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Voices of Pregnant Mothers: Accounts of Psychological Support from Midwives and Spouse at Sunyani Teaching Hospital, Ghana

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Article history: Received 33 November 2024, Reviewed 03 March 2025, Accepted for publication 06 March 2025

Abstract

Background: Support during pregnancy and childbirth significantly shape women's experiences and can mitigate challenges during delivery. Conversely, lack of emotional support, particularly from spouses and midwives, may lead to heightened anxiety and depression among expectant mothers, potentially impacting birth outcomes negatively.

Method: This qualitative study delved into the role of midwives and spouses in providing psychological support to pregnant women attending antenatal care at Bono Teaching Hospital, Ghana. Employing an exploratory design, thirty participants were purposively selected from the hospital's maternity and antenatal ward. Data was collected through interviews and analyzed using ATLAS.ti software.

Results:: Five main themes emerged: "Spousal support during pregnancy and childbirth," encompassing sub-themes such as providing financial assistance and assisting with household duties; "Midwives support during pregnancy and childbirth," including sub-themes like offering necessary care and preparing for childbirth; "Expected types of support," with sub-themes such as spouse presence during labour and patience from midwives; "Spousal barriers to support," which highlighted sub-themes like work commitments and financial constraints; and "Midwives barriers to support," revealed sub-themes such as disrespectful behaviour from pregnant women and noncompliance.

Conclusion: These themes showed the significance of diverse forms of support and illuminated challenges hindering psychological support. Understanding these dynamics could inform strategies to bolster support systems for pregnant women.

Keywords: Psychological support, Midwives, Spouse/Partners, Pregnancy, Childbirth

How to cite this article:

Manu N, Gbobbo J, Christian AA, Juabie BD, Asomah A, Mahmud A. Voices of Pregnant Mothers: Accounts of Psychological Support from Midwives and Spouse at Sunyani Teaching Hospital, Ghana. The Nigerian Health Journal 2025; 25(1):250 – 260.
https://doi.org/10.71637/tnhj.v25i1.964

Introduction

The goal of every woman going into pregnancy is to happily deliver a baby without complications. However, pregnancy can be a period of increased vulnerability, putting the expectant mother at risk of complications that can easily lead to death. Both parents are therefore required to face the new challenges during this period. Pregnancy could also be characterized by depression and anxiety.[1] In addition to the physical risks, there are psychological aspects to consider during pregnancy, since the emotional well-being of expectant mother and anxiety can significantly impact both the mother and the baby's health.[2].

Maternal mortality is currently a global health concern and reports have it that about 295,000 women died globally as a result of pregnancy and childbirth issues in the year 2017, and majority (94%) of these deaths were from low- and middle-income countries.[3] World Health Organization, report further showed that 86% of maternal deaths were from Sub-Saharan Africa and Southern Asia and that Sub-Saharan Africa alone accounted for two-thirds of maternal deaths. Ghana 's maternal mortality rate for 2020 was 263.0 (7.79%) increased from 2019 (4). All this higher maternal mortality rates deepen the anxiety level of the expectant mother. The adoption of the Sustainable Development Goals following lapses of the MDGs aimed at reducing maternal mortality rate globally to less than 70 per 100,000 live births by 2030. There is therefore the need for adequate psychological support for a woman during pregnancy, especially from the spouse and midwives to help achieved the sustainable development goals.

Pregnant mother with adequate psychological support from the spouse and midwife is much confident to deliver safely.[5] Midwives play a crucial role in the provision of maternal healthcare services, offering clinical expertise, emotional and psychological support, and guidance throughout the pregnancy and childbirth journey. The services and assistance are vital in ensuring safe and positive birth outcomes. Likewise, the role of the spouse or partner as a source of psychological support during pregnancy and childbirth period has gained recognition for its potential impact on maternal well-being and birth outcomes.[6]

Psychological support in pregnancy and childbirth is the expressed and instrumental reality which is provided by the midwife, community, social networks and reliable partners to pregnant women.[7] It influences women`s childbirth experience and it can reduce difficult, painful and long childbirth experience by reducing medical interventions (8). Psychological support in pregnancy entails appropriate reassurance, showing love such as a simple embrace, walking in company, encouraging the lady to take the necessary sleeps and snacks, helping her to make lifestyle modifications, including reducing the consumption of alcohol and caffeine, assisting throughout home chores to help her save her strength, making required changes in woman's energy-based sexual behaviors.[9]

