring woman is of critical importance in that through actual physical examination, data related to the client's health status can be collected for provision of proper midwifery care. The study revealed that none of the participants had a complete physical examination. Incomplete physical assessment can lead to wrong diagnosis which can eventually lead to wrong management. This implies that there are shortcuts to conducting physical assessment for labouring women which can negatively affect the maternal and neonatal health outcomes.

Inadequate Giving of Information

The results showed that majority of participants were both not informed and had no knowledge on danger signs in pregnancy, labour and delivery. Giving information to labouring women is very important in that it helps the women to identify complications earlier for quick interventions, allay anxiety which can negatively affect the progress of labour and to help gain cooperation from the clients since they can easily understand what is happening in their bodies that time. These results are in support with study findings by Nikiema et al. [15] which revealed that Malawi was one of the countries which had the highest unmet need for pregnancy information.

Lack of Pain Relief Measures

Childbirth is one of the most painful events that a woman is likely to experience. The findings from this study revealed that none of the participants received any pain relief measures during labour. The

participants expressed that they suffered with pain throughout the process of labour and delivery without any pharmacological and non-pharmacological interventions to relieve it. The lack of non-pharmacological interventions was worsened because of not allowing birth companions in the labour ward at the health facility who can assist with the provision of other non-pharmacological measures such as providing a cold or warm compress and reassurance. Lack of pain relief measures in a labouring woman can have physical and psychological effects on maternal and neonatal health outcomes. It can lead to stress which is associated with prolonged labour and negative birth experiences which can lead to postpartum depression. These findings are similar to the findings of a study by Kungwimba et al. [16] which also revealed that all the participants in the study did not receive any pharmacological intervention during labour. However, it is different in that study all clients in that study had birth companions who provided some non-pharmacological interventions for pain relief.

It is documented that although severe pain is not life threatening in a healthy labouring woman, it can have psychological consequences which can have adverse health outcomes. The pain of labour can be associated with catecholamine release which could in turn be accompanied by increased cardiac output, peripheral vascular resistance and increased oxygen consumption [17]. Literature suggests that postnatal depression may be more common when analgesia is not used and pain during labour has been correlated with development of post-traumatic stress disorder [18].

Lack of Food and Fluid Intake and Output

The study results revealed that most of the participants were not given any food during labour and some of them were not even aware about the importance of taking food during labour and delivery. This was evident from one of the participants who explained that she did not take food during labour for nine hours which meant that she was exposed to starvation. Lack of food intake during labour can lead to reduced energy levels in the labouring woman and this can negatively affect the woman's power to push during the second stage of labour. This is contrary to evidence from literature that suggests that labour is a strenuous process that requires energy and midwifery focuses on the normal physiological process of childbirth. It is also documented that long periods without food are stressful and can lead to an increase in the circulating catecholamine, which may increase arterial pressure, increase blood flow to active muscles while decreasing blood flow to organs not needed for rapid activity such as uterus and placenta. Lack of food can also lead to an increase in metabolism and the body's demand for glucose which has an effect on muscle strength, concentration and coagulation [19].

In addition, literature is also suggesting that restriction of oral intake may psychologically affect the labouring women by increasing the perception of pain and reducing morale which in turn may adversely affect the progress of labour [19]. This can negatively affect maternal and neonatal health outcomes. On the other hand, research has proven that use of intravenous fluids to replace oral intake in labouring women, has showed that there was evidence of harm when certain intravenous fluids containing glucose were used; it caused hyperglycaemia in the foetus followed by reactive hypoglycaemia in the neonate. There was also a high incidence of neonatal jaundice and a decrease in the blood pH in the newborn with concurrent increased lactic acid levels and foetal acidosis. Newborns were also more likely to experience transient tachypnoea of the newborn, weight loss in the first two days of life than those whose mothers ate and drank in labour. Therefore, intravenous fluids cannot be considered a completely safe substitute for food and fluids in labour [20].

