

# **Women's views and experiences of continuous support during childbirth: a meta-synthesis**

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**DECLARATION BY STUDENT**

I declare that "Women's views and experiences of continuous labour support during childbirth: a meta-synthesis" is my own work and that all the sources that I used or quoted are acknowledged by complete references.

*P Lunda*

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*09.12.2016*

Date

## **ABSTRACT**

**Background:** Despite the known benefits of continuous support during childbirth, the practice is still not routinely implemented in all maternity settings and women's perspectives might not be considered. This study aimed to provide midwives and other healthcare professionals with summaries of best available research evidence on women's views and experiences regarding continuous support during childbirth. The review question was: What were the views and experiences of women regarding continuous support during childbirth as reported in qualitative studies and in studies that adopted mixed research methods with a qualitative component that used semi-structured, in-depth or focus group interviews or case studies?

**Methods:** A detailed search was done on electronic data bases: EBSCOhost: Medline, PsychINFO, SocINDEX, OAlster, Scopus, SciELO, Science Direct, PubMed and Google Scholar. The data bases were searched for available literature using a predetermined search strategy. Reference lists of included studies were analysed to identify possible studies that were missing from data bases. The phenomenon of interest was women's views and experiences of continuous support during childbirth. Pre-determined inclusion and exclusion criteria were applied during the selection of eligible sources. In total 12 studies were included in the data analysis and synthesis.

**Results:** Two categories, according to women's perspectives on continuous support during childbirth, were identified namely the role and attributes of the support persons and challenging aspects regarding continuous support during childbirth. Some women did not distinguish between the role of a support person/doula and a midwife. Women's perspectives about continuous support during childbirth were influenced by culture, traditions and values, relationships with specific support persons as well as institutional practices, forms of supportive care received and the attributes of the support person. Clearly women preferred someone they were familiar and comfortable with.

**Conclusion:** Continuous support during childbirth was valued by most women. Health care institutions should include continuous support during childbirth in their policies and guidelines and birth plans.

**Key words:** birth companion, childbirth experiences, continuous childbirth support, doula, systematic review

## OPSOMMING

**Agtergrond:** Nieteenstaande die welbekende voordele van ononderbroke ondersteuning tydens kindergeboorte, word die praktyk steeds nie roetinegewys in alle verloskunde eenhede toegepas nie en vroue se beskouings word nie algemeen in ag geneem nie. Hierdie studie was daarop gemik om aan vroedvroue en ander gesondheidsorgwerkers 'n wetenskaplike opsomming te verskaf van die beste beskikbare navorsingsbewyse aangaande vroue se beskouings en ervarings betreffende ononderbroke ondersteuning tydens kindergeboorte. Die oorsigvraag was: Wat was vroue se beskouings en ervarings betreffende ononderbroke ondersteuning tydens kindergeboorte soos gerapporteer in kwalitatiewe studies en studies wat gemengde navorsingsmetodes met 'n kwalitatiewe komponent, en wat semi-gestruktureerde, indiepte en fokusgroep onderhoude of gevallestudies gebruik het om data in te samel?

**Metode:** 'n Gedetailleerde soektog is gedoen op elektroniese databasisse: EBSCOhost: Medline, PsychINFO, SocINDEX, OAlster, Scopus, SciELO, Science Direct, PubMed en Google Scholar. Die databasisse is deursoek vir beskikbare literatuur deur gebruik te maak van 'n voorafbepaalde soekstrategie. Bronnelyste van ingeslote studies is ontleed om studies te identifiseer wat moontlik deur ander databasisse gemis is. Die fenomeen van belang was vroue se beskouings en ervarings betreffende ononderbroke ondersteuning tydens kindergeboorte. Voorafbepaalde insluitings- en uitsluitingskriteria is gebruik gedurende die seleksie van geskikte bronne. 'n Totaal van 12 studies is ingesluit in die data analise en sintese.

**Resultate:** Twee kategorieë, volgens die vroue se beskouings betreffende ononderbroke ondersteuning tydens kindergeboorte, is geïdentifiseer naamlik die rol en eienskappe van ondersteuningspersone en uitdagende aspekte betreffende ononderbroke ondersteuning tydens kindergeboorte. Sommige vroue het nie onderskei tussen die rol van 'n ondersteuningspersoon/doula en 'n vroedvrou nie. Vroue se beskouings betreffende ononderbroke ondersteuning tydens kindergeboorte is beïnvloed deur kultuur, tradisies en waardes, verhoudings met spesifieke ondersteuningspersone en die eienskappe van die ondersteuningspersone. Dit blyk duidelik dat vroue iemand verkies met wie hulle bekend en gemaklik is.

**Gevolgtrekking:** Ononderbroke ondersteuning tydens kindergeboorte word waardeur deur die meeste vroue. Gesondheidsorginrigtings behoort ononderbroke ondersteuning tydens kindergeboorte in te sluit in hulle beleid en riglyne en geboorteplanne.

**Slutelwoorde:** geboorte metgesel, kindergeboorte ervarings, ononderbroke kindergeboorte ondersteuning, doula, sistematiese oorsig

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## LIST OF ABBREVIATIONS

ADA	American Dietetic Association
BBI	Better Births Initiative
CASP	Critical Appraisal Skills Programme
CBD	Community Based Doulas
CRD	Centre for Reviews and Dissemination
HREC	Human Research Ethics Committee
ICM	International Confederation of Midwives
LDRP	Labour, Delivery, Recovery and Postpartum unit
NAHO	National Aboriginal Health Organization
NVD	Normal Vaginal Delivery
NWU	North-West University
PICO	Acronym for Population of Interest, Comparison intervention and Outcome
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
RIS	Research Information Systems
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, Research Type
USA	United States of America
WHO	World Health Organization

## REPORT OUTLINE

The report was written according to the guidelines for submitting a dissertation in article format in the NWU Manual for Master's and doctoral studies (NWU, 2016:22).

One manuscript was written and prepared according to the guidelines of the specific journal selected, namely BioMed Central Pregnancy and Childbirth.

The following structure was followed during writing the research report:

**Section 1:** – Overview and literature review: part 1 study overview and part 2 literature review on continuous support during childbirth was done to describe the context of the study.

**Section 2:** – Manuscript for BMC Pregnancy and Childbirth including research findings and discussion titled: Women's experiences of continuous support during childbirth: a meta-synthesis.

**Section 3:** – Conclusions, limitations and recommendations of the study.

The researcher, Petronellah Lunda did the research and wrote the manuscript. Prof Karin Minnie and Mrs Petro Benadé were the study's supervisor and co-supervisor respectively and provided guidance for conducting the study and writing the manuscript.

Sections 1 and 3 are referenced according to the North-West University (NWU) referencing guide (2012). The manuscript (section 2) is referenced according to the BMC journal guidelines. Tables and figures are captured as additional files in section 2 of the dissertation.

## **SECTION 1: OVERVIEW AND LITERATURE REVIEW**

### **PART 1: STUDY OVERVIEW**

#### **1.1 INTRODUCTION**

Considering women's perspectives during provision of care is an essential aspect of midwifery. Thus it is necessary to consider women's perspectives about continuous support during childbirth.

In this part of section 1, the overview of the study will be discussed. Firstly, the background of and rationale for the study and problem statement are presented, followed by the research question, purpose of the study, research objectives, researcher's paradigmatic perspective and clarification of the concepts used in the study, and the research design and method. Quality assurance will be discussed in terms of measures observed to ensure rigour and ethical considerations will be explained. In part II of this section a brief literature review, emphasising the significance of the study, will be provided.

#### **1.2 BACKGROUND OF AND RATIONALE FOR THE STUDY**

The last quarter of the 20<sup>th</sup> century witnessed progress in medical expertise which increased aggressive interferences during childbirth (Romano & Lothian, 2008:94). These advances have probably caused midwives to spend more time managing machinery than offering comfort and support to women during childbirth. If women's needs and wishes are not the primary focus of care, but rather medical interventions and technology, then the birth process might be regarded as being a medical event, rather than the physical, emotional, and social event that it is (Green & Hotelling, 2014:194). Not all women require medically orientated care, since most women can have a physiological childbirth that begin and end without the routine use of medical interventions or drugs (Albers, 2007:207).

Institutional births expose women to unfamiliar environments with strangers (Albers, 2007:207). The unfamiliar environment could prompt feelings of uncertainty and distress causing women to tolerate almost anything to which they are exposed or to become uncooperative (Kritzinger, 2006:154). Women might become anxious about being abandoned or their babies being ill-treated should they disobey the professionals. Having a familiar and trusted support person could alleviate such anxiety (Rooks, 1999:370).

Fraser and Cooper (2009:477) and Rooks (1999:370) highlight that childbirth is an event with great implications for women and their families. Furthermore Rooks (1999:370) asserts that childbirth is regarded as a natural process and therefore should be treated as such until a

problem arises. Pascali-Bonaro (2003:5) maintains that women will have childbirth memories for a 'lifetime', thus labour companionship should be a precursor of a wonderful lifetime experience as the woman needs companionship, love and support to make the process bearable and memorable (Rooks, 1999:370). During childbirth, women have various needs which they expect their caregivers to meet. These needs range from a caring presence, pain relief, to being praised and receiving relevant information regarding childbirth (Bianchi & Adams, 2004:24).

Hodnett *et al.* (2012:3) consider 'physical, emotional support, information and advice and advocacy' as the main elements of childbirth support. Provision of information, regarding the process of childbirth, and praise from midwives will allow women to view it as a normal and significant event in life and not as a frightening one (Fenwick *et al.*, 2010:399). Each element of childbirth support comprises of different components, for example emotional support is said to include 'reassurance and praise, information and advocacy, while physical support includes comfort measures, such as touch and massage, warm baths, showers, encouraging fluid intake and output.' Some of these aspects could be assigned to persons specifically focussed on providing support, such as doulas while midwives provide the professional aspects of care (Campbell *et al.*, 2006:456). These elements can reduce women's worries associated with unpleasant childbirth effects.

Doula is a Greek word which means "woman caregiver" (Campbell *et al.*, 2006:456). A doula is a trained, 'non-medical' person (Hans *et al.*, 2013:486; Lantz, 2005:100). According to Green and Hotelling (2014:194) and Pascali-Bonaro and Kroeger (2004:19), the role of the doula is to provide support and guidance to the woman during childbirth and a sense of security and reassurance to the partner and family - their focus is on providing therapeutic care.

Part of therapeutic care is focused on the woman and her needs, hence there is need to consider women's views (Hatamleh *et al.*, 2013:502). This view is supported by Green (2012:294) by stating that caregivers, and those involved in research and in the formulation of guidelines, need to understand what women value and why, in order to consider these aspects. The significance of incorporating women's ideals in rendering care is emphasised by 'The Royal College of Midwives' (2014:6), when stating that midwives have a duty to enable women to make sound decisions based on their clinical needs and values. Moreover, the Confederation of Midwives (ICM), (2005:3), states that the goal of midwifery is to: 'Provide support and care to women and their families to ensure best outcomes which can be physical, emotional or social.' Consequently, the midwife in her professional capacity has to ensure that the woman has a memorable childbirth experience through shielding and supporting the

woman. Fraser and Cooper (2009:477) also maintain that the midwives and other support persons should be compassionate to women by recognising their needs and choices to promote autonomy. Unless women's voices are heard and considered, they will continue to be subjected to disempowering care and practices. Burman *et al.* (2013:239), Leap, (2009:15) and Pope *et al.* (2001:235) point out that health institutions and strategists need to come on board and align themselves to adopting and maintaining a woman-centred childbirth care approach.

Providing woman-centred care and maintaining sound relations with caregivers might help to reduce the fear and anxiety experienced by women during childbirth (Chan *et al.*, 2013:108). Good interpersonal relationships are the essence of midwifery care as midwife means "with woman." Forthcoming for the midwife is a caring approach, good communication skills, and 'being there' for women (Nicholls & Webb, 2006:427). Significantly a midwife should possess qualities and abilities that enable her to perceive women as individuals and treat them as such. Providing supportive care contributes to women having positive and satisfactory childbirth experiences (Bianchi & Adams, 2004:26).

A meta-synthesis would provide midwives and other healthcare professionals with a summary based on best available evidence which they can implement to render continuous support during childbirth that is evidence based and acceptable by women. Subsequently women will have positive and satisfactory childbirth experiences. The only related meta-synthesis was done by Bowers in 2002. The themes were: expectations of labor support, physical comfort, caring and emotional support, interpersonal communication style, communication of information and instructions, advocacy and competence of the professional. Furthermore, Bowers highlighted that no matter what the birth setting, the presence of a caring support person would enable women to overcome the stress and anxiety related to childbirth. The meta-synthesis of Bowers was done 15 years ago and hence there is a need for a recent meta-synthesis to generate a new scientific summary of women's' accounts.

### **1.3 PROBLEM STATEMENT**

It was evident from the introduction and background that there is no recent research synthesis focussing on women's views and experiences, which could be traced. A meta-synthesis in this regard had been done more than ten years ago by Bowers (2002). It reviewed and synthesized qualitative research studies of women's perceptions concerning professional labour support. Related meta-synthesis include: expert intra-partum maternity care (Downe *et al.*, 2007); first time mothers' experiences of early labour (Eri *et al.*, 2015); women's experiences of caesarean births (Puia, 2013) and a secondary analysis on women's long-term memories and

experiences of childbirth (Lundgren *et al.*, 2009). The availability of a scientific summary based on best evidence will afford busy practitioners access to a comprehensive body of knowledge without having to read numerous individual studies. Consequently the synthesis of evidence of women's views and experiences regarding continuous support during childbirth will contribute to evidence based practices that could be utilised to enhance women's childbirth experiences.

#### **1.4 RESEARCH QUESTION**

What is the best available research evidence about women's views and experiences regarding continuous support during childbirth?

#### **1.5 PURPOSE OF THE STUDY**

The purpose of the study was to integrate individual studies' findings related to women's views experiences of continuous support during childbirth in order to expand the understanding of the phenomenon. A synthesis of findings of qualitative studies about women's views and experiences, regarding continuous support during childbirth, will provide scientific evidence that is based on women's perspectives. More so a comprehensive body of knowledge about women's views and experiences will highlight the plight of women on issues that are important to them. By synthesising best evidence on women's views and experiences of continuous support during childbirth, healthcare providers will have a scientific summary that will facilitate their understanding of what women expect from their caregivers and, in turn, provide them with acceptable and desired type of care.

#### **1.6 RESEARCH OBJECTIVES**

The aim of this study is to systematically obtain, appraise and synthesise available research evidence concerning women's views and experiences of continuous support during childbirth in order to improve continuous labour support considering women's perspectives. Therefore the objectives are to:

- gather and appraise evidence about women's views and experiences concerning continuous support during childbirth and synthesise evidence regarding women's views and experiences of continuous support during childbirth.

## **1.7 PARADIGMIC PERSPECTIVES**

A paradigm is an integral part of the researcher's choice of design and the ensuing study thereof. When conducting research, the researcher considers and applies his/her paradigmatic perspectives throughout the research process as it forms the embodiment of the process. Polit and Beck (2012:6) state: "A paradigm is a world view, a general perspective on the world's complexities". Muller (1998:2) elaborates: "A person's world view is the way in which the person thinks about life and the world, linked to the values which the person sets for herself or himself within the context of this school of thought". Thus the paradigm should be clearly stated at the outset. In this study, the researcher departed from a constructivist paradigm. The ontological, epistemological and methodological dimensions that shape social sciences research will be discussed briefly as applied to the current study.

### **1.7.1 Constructivist paradigm**

A constructivist paradigm seeks to understand a phenomenon from the participants' point of view. It is grounded in inductive reasoning, seeks to explore, understand and assign meaning to the lived experiences of participants (Grove *et al.*, 2014:24; Wagner *et al.*, 2012:54). These authors state that a constructivist paradigm acknowledges that there are multiple social realities and not just one truth as the truth is context-dependent. In this study the social realities are vested in women's views and experiences of continuous labour support during childbirth. These realities are part of a group's social values which set them apart from other groups (Wagner *et al.*, 2012:54).

### **1.7.2 Ontological dimension**

Research in social sciences is always directed at an aspect or aspects of social reality. The reality could comprise human activities, characteristics, opinions, values or behaviours. This variety provides diverse angles on the nature of the research domain (Mouton & Marais, 1988:11). For the current study, the aspects of social reality included women's views and experiences of continuous support during childbirth.

### **1.7.3 Epistemological dimension**

According to Mouton and Marais (1988:14), the aim of undertaking a study is not merely to understand a phenomenon, but rather to provide a valid and reliable understanding of reality that can be used in shaping reality within the dimension of social sciences. Hence, once a research synthesis is available, it will provide a wider meaning and a better understanding of women's views and experiences of continuous support during childbirth. Qualitative studies

will be synthesised as they provide distinctive understanding into the subject of childbirth support (Bowers, 2002:742).

#### 1.7.4 Methodological dimension

Research in social sciences may be regarded as objective by virtue of it being critical, balanced, unbiased, systematic and controllable (Mouton & Marais 1988:15). In order to unravel the reality, systematic steps have to be undertaken in order to gather evidence that is scientific. Mouton and Marais (1988:14) emphasise that the methodological facet is concerned with the 'how' part of social science research. Accordingly a systematic review was chosen as the research method for the current study as it incorporates transparent, organised and structurally interrelated steps (Holly *et al.*, 2012:15).

#### 1.7.5 Central theoretical argument

According to Botma *et al.* (2010: 187) theoretical assumptions mirror the researcher's insight on existing theoretical frameworks pertaining to the problem under study, because scientific research does not occur in isolation. For this study the focus is on women's views and experiences of continuous support during childbirth. As mentioned in the background and problem statement, no recent meta-synthesis could be found on women's views and experiences on continuous support during childbirth, the last one was conducted in 2002 by Bowers. The outcomes of this study will be made available through a published article in order for healthcare workers to have a recent accessible scientific summary to use in practice for decision and policy making regarding continuous childbirth support.

#### 1.7.6 Concept clarification

Concepts that are central to this study are defined in table 1.1.

Table 1.1: Concepts used in the current study

Concept/s	Everyday use	Use in the current study
<b>Childbirth and labour</b>	Terms applied to the normal outcome of pregnancy with the birth of an infant (Blackwell's Nursing Dictionary, 2005:120:324).	The process of giving birth by a woman who was pregnant. The preferred term is childbirth but in the literature the terms 'labour' and 'delivery' (of a baby) are used. Consequently these three terms are used as synonyms throughout this dissertation.
<b>Continuous support</b>	"To be consistent by providing assistance that is continuous; always happening" (Compact Oxford English Dictionary, 2013:211, 1041)	The provision of help by the person present according to the woman's needs throughout the birthing process. Can include all types of support such as physical, psychological and emotional support.