Psychological support from spouse may serve as a pain relief for a woman in labour or during childbirth, and is necessary in that spouses are preferred companions for women in labour.[6]

Conversely, low levels of psychological support in pregnancy and childbirth is accompanied by negative childbirth experience and may also be a time of worry, anxiety, and affecting the mother and the unborn child's wellbeing.[9] Studies indicate that women with high pre-pregnancy stress and at the same time with no or little support had the highest chances of losing the pregnancy, difficulties with baby and emotional imbalance.[10]

Many researches had dealt with spousal support during pregnancy and childbirth all over the world 'the relationship between spousal support and depression, anxiety, stress, and prenatal attachment in high-risk pregnancies,' a husband support to the wife during pregnancy and delivery could prevent isolation and established emotional intimacy that prevents the environment of conflict between partners.[9]

Research on 'the effects of stress, depression, spousal and familial support on maternal identity in pregnant women' revealed that getting a husband's support during pregnancy and childbirth improves the perception of motherhood positively and that helps mothers to cope with the stressful factors experienced during pregnancy more easily.[11]

However, none of the researches done indicated mother's account of midwives and spouse psychological support during pregnancy and childbirth among women attending Sunyani Teaching Hospital, hence; there was a need for this study.

Methodology

Study Design

This study adopted the qualitative type and employed exploratory study design. This design was best since it allowed for the exploration of psychological support and barriers faced by participants during pregnancy and childbirth.

Print ISSN: 0189-9287 Online ISSN: 2992-345X

Study Setting
The study was carried out at the Sunyani Teaching Hospital, Ghana. Specifically, the data collection took place at the antenatal and maternity wards of the hospital. These are well established wards under the hospital. It operates at all days including weekends and offers OPD services.

The Sunyani Teaching Hospital was established on 11th May, 1927 by the British Colonial Masters as a hospital for Western Ashanti. The facility has undergone expansion since its establishment. It has been transformed into an ultra-modern hospital with the state-of-the-art medical facilities. Its vision is 'to be a World Class Healthcare Organization of repute applying best practices in the Medical and Nursing Care and in Training high caliber Medical Personnel. The hospital's mission is 'to provide quality driven, result-oriented, customer-centered and efficient healthcare services in a well-maintained environment with adequate number of well-motivated, competent and contended workforce who respect and value clients.

The hospital is located at the left-side along the main road leading from Sunyani Township to Techiman town. The hospital has a staff strength of about eight hundred consisting of health and non-health personnel.
Currently the hospital has about 400 beds, 15 wards and runs twenty-four-hour emergency care services. The hospital also provides outpatient department (OPD) services and other specialist care.

Study Population
The population for the study was pregnant women in all stages of pregnancy seeking care from the hospital antenatal unit. These groups were chosen based on an assumption that the pregnant mothers would have had sufficient experiences of the pregnancy and so they can reflect on their experiences on the support services receive from their partners and midwives.

Sample Size Determination
Mandal, have specified that choosing sample size for qualitative studies should be based on data saturation. However, it can also depend on the type of study, purpose of the study, how the findings can be used, resources and time available for the study (12). Based on this, a total of thirty (30) participants were used for this study.

Sampling Method
The Sunyani Teaching hospital was chosen as the study area based on purposive sampling technique. This is because; it serves as the only highest referral and Teaching Hospital in the Bono Region of Ghana.
The study also adopted a purposive sampling for recruiting the study participants. All eligible mothers seeking care from both the antenatal and maternity wards were identified. Each mother was approached personally. The purpose of the study and its importance were explained to each participant and their consent was obtained. The sampling processes continued for one month till all the (30) sample size was achieved, and when there was no new or relevant information emerged (data saturation).