The results also revealed that women were not adequately supported on urinary elimination. Most of the women were not encouraged to urinate frequently and some of them were told to be urinating in the basins which were meant for their babies disregarding that there could be possibility of transmitting infections to the newborn. Frequent emptying of urinary bladder is important because it helps to provide space in the pelvic region thereby aiding descent of the presenting part so lack of this intervention could have delayed the progress of labour. Literature suggests that women should be encouraged to empty her urinary bladder every 1 to 2 hours during labour because urine may interfere with descent of the

presenting part or reduce the capacity of the uterus to contract thereby increasing risk of postpartum haemorrhage [21].

Lack of Use of Various Labouring Positions

Results showed that the participants were not informed about the various labouring positions, so they were confined to lying in lateral positions. This could have delayed the progress of their labours. It was also found that they all delivered in lithotomy positions. Giving a labouring woman chance to choose her position for delivery empowers the woman and she feels relaxed during the process which facilitates delivery of the baby. There is evidence to suggest that changes to position may help to fasten the progress of labour and women should be encouraged to adopt any other position they find most comfortable as long as foetal well-being can be confirmed. Other positions such as sitting, walking, standing and kneeling are also associated with a reduction in first stage of labour. This is supported by a Cochrane review of 16 trials that involved 2530 women which found that the first stage of labour was approximately one hour shorter for those who were randomized to upright compared with supine and recumbent positions [22].

The results showed that all participants delivered in lithotomy position which is easy for the midwives to conduct the delivery but can have adverse effects on the foetal outcomes. It is documented that recumbent positions result in supine hypotension, diminished uterine activity and a reduction in the dimensions of pelvic outlet [21] so these positions are not recommended while Squatting increases the pelvic diameter by 8 mm which can facilitate quick delivery of the baby [23].

Lack of Mobility

The results revealed that there was lack of mobility during labour to some of the participants which could have delayed the progress of labour since mobilization in a labouring woman facilitates descent of the presenting part which enhances progress of labour. This prevents prolonged labour which can have negative effects on maternal and neonatal health outcomes. Shorter length of labour is an important outcome because every contraction is potentially painful which need to be intervened. Literature suggests that moving about can increase a woman's sense of control in labour and studies indicate that women who were upright or mobile, had shorter first stage of labour compared with women who were supine [22].

Psychological Care that was Rendered to Women During Labour and Delivery

The findings revealed that most participants did not receive adequate psychological support from midwives. It was revealed that birth companions are not allowed in the labour ward as such all the participants did not receive any support from their birth companions in labour ward. Presence of a birth companion in labour ward is very important to the psychological well-being of a labouring woman. There is evidence that good psychological support is important and can be provided by birth companions and midwives. It is argued that women in established labour should not be left on their own except for short periods of time or at their request [23]. Emotional support has a major impact on how women cope with pain in labour, and a Cochrane review on continuous support for women in labour concluded that emotional support, comfort measures and information may enhance normal labour processes as well as women's feelings of control and competence [24].

In addition, remaining at the labouring woman's side continuously throughout labour and delivery, a companion offers comfort techniques such as massage, touch and cold compress. There is some evidence that fear and anxiety induced by strangers in a clinical environment can trigger a catecholamine release that in turn can impede the progress of labour but when the labouring woman is calmer and more confident, labour proceeds more rapidly. This means that participants in this study were exposed to strangers (midwives and other health workers) who could have been a source of anxiety to them which can have negative effects on maternal and neonatal health outcomes [25].

The results also revealed that anxiety to some participants was not well managed. They were not adequately psychologically supported during labour and delivery since they were given threatening remarks, and their concerns were not well addressed. In addition, some of the participants who delivered on their own were scared and this increased their level of anxiety. Poorly managed anxiety in a labouring woman can lead to stress which can trigger an increase in the release of catecholamine levels thereby negatively affect the progress of labour. Literature suggests that anxiety about labour has been shown to be a predictor of negative consequences including a lack of satisfaction with the experience of labour and birth and poor emotional well-being in the postnatal period.