<b>Doula</b>	Doulas are trained non-medical professionals who provide physical comfort, emotional support, and information to mothers during childbirth and the immediate postpartum period (Hans <i>et al.</i> , 2013:446).	A trained female who offers continuous support during childbirth.
<b>Experience</b>	Practical contact with and observation of facts or an event which leave an impression (Compact Oxford dictionary, 2013: 349).	Women's accounts of childbirth - what they went through during the birthing process.
<b>Evidence analysis</b>	Evidence analysis describes steps the academic analysis team undertakes to identify research through database searches (ADA, 2012:21). These steps are similar to the systematic review's steps.	'Systematic review' will be used to describe steps undertaken by the researcher using a predetermined search strategy to identify relevant studies from databases.
<b>Meta-synthesis</b>	'Where a review of qualitative studies is undertaken to generate a synthesis' (CRD: 2009:268).	An in-depth review of studies using a qualitative approach and mixed methods with a qualitative element will be conducted.
<b>Midwife and midwifery and nurses</b>	A midwife is a person who has successfully completed a midwifery education programme that is recognised in the country where it is located. Midwifery involves rendering care and support to women during pregnancy, childbirth and the postpartum period (ICM, 2005:1).	In South Africa, most professional nurses are also midwives. In this study the term midwives shall be used to refer to a person who received professional education in midwifery and works with women during the antenatal, intra-partum and postpartum periods. Where the term 'nurse' is used, it also refers to nurses working with women during pregnancy, childbirth and postpartum.
<b>Support person</b>	A support person is an individual who offers encouragement or approval to someone (Compact Oxford English Dictionary, 2013:758).	The person present and designated to offer: emotional and physical care to the woman throughout childbirth. This can be a midwife, doula or other person.
<b>Systematic review</b>	Systematic reviews aim to identify, evaluate and summarise the findings of all relevant individual studies thereby making the available evidence more accessible to decision makers' (Centre for Reviews and Dissemination (CRD), 2009:v).	Steps will be undertaken to identify, evaluate and synthesise individual studies' findings relevant to the review question, and the meta-synthesis will be formulated on this basis.
<b>Thematic synthesis</b>	'A method used in the analysis of qualitative data to systematically identify the main, recurrent and/or most important themes and/or concepts across multiple responses' (CRD: 2009:275)	Narratives of women reported in individual eligible studies which will be used to identify core concepts on which the synthesis will be based.
<b>Views</b>	Manner of seeing a subject; opinion or mental attitude (The concise Oxford dictionary, 1197).	How the women perceive their childbirth experiences.

## 1.8 RESEARCH DESIGN AND METHODS

The research design and the methods used are discussed in this section.

### 1.8.1 Research design

In this study a systematic review was done of existing studies on women's views and experiences of continuous support during childbirth. An explorative descriptive design was followed, using a systematic review which entails a set of transparent, organised, structurally

interrelated steps (Holly *et al.*, 2012:15) aimed at searching and identifying relevant primary studies related to the research topic using electronic databases (Finfgeld-Connett & Johnson, 2012:3). Once identified, the relevant studies were subjected to a process of quality assessment to derive dependable findings for inclusion in the review (Thomas & Harden, 2008:6).

### 1.8.2 Research method

A meta-synthesis was used to integrate research evidence answering the research question, through careful sampling and data collection procedures, according to a selected protocol. The steps of the systematic review were adapted from the evidence analysis process of the American Dietetic Association (ADA) (2012:6-67) as outlined in Figure 1.1.

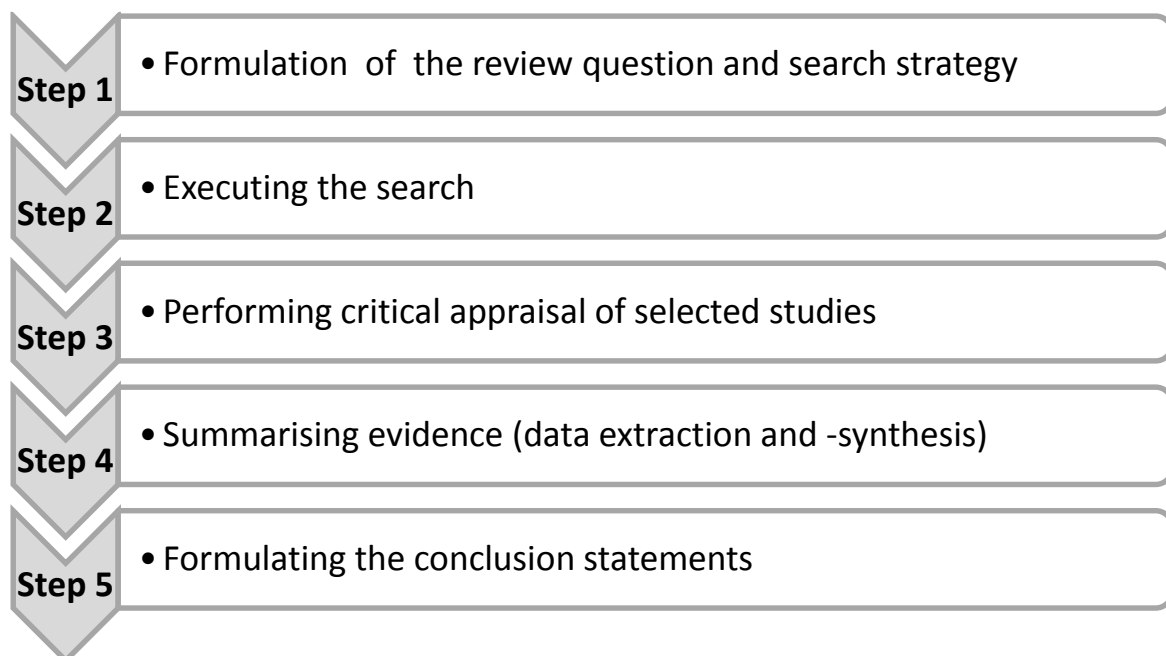


Figure 1.1: The five steps of a systematic review (adapted from ADA, 2012:6-67).

#### 1.8.2.1 Step 1- Formulation of the review question and search strategy

The review question was formulated to aid the search for relevant studies (ADA, 2012:3). The review question was formulated based on the SPIDER format as a search strategy tool to find available research evidence about women's views and experiences regarding continuous support during childbirth. SPIDER as a search strategy is more suitable to studies using qualitative methods and mixed methods while the PICOT tool is better suited to intervention studies (Cooke *et al.*, 2012:1440).

Table 1.2 Elements of the review question according to the acronym SPIDER.

<b>ELEMENTS OF THE SPIDER</b>	<b>ELEMENTS AS APPLIED IN THE CURRENT STUDY</b>
<b>search strategy</b>	
<b>S- Sample</b>	Patients; mothers; women who experienced labour
<b>PI - Phenomenon of Interest</b>	Continuous support; intra-partum care; labour/labour support; companionship; doula; one-to-one care; emotional support.
<b>D - Design</b>	Studies using a qualitative approach and mixed methods with a qualitative component
<b>E - Evaluation</b>	Experiences; perceptions; opinions; views
<b>R - Research type</b>	Semi-structured, in-depth or focus group interviews, case studies

Review question: What were the views and experiences of women regarding continuous support during childbirth as reported in qualitative studies and in studies that adopted mixed research methods with a qualitative component that used semi-structured, in-depth or focus group interviews or case studies?

Once a good review question had been formulated, the best and most appropriate research strategy that addressed the question was developed. This process involved several actions for meticulously identifying evidence. Documentation was done consistently of modifications of the search strategy as they occurred. The search strategy comprised selection of search words, databases, manual search and inclusion and exclusion criteria (ADA, 2012:21; Kitchenham, 2004:8; Melnyk & Fineout-Overholt, 2012:11). The search aimed to include all studies relevant to the review question. This eliminated researcher prejudice while simultaneously being specific regarding the search.

### **Search words**

The elements of the SPIDER method as applied in this study and their alternatives were used as search words in the search string and divided by AND and OR respectively.

- women OR patients OR mothers AND
- experience\* OR perception OR opinion OR view\* AND
- continuous\* AND
- labor\* OR childbirth\* OR delivery AND
- emotional support OR intra-partum care OR one-to-one care OR companionship AND/OR doula AND
- qualitative

The search strings were adapted according to each data base's requirements. An experienced librarian of the North-West University (NWU) library (Potchefstroom campus) assisted with the development of the final search strategy, the correct databases as well as search terms for the different databases (Holly *et al.*, 2012:21).

### Search methods

- **Electronic sources**

The following electronic databases and search engines available at the North-West University were included in the search strategy.

Table 1.3 Data bases used in the search strategy

Electronic databases and search engines	Type of literature included
<b>International:</b> EBSCOhost: <ul style="list-style-type: none"> <li>○ Academic Search Premier, CINAHL with full text, Health Source: Nursing Academic edition, Master FILE Premier, MEDLINE, PsychINFO with Full text and SocINDEX, OAlster, Scopus, SciELO, Science Direct</li> </ul>	Journal articles
Google scholar	Grey literature such as theses, dissertations and conference proceedings
<b>National:</b> Nexus SAePublications	Completed and current research in South Africa. South African journals and primary research publications

- **Manual search**

Reference lists of included studies were scrutinised to identify any studies missed during the search from the electronic data bases (Centre for Reviews and Disseminations (CRD), 2009:18; Ring *et al.*, 2011:11).

### **1.8.2.2 Step2- Executing the search**

The search was executed according to the search strategy as shown in Annexure A. Two mixed-method articles identified through the hand search strategy, were found to be valuable and were included in the sample.

Findings, and other information from studies, were exported and saved in RIS formatted folders and then imported into the EPPI-Reviewer 4, which is a computer software program for executing and documenting systematic reviews and syntheses (Gough *et al.*, 2013). EPPI-Reviewer 4 allows direct importing of RIS-formatted files from databases and from PubMed. Once files are imported, duplicates can easily be identified and managed, eliminating the lengthy process of sorting out duplicates manually.

Selection of the identified studies was guided by the eligibility criteria. Inclusion and exclusion criteria were used to filter the identified research reports to ensure that only potentially relevant studies were included (ADA, 2012:21).

The most relevant studies were selected in two phases:

1. The first phase involved the exclusion of irrelevant studies by the screening of titles and abstracts that were obviously not relevant to the research topic.
2. During phase two, the full text of studies that appeared to be applicable in the first phase were screened for eligibility according to the inclusion and exclusion criteria (ADA, 2012:38; CASP, 2013:1-6; Kitchenham, 2004:1-28). (Annexure B for a detailed description of excluded studies).

#### **Inclusion criteria**

- Studies including qualitative data.
- Studies published from January 2005 (to ensure more recent studies) up to July 2016 (the last month for executing the search strategy).
- Studies published in English and those with English abstracts enabling the researcher to decide on the document's relevance and its potential need for translation.

#### **Exclusion criteria**

In order to identify irrelevant studies, the following exclusion criteria were applied:

- Not primary research.
- Non-research reports.
- Views or experiences of stake-holders other than women who experienced childbirth, such as health care workers, fathers, family members and doulas.

- Quantitative studies related to women's views, experiences and perceptions of continuous labour support without a qualitative element.

### **1.8.2.3 Step 3- Performing the critical appraisal of selected studies**

The critical appraisal, done by evaluating the methodological quality of included studies, assisted in identifying those studies that qualified for inclusion in the research synthesis. A study could be excluded for deficiencies in ethical aspects or in the methodology (ADA, 2012:1-88; CASP, 2013; JBI, 2001:3; Kitchenham, 2004:1-28; Khan *et al.*, 2003). The Critical Appraisal Skills Programme (CASP) tool for qualitative studies was used for critical appraisal because it provides a systematic and objective rating of the methodological quality of primary qualitative studies as well as the qualitative section of mixed methods studies. (Annexure C).

The researcher and co-reviewer (an experienced researcher) used the CASP tool independently to appraise the selected studies and allocate a score out of 10. The team members discussed the cut-off point and agreed upon 7/10 to ensure that only trustworthy studies would be included in the data analysis and synthesis processes. In case of a difference of one or two marks, the average was considered. Depending on this outcome, the study was either included or excluded. Only studies that were of good quality (scoring at least 7/10) after critical appraisal were included for data extraction and synthesis (Dixon-Woods *et al.*, 2001:130). (Annexure D).

The systematic review process was recorded in a PRISMA flow chart (Moher *et al.*, 2009) as shown in figure 1.2.

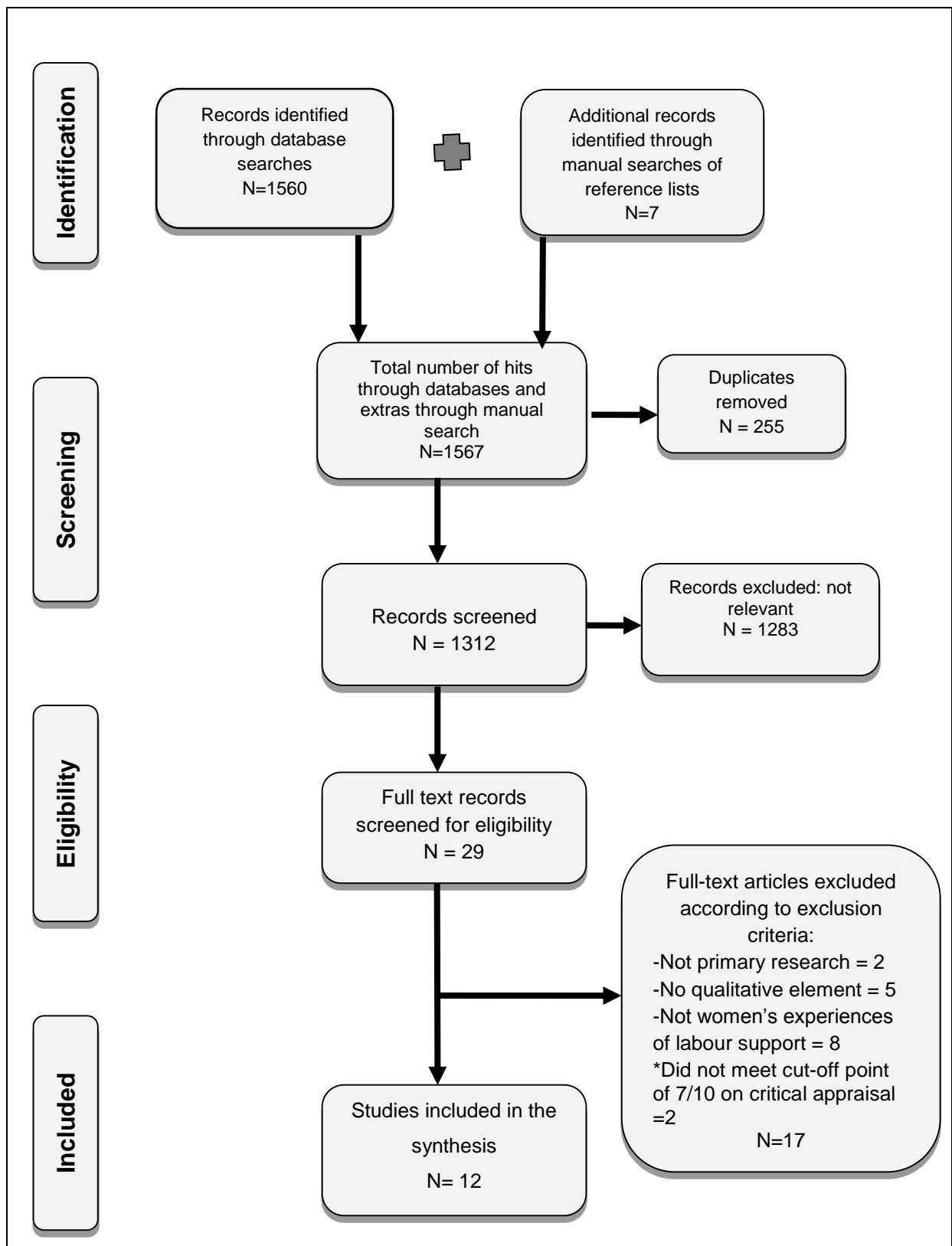


Figure 1.2 PRISMA flow chart of the systematic review process

#### **1.8.2.4 Step 4- Summarising the evidence (data extraction and synthesising of the findings)**

Once the relevant studies of high quality were selected, the researcher extracted the data. The data extraction was thoroughly checked by a co-reviewer to ensure relevance and correctness. A data extraction form (Annexure E) was developed in such a way that its items answered the research question to ensure that no significant findings were omitted. It was then used as a guide to extract data from the individual studies (ADA, 2012:1-88; Kitchenham, 2004:1-28).

Each of the 12 individual studies' findings were juxtaposed for identifying similarities and commonalities and subsequently organised into main categories and sub-categories that answered the review question (Thomas & Harden, 2008:12). The data from the 12 studies were extracted in sufficient detail to retain the integrity of each (Downe, 2008:7; Gough *et al.*, 2013:18; Sandelowski *et al.*, 1997:368).

Similar concepts between the studies were used to categorise women's narratives into main categories and sub-categories. The categories formed the base upon which the synthesis was founded (Thomas & Harden, 2008:12) and the research evidence was incorporated to answer the review question as outlined by ADA (2012:1-88). The synthesis was done using a thematic synthesis according to the guidelines by Thomas and Harden (2008:12). The synthesis comprised of a combination of data from 12 individual studies about women's views and experiences of continuous support during childbirth. The synthesis was executed in three stages;

- **Stages one and two: coding and developing descriptive themes**

After reading through the text for each individual study repeatedly, coding was then done manually 'line by line' to identify recurring concepts between studies. The concepts were documented and then grouped according to similarities in meaning based on women's narratives. This process was repeated until data saturation was attained, that is no new concepts emerged.

- **Stage three: generating analytical themes**

From the created groups, two main categories that described women's perceptions of continuous support during childbirth were identified and the remaining concepts were assigned to the relevant categories as sub-categories that best described women's views and experiences concerning continuous support during childbirth.

### **1.8.2.5 Step 5- Formulating the conclusion statements**

The conclusion statements were formulated, based on the synthesised categories and their implications for health care practice. Bias and limitations of the adopted systematic review process were also highlighted (ADA, 2012:50; CRD, 2009:81; Holly *et al.*, 2012:28). These will be discussed in section 3 of this dissertation.

## **1.9 MEASURES TO ENSURE RIGOUR**

Rigour ensures that the findings are of superior quality. It involves strict processes that are applied in a concise and consistent way to ensure superiority (Grove *et al.*, 2014:36). Thus, clear and systematic documentation of each step was maintained to provide a paper audit trail. The PRISMA flow diagram (figure 1.2) was used to document the screening process (Mohler, 2009). To prevent bias, the first researcher and the co-reviewer appraised the studies independently and compared their findings to reach consensus. The co-reviewer also thoroughly checked the data extracted by the researcher for relevance and correctness (Kitchenham, 2004:17).

All individual studies which were found to be relevant, were first critically appraised for reliability, validity and credibility before data-extraction, to ensure that only data of high quality studies were included in the current study's data analysis and synthesis processes (Cullum *et al.*, 2008:52). Fourteen studies were included according to the inclusion criteria but two were excluded after critical appraisal as they did not meet the cut-off point score of 7/10. The critical appraisal process entails careful and thorough examination of research evidence to critique its reliability, implications and relevance for the topic under study (Burls, 2009:2; JBI, 2001:5; Ring *et al.*, 2010:3).

Data extraction was based on women's narratives from the individual studies. The narratives provided rich data that described the phenomenon as experienced by the women. Saturation was attained once the same information recurred during subsequent analyses (Finfgeld-Connett & Johnson, 2012:4; Dixon-Woods *et al.*, 2001:130).

According to the Centre for Reviews and Dissemination (CRD, 2009:53), credibility of a synthesis is also determined by the method of synthesis. In this study a thematic synthesis was used. The included studies provided rich data that could be used during the synthesis process. Similarities and commonalities amongst the 12 included individual studies, were reviewed using women's accounts to capture the actual essence of their experiences and then synthesised according to the identified categories and sub-categories (Finfgeld-Connett & Johnson, 2012:3; Thomas & Harden, 2008:15).