Study Instrument
Data was collected from the participants using interview guide. The tool was designed by the researcher using related sample interview guides from sources such as the WHO and GHS as referencing material. The tool was sectioned into the following thematic areas; the socio-demographic information of respondents, partner support during pregnancy and childbirth, midwives' support during pregnancy and childbirth, kind of support expected by mothers during pregnancy and childbirth and factors serving as barriers to support during pregnancy and childbirth. The interview guide was made up of open-ended and probing questions.

Research rigor was ensured through trustworthiness principles in qualitative research, which encompassed four key principles. That is; credibility, transferability, dependability, and conformability. Each of these principles ensures the rigor and robustness of the study. Below is a discussion of these principles as they apply to this study.

Credibility: Strategies employed to enhance credibility were; spending adequate time with participants during interviews to build trust and obtained in-depth information.

Transferability was achieved through providing detailed descriptions of the research context, participants, and the phenomena under study, which allowed readers to determine the applicability of the findings to another context.

Dependability focused on audit trail by keeping detailed records of all the research processes, including data collection, analysis methods, and decision-making processes.

Conformability: Audit was also achieved by providing a clear description of the research process and allowing

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others to trace the findings back to their sources. Also, external audit was carried out by the research supervisors.

Data Collection Procedure

Administration of the interview guide employed face-to-face interviews with participants. Each participant was engaged to solicit responses on the issue. The approach of data collection was most appropriate for the study and it helped elicit detailed responses.

The languages that were used during the interview process were English and Twi. The researcher interviewed mothers who could speak English and the briefed field assistants interviewed mothers who speak Twi. An interview with a participant lasted for 20-30 minutes. Numbers were assigned to participants instead of their names. This was to ensure anonymity and confidentiality. Data saturation was reached after interview with the thirtieth participant. At this point, it was realized that enough data has been collected to adequately address the research questions. Also, no new information was emerging from the data collection. Data collected were stored on only the researcher's computer and kept under lock which would be destroyed after five years. The data were only used for the intended purpose.

Method of Data Analysis

Data were analyzed using thematic analysis with the aid of ATLAS.ti software. This software allowed the researcher to appropriately analyze the views of participants with the help of the study objectives serving as themes. The software had features such as character-based coding, rich text capabilities, and multimedia functions that are crucial for qualitative data management and improvement in the accuracy of qualitative studies.

The audio-taped recorded interviews were transcribed verbatim after a minimum of three times repeated listening and translated into English. The transcripts were cross-checked, edited, and validated by listening to audio files and comparing them with field notes to ensure they matched the unique codes and responses of participants.

Interview transcripts were stored using Microsoft Office Word. The researcher developed a folder for the interview transcripts. The data within the folder was coded and imported into the software for analysis.
The analysis followed the six steps of data analysis procedure in qualitative research work and that included; step 1; becoming familiar with the collected data, step 2; generating initial codes, step 3; searching for themes, step 4; reviewing themes, step 5; defining themes; and the last which is step 6, involved the write up from the analysis.
Step 1; Becoming familiar with the collected data: In this initial step, the researcher formed part of the collected data, which was transcribed from the interviews. The goal was to gain a deep understanding of the data by reading and re-reading the transcribed data, taking notes, and highlighting interesting or relevant sections.

Step 2; Generating initial codes: Once familiar with the data, the researcher started the coding process by systematically labeling or categorizing segments of the data with short, descriptive labels known as codes. These codes are often generated inductively, meaning they emerged directly from the data rather than being pre-determined.

Step 3; Searching for themes: After coding several segments of data, the researcher started to look for patterns, similarities, and connections between the codes. This involved organizing related codes into potential themes or patterns that reflected the important aspects of the data. Step 4; Reviewing themes: Once potential themes had been identified, the researcher reviewed and refined them by examining how well they capture the essence of the data. This involved revisiting the data to ensure that the themes were supported by multiple instances or examples.

Step 5; Defining themes: In this step, the researcher defined and name the final themes that emerged from the data. Each theme represented a coherent and meaningful pattern or concept that helped to answer the research questions or objectives.

Step 6; Write-Up from the analysis: The final step involved writing up the findings of the analysis in a coherent and compelling manner. This included providing a detailed description of each theme, supporting them with illustrative quotes or examples from the data, and discussing their implications in relation to the research question or objectives. These steps provided a systematic framework for analyzing the qualitative data and uncovered meaningful insights for the study.