The results showed that there was inconsistency in maintenance of privacy in that there was lack of visual privacy to some of the participants such that their private parts were exposed to other people. To some participants who were delivering in the hospital for the first time even though lack of privacy was a normal routine in the hospital setting while it is mismanagement. Lack of privacy for labouring women is degrading to the women and depriving them of their rights to privacy. This can have a negative effect on their birth experience which can eventually affect their decisions as to where to have the next delivery. Literature suggests that a woman's emotional well-being should be assessed regularly and should include paying attention to maintaining privacy during labour by use of curtains, speaking in a low tone and avoiding the presence of unnecessary persons in the labour room.

The study also revealed that few participants ($n = 2$) were dissatisfied with the attitudes that midwives portrayed during provision of labour and delivery care. They were not closely attended to, such that few had self-deliveries and another midwife was busy with her cell phone instead of attending to the clients. Displaying negative attitudes to labouring women can affect their psychological wellbeing and can also lead to negative birth outcomes due to acts of negligence which is also violating the women's rights to fair treatment.

Documentation of labour and delivery care.

Labour and delivery care records are the most important source of information and correct documentation is important for women's safety and communication between health care providers. On the contrary, the results indicated that there was inadequate and false documentation of information. For example, the results showed that few women ($n = 3$) had self-deliveries, but in their files, it was indicated that midwives conducted the deliveries. Giving false information about clients can negatively affect management of the clients thereby affecting maternal and neonatal health outcomes.

CONCLUSION

Provision of adequate normal labour and delivery care can significantly improve maternal and neonatal health outcomes in Malawi and enhance a positive birth experience. The study which sought to explore experiences of women on labour and delivery care received at Mzimba District Hospital has revealed gaps that need to be addressed to improve labour and delivery care. The results indicate that the participants received inadequate intrapartum care; there was inadequate history taking and physical assessment, lack of pain relief measures, lack of birth companion, lack of food and fluid intake, lack of use of various positions and poor attitudes of midwives during labour and delivery.

However, literature suggests that utilizing evidence-based midwifery care that includes thorough history taking and physical assessment, use of pain relief measures, having a birth companion in labour ward, providing food and fluid, use of various positions and displaying positive attitudes with good communication skills to labouring women can significantly improve maternal and neonatal health outcomes. It is therefore recommended that midwives should be encouraged to implement evidence-based midwifery care which can help to improve maternal and neonatal health outcomes. The district health office (Nursing Section) should regularly conduct supportive supervision and sessions on professional conduct. The Reproductive Health Unit and policy makers should assist in improving

midwifery care by developing guidelines on management of a woman during normal labour and delivery and to reinforce supervision. This will help to improve maternal and neonatal health outcomes in Malawi because complications which can have a negative impact on maternal and neonatal health will be prevented.

Limitations of the Study

The study used purposive and not random sampling where each of the potential participants is given a chance of being selected. Apart from that, the study was conducted at one facility, as such the results cannot be generalized to the entire population. The researchers also encountered time constraint because the study was undertaken when other courses were in progress, so it was difficult to allocate enough time for the study. The devaluation of the kwacha also affected the study because most of the prices of several items had risen which was contrary to the budget that was prepared.