## **1.10 ETHICAL CONSIDERATIONS**

Though meta-syntheses and systematic reviews have different ethical considerations from primary studies involving human participants, the researcher had an obligation to conduct the review in an acceptable and ethical manner. Permission to conduct the study was obtained from the North-West University - Potchefstroom Campus Human Research Ethics Committee (HREC). (Ethics permission number NWU-00002-16-S1). (Annexure F).

The following guidelines were adhered to during the current study:

Respect for the scientific community was observed by submitting the proposal to the scientific committee of the research entity of the NWU for approval of the methodological integrity of the study. Ethics were upheld by conducting the research in a competent, rigorous and methodologically sound manner, as well as by keeping a detailed report of the review and reporting the research findings in an unbiased manner (Brink *et al.*, 2012:32-45; Grove *et al.*, 2014:159-191; Mouton, 2014:239-242; Polit & Beck, 2012:81-95; Wagner & Wiffen, 2011:133-134). As for the synthesis, only studies that were ethically executed were included. Bias and limitations of these studies were also highlighted (ADA, 2012:50; Holly *et al.*, 2012: 28).

Data were collected from reliable and valid sources and a detailed documentation of the search strategy has been provided. The sources were properly referenced and a reference list was compiled as proof that the sources actually exist in order to maintain truthfulness (Mouton, 2014:243).

The research process is in the public domain and transparent as it was registered on PROSPERO, the registration number is CRD42016045282. Research findings will also be made public to ensure openness (Mouton, 2014:243) through the publication of an article, presentation at scientific conferences such as the North West Province Midwifery Symposium and at the Provincial Research Day. Persons who provided guidance and assistance were recognised and acknowledged.

## **1.11 SUMMARY**

Section one, part one provided an overview of the study. The background of and the rationale for the study were discussed, followed by the problem statement, the research question and the objectives. Continuous labour support is an integral part of childbirth. The paradigmatic perspectives, concept clarification, research design and method were discussed. The systematic review, as a research design and method, was explained, followed by the five steps specifying how the review was conducted. Lastly rigour and ethical considerations were addressed.

## **SECTION 1**

### **PART 2 LITERATURE REVIEW ON CONTINUOUS SUPPORT DURING CHILDBIRTH**

#### **1.12 INTRODUCTION**

A literature review forms an important part of any study (Mouton, 2014:86). The manual for master's and doctoral studies of the NWU, prescribe that if the research report is presented in article format, a literature review must also be done (NWU, 2016:22). Because the study itself is a systematic review only a short literature review was conducted to provide more background information about continuous support during childbirth, without specifically focussing on the views and experiences of women during childbirth. The literature review will firstly address the role of a midwife, then factors affecting midwifery, the types of support during childbirth and lastly the advantages of continuous support during childbirth.

#### **1.13 LITERATURE REVIEW**

A literature review was undertaken to highlight aspects regarding childbirth support, the midwife and midwifery care. Thus the review will identify what is known and what still needs to be investigated.

The literature search was done using the NWU's library services to access the databases with the following search words: nursing, midwife, labour, childbirth, women, care and companionship.

The following databases of the NWU Ferdinand Postma Library were searched: EbscoHost including: Academic Search Premier, CINAHL full text, Health Source Nursing/Academic Edition, Medline, SocINDEX, PsychINFO and Science Direct, SAePublications and Google Scholar. As this part was a regular literature review and not a systematic review, textbooks were also used in this part of the study.

##### **1.13.1 The role of a midwife**

According to the ICM (2005:3), a midwife is defined as 'a responsible person and accountable professional who works in partnership with women to give the necessary support, care, and advice during pregnancy, labour and the postpartum period'. The ICM highlights that midwives have a duty to care and ensure positive birthing experiences for women and concurrently to ensure optimal health outcomes for the woman and her baby. In many countries like the Netherlands (The Royal Dutch Organisation of Midwives, 2012:1); the United Kingdom (The

Royal College of Midwives, 2014:14); New Zealand (New Zealand College of Midwives, 2015) and Sweden (Wilde-Larsson *et al.*, 2011:1168), midwives are the main providers of maternity care, and also provide continuous support during labour.

Midwives, being the main providers of maternity care, are expected to be compassionate, caring, kind, skilful and competent, trustworthy, knowledgeable and good communicators as was indicated by an integrative literature study by Nicholls and Webb (2006:427) on what makes a good midwife. These findings are supported by a study by Lundgren *et al.* (2009:120) on 'long-term memories and experiences of childbirth in a Nordic context' which reported that women perceived a good midwife as being one who inspired hope in the woman. The midwife has a multifaceted role including supervision, guiding, mentoring, leading as well as offering a caring presence to women during childbirth as was found by Byrom and Downe (2010:133). These authors reported that a good midwife is one who is clinically competent, sociable and approachable. However this might not be the case if midwifery care is medically inclined where a midwife might be seen as an imposing figure (Nicholls & Webb, 2006:427).

Women expected midwives to be skilful, warm and caring in their demeanour and put women first (Gibbins & Thomson, 2001:308; Hyde & Roche-Reid, 2004:2617; Lundgren *et al.*, 2009:120). However, sometimes midwives were caught between rendering ideal care and abiding with traditional practices that did not consider women's views as reported in Downe's (2006:554) article 'Engaging with the concept of unique normality in childbirth.' Thus when faced with a predicament, midwives should apply evidenced based practices that put women first in order to render care that is acceptable by women (Byrom & Downe, 2010:136).

### **1.13.2 Factors affecting continuous support during childbirth**

Two Jordanian studies, a non-randomised comparison study of nulliparous women by Khresheh (2010:24) and an evaluation of the experiences of Jordanian women with maternity care services by Hatamleh *et al.* (2013:502), attributed the lack of continuous support during childbirth to the shortage of midwives. This was supported by Shimpuku *et al.* (2013:467) in a study that explored women's perceptions of childbirth experience at a hospital in rural Tanzania where one midwife was responsible for up to 65 patients in a unit as well as managing the births of 10-15 babies per day. A study done by Rala (2014:127) in South Africa on 'opinions of labouring women about companionship in the labour wards' revealed that, companionship is not provided in state owned healthcare institutions and this contributes to maternal dissatisfaction about maternity care services. Henceforth there is need for approaches that promote and advocate for childbirth companionship in state health-care maternity units. Despite the challenges in the work environment such as shortage of staff, the midwife still has an obligation to enable women to have a companion of their choice. Honikman

*et al.* (2015:284) points out that to curb maltreatment of women during childbirth, 'the patient-centred maternity care code' that does not condone offensive behaviours towards women, their families and community was developed in the Cape Metro, South Africa in 2013.

Even with sufficient numbers of midwives, they might be unable to provide continuous support to women because they work within multidisciplinary teams with a preference for medical interventions (Hyde & Roche-Reid, 2004:2620; Kritzinger, 2006:156; Payant *et al.*, 2008:412). Consequently midwives might spend much time on 'nursing technology' (Hottenstein, 2005:246), influencing midwives' ability to render continuous childbirth support (Payant *et al.*, 2008:412; Smith *et al.*, 2004:119). Brown *et al.* (2007) alluded that even where there is willingness to implement continuous support during childbirth, lack of continuity due to healthcare institution practices and policies such as rotation of midwives in and out of a maternity unit may hamper its success and sustainability.

### **1.13.3 Advantages of continuous support during childbirth**

The effectiveness of continuous support during childbirth has been well documented in the Cochrane review of 22 randomised controlled trials involving 15,288 women and investigating 'continuous support for women during childbirth' by Hodnett *et al.* (2012) revealing the following benefits: increased numbers of spontaneous vaginal births resulting in fewer instrument-assisted births and the reduced need for epidural analgesia as well as improved neonatal well-being. Supporting these claims, McGrath and Kennell (2008:96) state that in practices where medical interventions are the norm, the very presence of a support person might influence the doctor into carefully considering whether the medical intervention is really necessary. Furthermore women desire a memorable childbirth filled with positive experiences. Continuous support during childbirth has both a calming effect on the woman enhancing the childbirth process and neonatal outcomes (Campbell *et al.*, 2006:460; Pascali-Bonaro & Kroeger, 2004:19).

Women need warmth and genuineness from their caregivers in order to feel safe and have a satisfactory experience (Chan *et al.*, 2013:106; Khresheh, 2010:e23; Rosen, 2004:30). Companionship during childbirth should be encouraged and its significance is emphasised by the World Health Organization (WHO, 2015:14), by including this aspect in the safe childbirth checklist items.

Support during childbirth is not universally practised, as revealed in a South African pilot randomised controlled trial of an intervention to 'promote childbirth companions in hospital deliveries' conducted at 10 hospitals involving 2090 women, by Brown *et al.* (2007). The study reported that the majority of hospitals in South Africa did not provide or allow a companion, as

only 5% of women reported having childbirth support. Women might feel distraught if midwives are not readily available to offer support. The findings are supported by a study by Chadwick *et al.* (2014) on women's views about public maternity settings in Cape Town, South Africa, where incidences of neglect prevailed and by Jamas *et al.* (2011) on reasons why women sought care at a different birth centre for their next child's birth in Brazil to avoid neglect by midwives.

#### **1.13.4 Elements of continuous support during childbirth**

Continuous support during childbirth involves different types of care. According to the review by Hodnett *et al.* (2012:3) provision of information and advice, emotional support, continuous presence, comfort measures and advocacy might decrease women's nervousness, fears and unpleasant outcomes related to childbirth. Comfort measures such as relaxation techniques, massages, mobility, using upright positions, pelvic rocking exercises and pain relief could reduce the duration of the childbirth process (Campbell, 2007:222; Hottenstein, 2005:246). Additionally visual and audio distraction such as television or music could divert the women's focus away from their labour pains (Hottenstein, 2005:246). The appropriate use of technology is necessary, as practices such as intermittent foetal monitoring permits the mother to mobilise, have a warm bath or shower that promote relaxation, enhancing the outcomes (Simkin & Bolding, 2004:492). These approaches might boost maternal self-confidence and increase the number of spontaneous deliveries (Albers, 2007:210).

#### **1.13.5 Continuous support during childbirth provided by non-midwives**

Doulas are trained para-professionals who help women to deliver in a safe and calming environment (Hans *et al.*, 2013:446; Pascali-Bonaro, 2003:4). Doulas provide continuous support and comfort throughout the process of childbirth (Bianchi & Adams 2004:26). Their role entails provision of information and advice, as well as emotional and physical support (Hans *et al.*, 2013:448). Doulas also act as intermediaries between the woman, her family and the midwives. Once the baby is born the doula might assist the mother with breastfeeding of the baby (National Aboriginal Health Organization, [NAHO], 2008:13). According to a study by Campbell (2007:227) in New Jersey, United States of America (USA), that examined the impact of doula support at 6 to 8 weeks postpartum, and a randomised pilot study on promoting companionship in South Africa by Brown *et al.* (2007:4), the appointment of doulas could prove to be challenging if funds are insufficient.

Campbell (2007:227) further states that a less costly substitute for a professional doula can be a trained female friend or relative chosen by the woman. McGrath and Kennell (2008:96) suggest that continuous support during childbirth can be provided by the father, friend or

relative who is not influenced by institutional norms, though support by male partners might not be as effective as that of trained doulas. Hence fathers might not be the ideal principal support persons. However, the presence of a doula could also facilitate the fathers' presence and support (Pascali-Bonaro & Kroeger, 2004:19).

The midwife should provide information about childbirth and support during childbirth so that the woman and her chosen support person can make informed decisions (Green & Hotelling, 2014:197; Rosen, 2004:30). This view is supported by Campbell *et al.* (2006:462) when stating that birthing institutions and service providers should consider a preparation programme for women and their female companions during pregnancy.

#### **1.14 CONCLUSION**

The significance of this study is rooted in the provision of continuous labour support placing women at the centre of care. The literature indicates that continuous support during childbirth could have numerous benefits which are influenced by the birth environment and support persons. Thus it is imperative to hear the women's side of the 'story' regarding labour support if their needs are going to form the foundation of women-centred maternity care services based on realistic expectations. Through the provision of continuous intra-partum support and caring, women could feel valued, and the birth outcomes could be improved for the women and their new born babies.

## **SECTION 2**

### **MANUSCRIPT: WOMEN'S EXPERIENCES OF CONTINUOUS SUPPORT DURING CHILDBIRTH: A META-SYNTHESIS**

#### **Introduction**

In this Section the manuscript of the article that will be submitted to *BMC Pregnancy and Childbirth* on-line open-access journal is presented. The article must be written according to the guidelines for authors and therefore these guidelines are firstly included. Some parts of the content of the guidelines were deleted to only include parts relevant to this manuscript.

To ensure that the manuscript is a complete unit, the introduction and background are included again as already presented in section 1. The objectives, methodology and other headings follow. The research findings and discussion are presented for the first time as part of the manuscript.

In section 3 the conclusions, limitations and recommendations are presented followed by the references and appendices.

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- [Abstract](#)
- [Keywords](#)
- [Background](#)
- [Methods](#)
- [Results and discussion](#)
- [Conclusions](#)
- [List of abbreviations used](#) (if any)
- [Competing interests](#)
- [Authors' contributions](#)
- [Authors' information](#)
- [Acknowledgements](#)
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Doe J. Title of subordinate document. In: The dictionary of substances and their effects. Royal Society of Chemistry. 1999. [http://www.rsc.org/dose/title of subordinate document](http://www.rsc.org/dose/title%20of%20subordinate%20document). Accessed 15 Jan 1999.

*Online database*

Healthwise Knowledgebase. US Pharmacopeia, Rockville. 1998. <http://www.healthwise.org>. Accessed 21 Sept 1998.

*Supplementary material/private homepage*

Doe J. Title of supplementary material. 2000. <http://www.privatehomepage.com>. Accessed 22 Feb 2000.

*University site*

Doe, J: Title of preprint. <http://www.uni-heidelberg.de/mydata.html> (1999). Accessed 25 Dec 1999.

*FTP site*

Doe, J: Trivial HTTP, RFC2169. <ftp://ftp.isi.edu/in-notes/rfc2169.txt> (1999). Accessed 12 Nov 1999.

*Organization site*

ISSN International Centre: The ISSN register. <http://www.issn.org> (2006). Accessed 20 Feb 2007.

*Dataset with persistent identifier*

Zheng L-Y, Guo X-S, He B, Sun L-J, Peng Y, Dong S-S, et al. Genome data from sweet and grain sorghum (*Sorghum bicolor*). GigaScience Database. 2011. <http://dx.doi.org/10.5524/100012>.

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## **TITLE**

**Women's experiences of continuous support during childbirth: a meta-synthesis.**

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## **ABSTRACT**

**Background:** Despite the known benefits of continuous support during childbirth, the practice is still not routinely implemented in all maternity settings and women's perspectives might not be considered. This study aimed to provide midwives and other healthcare professionals with a scientific summary of best available research evidence on women's views and experiences regarding continuous support during childbirth. The review question was: What were the views and experiences of women regarding continuous support during childbirth as reported in qualitative studies and in studies that adopted mixed research methods with a qualitative component that used semi-structured, in-depth or focus group interviews or case studies?

**Methods:** A detailed search was done on electronic data bases: EBSCOhost: Medline, PsychINFO, SocINDEX, OAlster, Scopus, SciELO, Science Direct, PubMed and Google Scholar. The databases were searched for available literature using a predetermined search strategy. Reference lists of included studies were analysed to identify possible studies that were missing from data bases. The phenomenon of interest was women's views and experiences of continuous support during childbirth. Pre-determined inclusion and exclusion criteria were applied during the selection of eligible sources. In total 12 studies were included in the data analysis and synthesis.

**Results:** Two categories, according to women's perspectives on continuous support during childbirth, were identified namely the role and attributes of the support persons and challenging aspects regarding continuous support during childbirth. Some women did not distinguish between the role of a support person/doula and a midwife. Women's perspectives about continuous support during childbirth were influenced by culture, traditions and values, relationships with specific support persons as well as institutional practices, forms of supportive care received and the attributes of the support person. Clearly women preferred someone they were familiar and comfortable with.

**Conclusion:** Continuous support during childbirth was valued by most women. Health care institutions should include continuous support during childbirth in their policies and guidelines and birth plans.

**Key words:** birth companion, childbirth experiences, continuous childbirth support, doula, systematic review

## **BACKGROUND**

Childbirth is a life-changing experience for women with lifelong memories [1, 2]. Thus midwives should be familiar with women's diverse needs during childbirth [3], including emotional, physical and informational needs [4]. Good interpersonal relationships could reduce the fear associated with childbirth [6] and subsequently contribute to a satisfactory birth experience [5].

Continuous support during childbirth affects both the woman's experiences and the birth outcomes [7]. It reduces the need for medical interventions, reduces medicated births and improves both maternal and neonatal outcomes [4, 8, 9]. Continuous support during childbirth is not universally implemented probably due to a high rate of utilising medical interventions such as epidural anaesthesia in hospital settings [10]. Advances in medical expertise during the last three decades contributed to increased numbers of invasive procedures during childbirth [11]. Consequently midwives might spend much time attending to technology and routine interventions instead of offering continuous support during childbirth which is likely to be cost effective and beneficial for the woman [12]). Another factor that contributes to the lack of continuous childbirth support is the shortage of midwives [13]. Due to the absence of a childbirth support person women might feel deserted, distraught and petrified [14-15].

A review of continuous support for women during childbirth by Hodnett et al. [4] revealed that through provision of continuous labour support various benefits were realised; 'reduction in the need for epidural, assisted deliveries, caesarean section births, postpartum depression and neonatal admissions'. Similarly Pascali-Bonaro [2] reported; a reduction in the use of oxytocin, analgesia, instrumental deliveries and duration of labour as well as improved maternal satisfaction, bonding with the baby and improved neonatal outcomes' and a reduction in a woman's anxiety [9]. Thus women need continuous support during the birth

process to enhance positive outcomes [16]. Consequently there is a need to hear and consider women's opinions and the preferred approaches used by women [13, 17, 18].

Midwives have a duty to promote safety and security for women in the birth environment [19, 20]. Moreover women perceive hospital births as safer when compared to home births [21]. According to Nicholls and Webb [22] the term midwife means "with woman". A midwife should portray a caring approach, have good communication skills, and be available to women. Where midwives are unable to render continuous support during childbirth, some aspects of care could be assigned to other support persons such as doulas, while midwives focus on the professional aspects [8].

There is a need to explore and synthesise women's views and experiences regarding continuous support during childbirth. The Royal College of Midwives [23], point out that a midwife has a role to guide women in making well-versed decisions that are acceptable clinically and personally. In many settings women's voices still need to be heard [15]. Therefore there is a need to align care to a woman with a 'woman-centred' approach [13, 16-18]. Considering women's perspectives will generate information required for formulating midwifery guidelines pertaining to continuous support during childbirth. Therefore the undertaking of a systematic review to establish common perspectives of women is worthwhile.

Other associated meta-syntheses have been done to synthesise women's perceptions regarding varying aspects of childbirth. These meta-syntheses focussed on first time mothers' experiences during early labour by Eri et al. [24]; women's experiences of caesarean births by Puia [25]; a secondary analysis of long-term memories and experiences of childbirth by Lundgren et al. [1] and expert intra-partum care by Downe et al. [26]. A similar meta-synthesis that reviewed and synthesised qualitative research evidence of women's perceptions of professional labour support was done by Bowers [27], it synthesised

17 qualitative studies. However, the review by Bowers [27] focussed only on professional childbirth support and was already done in indicating the need for the current study.