Ethical approval

The study proposal was presented to the University of Port Harcourt ethical committee board for ethical clearance. Upon granted approval with ethical number UPH/CEREMAD/REC/MM95/055, the ethical

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clearance for the study and introductory letter was presented to the administration/authorities of the Sunyani Teaching Hospitals in the Bono Region, Ghana that served as the study areas. Participants' consent for participation was obtained before enrolled into the study. The content and the intention of the research were clearly explained to all the participants in English and in the local dialect (Twi). Participants were made to tick the agreement section on the interview guide to prove their acceptance to participate in the study before enrolled into the study. The research was conducted in a confidential and anonymous manner. Participants were assured of confidentiality with regards to the information given. Numbers were assigned to each participant instead of names to protect participant identity. Also, address of participants was not captured on the interview guide. There was no risk to any of the participants. Also, the research method did not involve experiments or inflicted any form of pain on the participants. Participants had the right to withdrawn from the study at any point in time without any implications.

Results

Socio-demographic characteristics of participants

Thirty (30) participants were interviewed in all. Among the participants, Interviewee 20 was the eldest, at 40 years, while Interviewee 10 was the youngest, at 17 years. Notably, Interviewee 1 was unaware of her gestational age, whereas Interviewee 15 had the longest gestational period recorded at 42 weeks. Conversely, interviewees 6 and 22 had the shortest gestational periods, both at 4 weeks. Most participants were primiparous, expecting their first child, including interviewees 7, 8, 10, 14, and 15, while others, like interviewees 27, 22, 24, and 3, had up to four children. Educationally, the majority had attained some level of education, with tertiary education being the highest achieved by interviewees 6, 15, 16, among others, while others, such as interviewees 30, 20, and 1, had basic education backgrounds. In terms of occupation, trading was the most common, although some participants were unemployed or engaged in civil service roles. The majority of participants identified as Christians, with a minority being Muslims. Six participants were unmarried but in relationships, while the rest were formally married. Most spouses were employed in government roles, with a few working as farmers. Regarding family structure, most participants lived in nuclear families, while some resided in extended families. However, Interviewees 8 and 14 did not fit into either category.

Spousal support during pregnancy and childbirth

It was observed that most husbands were generally supportive during pregnancy and childbirth. Support offered by husbands included; providing financial assistance, helping with house duties and offering emotional encouragement. For example; the second interviewee mentioned that her husband was more supportive.

"He supports financially and emotionally but he doesn't help around the house since we have a domestic worker for that" (Interviewee 11).

"He supports emotionally and he doesn't stress me, he also provides financially, he is not mostly home so I do the house work by myself" (Interviewee 11).

"He has been generally supportive financially and emotionally, when he is home, he helps with the house, but when he isn't, I do it myself" (Interviewee 13).

Midwives' support during pregnancy and childbirth

Midwives were perceived positively in terms of the care and support they provided during pregnancy and childbirth. Midwives' support during pregnancy and childbirth reported by participants included; Attentive to the needs of pregnant women,

example; Interviewee 1 mentioned that

"once you are able to communicate your problem to them, they do their best to help you" (Interviewee 1).

Interviewee 3 also said

"*they also do all their supposed to do and try to find out if we need extra care" (Interviewee 3).* Interviewee 13 added that *"they are doing their best"*

which also indicated that midwives were attentive to the needs of pregnant women by providing necessary information and care during pregnancy and childbirth.

They also indicated that midwives offered the necessary care and examples were; both the 2nd and 5th interviewees expressed satisfaction with the support received from midwives. They mentioned that midwives did their jobs well, asked necessary questions, provided care, and helped prepare for childbirth.

In addition, midwives were mentioned to give information and guidance throughout the birth process. For example;

Interviewee 11 mentioned that *"they have been extremely supportive, and I ask a lot of questions, so I get a lot of helpful information. They do all that is necessary for my well-being" (Interviewee11).*

"They do their best, they offer counseling and advice and help us in our nutrition" (Interviewee 20).