REFERENCES

1. Halldorsdottir S, Karlsdottir SI. Journeying through labour and delivery: perceptions of women who have given birth. Midwifery. 1996; 12: 48–61.
2. Cheung W, Ip WY, Chan D. Maternal anxiety and feelings of control during labour, a study of Chinese first-time pregnant women. Midwifery. 2007; 23 (2): 123–130. Doi: 10.1016/j.midw.2006.05.001.
3. Larkin P, Begley CM, Devane D. Women's experiences of labour and birth: an evolutionary concept analysis. Midwifery. 2009; 25: e49–e59.
4. Moore M, Armbruster D, Graeff J, Copeland R. Assessing the "caring" behaviours of skilled maternity care providers during labour and delivery: experience from Kenya and Bangladesh. The Change Project for Educational Development. Washington, DC, USA: The Manoff Group; 2002.
5. Kamwendo LA, Bullough C. Insights on skilled attendance at birth in Malawi – the findings of a structured document and literature review. Malawi Med J: 2005; 16 (2): 40–42.
6. National Statistical Office. Malawi Demographic and Health Survey 2010. Zomba, Malawi: National Statistical Office; 2011.
7. Fauveau V, Sherratt DR, de Bernis L. Human resources for maternal health: multi-purpose or specialists? Human Resour Health. 2008; 6: Article 21. doi: 10.1186/1478-4491-6-21.
8. Rice PL, Naksook C. The experience of pregnancy, labour and birth in Thai women in Australia. Midwifery. 1998; 14: 74–84.
9. Grossmann-Kendall F, Filippi V, De Koninck M, Kanhonou L. Giving birth in maternity hospitals in Benin: testimonies of women. Reprod Health Matters. 2001; 9 (18): 90–98.
10. Kuo SC, Wu CJ, Mu PF. Taiwanese women's experiences in interaction with their midwives during their antenatal checks and during labour. Midwifery. 2010; 26: 450–456.
11. Polit DF, Beck CT. Essentials of Nursing Research, Methods, Appraisal and Utilization. 6th edition. Philadelphia, PA, USA: Lippincott Williams & Wilkins.
12. Braun V, Clarke V. Using thematic analysis in Psychology. Qual Res Psychol. 2006; 3: 77–101.
13. Kululanga LI, Malata A, Chirwa E, Sundby J. Malawian fathers' views and experiences of attending the birth of their children: a qualitative study. BMC Pregnancy Childbirth. 2012; 12: 141.
14. Ministry of Health. Integrated Maternal & Neonatal Care Training Manual. Lilongwe, Malawi: Ministry of Health; 2009.
15. Nikiema B, Beninguisse G, Haggerty JL. Providing information on pregnancy complications during antenatal visits: unmet educational needs in Subsaharan Africa. Health Policy Plan. 2009; 24 (5): 367–376.
16. Kungwimba E, Malata A, Maluwa A, Chirwa E. Experiences of women with support they received from their birth companions during labour and delivery in Malawi. Health. 2013; 5 (1): 45–52. Doi: 10.4236/health.2013.51007.
17. Nwasor EO, Adaji SE, Bature SB, Shittu OS. Pain relief in labour, a survey of awareness, attitude and practice of health care providers in Zaria, Nigeria. J Pain Res. 2011; 4: 227–232.

18. Hiltunen P, Raudaskoski T, Ebeling H, Moilanen I. Does pain relief during delivery decrease the risk of postnatal depression? Acta Obstet Gynaecol Scand. 2004; 83: 257–261.
19. Parsons M. Policy or tradition: oral intake in labour. Aust J Midwifery. 2001; 14 (3): 6–12.
20. Maharaj D. Eating and drinking in labour: should it be allowed? Eur J Obstetr Gynaecol Reprod Biol. 2009; 146: 3–7.
21. Fraser DM, Cooper MA. Myles Textbook for Midwives. 15th edition. Edinburgh, UK: Elsevier; 2009.
22. Lawrence A, Lewis L, Hofmeyer GJ, Dowswell T, Styles C. Maternal positions and mobility during first stage labour. Cochrane Database Syst Rev. 2009; (2): CD003934.
23. Selman T, Johnston T. Mechanisms and management of normal labour. Obstetr Gynaecol Reprod Med. 2010; 20 (7): 201–206.
24. Neap N, Dodwel M, Newburn M. Working with pain in labour: an overview of evidence. New Digest. 2010; 49: 22–26.
25. Pascali-Bonaro D, Kroeger M. Continuous female companionship during childbirth: a crucial resource in time of stress or calm. Midwifery Women's Health. 2004; 49 (1): 19–27.