Hence the research question for the current study was: What is the best available research evidence about women's views and experiences regarding continuous support during childbirth?

### **Research purpose**

The purpose of the study was to integrate individual studies' findings related to women's views and experiences of continuous support during childbirth in order to expand the understanding of the phenomenon. A synthesis of findings of qualitative studies about women's views and experiences, regarding continuous support during childbirth, will provide scientific evidence that is based on women's perspectives. More so a comprehensive body of knowledge about women's views and experiences will highlight the plight of women on issues important to them. By synthesising best evidence on women's views and experiences of continuous support during childbirth, healthcare providers will have a scientific summary that will facilitate their understanding of what women expect from their caregivers and, in turn, provide them with acceptable and desired type of care.

### **Research design**

An explorative descriptive design, using a systematic review, was followed to address the research question. A systematic review incorporates a set of obvious, logical, structurally interrelated steps, carried out in a way that avoids bias and allows for peer review and independent verification [28].

The systematic review process involves five steps adapted from the guidelines for evidence analysis of the American Dietetic Association (ADA) [29]. (1) Formulation of the review question and search strategy, (2) executing the search, (3) performing critical appraisal of selected studies, (4) summarising the evidence (data extraction from relevant studies and synthesising the findings) and (5) formulating the conclusion statements.

## Formulation of the review question and search strategy

The review question was formulated according to the SPIDER format. SPIDER is an efficient search strategy tool to use for qualitative methods and mixed methods [30]. (Table 1).

Table 1 Elements of the review question according to the acronym SPIDER

ELEMENTS OF SPIDER	ELEMENTS OF SPIDER APPLIED TO THIS STUDY
<b>S - Sample</b>	Patients; mothers; women who had experienced childbirth
<b>PI - Phenomenon of interest</b>	Continuous support, intra-partum care; labour/labour support; companionship; doula; one-to-one care; emotional support
<b>D - Design</b>	Studies using a qualitative approach and mixed research methods with a qualitative component
<b>E - Evaluation</b>	Experiences; perceptions; opinions; views
<b>R - Research type</b>	Semi-structured, in-depth or focus group interviews, case studies

Review question: What were the views and experiences of women regarding continuous support during childbirth as reported in studies that adopted qualitative and mixed research methods with a qualitative component using semi-structured, in-depth or focus group interviews or case studies to collect data?

The first author and a competent librarian did a scoping search about available literature on the topic [31]. Focusing and periodic re-focusing enabled the identification of relevant studies [32].

The search was implemented using specific keywords based on the review question. The search words were used according to SPIDER (Table 2).

- women OR patients OR mothers AND
- experience\* OR perception\* OR opinion\* OR view\* AND
- continuous\* AND
- labor\* OR childbirth OR delivery AND
- emotional support OR intra-partum care\* OR one-to-one care OR companionship\*  
OR doula AND

- qualitative

The use of alternative words and spelling provides a more rigorous search thereby eliminating bias and the potential of missing relevant studies [33]. Duplicate studies were removed and subsequently the studies were screened for relevance to the topic.

### **Executing the search**

The literature search comprised an electronic and a manual search.

- **Electronic search**

The following electronic databases: EBSCOhost: Medline, PsychINFO, SocINDEX, OALster, Scopus, SciELO, PubMed were searched for studies reported as journals, dissertations and theses, research reports and conference proceedings. SAEpublications, Nexus and Google Scholar were used to search for unpublished literature such as dissertations and theses.

- **Manual search**

Reference lists of included studies were scrutinised to identify any studies overlooked during the search from the databases [34, 35]. The search process was outlined using the PRISMA flow diagram [36]. (See Additional file 1; PRISMA flow chart of the systematic review).

Information of studies identified through the databases were exported and saved in RIS formatted folders and then imported into the EPPI-Reviewer 4 computer software that it could be used for the systematic review and synthesis [37]. It also proved valuable to identify duplicate articles.

- Eligibility criteria

The next step was exclusion of irrelevant studies during screening of titles and abstracts that were deemed not to be relevant to the research topic. Then full texts of potentially applicable studies were screened to determine whether or not they fulfilled the eligibility criteria [29, 38, 39]. (Table 2).

Table 2 Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> <li>• Studies related to women’s views, experiences and perceptions of continuous support during childbirth</li> <li>• Published between January 2005 (for more recent studies) and July 2016</li> <li>• Written in English or with English abstracts</li> <li>• Primary studies</li> </ul>	<ul style="list-style-type: none"> <li>• Studies about continuous support not focusing on women’s experiences or views related to childbirth</li> <li>• Published before 2005</li> <li>• Studies not written in English without an English abstract</li> <li>• Not primary research</li> <li>• Non-research reports</li> </ul>

### Critical appraisal of selected studies

Two team members independently appraised the papers for eligibility and quality while the third member verified the data entries and decisions. Although there are different critical appraisal instruments for qualitative studies, the Critical Appraisal Skills Programme (CASP) tool for qualitative studies was used [40] because of its applicability to different qualitative study designs. The CASP tool assessed whether a study had a clear purpose and appropriate methodology, an appropriate research design to address the aims, a thorough description of the recruitment process and an appropriate data collection method, discussed data analysis, discussed the role of the researcher and reflexivity, addressed ethical issues, provided clear statements of findings and specified the implications for practice (Additional file 2; Critical appraisal mark allocation). Studies were appraised accordingly and the agreed upon cut-off score of 7/10 was applied ensuring that only rigorously executed studies were included in the synthesis. The search process was outlined using the PRISMA flow diagram [36]. (Additional file 1; PRISMA flow chart of the systematic review).

### Data extraction

Once the 12 relevant high quality studies had been selected, data extraction was done by the researcher and independently checked for relevance and correctness by a co-reviewer. A data extraction form was developed in such a way that its items answered the review

question to ensure that no significant findings were omitted. It was then used as a guide to extract data from the individual studies [29, 39].

### **Data synthesis**

Data synthesis involved identification and translation of similar concepts between the studies categorising women's narratives into categories. The categories comprised the basis of the synthesis [33] to incorporate research evidence to answer the review question as outlined by ADA [29]. The synthesis was done using a thematic synthesis according to Thomas and Harden's [25] guidelines. It involved combining data from 12 individual studies about women's views and experiences of continuous support during childbirth. The synthesis was done in three stages;

#### **Stages one and two: coding and developing descriptive themes**

Coding of the text for each study was done 'line by line' manually. Recurring concepts between studies were identified and documented and then grouped according to similarities in meaning based on original accounts. This process was repeated until no new concepts emerged.

#### **Stage three: generating analytical themes**

From the groups, two main categories that described women's perceptions of continuous support during childbirth were identified and the remaining concepts were assigned to the relevant main category according to sub-categories that best described women's views and experiences concerning continuous support during childbirth.

### **Ethical approval**

Permission to conduct the study was obtained from the North-West University - Potchefstroom Campus Human Research Ethics Committee (HREC) (Ethics permission number NWU-00002-16-S1).

## **Characteristics of the included studies**

All the studies that met the inclusion criteria had an English abstract and full text. Ten (10) qualitative studies and two mixed-methods studies with qualitative elements were included in the synthesis. The studies adopted phenomenological, ethnographic, naturalistic, grounded theory, interpretive descriptive and hermeneutic designs. Data collection in the 12 primary studies mainly used semi-structured interviews and focus group interviews. Data analysis methods included thematic analysis and content analysis.

The critical appraisal revealed that most studies provided clear statements of the research aims, appropriate methodology, study design and data collection methods. They also provided sufficient information about the recruitment process, data analysis, findings, value of the research and contribution to practice. However, discussions of the role of the researcher and reflexivity and ethical issues were either insufficient or absent in most studies. Nonetheless only two studies, (Etowa [41]; Koumouitzes-Douvia & Carr [42]), were excluded because they did not meet the cut-off score of 7/10.

The 12 analysed studies reported the views and experiences of 425 women. Three studies had samples of primiparous women only (Kungwimba et al. [43]; Sapkota et al. [44]; Simpson [45]), while the rest included both primiparous and multiparous women. The included studies described women's perceptions and experiences of childbirth support provided by different care givers including nurses, trained doulas, husbands, mothers, mothers-in-law, sisters and female friends.

Seven studies focused on women's experiences and perspectives of supportive care during childbirth in general (Kungwimba et al. [43], Simpson [45], Banda et al. [46], Berg & Terstad [47], Hunter [48], Lundgren [49], MacKinnon et al. [50]), while two studies reported on women's experience of giving birth with their husbands' support (Sapkota et al. [44] and Bakhta & Lee [52]). The following themes were addressed in single studies: foreign-born women's experiences of community-based doulas (Akhavan & Edge [52]), women's

perceptions about labour companionship at public teaching hospitals (Kabakian-Kasholian, El-Nemer & Bashour [53]) and the meaning of the nurse's presence during childbirth (Price et al. [54]).

The birth settings comprised midwife-led units, home births, hospital settings and birth centres. The studies were conducted in Canada [45, 50, 54], Egypt, Lebanon and Syria [53], Malawi [43, 46], Nepal [44], Russia [51], Sweden [47, 49, 52], and the United States of America [48]. (Additional file 3; Populated data extraction table of included studies).

## **FINDINGS**

Quotations extracted from the original studies, are provided to support the categories. The term 'midwife' is used except when an individual study refers to nurses specifically.

The findings were synthesised according to two categories and their respective sub-categories (Additional file 5; The roles and attributes of the support person as perceived by the new mothers and Additional file 6; Challenges regarding aspects of continuous support during childbirth as perceived by the new mothers).

### **The roles and attributes of support persons as perceived by the new mothers**

The various roles played by and attributes of the support persons, will be discussed under the type of support persons, physical presence, provider of emotional support, provider of physical support, provider of information and advice, advocacy role and favourable interpersonal relationships.

#### ***The type of support person***

The providers of supportive care comprised of doulas, female relatives or friends, husbands/partners and midwives. The reasons for these choices included positive previous experiences with the support person, family or intimate relationships which afforded the

women some control [43-46, 48, 51, 53, 54] while others had community based doulas (CBD) [47, 49, 50, 52].

The preferred support person was a female relative or friend [46, 47, 50]. A female support person was preferred because intuitively a woman knows and anticipates what another woman needs during childbirth [52, 53].

*“The support of your family gives you power. You will be better prepared and not scared.”* [53].

*“A woman feels what the other woman needs during labor and delivery, and knows how to deal with her.”* [53].

In contrast some women preferred someone who was not a relative. [47, 48].

*“There can be a lot of relationship baggage’ when a woman’s mother is in the room, which some women know will not be helpful in labor* [48].

Foreign women in the study of Akhavan and Edge [54] found solace in the doula, as someone they could relate to in their ‘own language’ in a ‘foreign land’.

*“I had broken my arm and was very worried...I have no family in Sweden. I was wondering if I could do it, and the doula gave me a lot of support.”* [52].

Furthermore, doulas were the stronghold for couples since husbands also needed emotional support during childbirth [45, 47].

*“Without her it would only have been him and me, we had only had each other and I can’t support him when I am giving birth, someone else has to do that.”* [47].

The husband was more than a support person and the obvious choice to share the birth of their child since he offered ‘special support’ due to the intimate nature of the relationship [44,

45, 48, 54]. The husband and doula formed a team [52] but they took on a passive role as midwives took over [44] during the second stage of childbirth.

*The husband was part of a family unit: "You feel closer...we were always a really close family, but you feel even more of a bond...especially with your husband. You feel, wow, you've experienced this together."* [54].

*"My husband went away only when I was pushing. He preferred not to look. He was a little bit scared...maybe. I think it's quite natural for men. It was fine because we discussed it before the delivery had started. I said he was free to do anything he likes. I understand that it could be quite stressful for him. Maybe even more stressful than for me, because I think we are designed for this much better than men"* [45].

The husband as a support person was a desired person with whom to share the birthing experience [44, 45, 53, 52].

*"His presence and positive affirmations sufficed. I felt like my husband took good care of me. He rubbed my back, and encouraged me to take frequent drinks to keep up the energy."* [44].

Some women were embarrassed or worried about their husbands' presence [44]. Others did not entertain the idea of having a husband as a support person as it was culturally unacceptable [51].

*"I could read his face. He was sweating and restless. It was very difficult for him to see me in pain. So my heart ached to see him suffer that way."* [44].

Those women who had midwives for support, verbalised that the midwives worked collaboratively with their partners thus the support was appreciated [50].

In conclusion the decision to have a support person during childbirth is an individual woman's choice. The basis for her choice has mitigating factors such as familiarity, previous

experience or institutional norms. Females were preferred support persons rather than husbands.

### ***Physical presence***

The continual presence of a support person provided a sense of security so it helped the woman to remain focused [56]. The support person was expected to be compassionate, caring, devoted, a good communicator and sociable so that women could freely express themselves [48, 54]. The support person should be more than just present as he/she should also be knowledgeable about childbirth in order to provide appropriate support [49, 50, 52].

Women appreciated a familiar midwife to confide in as the childbirth process progressed [50]. Thus the midwife's presence was viewed as consoling as well as dependable [45, 50]. This was also true for nurses. Generally the women treasured each moment the nurses spent with them [45, 46, 50]. Furthermore the nurses were trustworthy and skilled to help during childbirth [50].

*"I went in knowing that we would see the doctor somewhat but knowing that the doctor wouldn't be around all the time, but I don't think you realize how much dependency you have on the nurses...The role the nurse plays is, in a lot of ways, more important than the doctor's role."* [50].

*"The midwife took very good care of me. I don't think this could have happened if I did not have someone there with me."* [46].

However, it was not always possible for midwives to provide continuous support during childbirth [49], which resulted in women feeling less valued due to a lack of continuous attention [43, 49, 50]. Subsequently one woman compared the lack of constant support to a piece of merchandise waiting to be processed in a factory that does not need affection [49].

*"...Similarly when I had experienced something strange I asked her (companion) and she told me what to do. But there were no nurses."* [43].

*“Nobody came over and stroked my hair or just held my hand and said, you know, we’re coming right with you. So I was desperately hanging on to Ron [my partner]. At one point the nurse projected a non-caring attitude, [the nurse] had said, you can push, like, she literally then went back to whatever she was doing.” [50].*

Nevertheless in instances where a midwife’s continuous presence was not feasible, intermittent presence was also accepted [44, 45, 47, 49]. Some women did not want bystanders during the actual birth process [54] for privacy and modesty [51].

*“...this is something a woman should go through alone” or that “this is the time to concentrate on yourself, and having someone else around will be a distraction.” [53].*

As for the doula, her presence was harmonising the birthing process because she enabled the woman to ‘capitulate’ herself completely throughout the course of childbirth [49, 54]. She was seen as the ‘missing piece in the puzzle’ [47] and provided care that was ‘intimate’ [49]. One woman termed the doula as “a birthing sister” and “a positive witch” [47]. Ultimately the doula provided companionship so the women did not feel “gharib” (alone) [52].

*“The Swedish midwives were there to check that the birth went well, the doula had her place, the midwife went in and out and was replaced. The doula was there all the time...I screamed, the doula told me to breathe, it helps the child to be delivered easily.” [52].*

Clearly the doula was able to provide a continuous presence due to her focus being on one woman unlike midwives who had to attend to many women and also to other tasks [45, 48, 49, 52].

*“It was so wonderful to have her (doula) there with me, her just being there. There is something special about having her there...” [49].*

In conclusion, most women appreciated the physical presence of a support person.

### ***Provider of emotional support***

Several studies reported that an important role of the support person is to provide emotional support which women found inspiring [43-45]. Emotional support included affirmative words, reassurance, showing sensitivity to the woman's fears, talking and praising for endurance, and providing spiritual inspiration [43, 46, 47, 52, 53].

*"They came in and said, 'you're doing really great... you're doing excellent. They gave a lot of positive affirmations, which made me feel really good and it kind of helped me get through it.'" [45].*

Through her emotional support, the doula provided positive experiences [45, 48, 49]. The doula also enhanced the women's self-trust affording women inner strength to bear the pain [44, 45, 49]. She was like a "real sister" because of her unwavering support and encouragement [54]. Subsequently women derived strength from the doula's affirmative words.

Spirituality was another form of emotional support [43, 47].

*"She had so much spirituality too, maybe that way it was much more peaceful and safer too, when she was here...just because of her presence I became more calm."* [43].

Emotional support from their support persons enhanced women's endurance to remain focused during childbirth. This was possible because the support persons were compassionate and caring.

### ***Provider of physical support***

The role of comfort measures is to relieve the pain associated with childbirth. They included; back massages, holding hands, and breathing techniques [43,45, 49]. Mobilisation and adopting comfortable positions were also encouraged [53], birth balls were used for pelvic

rocking and others opted for self-hypnosis [45]. Hygienic and elimination aspects were also attended to [43]. These comfort measures, enabled women to retain a state of physical well-being.

*“When I wanted to go to the toilet she held me by hand to and from the toilet, she made my bed so that I could sleep there comfortably. When the nurse said that I needed food because I was hungry, my mother prepared porridge for me to eat.”*  
[43].

Physical comfort measures facilitated relaxation and pain relief for women. Different techniques were applied depending on a woman’s needs and preferences.

### ***Provider of information and advice***

Interactions between the woman and her caregivers, through information sharing, were essential for establishing interpersonal relations comprising an important aspect of a woman’s childbirth experiences [50]. For women without antenatal preparation, the doula facilitated self-awareness and confidence [47, 52].

*“I did not know what happens, for example, when the baby comes out...I knew nothing about childbirth...The doula informed me about all these issues.”* [52].

Provision of guidance during the early stages of childbirth resulted in women being more relaxed and cooperative [49, 52]. Women could acknowledge their need for physical support if they are well informed about the indications for the comfort measures so that they could cooperate. Thus during active labour women were guided on positions to adopt as well as breathing and relaxation techniques to expedite labour [43-45, 49]. Women valued regular information and updates about the process of labour from the midwives [43, 52, 54].

*“She taught me how to work with the pain... I could relax...to not be tense...because last time I was tense all the time and then the contractions went worse...but this time when the contractions came, she talked to me and said that you can manage and*

*everything is OK...you enter deep into the contractions...like a...I don't know how to explain this...it is not dangerous and it is not going to be worse and you can manage it."* [49].

*"She [doula] helped me to relax and use the oxygen, told me that I should not be afraid...My first child was born by caesarean section. This time it was 10 cm open, no complications...The doula was like a real sister and supported me so I wasn't sad or angry."* [52].

Consequently women had faith in the support person's ability to provide relevant information and advice [47, 48, 52].

*"It was a supportive person who came along...one who had...been there before who knew. Not to help with the medical part but just to be there, support and explain what might happen, what you can ask for and so on."* [47].

Preparation for childbirth should start during the prenatal period through education to enlighten women about the birthing process and childbirth services accessible to them so that they can prepare and make informed decisions.

### **Advocacy role**

Establishing communication channels with caregivers was desired by most women to ensure a common ground [47, 49, 50, 52]. Hence the support persons also represented the women when they could not speak for themselves [54]. A known close female support person could enhance the women's feelings of security in the strange birth environment [53].

*"For me it was very important to get to know the person who was going to be with me you to feel secure with her before-hand."* [49].

*"It's nice, 'cause you just feel like quitting...to have three people [health professionals and partner] encouraging you and cheering you on instead of it being just one."* [54].