The 5th interviewee also said *"they do their jobs well, they ask the necessary questions and ensure that everything is going well with me, and helped me prepare well for my caesarian section" (Interviewee 5)*

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Kind of support expected by participants during pregnancy and childbirth

Expectation from spouse

The participants generally expected emotional support, financial support, practical / involvement in household chores and presence during labour. Comments made included:

The second interviewee expressed "a desire for her husband to handle childcare responsibilities while she attends antenatal appointments" (*2nd Interviewee*).

The fifth interviewee wished her husband could accompany her to the hospital. (5th *Interviewee*). *"A desire for more involvement in household chores" (Interviewee 25).*

Expectations from midwives

Most participants mentioned patience, empathy, additional/gentle care, emotional support and provision of essential information as kinds of support required from midwives during pregnancy and childbirth. Examples of their comments were;

the 5th interviewee stated that, *"I expect that some of them be more patience with us and pamper us"* (*Interviewee 5*).

"I wish they were more patient and empathetic when we're in pain during the labour period" (Interviewee 12).

"I wish they should be extra patient and gentle" (Interviewee 13).

"*I wish they can handle things with patience and care"* (*Interviewee 15*).

"To be extra patient and gentle" (Interviewee 16).

Spousal barriers to support participants during pregnancy and childbirth

Spousal barriers to support participants during pregnancy and childbirth yielded; work commitments, financial constraints, potential strains in the marital relationship, perceived disrespect from pregnant women and lack of consideration for husband's needs, unplanned pregnancies and already having many children. Examples of confessions given by participants were; the second interviewee mentioned that *"my husband was more supportive but getting an appointment in the mining company his availability has decreased due to his job (2nd Interviewee).*

and so, many of the participants had support barriers due to the job of their husbands.

"If he probably has another woman elsewhere who is taking all his time, he probably won't pay much attention to you" (5th Interviewee).

"If you always respect your husband and always consider his needs, he will always do his best for you during your pregnancy, but if you don't, there's a high possibility he would also not mind you" (2nd Interviewee.)

The 11th interviewee mentioned unplanned pregnancy as a barrier to support from husbands during pregnancy and childbirth. The 16th interviewee also mentioned having more children than planned as a barrier to support from husbands during pregnancy and childbirth.

Midwives' barriers to support mothers during pregnancy and childbirth

Potential barriers to midwives' support included disrespectful behaviour from pregnant women and noncompliance. The participants who mentioned disrespect and noncompliance as barriers to support were the 12th interviewee and the 14th interviewee.

The 12th Interviewee stated that

"Noncompliance on the part of the clients" Serves as barriers to midwife's support during pregnancy and childbirth. The 14th Interviewee In response to the question about what prevents midwives from supporting their partners during pregnancy and childbirth, the interviewee mentioned *"Constant disrespect and being selfish" (Interviewee 14)*

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Summary of the findings

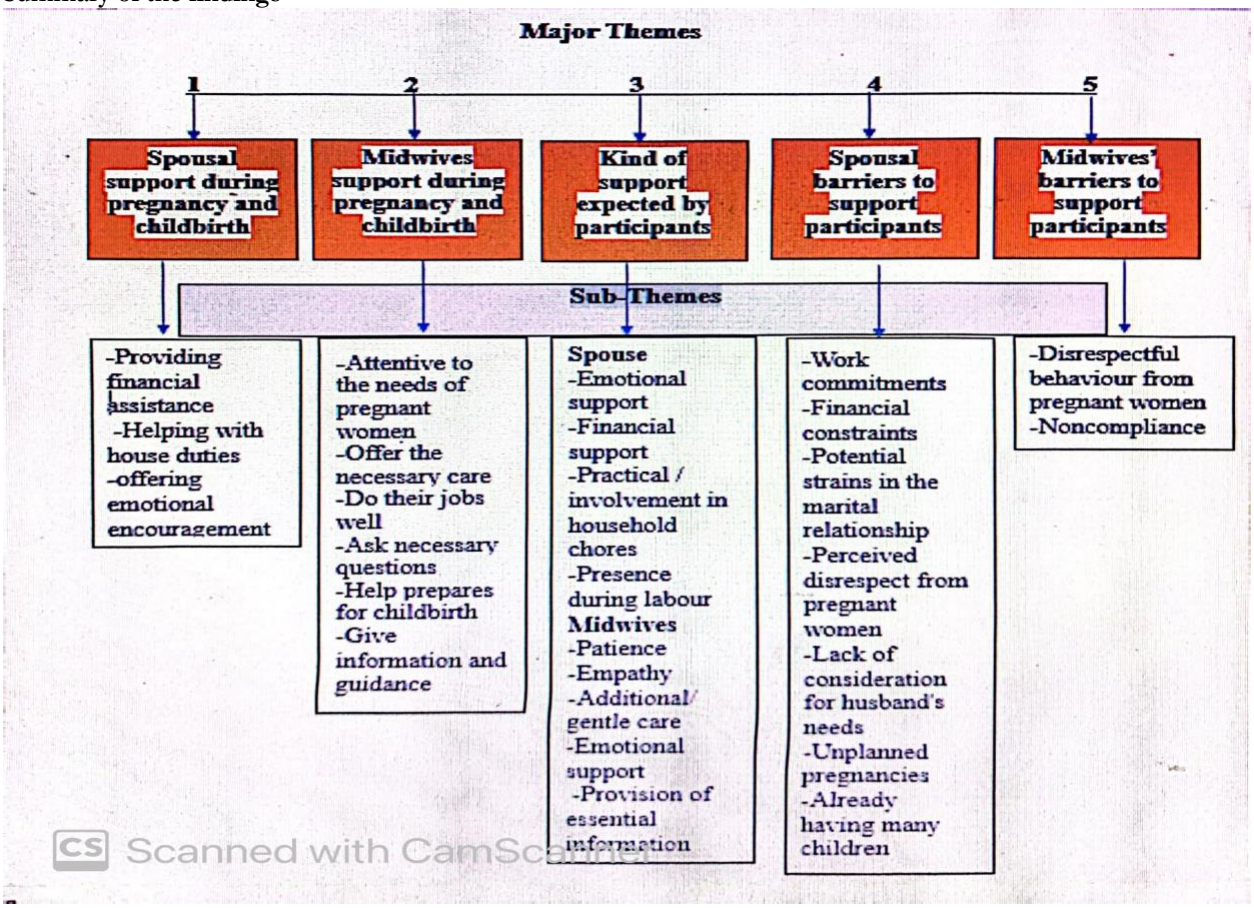

Figure 1. Major Themes

Discussion of findings

The findings regarding spousal support during pregnancy and childbirth reflected a common theme observed in previous research. Husbands were often identified as important sources of support for pregnant women, provided various forms of assistance to ensure the well-being of their partners and unborn children.

The provision of financial assistance by husbands aligned with studies highlighted the role of economic resources in facilitating access to maternal healthcare services and meeting the financial demands associated with pregnancy and childbirth.[11] Financial stability enabled women to afford essential prenatal care, included antenatal visits, medications, and hospital fees. Emotional encouragement from husbands was recognized as a crucial aspect of spousal support during pregnancy and childbirth.[13] Emotional support could alleviate stress and anxiety, promote maternal well-being, and strengthen the bond between partners during the transition to parenthood. The division of household chores and responsibilities between spouses might vary depending on cultural norms, socioeconomic status, and individual preference.[14] While some husbands actively participated in household duties, others might rely on external assistance, such as domestic workers, to fulfill these tasks. However, the absence of direct involvement in household chores did not necessarily imply a lack of support from husbands, as demonstrated by their contributions in other areas.

The accounts provided by the participants highlighted the positive perception of midwives and the valuable support they offered during pregnancy and childbirth. Participants expressed satisfaction with the attentiveness of midwives to their needs. This was consistent with previous literature emphasized the importance of patient-centered care and individualized support from healthcare providers.[9] Midwives' ability to listen to women's concerns, addressed their questions, and

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provided appropriate care contributed to a positive childbirth experience. Participants acknowledged the comprehensive care provided by midwives throughout the pregnancy and childbirth process. This included monitoring the progress of pregnancy, offered guidance on prenatal care practices, and ensured women were well-prepared for childbirth. The supportive role of midwives extended beyond medical interventions to encompass emotional support, counseling, and education on nutrition and healthy lifestyle choices. Midwives were recognized for their role in offered information and guidance to women during pregnancy and childbirth. This aligned with the principles of informed decision-making and shared decision-making, which were fundamental to respectful maternity care (3). By empowering women with knowledge about their childbirth options and ensured they were actively involved in decision-making, midwives promoted autonomy and dignity in maternity care.