An intermediary between the women and midwives or between women and family members not present in the delivery room was essential [54] and since the doula was familiar with the birth environment, she acted as that intermediary person [47, 48, 52, 54].

*“I think they had the impression that they could come back in as soon as the baby was out, but...you don’t want people piling in when you’re being sutured...But at the same time, if someone could be a communicator for them because they have no way of finding out from us what was going on.” [54].*

Occasionally husbands also mediated, when there was less interaction from the midwives during the early stages of childbirth. They were regarded as being more confident and flexible to convey the women’s needs to the midwives than female relatives [44]. Just prior to the ‘second stage’ of labour, some husbands interceded on behalf of their wives with the midwives [45] because labour pains coupled with the unusual environment caused apprehension [47, 54]. Midwives also represented the women and their families at the professional level [45].

*“She knows a lot about the childbirth. She has been there before. She can explain and clarify...To have someone with me who knew the surroundings in the delivery ward was important.” [47].*

Due to the vulnerability of women during childbirth, their mediators ensured that their needs were met. The support persons as well as midwives played this role.

### ***Favourable interpersonal relationships***

Some women chose their husbands [44, 45, 54], close female relatives or friends [46, 47, 50, 54] to be their support persons, based on the nature of their personal relationships as this permitted them to retain some control over the birth process. Knowing the attending midwife was desired by women [50]. Meeting the caregiver for the first time during childbirth was not optimal as it caused women to feel apprehensive [46, 52]. Midwives’ compassion

and openness enhanced the establishment of a trusting relationship and subsequent trust in the midwife's skills and competencies [45, 50].

*“Like, I think with my first child, the nurses I remember quite vividly because I was concentrating on everything they said. It was so much more pertinent and important to me than what the partner was saying at that time...Because they've done it a million times and you know if they're saying hold on or breathe, that that's really what you need to do.” [50].*

Meeting the doula during pregnancy was cherished as it enabled the establishment of a personal relationship enhancing the chances of a satisfactory childbirth experience [47, 52].

Women related more easily to persons with whom they shared beliefs with, than with strangers [46, 47].

Good interpersonal relationships promoted women's self-confidence and their trust in the support persons, facilitating interactions with support persons.

### **Challenges regarding aspects of continuous support during childbirth as perceived by the new mothers**

The challenges ranged from undesirable attributes of support persons, women's and support persons' knowledge deficiencies, undesired forms of supportive care, unfavourable institutional practices and undesirable support persons.

#### ***Undesirable attributes of support persons***

Not all women had positive experiences as some support persons lacked compassion and were not caring persons [43, 52].

*“I was in pain and I asked her to allow me to go to the toilet to urinate. Surprisingly her response was that she was going home and will leave me alone. She left but came back after a nurse pleaded with her. She told me that I was troublesome. You*

*know it was my first time... smiling... On the second time, during a contraction I wanted to wake up but she advised me to lie down. I told her that I was failing to lie down, and she said again that she was going to abandon me.” [43].*

A support person should be compassionate, caring and understanding, and have the ability to establish a good relationship with a specific woman and be able to understand her body language [49]. An impolite or unsociable support person or midwife could increase anxiety and stress levels of a woman during childbirth.

### ***Women’s and support persons’ knowledge deficiencies***

Support persons’ knowledge deficits adversely affected women’s experiences. Due to a lack of knowledge some support persons were unable to render the required support to women [43, 52].

*“(Crying)...8 hours, I cried the whole time...The doula did nothing ... (crying) ...she yelled at me that I should keep quiet. She was scared. She did not know what to do.” [52].*

Banda et al. [46] indicated that some women were not aware of the option of having a birth companion so they ended up with whoever was available. Certain institutional traditions were apparently not communicated during pregnancy, causing frustrations for women [45, 54]. Conversely, due to lack of prior information, some women expected too much from the supportive persons as they could not separate the role of support persons from that of midwives [43]. A non-Canadian couple erroneously thought that in Canada a father was obliged to be present during childbirth causing him to stay despite his discomfort.

*“Actually, I was OK that my husband wouldn’t stay with me. Here in Canada, we understood that it is not even the usual experience it is the mandatory experience for fathers to be with their wives during labour. My husband said, I probably have no choice...so I have to be with you.” [45].*

Lack of information about organisational norms by both women and support persons could cause disillusionment during childbirth.

### ***Undesirable forms of supportive care***

Women had different preferences and perceptions of supportive care. Some women found the imposition of certain interventions irritating because they perceived childbirth to be a natural process that does not require medical interventions [45]. Other women did not want the support persons to be present during the actual birth process [54] because childbirth is a personal experience which does not need onlookers while some women did not want support persons at all for the sake of privacy [51].

*“My opinion of it (childbirth) was that it’s not a social gathering and it’s basically mine and [partner’s] experience to share...I’m not going to straddle my legs up here with them sitting right there. Yeah, it’s time to leave. It’s not a concert!” [54].*

*“Are you having any pain? Do you want any pain medication? Do you want an epidural? How are you feeling? Any of those types of questions and we had discussed it that I wanted no epidural; I wanted no medication of any sort... and I didn’t want to answer questions.” [45].*

Women wished to give birth peacefully in an environment free from distractions and hindrances such as medical interventions. Women’s preferences should be considered as long as they do not pose risks for the mother or baby.

### ***Unfavourable institutional practices***

Women found certain institutional practices to be undesirable [45, 50]. Such an example was the ‘obstetric triage’, where women had to be checked by medical specialists before they encountered midwives, depriving them of continuous childbirth support from intra-partum midwives [48]. Midwives’ inability to always offer continuous childbirth support was attributed to high patient turnover rates [47].

Limitations on visitors in the birthing environment disappointed some women as they could not have all their chosen support persons with them [54].

*“The nurse took me aside privately and said, ‘It might be a problem having so many people with you.’ And I was kind of taken aback...it never occurred to me. I thought ‘It’s my birth, it’s my choice.’” [54].*

According to Kabakian-Khasholian et al. [53] stakeholders agreed that liberal visitation policies would increase noise levels and overcrowding which could increase the spread of micro-organisms in the birthing rooms.

Women wish to be involved in making decisions affecting them and not to have decisions imposed upon them. This can be achieved by engaging with women and by formulating policies that embrace women’s perspectives.

### ***Undesirable support persons***

Studies by Simpson [45], Banda et al. [46] Hunter [52] and Price et al. [54] reported that a specific support person might be unsuitable for a specific woman. For instance, the presence of mothers-in-law was sometimes experienced to be a ‘burden’ when they were not offering any support [46]. Family members were not ideal support persons for some women due to family-related conflicts [45, 48, 54]. Relatives in waiting rooms caused stress for some women [45].

*“I don’t even know if it’s important to have them with me as it is for them to be able to witness the birth of the baby...And I guess maybe I did it for everybody else except me.” [54].*

*“I have a family that takes control. And I was in pain—when I’m in pain, I want people who want to take control to leave me alone and let me do what I want.” [54].*

Some women experienced discomfort and embarrassment in their husbands’ presence [44, 45, 51, 53], especially during vaginal examinations [46] or while bearing down [47]. The

husband was perceived as being an unnatural support person [47] so his presence was not valued.

*“I think I had to ask him, would you please...And then he kind of did it [massage]....And then I said, yeah, it’s OK, don’t bother...go find a TV, man, or whatever (laughing). And he was quite happy to...” [45].*

*“I like my husband to be present but at the same time I am very shy...I don’t want my husband to see me in a situation where I am weak.” [53].*

Cultural aspects influenced women’s perceptions about childbirth support provided by a male partner or husband. Unlike their Arab and Nepalese counterparts (Sapkota et al. [44], Akhavan & Edge [52] and Kabakian-Khasholian et al. [53]), most Russian women in Bakhta and Lee’s study [51] did not want their husbands as support persons as it was culturally unacceptable for husbands to witness their wives giving birth. They believed the birthing process does not require spectators, especially not husbands.

*“This is something a woman should go through alone” or “this is the time to concentrate on yourself, and having someone else around will be a distraction.” [51].*

Cultural background and values influence women’s perceptions of continuous support during childbirth particularly for a male partner or husband as support person. Education on the diverse cultural issues will empower midwives and other health care workers to apply methods that embrace cultural diversity.

## **DISCUSSION OF FINDINGS IN RELATION TO OTHER LITERATURE**

The discussion of the current study’s findings were integrated with other literature that investigated aspects of childbirth such as women’s experiences of maternity services, the nature of modern midwifery practice, woman-centred care, doulas as support persons and companionship during childbirth. The discussion regarding women’s views and experiences regarding continuous support during childbirth will be presented according to the categories

of the roles and attributes of the support persons, and challenges regarding aspects of providing continuous support during childbirth.

### **The roles and attributes of support persons as perceived by the new mothers**

Factors that influenced women's perceptions about continuous support during childbirth will be discussed in relation to documents not included in the current study's systematic review. Implications of these studies' findings will be addressed.

#### ***The type of support persons***

The synthesis of the findings of the current study's systematic review revealed that the type of support persons varied. Support persons included midwives, nurses, doulas, husbands and female relatives or friends. As for doulas, in North America they are trained para-professionals [9, 45, 48] whereas in Arabian [44, 53] and African countries [43, 46], female relatives or friends provide support with minimal or no training. In this review doula refers to a trained para-professional while support person includes all individuals that provide support.

In the current review the support person was expected to be gentle, empathetic and respectful in establishing a close and trusting relationship with the woman [45, 50], knowledgeable and culturally cognisant [6] to accommodate different cultural values.

Similarly other studies found that women expected a support person to be knowledgeable about childbirth either through experience or training [42], or a skilled and proficient midwife [1] for providing efficient and effective care.

The favourite support person was female as she would understand another woman's outlook [46, 47, 50, 52, 53]. These sentiments are echoed by Swedish women in a study by Berg et al. [55] who appreciated the labour support provided by fellow women whom they perceived to be good at performing a "woman's job." Similarly other studies [7-9] identified the providers of labour support as female relatives or friends, husbands/partners, doulas and midwives.

The current systematic review's synthesis indicated that the doula was ideal as a primary support person compared to a relative or husband with emotions vested in the birth of 'their baby' [47, 49]. The doula provided individualised attention to women [47-49], emotional support to husbands and links between women and midwives [45-47]. However the relationship between the midwife and the doula might be problematic if the midwife feel that the doula is performing the midwife's job [48].

Doulas provide care directly matching individual women's needs and desires [48, 49, 52] by actively involving women in the birthing process and by empowering them through providing information and advice, as well as emotional and physical support [45, 48, 49, 52]. These findings are supported by the study by Hodnett et al. [4] who identified the elements of childbirth support as 'provision of information and advice, emotional support, continuous presence, comfort measures and advocacy'.

The midwives' supportive role was insufficient for women as midwives were unable to be continuously physically present [49]. However, midwives are expected to be with the woman during childbirth, whether continuously or interrupted [45], though their focus is more on provision of the 'medical care' than supportive care [49]. Unlike doulas, midwives occupy a multifaceted role that requires them to provide comprehensive care during all the different stages of childbirth up to discharge from the institution [45]. Supporting the findings of the current systematic review synthesis, Byrom and Downe's [56] findings highlight that a midwife possesses skills and attributes enabling her to provide comprehensive care, concurring with the International Confederation of Midwives' (ICM) (2005:3) [57] definition of the midwife as being 'a responsible person and accountable professional who work in partnership with women to give the necessary support, care, and advice during pregnancy, labour and the postpartum period'.

The father was favoured to be present for the birth of the baby by Nepalese and Canadian women [44, 45, 54]. In their study McGrath and Kennell [9] concur that the husband is an

ideal support person because of the intimate relationship with the woman. The husband and doula complemented each other [52]. However, for some women their husbands' presence was emotionally stressful [46]. More so husbands were culturally forbidden to witness childbirth [51]. While some women felt that their husbands also needed support [42].

Women's choice of support persons was influenced by their preference for birth settings. Support persons should be able to provide holistic care to women during childbirth.

### ***Physical presence***

The findings of the current systematic review synthesis revealed that the presence of a support person was preferred as it implied that women's needs were met. The women expected their support persons to be available throughout the birthing process, implying that dependence on the midwife led to feelings of desertion when midwives could not offer continuous support [41, 49, 50,]. The lack of continuous support from the midwives made one woman feel as if she was a piece of merchandise in a 'production line' waiting to be processed [49]. Similar findings were reported by Jamas et al. [5] in a Brazilian study where one woman narrated feeling as though she was an 'object' waiting to be 'produced'. Similarly studies done in Tanzania [58] and South Africa [13] found that women felt abandoned due to the lack of constant attention from midwives. However, women whose support persons were not only midwives, appreciated the continuous presence of their support persons who focused on providing support [44, 45, 48, 49, 52,]. Similarly Melender [59] found that the very presence of a support person was reassuring and comforting.

The sentiments women reported in these studies emphasise the value of constant support during childbirth. Thus doulas or other support persons might provide ideal continuous support during childbirth due to their focus on one woman at a time.

### ***Provider of emotional support***

The current systematic review revealed that the support persons' emotional support enabled women to remain focused during childbirth. Emotional support was highly valued, as it consoled and gave women courage and strength to endure the process of childbirth [44, 45]. The emotional support comprised encouragement, empathy, and applause for fortitude [43, 45, 46]. Similar to the findings of the current systematic review, Lundgren et al. [1] and Chan et al. [6] found that gentle communication, praise, compassion and reassurance had calming effects on women. Lundgren et al. [1] and Pascali-Bonaro [2] highlight that childbirth has a lifelong impact on women.

Support persons should be sensitive and mindful of what and how they convey information to women as it could either have a positive or a negative lifelong effect on the woman.

### ***Provider of physical support***

Another revelation from the current meta-synthesis was that physical comfort measures facilitated relaxation and provided pain relief but that the different techniques depended on a woman's needs and preference. The comfort measures included massages, warm baths, breathing techniques and holding of hands [43, 45, 49]. Help with mobilisation and adoption of more comfortable positions were also appreciated [44, 53]. These measures enabled women to go through the phases of childbirth in a state of optimal physical well-being. Even when opting for an epidural [45] or entonox [49], most women valued continuous support. Some women reckoned they did not need any form of physical support because they were self-sufficient [47]. Studies by Green and Hotelling [60]; Simkin and Bolding [61] advocate for mobility and other comfort measures as a way of not restricting women while promoting and expediting spontaneous childbirth.

Women's preferences regarding comfort measures varied and not all women appreciated or wanted them.

### ***Provider of information and advice***

The current systematic review synthesis showed that prenatal education enlightened women about the birthing process and accessible services so that they could prepare for childbirth and make informed decisions. Information and advice from midwives and doulas fostered familiarity with the birthing process and practices [45, 47, 52] and enhanced women's emotional stability [49, 52]. Women who did not meet the midwife or doula during their pregnancies wished they had done so because they lacked relevant information [46, 52]. Studies by Hodnett et al. [4] and Campbell [8] advocate for the provision of prenatal childbirth education and provision of information during labour to relieve anxiety and enable women to make informed decisions in order to improve both maternal and neonatal outcomes.

During childbirth constant reassurance of women and updates about their progress from midwives should be a norm [45]. That is essential because support persons are not medically educated about the physiology of childbirth to offer such information. Intra-partum information and guidance enabled women to remain focused and to cooperate during childbirth [43, 47, 49, 52]. Support persons' lack of knowledge caused emotional distress. A lack of knowledge by Malawian [43, 46] and Swedish women [52] caused disillusionment. However, some women empowered themselves through reading accessible materials about childbirth [45]. Melender [59] found that women valued active involvement and informed consent in decisions affecting them.

Antenatal preparation helps to reduce fear of childbirth which is the most vulnerable time for a woman.

### ***Advocacy role***

The current systematic review indicated that due to the vulnerable nature of women during childbirth, women need mediators to ensure that their needs are met. Support persons and midwives fulfilled this role. Open channels of communication enhanced feelings of security for the women in the 'unusual' birth environment [47, 49, 50, 52]. The support person acted

as a mediator [45, 54] and the doula, being familiar with the birth environment, acted as a 'relay person' [45, 47, 49, 52, 54]. These findings are supported by Melender [59] and Green and Hotelling [60] who highlight the need for a mediator during childbirth to convey women's wishes to midwives or vice-versa.

This relay of messages between women and midwives promoted harmonious and trusting relationships with the care providers and enhanced their confidence in the care provided.

### ***Favourable interpersonal relationships***

The findings of the current systematic review show that good interpersonal relationships promote steadiness in the woman and trust in the support person, facilitating interactions with support persons. Women need to feel uninhibited during childbirth and some had their husbands as support persons because of the intimate relationship [44, 45, 54] as well as close female relatives or friends [46, 47, 50, 53, 54]. Kind-heartedness and sincerity from the midwives facilitated the development of a trusting relationship with the women [45, 50]. Similar findings were reported by Lundgren et al. [1], Chan et al. [6] and Bowers [27].

Meeting and establishing a relationship with the midwife or doula prenatally facilitated the development of a trusting interpersonal relationship based on sound knowledge. Good interpersonal relationships during childbirth boosted women's confidence in the care provided.

### **Challenges regarding aspects of continuous support during childbirth as perceived by the new mothers**

Though most women had positive experiences related to supportive care provided by their support persons, this was not the case for all women.

### ***Undesirable attributes of support persons***

The current meta-synthesis found that during childbirth women preferred a support person who is compassionate caring and skillful. A rude or unsociable support person or midwife could cause anxiety, stress and stubbornness. Some women were upset by their support persons' lack of empathy and gentleness [46, 50, 52, 53] and some midwives were perceived as being detached because of their unfriendly demeanour [49]. Midwives' negative attitudes towards doulas were unsettling for some women [47, 48]. Husbands' inability to offer physical support and hope caused some women to feel gloomy and disappointed [44, 45]. Women need kind-heartedness and sincerity from the midwives and support persons to enhance a closer and a trusting relationship [45, 50]. Findings by Lundgren et al. [1] and Chan et al. [6] revealed that gentle communication and quietness in the birthing rooms had reassuring and calming effects on women.

Warmth, gentleness and affirmative words uplifted and encouraged women as compared to rudeness and indifference. Midwives and all support persons should be sensitive towards women.

### ***Women's and support persons' knowledge deficiencies***

The current systematic review found that support persons' and women's lack of information about organisational norms contributed to disillusionment during childbirth. For example the absence of essential support or the provision of wrong advice to women by their support persons due to knowledge deficiencies caused disappointments [43, 52]. Some women had unrealistic expectations from their support persons as they could not distinguish between midwives' and support persons' roles. Knowledge deficits were both frustrating for women as the care provided did not meet their expectations [43, 46, 52, 54].

Hodnett et al. [4]; Chan et al. [6] and Rala et al. [62] agree that midwifery care should include information and education which should commence during prenatal care. Papagni and Buckner [63] concur that there should be a clear distinction of roles between team members

so that they can all work towards provision of optimal care. This view is supported by the World Health Organization (WHO) [64] who recommend that healthcare workers including managers should be educated on both labour and childbirth companionship so that, women can be well informed to make independent and sound decisions.

### ***Undesirable forms of supportive care***

In the current systematic review women wished to give birth in a quiet and peaceful environment free from distractions and interruptions such as medical interventions. Considering women's perspectives would enhance their experience of childbirth, reduce feelings of isolation, improve pain management and possibly reduce the numbers of assisted deliveries [54]. Women expect care matching their desires otherwise they might feel disillusioned [49]. For a woman to have a satisfying childbirth experience, the midwife should be on board to mediate good interpersonal relationships with women and their chosen support persons [43, 45, 54].