Participants articulated several expectations from their spouses during pregnancy and childbirth, included emotional support, financial support, practical involvement in household chores, and presence during labour. The participants expressed a desire for emotional support from their spouses, indicated the importance of feeling understood and supported during the pregnancy journey. This aligned with previous research highlighted the significant role of emotional support from partners in promoted maternal well-being and reduced stress during pregnancy.[2] Many participants mentioned the importance of financial support from their spouses, emphasized the need for financial stability to cover medical expenses, childbirth-related costs, and other essential needs during pregnancy. Financial support from partners had been associated with improved maternal health outcomes and access to quality prenatal care.[15] Some participants expressed a desire for their spouses to be more involved in household chores, particularly during pregnancy when physical discomfort might limit their ability to perform certain tasks. This reflected the evolved role of men in caregiving and household responsibilities, contributed to a more equitable division of labour within the household.[9] Several participants wished for their spouses to accompany them during labour, highlighted the importance of emotional support and companionship during this critical time. Spousal presence during labour had been associated with reduced anxiety and increased satisfaction with the childbirth experience for women.[11]

With respect to expectation from midwives, participants again articulated expectations from midwives during pregnancy and childbirth emphasized the need for patience, empathy, additional/gentle care, emotional support, and provision of essential information. Participants expressed a desire for midwives to demonstrate patience and empathy, particularly during labour when women might experience pain and discomfort. This indicated the importance of compassionate care and respectful communication from healthcare providers in promoted positive childbirth experiences (9). Some participants wished for midwives to provide additional or gentler care, reflected a desire for personalized and supportive maternity care that met their individual needs and preferences. This echoed the principles of woman-centered care, which prioritized the physical, emotional, and psychological well-being of women throughout the childbirth process.[3] Participants highlighted the importance of emotional support from midwives, emphasized the need for reassurance, encouragement, and understanding during pregnancy and childbirth. Emotional support from healthcare providers had been linked to improved maternal satisfaction, reduced fear of childbirth, and better birth outcomes.[5] Many participants expected midwives to provide essential information about pregnancy, childbirth, and postpartum care, enabled them to make informed decisions and actively participate in their maternity care journey. Access to accurate and timely information was essential for empowering women and promoting autonomy in maternity care.[1]

Despite the importance of spousal support during pregnancy and childbirth, participants identified several barriers that hindered their partners' ability to provide adequate support. These barriers included work commitments, financial constraints, strains in the marital relationship, perceived disrespect from pregnant women, and lack of consideration for husbands' needs, unplanned pregnancies, and already having many children. Many participants cited their husbands' work commitments as a significant barrier to provide support during pregnancy and childbirth. Demanding job schedules, long working hours, and limited flexibility made it challenging for spouses to accompany them to appointments or be physically present during labour and delivery. This aligned with previous research highlighted the impact of work-related stress on spousal support and involvement in maternity care.[16] Financial limitations also posed barriers to spousal support, as some husbands struggled to provide adequate financial assistance for medical expenses, prenatal care, and childbirth-related costs. Economic instability and limited resources might exacerbate stress and strain within the marital relationship, impacted the overall support

Print ISSN: 0189-9287 Online ISSN: 2992-345X

provided by partners during pregnancy.[17] Participants mentioned strains in the marital relationship as a barrier to spousal support during pregnancy and childbirth. Conflicts, misunderstandings, or unresolved issues between spouses might diminish emotional support, communication, and cooperation, negatively affected the pregnancy experience for women.[5] Some participants expressed feelings of disrespect from their pregnant partners or perceived a lack of consideration for their needs, which contributed to decreased support from husbands. This suggested the importance of mutual respect, understanding, and effective communication within the marital relationship to foster supportive dynamics during pregnancy and childbirth.[18] Unplanned pregnancies and having more children than planned were identified as additional barriers to spousal support during pregnancy and childbirth. These circumstances might lead to feelings of stress, financial strain, and emotional overwhelm, reduced partners' capacity to provide adequate support and involvement in maternity care.

While midwives were generally perceived positively for the care and support, they provided during pregnancy and childbirth, participants identified certain barriers that hindered effective support from midwives. These barriers included disrespectful behaviour from pregnant women and instances of noncompliance with medical advice or recommendations. Some participants mentioned instances where disrespectful behaviour from pregnant women served as a barrier to midwives' support during pregnancy and childbirth. This could manifest as rude or dismissive attitudes towards midwives, which might impact the quality of care provided and the overall experience for both parties. Disrespectful interactions might stem from various factors, including cultural differences, communication breakdowns, or underlying stressors, highlighted the importance of addressed interpersonal dynamics within the healthcare setting.[19] Noncompliance with medical advice or recommendations was cited as another barrier to midwives' support during pregnancy and childbirth. Participants noted that when pregnant women failed to adhere to prescribed treatment regimens, attend scheduled appointments, or follow childbirth preparation guidelines, it could impede the midwives' ability to provide optimal care and support. Noncompliance might result from various factors, including lack of understanding, fear, or personal beliefs, underscored the importance of patient education, counseling, and shared decision-making in maternity care (10).

Implication of the findings

The research contributed to knowledge by shedding light on the nuanced role of psychological support needed during pregnancy and childbirth, particularly within the Ghanaian context. By exploring the perspectives of both partners and healthcare providers, the study provided a comprehensive understanding of the various forms of support and barriers encountered during this crucial period. Additionally, the identification of specific sub-themes, such as spousal assistance with financial matters and midwives' provision of necessary care, added depth to existing literature on the subject. Furthermore, the study showed the importance of addressing barriers to support, such as work commitments and disrespectful behaviour, to enhance maternal well-being and improved birth outcomes. Overall, the findings contributed valuable insights that could inform the development of strategies and interventions aimed at strengthened support systems for pregnant women, ultimately led to improved maternal and neonatal health outcomes.

Conclusion

The findings of this study indicated the importance of spousal and midwife support during pregnancy and childbirth in ensuring positive maternal and neonatal outcomes. While both spouses and midwives played crucial roles in providing support, various factors were identified to influence the quality and effectiveness of this support. Spouses' support was essential for pregnant women's emotional well-being, financial stability, and overall health during pregnancy and childbirth. However, challenges such as work commitments, financial constraints, and strained relationships were identified to impede spousal support. Midwives' support was critical for ensured safe and positivechildbirth experiences. While midwives were generally perceived positively, disrespectful behaviour from pregnant women and noncompliance with medical advice posed challenges to effective support rendered by midwives.

Declarations

Authors' Contribution:

Manu Naomi (Conducted the primary research, including data collection, analysis, and interpretation, drafted the manuscript, integrating feedback from other authors, coordinated the revision process and finalized the article for submission)

Josephine Gbobo (Provided overall guidance and support throughout the research work, provided critical feedback and intellectual inputs throughout the research process, including reviewing and revising the

Print ISSN: 0189-9287 Online ISSN: 2992-345X

manuscript, ensured the research adhered to ethical *guidelines and institutional protocols)*
Ankamah Ababio Christian (Assisted with qualitative data analysis, helped draft sections of the manuscript, particularly related to the study methodology and results, assisted with the draft of the study tool)
Bennin Douri Juabie (Assisted with interpretation of data and findings, contributed to manuscript revision, provided expertise in aspects like; conceptual framework of the study, assisted with review of theories related to the study)
Asomah Amanda (Helped with manuscript revision, assisted with discussion of the study results, helped with data collection, helped with pretest of study tool
Ali Mahmud (Helped with manuscript drafting and revision, assisted with the draft of ethical clearance and cover letters, assisted with drafting the study tool, assisted with data collection)
Conflict of interest: There is no conflict of interest to declare
Funding: The research is self-sponsored without any external sources of fund or grant awarded

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Print ISSN: 0189-9287 Online ISSN: 2992-345X

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Print ISSN: 0189-9287 Online ISSN: 2992-345X