For some women, having any support person [51] or having 'bystanders' during the actual birth of the baby [54] was intolerable. Meeting the doula during childbirth was disconcerting [52] and so was the lack of constant supportive care from midwives [49, 50]. Support persons' refusal to assist women caused feelings of desolation [43].

Berg et al. [55] and Green and Hotelling [60] concede that women need respect and acknowledgement during childbirth, as well as listening and considering their wishes to participate in decisions affecting them.

Women's preferences and perspectives should be considered as long they do not pose any risks for mother or baby in order to ensure desirable experiences.

### ***Unfavourable institutional practices***

Evidence from the current systematic review synthesis shows that women wished to be involved in decisions affecting them and not to have decisions imposed on them by

institutions. Institutionalised births are common [47] and midwifery care is influenced by institutional norms. Some of these norms are not 'user friendly' [46] as they might deprive women of continuous support during childbirth [50]. Some women get frustrated if they cannot have all their selected support persons with them [54]. Women might feel dismayed [52] by the care provided by midwives and support persons [50]. WHO [64] recommends that health institutions should offer services that are of acceptable standards to women through respect for their choices and maintaining autonomy.

Visitation restriction remained a challenge in many settings. Women's views and perceptions should be considered when revisiting traditional practices and policies about who should be allowed to be present during childbirth. Price et al. [54] further state that prenatal education would make women aware about institutional policies enabling them to plan accordingly. Studies done in Brazil by Jamas et al. [5] and Finland by Melender [59] found that women were frustrated when not all their chosen support persons could be accommodated due to institutional rules.

Women's views and perspectives on childbirth should be considered when formulating guidelines and policies.

### ***Undesirable support persons***

The current systematic review found that women's preferences for support persons were influenced by principles and traditions, especially concerning the husband as support person. Women might give birth with their husbands present with or without a support person [47]. While some women opted for their husbands as primary support persons [54], others had reservations as it was considered to be embarrassing and traditionally unacceptable to have husbands or male persons present during childbirth [51-53]. Russian women felt that the husband's presence would affect their sex lives negatively in future, and that giving birth was not a 'social event' that required spectators [51]. However, other women

tolerated their husbands' involvement during the early stages but not during the advanced stages of childbirth for privacy-related reasons [44, 45].

The current review indicated that the husband's presence could cause awkwardness for the woman and the husband when considered to be culturally unacceptable for a man to witness childbirth [44, 51]. This was the case with women in Nepal [44], Russia [51], Sweden [52] and Jordan, Egypt and Syria [53]. However, McGrath and Kennell [9] reported that in North America the husband's presence during childbirth is vital because of his intimate relationship with the woman and the 'newborn' baby [9]. If husbands are to provide childbirth support, measures should be in place to limit the couple's emotional discomfort [45]. Health care professionals should be knowledgeable about cultural diversity in the birth environment [51]. Koumouitzes-Douvia and Carr [42] state that husbands cannot be expected to be sole providers of support as they also need emotional support.

In the current systematic review besides husbands, mothers-in-law or mothers were not always favoured [46, 49] nor family members due to potential family conflicts [45, 46, 48, 54]. Education about the diverse nature of culture could enable health care professionals to understand the different cultural influences on women. Women's choices for specific support persons should be acknowledged by caregivers.

## **CONCLUSION**

The current systematic review revealed that most women valued continuous support during childbirth. Their experiences were influenced by institutional practices, physical support, support persons, emotional support, interpersonal relationships and cultural orientation.

Respect for women's choices of support persons, provision of acceptable emotional and physical support as well as being there for women through sound interpersonal relationships during childbirth could enhance women's positive experiences. Educating women about institutional practices during pregnancy and acknowledging cultural diversity could address

some negative childbirth-related experiences. Women should be treated as unique individuals with different preferences providing continuous woman-centred childbirth support.

### **ABBREVIATIONS USED**

ADA: American Dietetic Association; CASP: Critical Appraisal Skills Programme; CBD: Community Based Doula; CRD: Centre for Reviews and Dissemination; HREC: Human Research Ethics Committee; ICM: International Confederation for Midwives; LDRP: Labour, Delivery, Recovery and Postpartum unit; NVD: Normal Vaginal Delivery; PICO: Population, Intervention, Comparison intervention, Outcome; PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses; RIS: Research Information Systems; SPIDER: Sample, Phenomenon of Interest, Design, Evaluation, Research type; WHO: World Health Organization.

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### **Competing interests**

There are no competing interests.

### **Authors' contributions**

This article is based on a dissertation for a master's degree in nursing by the first author.

The co-authors were the supervisors of this study.

## REFERENCES

1. Lundgren I, Karlsdottir SI, Bondas T. Long-term memories and experiences of childbirth in a Nordic context - a secondary analysis. *Int J Qual Studies Health Well-being*. 2009; 4(2):115-128.
2. Pascali-Bonaro D. Childbirth education and doula care during times of trauma, stress, and grieving. *J Perinat Edu*. 2003; 12(4):1-7.
3. Green JM. Integrating women's views into maternity care research and practice. *Birth*. 2012; 1-5.
4. Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. 2012. <http://www.childconnection.org/pdfs/cochranedatabaseSyst Rev.pdf>. Accessed 8 Apr 2015.
5. Jamas MT, Hoga LAK, Tanaka ACA. Mothers' birth care experiences in a Brazilian birth centre. *Midwifery*. 2011; 27:693-699.
6. Chan CYZ, Wong SK, Lam MW, Wong YK, Kwok CY. An exploration of postpartum women's perspective on desired obstetric nursing qualities. *J Clinical Nurs*. 2013; 23:103-112.
7. Pascali-Bonaro D, Kroeger M. Continuous female companionship during childbirth: A crucial resource in times of stress or calm. *J Midwifery Women's Health*. 2004. *J Midwifery Women Health*. 2004;49 suppl 1:19-27.
8. Campbell DA, Lake MF, Falk M, Backstrand JR. Randomized control trial of continuous support in labor by a lay doula. *JOGNN*. 2006; 35:456-464.
9. McGrath SK, Kennell JH. A randomized controlled trial of continuous labor support for middle-class couples: Effect on cesarean delivery rates. *Birth*. 2008; 35(2):92-97.
10. Bianchi AL, Adams, ED. Doulas, labor support and nurses. *ICJE*. 2004; 19 suppl 4:24-30.
11. Romano AM, Lothian JA. Promoting, protecting, and supporting normal birth: A Look at the evidence. *JOGNN*. 2008; 37(1):94-105.
12. Albers LL. The evidence for physiologic management of the active phase of the first stage of labor. *J Midwifery Women Health*. 2007; (52):207-215.
13. Chadwick RJ, Cooper D, Harries J. Narratives of distress about birth in South African public maternity settings: A qualitative study. *Midwifery*. 2014; (30):862-868.
14. Burman ME, Robinson B, Hart AM. Linking evidence-based nursing practice and patient-centered care. *Nurs Admin Quarterly*. 2013; 37 suppl 3:231-241.
15. Kritzinger S. Why do women go along with this stuff? *Birth*. 2006; 33(2):154-158.
16. Hatamleh R, Shaban IA, Homer C. Evaluating the experience of Jordanian women with maternity care services. *Health Care Women Int*. 2013; (34):499-512.

17. Leap N. Woman-centred or women-centred care: does it matter? *J British Mid.* 2009; 17(1):12-16.
18. Pope R, Graham L, Patel S. Woman-centred care. *Int J Nursing Studies.* 2001; (38):227-238.
19. Baker K. The importance of effective support during childbirth. *BJM.* 2010; 18 suppl 10:665-668.
20. Maputle MS, Hiss DC. Criteria to facilitate the implementation of woman-centred care in childbirth units of Limpopo Province, South Africa (Part 2). *Curationis.* 2013; 36(1):1-7.
21. Lothian JA. Do not disturb: The importance of privacy in labor. *J Perinat Edu.* 2004; 13(3):1-6.
22. Nicholls I, Webb C. What makes a good midwife? An integrative review of methodologically-diverse research. *J Adv Nurs.* 2006; 4:414-429.
23. The Royal College of Midwives. High quality midwifery care. 2014. [http://www.rcm.org.uk/sites/default/files/High Quality Midwifery Care Final](http://www.rcm.org.uk/sites/default/files/High%20Quality%20Midwifery%20Care%20Final.pdf). Accessed 31 Mar 2017.
24. Eri TS, Bondas T, Gross MM, Janssen P, Green JM. A balancing act in an unknown territory: A meta-synthesis of first-time mothers' experiences in early labour. *Midwifery.* 2015; 1:e58-e67.
25. Puia D. A meta-synthesis of women's experiences of a caesarean birth. *Matern Child Nurs.* 2013; 8(1):41-47.
26. Downe S, Simpson L, Trafford K. Expert intra-partum maternity care: a meta-synthesis. *J Adv Nurs.* 2007; 57(2):127-140.
27. Bowers BB. Mothers' experiences of labor support: Exploration of qualitative research. *JOGNN.* 2002; 31:742-752.
28. Holly C, Salmond SW, Saimbert MK. Comprehensive systematic review for advanced nursing. 2012. [http://www.midwiferycollege.org/AcademicProgramme/ Downloads /MSM/550 Comprehensive systematic review for advanced nursing.pdf](http://www.midwiferycollege.org/AcademicProgramme/Downloads/MSM/550%20Comprehensivesystematicreviewforadvancednursing.pdf). Accessed 31 March 2017.
29. ADA (American Dietetic Association). Evidence analysis manual: steps in the ADA evidence analysis process. Chicago: Scientific Affairs and Research, American Dietetic Association. 2012. [https://www.andean.org/files/Docs/2012\\_Jan\\_EA\\_Manual](https://www.andean.org/files/Docs/2012_Jan_EA_Manual.pdf). Accessed 30 Mar 2015.
30. Cooke A, Smith D, Andrew B. Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qual Health Res.* 2012; 22(10):1435-1443.
31. Benoot C, Hannes K, Bilsen J. The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. *BMC Medical Res Methodol.* 2016; doi 10.1186/s12874-016-0114-6.

32. Finfgeld-Connett D, Johnson ED. Literature search strategies for conducting knowledge-building and theory-generating qualitative systematic reviews. *J Adv Nurs*. 2012; 69(1):194-204.
33. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. EPPI-Centre, Social Science Research Unit, Institute of Education, University of London. 2008.
34. CRD (Centre for Reviews and Disseminations). Systematic reviews: CRD's guidance for undertaking reviews in health care. York: University of York. 2009. [http://www.york.ac.uk/inst/crd/pdf/Systematic\\_Reviews.pdf](http://www.york.ac.uk/inst/crd/pdf/Systematic_Reviews.pdf). Accessed 31 Mar 2017.
35. Ring N, Ritchie K, Mandava L, Jepson R. A guide to synthesising qualitative research for researchers undertaking health technology assessments and systematic reviews. National Health System, Quality Improvement: Scotland. 2010. <http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=04df262c-ec...pdf>. Accessed 1 Apr 2015.
36. Moher D, Liberati A, Tetzlaff J, Altman DG. PRISMA flow diagram. 2009. <http://www.PRISMA-statement.org/documents/PRISMA%202009%20flow%20diagram.pdf>. Accessed 31 March 2017.
37. Gough D, Oliver S, Thomas J. Learning from Research: Systematic reviews for informing policy decisions. A quick guide. EPPI-Centre: Social Science Research Unit, Institute of Education University of London. 2013.
38. Hannes K, Lockwood G & Pearson A. A Comparative analysis of three online appraisal instruments' ability to assess validity in qualitative research. *Qual Health Res*. 2010; 20(12):1736-1743.
39. Kitchenham, B. Procedures for performing systematic review. 2004. [http://www.people.ucalgary.ca/~medlibrary/kitchenham\\_2004.pdf](http://www.people.ucalgary.ca/~medlibrary/kitchenham_2004.pdf). Accessed 30 Mar 2015.
40. CASP (Critical Appraisal Skills Programme). Making sense of evidence. 10 questions to help you make sense of qualitative research. 2013. [http://www.columbia.edu/~mvp19/RMC/M3/CASP\\_Qual.pdf](http://www.columbia.edu/~mvp19/RMC/M3/CASP_Qual.pdf). Accessed 26 Apr 2015.
41. Etowa JB. Black women's perceptions of supportive care during childbirth. *Int J Childbirth Edu*. 2012; 27(1):28-32.
42. Koumouitzes-Douvia J, Carr CA. Women's perceptions of their doula support. *J Perinat Edu* 2006; 15(4):34-40.
43. Kungwimba E, Malata A, Maluwa A, Chirwa E. Experiences of women with support they received from their birth companion during labour and delivery. *Health*. 2013; (5):45-52.
44. Sapkota S, Kobayashi T, Takase M. Women's experience of giving birth with their husband's support in Nepal. *J Brit Midwifery*. 2011; 19(7):427-432.
45. Simpson MJ. Women's perspectives on supportive care during labour and delivery. Vancouver: University of British Columbia (Dissertation-Master's degree). 2012.

46. Banda G, Kafulafula G, Nyirenda E, Tauro F, Kalilani L. Acceptability and experience of supportive companionship during childbirth in Malawi. *BJOG* 2010; (117):937-945.
47. Berg M, Terstad A. Swedish women's experiences of doula support during childbirth. *Midwifery*. 2006; (22):330-338.
48. Hunter C. Intimate space within institutionalized birth: Women's experiences birthing with doulas. *Anthropology Med*. 2012; 19(3):315-326.
49. Lundgren I. Swedish women's experiences of doula support during childbirth. *Midwifery*. 2010; (26):173–180.
50. MacKinnon K, McIntyre M, Quance M. The meaning of the nurse's presence during childbirth. *JOGNN*. 2005; (34):28-36.
51. Bakhta Y, Lee R. A survey of Russian women regarding the presence of a companion during labor. *Int J Gynaecol Obstet*. 2010; (109):201-203.
52. Akhavan S, Edge D. Foreign-born women's experiences of community-based doulas in Sweden-A qualitative study. *Health Care Women Int*. 2012; (33):833-848.
53. Kabakian-Khasholian T, El-Nemer A, Bashour H. Perceptions about labor companionship at public teaching hospitals in three Arab countries. *Int J Gynaecol Obstet*. 2015; (129):223-226.
54. Price S, Noseworthy J, Thornton J. Women's experience with social presence during childbirth. *Matern Child Nurs*. 2007; 32(3):184-191.
55. Berg M, Olafsdottir OA, Lundgren I. A midwifery model of woman-centred childbirth care – In Swedish and Icelandic settings. *Sexual Reprod Health Care*. 2012; 3:79-87.
56. Byrom S, Downe S. 'She sort of shines': midwives' accounts of 'good' midwifery and 'good' leadership. *Midwifery*. 2010; 26:126-137.
57. ICM (International Confederation of Midwives). International definition of the midwife. 2005. <http://www.internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/.pdf>. Accessed: 19 Aug 2015.
58. Shimpuku Y, Patil CL, Norr KF, Hill PD. Women's perceptions of childbirth experience at a hospital in rural Tanzania. *Health Care Women Int*. 2013; (934):461–481.
59. Melender H. What constitutes a good childbirth? A qualitative study of pregnant Finnish women. *J Midwifery Women's Health*. 2006; (51):331–339.
60. Green J, Hotelling BA. Healthy birth practice #3: bring a loved one, friend, or doula for continuous support. *J Perinat Edu*. 2014; 23(4):194-197.
61. Simkin P, Bolding A. Update on non-pharmacologic approaches to relieve labor pain and prevent suffering. *J Midwifery Women's Health*. 2004; 49:489–504.
62. Rala N, James, S, Tshotsho, N. Opinions of labouring women about companionship in labour wards. *J Afr Mid Women's Health*. 2014; 8(3):123-127.

63. Papagni K, Buckner E. Doula support and attitudes of intrapartum nurses: A qualitative study from the patient's perspective. *J Perinat Edu.* 2006; 15(1):11-18.
64. World Health Organization (WHO). Companion of choice during labour and childbirth for improved quality of care. <http://www.who.int/reproductivehealth>. 2016. Accessed: 31 Mar 2017.

## ADDITIONAL FILES

**Additional file 1:** PRISMA flow chart of the systematic review



## Additional file 2

### Critical appraisal mark allocation

Authors/title/ bibliographic information	Type of study design, setting and language of data collection	Sampling, sample size and demographics	Data collection technique and analysis	Rigour
<p>Akhavan S, Edge D. Foreign-born women's experiences of community-based doulas in Sweden-A qualitative study. Health Care Women Int. 2012; (33):833-848.</p>	<p>Design: Exploratory Setting: hospitals in the Vastra Gotaland region, Sweden Language: Arabic, Somali and Turkish.</p>	<p>Sampling: purposive Sample: 10 Age: 23–31 Parity: 4 multiparous Place of delivery: hospital Mode of delivery: NVD Post-delivery period: 3 and 6 weeks postpartum</p>	<p>Data collection: semi-structured interviews Venue: women's homes Data analysis: content analysis</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: clear.</li> <li>2. Methodology: appropriate and sufficiently discussed.</li> <li>3. Research design: appropriate to address aims.</li> <li>4. Recruitment: process sufficiently discussed.</li> <li>5. Data collection method: appropriate.</li> <li>6. Relationship between researcher and participants (reflexivity): Cannot tell.</li> <li>7. Ethical issues: sufficiently considered.</li> <li>8. Data analysis: sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> <li>10. Value of research: discussed and its contribution to practice and the need for further research indicated.</li> </ol> <p>C/A = 9/10 INCLUDED</p>
<p>Bakhta Y, Lee R. A survey of Russian women regarding the presence of a companion during</p>	<p>Design: qualitative survey Setting: Omsk County maternity and delivery hospital Language: Russian</p>	<p>Sampling: convenient Sample: 70 Age: 25.4 average Parity: 1.6 average Place of delivery: hospital</p>	<p>Data collection: person-to-person interviews Venue: hospital Data analysis: content analysis</p>	<ol style="list-style-type: none"> <li>1. Statement of aims: clear.</li> <li>2. Methodology: appropriate and sufficiently discussed.</li> <li>3. Research design: appropriate to address aims.</li> <li>4. Recruitment process: sufficiently discussed.</li> </ol>

<p>labor. Int J Gynaecol Obstet. 2010; (109):201-203.</p>		<p>Post-delivery period: 2 days post-partum (21 women)</p>		<ol style="list-style-type: none"> <li>5. Data collection method interviews were appropriate though women's narratives are few.</li> <li>6. Relationship between researcher and participants (reflexivity) sufficiently discussed regarding Russian speaking primary investigator.</li> <li>7. Ethical issues: considered.</li> <li>8. Data analysis: analysed by statistician.</li> <li>9. A clear statement of findings was provided.</li> <li>10. Value of research: discussed and its contribution to practice.</li> </ol> <p>C/A=8/10 INCLUDED</p>
<p>Banda G, Kafulafula G, Nyirenda E, Taulo F, Kalilani L. Acceptability and experience of supportive companionship during childbirth in Malawi. BJOG 2010; (117):937-945.</p>	<p>Design: Cross-sectional surveys before and after introducing supportive companionship. Setting: Maternity facilities in Blantyre City, Malawi. Language: English and Chichewa</p>	<p>Sampling: variety of sampling methods Sample: 202 first study, 174 second study Age: ≤ 23-43 years Parity: primiparous and multiparous Place of delivery: hospital and health centers Mode of delivery: NVD Post-delivery period: while still in postnatal ward</p>	<p>Data collection: mixed methods using interviews using questionnaire with closed and open-ended questions Venue: a private room at hospital Data analysis: content analysis for qualitative data</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: clear.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: appropriate to address aims.</li> <li>4. Recruitment process: sufficiently discussed.</li> <li>5. Data collection: method interviews were appropriate to get women's narratives though few.</li> <li>6. Relationship between researcher and participants (reflexivity) not discussed.</li> <li>7. Ethical issues: clear.</li> <li>8. Data analysis, content analysis was sufficiently discussed.</li> <li>9. A clear statement of findings was provided.</li> <li>10. Value of research: Recommendations for further research were made.</li> </ol> <p>C/A = 9/10</p>

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Berg M, Terstad A. Swedish women's experiences of doula support during childbirth. Midwifery. 2006; (22):330-338.	Design: Phenomenology Setting: 2 large Swedish cities. Language: Swedish and English	Sampling: purposeful Sample: 10 women (6 hospital delivery and 4 home) Age: 25-35 years Parity: primiparous and multiparous Place of delivery: 6 in hospital and 4 at home Mode of delivery: not specified Post-delivery period: 1-2 months	Data collection: open-ended interviews 40-70 minutes Venue: women's homes Data analysis: thematic analysis	1. Statement of aims of research: is clear and relevant. 2. Methodology: appropriate. 3. Research design: appropriate to address aim. 4. Recruitment strategy: appropriate and selection process discussed appropriately. Reasons for size of sample given. 5. Data collection method was explicit and appropriate. 6. Relationship between researcher and participants (reflexivity): not considered. 7. Ethical issues: considered sufficiently. 8. Data analysis: sufficiently discussed. 9. Findings: a clear statement provided. 10. Value of research: More research was recommended.  CA 9/10 INCLUDED
Etowa JB. Black women's perceptions of supportive care during childbirth. Int J Childbirth Edu. 2012; 27(1):28-32.	Design: qualitative (not specified) Setting: North End Community Health Centre located in the capital city of one of Canada's Atlantic provinces Language: English	Sampling : purposive Sample: 10 Age: 18-40 years Parity: 5 primiparous and 5 multiparous Place of delivery: healthcare institution Mode of delivery: not specified	Data collection: individual interviews and focus group interviews Venue: not specified Data analysis: thematic analysis	1. Statement of aims of research: clear. 2. Methodology: is relevant and applicable in addressing the research goal. 3. Research design: only qualitative. 4. Recruitment strategy: appropriate to some extent. Reason for sample size not given. 5. Data collection method: was appropriate, discussed to some extent.

		Post-delivery period: within 2 years and focus group interviews 6 weeks after interviews		<p>6. Relationship between researcher and participants (reflexivity): not considered.</p> <p>7. Ethical issues: considered to some extent. Rights of participants not discussed.</p> <p>8. Data analysis: sufficiently discussed.</p> <p>9. Findings: Only one key finding was discussed. Value of research: No reference to further research made.</p> <p>C/A = 6/10 EXCLUDED</p>
Hunter C. Intimate space within institutionalized birth: Women's experiences birthing with doulas. Anthropology Med. 2012; 19(3):315-326.	Design: Ethnography. Setting: birth education centre in a mid-sized homogenous Midwestern town in America Language: English	Sampling: purposive Sample: 9 doulas and 9 mothers Age: not specified Parity: not specified Place of delivery: hospital Mode of delivery: 8 had NVD of which 2 used pain medication, 1 caesarean section Post-delivery period: not specified	Data collection: interviews Venue: birth education center Data analysis: ethnographic analysis using Atlas ti qualitative software	<p>1. Statement of aims of research: clear.</p> <p>2. Methodology: appropriate.</p> <p>3. Research design: appropriate to address aims.</p> <p>4. Recruitment strategy: snow ball technique was appropriate to address aim and process discussed. Reasons for size of sample given.</p> <p>5. Data collection method: Data was collected over a long period and observations could be subjective.</p> <p>6. Relationship between researcher and participants (Reflexivity): not discussed.</p> <p>7. Ethical issues: considered.</p> <p>8. Data analysis: sufficiently discussed.</p> <p>9. Findings: a clear statement, provided.</p> <p>10. Value of research: Further research suggested.</p> <p>C/A = 8/10 INCLUDED</p>

<p>Kabakian-Khasholian T, El-Nemer A. Bashour H. Perceptions about labor companionship at public teaching hospitals in three Arab countries. Int J Gynaecol Obstet. 2015; (129):223-226.</p>	<p>Design: qualitative (not specified) Setting: three large public teaching hospitals in Beirut (Lebanon), Damascus (Syria), and Mansoura (Egypt). Language: Interviews in Arabic translated into English</p>	<p>Sampling: purposive Sample: mothers-69 Age: 18-38 years Parity: primiparous and multiparous Place of delivery: hospitals Mode of delivery: NVD Post-delivery period: immediate postpartum</p>	<p>Data collection: Semi-structured interviews Venue: private space in the hospital Data analysis: thematic analysis</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: is clear.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: appropriate to address aims.</li> <li>4. Recruitment: purposive; process discussed.</li> <li>5. Data collection method: appropriate.</li> <li>6. Relationship between researcher and participants (Reflexivity): No proof.</li> <li>7. Ethical issues: considered.</li> <li>8. Data analysis sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> <li>10. Value of research: valuable as it contributes to practice.</li> </ol> <p>CA 9/10 INCLUDED</p>
<p>Koumouitzes-Douvia J. Carr CA. Women's perceptions of their doula support. J Perinat Edu 2006; 15(4):34-40.</p>	<p>Design: only stated qualitative Setting: hospitals Language: English</p>	<p>Sampling: purposeful Sample: 12 Age: 30-37 years Parity: 11 primiparous and 1 multiparous  Place of delivery: hospital Mode of delivery: 10 NVD, 2 caesarean section Post-delivery period: 7 -16 weeks</p>	<p>Data collection: interviews Venue: homes of participants Data analysis: content analysis.</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: is clear.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: are appropriate to address aims.</li> <li>4. Recruitment: the process was prone to biasness as the recruiters were the doulas.</li> <li>5. Data collection method: appropriate, but not sufficiently discussed.</li> <li>6. Relationship between researcher and participants (Reflexivity): not discussed.</li> <li>7. Ethical issues: not addressed. Moreover subjects were paid.</li> <li>8. Data analysis: sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> </ol>

				10. Value of research: Further research recommended. CA 6/10 EXCLUDED
Kungwimba E, Malata A, Maluwa A, Chirwa E. Experiences of women with support they received from their birth companion during labour and delivery. Health. 2013; (5):45-52.	Design: descriptive Setting: public hospital Malawi Language: Chichewa and English	Sampling: Purposive Sample: 20 Age: 15-30 years Parity: all primiparous Place of delivery: hospital Mode of delivery: NVD Post-delivery period: immediate postpartum	Data collection: in-depth interviews using open-ended interview guide. Venue: postnatal ward Data analysis: content analysis-manually	1. Statement of aims of research: is clear. 2. Methodology: appropriate. 3. Research design: are appropriate to address aims. 4. Recruitment: process discussed. 5. Data collection method: appropriate. 6. Relationship between researcher and participants (Reflexivity): Not discussed. 7. Ethical issues: considered. 8. Data analysis sufficiently discussed. 9. Findings: a clear statement provided. 10. Value of the research: Contribution and implications for practice is discussed. CA 9/10 INCLUDED
Lundgren I. Swedish women's experiences of doula support during childbirth. Midwifery. 2010; (26):173-180.	Design: hermeneutic Setting: 2 maternity hospitals in Sweden Language: Swedish	Sampling: Purposive Sample: 9 Age: 15-40 years Parity: 7 primiparous and 2 multiparous Place of delivery: hospital Mode of delivery : 6 NVD, 1 planned, 2 emergency caesarean	Data collection: interviews Venue: woman's home or place of woman's choice Data analysis: thematic analysis	1. Statement of aims of research: clear. 2. Methodology: appropriate. 3. Research design: appropriate to address aims. 4. Recruitment strategy: purposive and process discussed. 5. Data collection method: appropriate. 6. Relationship between researcher and participants (Reflexivity): not discussed. 7. Ethical issues: considered to some extent. 8. Data analysis: sufficiently discussed.

		Post-delivery period: 1-8 months		<p>9. Findings: a clear statement provided in relation to the research question.</p> <p>10. Value of the research: contribution and implications for practice are discussed.</p> <p>CA 9/10 INCLUDED</p>
MacKinnon K, McIntyre M, Quance M. The meaning of the nurse's presence during childbirth. JOGNN. 2005; (34):28-36.	<p>Design: Hermeneutic phenomenological inquiry</p> <p>Setting: urban center in Canada</p> <p>Language: English</p>	<p>Sampling: purposive</p> <p>Sample: 6</p> <p>Age: Not younger than 36 years of age</p> <p>Parity: 4 primiparous and 2 multiparous</p> <p>Place of delivery: hospital</p> <p>Mode of delivery type: NVD</p> <p>Post-delivery period: 6 months</p>	<p>Data collection: open-ended interviews</p> <p>Venue: not specified</p> <p>Data analysis: thematic analysis</p>	<ul style="list-style-type: none"> <li>• Statement of aims of research: is clear.</li> <li>• Methodology: appropriate.</li> <li>• Research design: is appropriate to address aims.</li> <li>• Recruitment: purposive; process discussed.</li> <li>• Data collection method: appropriate.</li> <li>• Relationship between researcher and participants (Reflexivity): Not clear.</li> <li>• Ethical issues: not clear on permission, only that each woman was given a pseudonym.</li> <li>• Data analysis sufficiently discussed.</li> <li>• Findings: a clear statement provided.</li> <li>• Value of the research: implications for practice discussed and further research recommended.</li> </ul> <p>CA 8/10 INCLUDED</p>
Price S, Noseworthy J, Thornton J. Women's experience with social presence during childbirth. Matern	<p>Design: naturalistic</p> <p>Setting: tertiary birth care Eastern Canada</p> <p>Language: English</p>	<p>Sampling: purposive</p> <p>Sample: 16</p> <p>Age: 22-37 years</p> <p>Parity: 9 primiparous and 7 multiparous</p>	<p>Data collection: open-ended interviews</p> <p>Venue: postnatal ward</p> <p>Data analysis: thematic analysis</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: is clear.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: are appropriate to address aims.</li> <li>4. Recruitment: purposive; process discussed.</li> <li>5. Data collection method: appropriate.</li> </ol>

<p>Child Nurs. 2007; 32(3):184-191.</p>		<p>Place of delivery: tertiary care birth unit Mode of delivery: NVD Post-delivery period: immediate postpartum before discharge</p>		<p>6. Relationship between researcher and participants (Reflexivity): Cannot tell. 7. Ethical issues: considered. 8. Data analysis sufficiently discussed. 9. Findings: a clear statement provided. 10. Value of the research: implications for practice discussed. CA 9/10 INCLUDED</p>
<p>Sapkota S, Kobayashi T, Takase M. Women's experience of giving birth with their husband's support in Nepal. J Brit Midwifery. 2011; 19(7):427-432.</p>	<p>Design: qualitative (not specified) Setting: Midwife led birthing center located within the tertiary care maternity and women's hospital in Kathmandu, Nepal. Language: Nepali translated into English</p>	<p>Sampling: purposeful Sample: 12 Age: 18 -28 years Parity: primiparous Place of delivery: birth centre Mode of delivery: NVD Post-delivery period: within 7 days</p>	<p>Data collection: in-depth semi-structured interviews Venue: separate room within the birthing center Data analysis: thematic analysis</p>	<p>1. Statement of aims of research: is clear. 2. Methodology: appropriate. 3. Research design: not discussed, only mentions qualitative in abstract. 4. Recruitment: purposive; recruitment process discussed. 5. Data collection method: appropriate. 6. Relationship between researcher and participants (Reflexivity): discussed to some extent. 7. Ethical issues: considered to some extent. 8. Data analysis: sufficiently discussed. 9. Findings: a clear statement provided. 10. Value of research: discussed and its contribution to practice and further research recommended. C/A = 8/10 INCLUDED</p>

<p>Simpson MJ. Women's perspectives on supportive care during labour and delivery. Vancouver: University of British Columbia (Dissertation-Master's degree). 2012.</p>	<p>Design: interpretive descriptive  Setting: Labour, delivery, recovery and postpartum (LDRP) unit in a large metropolitan hospital  Language: English</p>	<p>Sampling: Theoretical snowball  Sample: 8  Age: 25-39  Parity: primiparous  Place of delivery: hospital  Mode of delivery :7 NVD (1 vacuum, 1 forceps), 1 caesarean section  Post-delivery period: 7 weeks – 7 months</p>	<p>Data collection: semi-structured, open ended interviews  Venue:women's homes  Data analysis: thematic analysis</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: clear.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: appropriate to address aims.</li> <li>4. Recruitment: purposive; recruitment process discussed.</li> <li>5. Data collection method: appropriate.</li> <li>6. Relationship between researcher and participants (Reflexivity): discussed.</li> <li>7. Ethical issues: considered.</li> <li>8. Data analysis: sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> <li>10. Value of research: conclusions contribute to existing knowledge and further research is recommended.</li> </ol> <p>CA = 9/10  INCLUDED</p>
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### Additional file 3

Populated data extraction table of studies included

Author/ location	Methodology	Study focus sample	Sample size, parity	Birth companions	Mode of delivery and place	Highlights from each study
Akhavan & Edge (2012) Sweden	Exploratory	Foreign born women's experiences of community-based doula support	n=10	Community- based doulas	NVD Hospital	<ul style="list-style-type: none"> <li>- Someone who speaks the same language in a foreign country, a desired companion, she is more than an interpreter. "I was so happy that someone who can speak both languages will follow me to hospital"</li> <li>- Motivated to become a doula once she has learnt Swedish</li> <li>- No continuity of support after childbirth-women were deserted soon after childbirth</li> </ul>
Bakhta & Lee (2010) Russia	Qualitative survey	Attitudes of Russian women towards the presence of a support person during labor	n=70	Husbands	NVD Hospital	<ul style="list-style-type: none"> <li>- Husband not ideal birth companion, should stay away from childbirth "if something goes wrong during labor, he will panic, faint, and hurt himself."</li> <li>- No need to interfere in a natural process</li> <li>- Childbirth is a private moment no need for social interaction</li> </ul>
Banda et al.(2010) Malawi	Variety of sampling methods	Women's perceptions of companionship during labor	n=192	Husbands, female relatives, mothers-in-law	NVD Hospital Health centre	<ul style="list-style-type: none"> <li>- Companion very helpful, gave sound advice. 'My companion was telling me what to do at different times'</li> <li>- Nurse-patient link, someone to talk to</li> <li>- Mother-in-law a discomforting presence</li> </ul>
Berg & Terstad (2006) Sweden	Phenomenology	Women's experiences of having a doula present during childbirth	n=10 5 primiparous 5 multiparous	Trained doulas	Hospital Home	<ul style="list-style-type: none"> <li>- The doula does it all; she is an all-rounder "She knows a lot about the childbirth. She has been there before. She can explain and clarify."</li> <li>- She has a spectacular and phenomenal role</li> <li>- Doula a neutral person</li> </ul>

Hunter (2012) United States of America	Ethnography	Mother-doula relationship during the birth experience.	n=9	Trained doulas	8 NVD 1 caesarean Hospital	<ul style="list-style-type: none"> <li>- The doula completes the childbirth process</li> <li>- "...but it was Henry [husband] and my doula that were supporting me. I don't think it was like the nurses didn't care about me..."</li> </ul>
Kabakian- Khasholian et al. (2015) Lebanon, Syria and Egypt	Qualitative (not specified)	Perspectives of women, female relatives, and health care providers on labor companionship.	n=69 28 primiparous 41 multiparous	Female relatives	NVD Hospital	<ul style="list-style-type: none"> <li>- Female companion a very relevant person</li> <li>- Fear of labour pain and childbirth is equated to 'death' and 're-birth'</li> <li>- Husbands to witness the pain of childbirth in order to value wives. "He has to fear for my safety, he has to feel with me the pain I am going through and appreciate me for what I am going through."</li> </ul>
Kungwimba et al. (2013) Malawi	Descriptive	Participant's knowledge regarding birth companionship.	n=20 Primiparous	Female relatives Own mothers Mothers-in-law	NVD Hospital	<ul style="list-style-type: none"> <li>- Some companions were unkind. "...surprisingly her response was that she was going home and will leave me alone. She left but came back after a nurse pleaded with her."</li> <li>- Some birth companions gave contradictory advice from nurses</li> <li>- Given assistance during delivery by companion. "She was holding my head to raise me a little bit and assisted me to push effectively."</li> </ul>
Lundgren (2008) Sweden	Qualitative (not specified)	Women's experiences of doula support during childbirth.	n=9 7 primiparous 2 multiparous	Trained doulas plus extra person; female friend, mother, partner	6 NVD 3 caesarean Hospital	<ul style="list-style-type: none"> <li>- Birth is a life event focusing on the woman during antenatal and postpartum period</li> <li>- The doula mediated trust. "I heard her voice all the time and she calmed me down".</li> <li>- Labour ward was like a 'production line' "since they [nurses] are running in and out the rooms. They are not present all the time.</li> </ul>
MacKinnon et al. (2005) Canada	Hermeneutic	To develop a new understanding of what it means for a nurse to be present during childbirth.	n=6 4 primiparous 2 multiparous	Nurses	NVD hospital	<ul style="list-style-type: none"> <li>- The "obstetric triage" a barrier to effective continuous labour support</li> <li>- The nurse an advocate between family and other health professionals. "...The role the nurse plays is, in a lot of ways, more important than the doctor's role."</li> </ul>
Price et al. (2007) Canada	Naturalistic	The meaning and significance women attach to family and	n=16 9 primiparous 7 multiparous	Husbands/ partners, female relatives or	NVD tertiary care birth unit	<ul style="list-style-type: none"> <li>- Husband the preferred choice for intimate family time and participant in childbirth. "It's more of a personal connection whereas a nurse...you don't</li> </ul>

		friend presence during childbirth within a tertiary care birth unit		friend plus extra person; own mothers, or doula		really know them. I mean...they don't all have to be nice, but the nurses it's their job." <ul style="list-style-type: none"> <li>- Woman's event, so she chooses companion</li> <li>- Visitation policy restrictive</li> <li>- Comprehensive support</li> <li>- Childbirth is a personal and private moment</li> </ul>
Sapkota et al. (2011) Nepal	Qualitative (not specified)	To explore women's experiences of giving birth with their husbands' support in urban Nepal.	n=12 primiparous	Husbands	NVD Midwife-led birthing centre	<ul style="list-style-type: none"> <li>- Embarrassment, discomfort and feelings of guilt by husband's presence</li> <li>- Husband passive, not needed</li> <li>- For others, husband's presence a source of comfort and calmness "I felt like my husband took good care of me. He rubbed my back, and encouraged me to take frequent drinks to keep up the energy."</li> </ul>
Simpson (2008) Canada	Interpretive descriptive	Women's perceptions of the support that they received during labour and delivery.	n=8 primiparous	Nurses as primary supporters Husbands plus extra person: female supporter	NVD, forceps, vacuum, caesarean section hospital	<ul style="list-style-type: none"> <li>- Husband not wanted during the active phase before "pushing"</li> <li>- Induction not an option, childbirth not a disease</li> <li>- Nurses were very helpful. "The environment itself was very relaxed. As far as the nurses being there the whole time, I'm glad they were".</li> </ul>

## Additional file 4

The roles and attributes of support persons as perceived by the new mothers

Study	The type of support persons	Physical presence	Provider of emotional support	Provider of physical support	Provider of information and advice	Advocacy role	Interpersonal relationships
Akhavan & Edge (2012)	<ul style="list-style-type: none"> <li>- The doula a source of fulfillment represented "human rights and dignity"</li> </ul>	<ul style="list-style-type: none"> <li>- The doula eliminated the feeling of "gharib" (isolation)</li> </ul>	<ul style="list-style-type: none"> <li>- Softened the feeling of loneliness</li> <li>- Gained confidence</li> <li>- Fears conquered</li> </ul>	<ul style="list-style-type: none"> <li>- Provision of oxygen</li> <li>- Breathing techniques</li> </ul>	<ul style="list-style-type: none"> <li>- Doula knowledgeable and experienced</li> <li>- She gave "medical information"</li> </ul>	<ul style="list-style-type: none"> <li>- Father-doula-midwife partnership</li> </ul>	<ul style="list-style-type: none"> <li>- Common language</li> <li>- Treated with respect and dignity</li> <li>- Doula-woman relationship established during antenatal period</li> <li>- Continued support during postnatal period</li> </ul>
Bakhta & Lee (2010)	<ul style="list-style-type: none"> <li>- Husbands</li> <li>- Mothers</li> <li>- No need for a support person</li> </ul>	Private event no need for interaction	_____	_____	_____	_____	-
Banda et al. (2010)	<ul style="list-style-type: none"> <li>- Female relatives of which women were happy to have</li> </ul>	<ul style="list-style-type: none"> <li>- Acceptable companionship</li> </ul>	<ul style="list-style-type: none"> <li>- Sympathetic</li> <li>- Continual presence</li> <li>- Reassurance and praise</li> </ul>	<ul style="list-style-type: none"> <li>- Mobilisation</li> <li>- Food and water</li> <li>- Position changing</li> <li>- Elimination- both bowel and urinal</li> </ul>	<ul style="list-style-type: none"> <li>- Source of vital information through instructions</li> </ul>	<ul style="list-style-type: none"> <li>- Communication link between women and health professionals</li> </ul>	<ul style="list-style-type: none"> <li>- Witness to the birthing process</li> <li>- Companionship</li> </ul>

Berg & Terstad (2006)	<ul style="list-style-type: none"> <li>- The doula was desired and comforting in her care</li> <li>- "A birthing sister" and "a positive witch"</li> </ul>	<ul style="list-style-type: none"> <li>- The missing "piece" of the "puzzle"</li> <li>- Accessible presence</li> </ul>	<ul style="list-style-type: none"> <li>- Readily available and dependable presence</li> <li>- Reassurance</li> </ul>	<ul style="list-style-type: none"> <li>- Massages, entonox, cold compresses to the forehead</li> <li>- Water to drink</li> <li>- Hygienic needs</li> </ul>	<ul style="list-style-type: none"> <li>- Extensive experience; explains and clarifies</li> <li>- Relevant advice</li> </ul>	<ul style="list-style-type: none"> <li>- A link between the couple and midwife</li> <li>- The doula a "guarantor"</li> </ul>	<ul style="list-style-type: none"> <li>- "Sisterly" relationship</li> <li>- "An affirmative person"</li> </ul>
Hunter (2012)	<ul style="list-style-type: none"> <li>- The doula provided "womanly support"</li> <li>- Female relatives</li> </ul>	<ul style="list-style-type: none"> <li>- Great to have a doula present</li> <li>- "Being with me"</li> </ul>	<ul style="list-style-type: none"> <li>- Caring and constant presence described as 'being with me'.</li> <li>- Individualised care</li> </ul>	<ul style="list-style-type: none"> <li>- Hand holding, stroking the hair, giving water,</li> <li>- Hygienic measures such as wiping of blood from legs and assistance with going to the bathroom</li> </ul>	<ul style="list-style-type: none"> <li>- _____</li> </ul>	<ul style="list-style-type: none"> <li>- Represents one voice in labour</li> </ul>	<ul style="list-style-type: none"> <li>- Very close and personal with the doula</li> <li>- Familial relationship with husband</li> </ul>
Lundgren (2008)	<ul style="list-style-type: none"> <li>- The doula respected the woman's wishes</li> <li>- Female relatives, partners</li> </ul>	<ul style="list-style-type: none"> <li>- The doula "helped me all the time"</li> </ul>	<ul style="list-style-type: none"> <li>- Prenatal doula support facilitated composure, it was "like being in a bubble"</li> <li>- Praise and reassurance</li> </ul>	<ul style="list-style-type: none"> <li>- Entonox inhalation, massages and breathing techniques</li> </ul>	<ul style="list-style-type: none"> <li>- Boosting guidance</li> <li>- A teacher</li> </ul>	<ul style="list-style-type: none"> <li>- The doula a link between the couple and midwife</li> <li>- The doula was a source of security and trust</li> </ul>	<ul style="list-style-type: none"> <li>- The doula provided a sisterly presence</li> <li>- Doula-woman relationship established during antenatal and continued into postpartum period</li> </ul>

Kabakian-Kasholian et al. (2015)	<ul style="list-style-type: none"> <li>- Female relatives, “a woman knows how to deal with her”</li> <li>- “The support of your family gives you power.”</li> </ul>	<ul style="list-style-type: none"> <li>- Presence of a companion mediates protection</li> </ul>	<ul style="list-style-type: none"> <li>- Another woman knows best</li> <li>- Reassuring and encouraging presence</li> <li>- “She would be caring and I might forget the pain”</li> </ul>	<ul style="list-style-type: none"> <li>- Holding of hands</li> <li>- “I would feel comforted when holding her hand”</li> <li>- Mobilisation</li> </ul>	<ul style="list-style-type: none"> <li>- _____</li> </ul>	<ul style="list-style-type: none"> <li>- _____</li> </ul>	<ul style="list-style-type: none"> <li>- Familial relationship</li> <li>- Reassuring and encouraging presence</li> </ul>
Kungwimba et al. (2013)	<ul style="list-style-type: none"> <li>- Female or male</li> <li>- Some companions were unfriendly at times</li> </ul>	<ul style="list-style-type: none"> <li>- Midwives’ constant presence, highly desired but was not possible</li> </ul>	<ul style="list-style-type: none"> <li>- Source of security</li> <li>- Reassurance and praise</li> <li>- Dependable and prayer partner</li> </ul>	<ul style="list-style-type: none"> <li>- Back massage, warm bath, food and fluids, changing of beddings, mobilisation and accompaniment to the toilet</li> </ul>	<ul style="list-style-type: none"> <li>- Provision of instructions during second stage</li> <li>- “My mother was advising me on what to do....”</li> </ul>	<ul style="list-style-type: none"> <li>- _____</li> </ul>	<ul style="list-style-type: none"> <li>- _____</li> </ul>
MacKinnon et al. (2005)	<ul style="list-style-type: none"> <li>- Husband, doula and nurses who provided invaluable care “more important role than the doctor”</li> </ul>	<ul style="list-style-type: none"> <li>- Nurses’ presence “imperative”</li> <li>- Nurse’s absence indicates a “gap” in the care</li> </ul>	<ul style="list-style-type: none"> <li>- Completely present</li> <li>- Caring and not clinical</li> </ul>	<ul style="list-style-type: none"> <li>- Stroking of hair</li> <li>- Breathing techniques</li> </ul>	<ul style="list-style-type: none"> <li>- Knowledgeable and dependable</li> <li>- Continuous feedback</li> <li>- Skilled and competent</li> </ul>	<ul style="list-style-type: none"> <li>- The nurse, a go-between family and institution</li> </ul>	<ul style="list-style-type: none"> <li>- Individualised, constant</li> <li>- Nurse-woman trusting relationship</li> </ul>
Price et al. (2007)	<ul style="list-style-type: none"> <li>- Women chose partners and female relatives</li> </ul>	<ul style="list-style-type: none"> <li>- The presence of the support person, aided</li> </ul>	<ul style="list-style-type: none"> <li>- Continual presence</li> </ul>	<ul style="list-style-type: none"> <li>-</li> </ul>	<ul style="list-style-type: none"> <li>- Expert advice</li> </ul>	<ul style="list-style-type: none"> <li>- Complementary role</li> </ul>	<ul style="list-style-type: none"> <li>- Intimate relationship</li> <li>- Individualised support</li> </ul>

	<ul style="list-style-type: none"> <li>- "My birth"</li> <li>- "My choice"</li> </ul>	<p>them to <i>"pass the time"</i> or <i>"forget the pain."</i></p>	<ul style="list-style-type: none"> <li>- Compassionate and unconditional support</li> <li>- Comfort and control</li> <li>- Encouragement and reassurance</li> </ul>		<ul style="list-style-type: none"> <li>- Provision of information about childbirth</li> </ul>	<ul style="list-style-type: none"> <li>- Partner-nurse team</li> </ul>	<ul style="list-style-type: none"> <li>- Family bond and share in birth experience</li> <li>- "Security...knowing I was there with my sister..."</li> </ul>
Sapkota et al. (2011)	<ul style="list-style-type: none"> <li>- Husbands though not favoured by all women</li> </ul>	<ul style="list-style-type: none"> <li>- Mixed emotions prevailed regarding husbands' presence</li> </ul>	<ul style="list-style-type: none"> <li>- Acknowledgement of efforts by husbands</li> <li>- Husbands' presence empowering and a source of inner strength</li> </ul>	<ul style="list-style-type: none"> <li>- Provision of fluids</li> <li>- Position changing</li> <li>- Back rubs</li> <li>- Breathing and pushing techniques</li> </ul>	<ul style="list-style-type: none"> <li>- Guidance on physical measures to relieve pain</li> </ul>	<ul style="list-style-type: none"> <li>- Husbands were a communication link between wives and midwives</li> </ul>	<ul style="list-style-type: none"> <li>- Well cared for by husbands</li> </ul>
Simpson (2008)	<ul style="list-style-type: none"> <li>- Husbands, doulas and nurses</li> </ul>	<ul style="list-style-type: none"> <li>- Both intermittent and continuous presence was acceptable</li> <li>- Husband's presence "pivotal"</li> </ul>	<ul style="list-style-type: none"> <li>- Humour, empathy and kindness</li> <li>- Self-awareness and inner-control</li> </ul>	<ul style="list-style-type: none"> <li>- Back massages, visualisation, breathing and distraction techniques</li> <li>- counter pressure, hydrotherapy</li> <li>- Self-hypnosis</li> <li>- Epidural</li> </ul>	<ul style="list-style-type: none"> <li>- Instructions on how to push during the second stage</li> <li>- Informed choice</li> <li>- Information on progress of labour</li> </ul>	<ul style="list-style-type: none"> <li>- Timely expert intervention</li> <li>- Advocate who stands up for women</li> <li>- Doula supporter for the primary support person</li> </ul>	<ul style="list-style-type: none"> <li>- Emotional connection with husbands</li> <li>- Shared intimate experience with husbands</li> </ul>

## Additional file 5

Challenges regarding aspects of continuous support during childbirth as perceived by the new mothers

Study	Undesirable qualities of a support persons	Women's and support persons' knowledge deficiencies	Undesirable forms of supportive care	Unfavourable institutional practices	Undesirable support persons
Akhavan& Edge (2012)	- Lack of compassion by some doulas	- The doula was 'scared' as she did not know what to do	- Meeting the doula for the first time during labour -	- _____	- _____
Bakhta & Lee (2010)	_____	_____	- Intrusion - childbirth is a medical process which does not need social interaction - It's a private and personal process, only doctors and nurses can relieve the stress and anxiety	_____	- Embarrassed about husband's attendance - Husband a distracter - Husbands presence will later affect sex life
Banda et al. (2010)	_____	- Unaware of option of choosing birth companion	_____	- Unclear guidelines on labour support	- Mother-in-law's presence a burden
Berg & Terstad (2006)	- Unhelpful attitude of nurses towards doulas	_____	_____	_____	_____

Hunter (2012)	- Unhelpful attitude of nurses towards doulas	_____	_____	_____	- Own mother unwelcome due to emotional involvement
Lundgren, (2010)	- Disregard for woman's wishes	_____	- Lack of constant helpful care from midwives - Unfamiliar support person	_____	_____
Kabakian-Kasholian et al. (2015)	- Lack of compassion and caring	- Lack knowledge of childbirth by women, so they associate it with "death"	- Intrusion - childbirth is a private moment it is better to deliver alone or at home	- Restrictive visitation policies	- Husbands presence awkward and an embarrassment
Kungwimba et al. (2013)	- Neglect and abuse - Judgmental attitude by birth companions	- Denial of food and fluids by birth companion and provision of contradictory advice		- _____	- _____
MacKinnon et al. (2005)	- Nurses lack of compassion	_____	- Lack of continuous presence from the nurses	- Interference from doctors 'Obstetrical triage'	_____
Price et al. (2007)	- Unaware of 'visitation boundaries'	- Labour support was not included in prenatal education	- _____	- 'Visitation boundaries'	- _____
Sapkota et al. (2011)	- Husbands' inability to offer physical support	_____	- _____	- _____	- Husband's emotional state a humiliation
Simpson (2008)	_____	- Women unfamiliar with labour support practices	- Interventions and lack of privacy during the early phases of labour	- Imposition of medical interventions	- Husband during second stage and pushing - Family members offer distraction

## **SECTION 3**

### **CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS**

#### **3.1 INTRODUCTION**

In this section the conclusions about the best available evidence regarding women's views and experiences about continuous support during childbirth are presented. As described in 1.8 of section 1 of this dissertation, the facet of the social realism studied through identification, exploration and synthesis of best available research evidence comprised women's views and experiences of continuous support during childbirth provided by different support persons in various settings. The evaluation of the study in relation to rigour and the argument of identified limitations will be conveyed. Recommendations will be made for future research, midwifery practice and nursing/midwifery education.

#### **3.2 EVALUATION OF RIGOUR**

A systematic review entails a set of transparent, orderly, structurally interrelated steps, carried out in a way that avoids bias and allows for peer review and independent verification in order to address a clearly defined question (Holly *et al.*, 2012:15). A systematic review was chosen because it is considered to be the most potent tool to review and synthesise evidence on which clinical decisions can be grounded (Kitchenham, 2004:2). To ensure rigour, logical steps according to ADA, (2012) were followed: firstly the problem identification stage, the literature search stage, the data evaluation stage, the data analysis stage, and lastly the presentation stage.

##### **3.2.1 Problem identification stage**

Through the initial literature search, a clear researchable problem was identified with a specific review purpose which provided the systematic review with precincts and direction. The ontological, epistemological and methodological dimensions that shape social sciences research (Mouton & Marais, 1988:11) guided the review.

The terminology used was clarified according to its applicability to the review (Table 1.1). The systematic review, as a chosen method was discussed in section 1.8, and then the review question was formulated using the SPIDER format (Cooke *et al.*, 2012:1440).

Table 3.1 Elements of the review question according to the acronym SPIDER

ELEMENTS OF THE SPIDER	SEARCH TERMS
<b>S - Sample</b>	Patients; mothers; women who experienced labour
<b>PI - Phenomenon of Interest</b>	continuous support, intra-partum care; labour/labour support; companionship; doula; one-to-one care; emotional support
<b>D - Design</b>	Studies using a qualitative approach and mixed methods with a qualitative component
<b>E - Evaluation</b>	Experiences; perceptions; opinions; views
<b>R - Research type</b>	Semi-structured interviews, in-depth interviews, focus group interviews, case studies

**Review question:**

*What were the views and experiences of women regarding continuous support during childbirth as reported in qualitative studies and in studies that adopted mixed research methods with a qualitative component using semi-structured, in-depth or focus group interviews or case studies to collect data?*

**3.2.2 Literature search stage**

The search was clearly described and a schematic presentation of the review was illustrated using a PRISMA flow chart (Moher *et al.*, 2009) (Figure 3.1). Diverse studies from different settings, that explored women’s views and experiences of continuous support during childbirth, were included to reduce publication bias. Grey literature, higher degree dissertations and reference lists of included studies were analysed to recognise any studies missed during the search from the electronic data bases (Centre for Reviews and Disseminations (CRD), 2009:18; Ring *et al.*, 2011:11). These studies were added to those identified through the electronic databases.

The key search terms were formulated based on the research topic (ADA, 2012:21; Kitchenham, 2004:8; Melnyk & Fineout-Overhult, 2012:11).The study was executed according to a pre-planned systematic review protocol and averted selecting primary studies based on perceptions or preference (JBI, 2001:2; Kitchenham, 2004:4). The search was concluded once there were no new studies emerging.

Strategies to limit different types of bias were applied such as consultation of the librarian during the scoping and formulation of the search strategies right up to its realisation (ADA, 2012:21;

Kitchenham, 2004:8; Melnyk & Fineout-Overhult, 2012:11). This guaranteed an inclusive and exhaustive search.

To decrease language bias, non-English studies with English abstracts were also included (JBI, 2001:3; Kitchenham, 2004:7-9).

### **3.2.3 Data evaluation stage**

Once an individual study was found to be relevant to the research topic, it was critically appraised. The primary studies were critically appraised for methodology and quality using the CASP tool because of its applicability to the research design (CASP, 2013). The critical appraisal was conducted independently by the first reviewer and co-reviewer under the guidance of an experienced researcher.

### **3.2.4 Data synthesis stage**

All 12 included primary studies had a qualitative element. Descriptive tables were utilised to elaborate details of individual included studies. Similarities, commonalities and differences among the individual studies were identified through using women's narratives and then synthesised according to categories and sub-categories (Downe, 2008:7; Gough *et al.*, 2013:18; Sandelowski *et al.*, 1997:368) applying the steps specified by Thomas and Harden (2008:6). There were two categories with both positive and negative experiences and views. These were conveyed based on individual women's narratives to capture the actual essence of these experiences (Thomas & Harden, 2008:14).

### **3.2.5 Presentation**

The study was presented in three sections: 1- the study overview; 2- the manuscript/article and 3- the conclusions, recommendations and limitations. The statements in section 3 comprise aspects pertaining to individual studies as well as to the current study itself.

## **3.3 CONCLUSION**

In section 1 the review question that needed to be answered was:

*What were the views and experiences of women regarding continuous support during childbirth as reported in studies using qualitative and mixed research methods with a qualitative component such as semi-structured, in-depth or focus group interviews or case studies?*

The review question had to be addressed as the “bottom-line answer” the target for the systematic steps undertaken during the review process (ADA, 2012:66). Hence conclusion statements were formulated, to answer the review question. The conclusion statements were formulated based on women’s experiences of continuous childbirth support.

The conclusion statements will be discussed under the two main categories and their respective sub-categories (Table 3.2).

Table 3.2 Categories and sub-categories identified from women’s perspectives

Categories	Sub-categories
<b>The roles and attributes of support persons as perceived by the new mothers</b>	<ul style="list-style-type: none"> <li>- The type of support persons</li> <li>- Physical presence</li> <li>- Provider of emotional support</li> <li>- Provider of physical support</li> <li>- Provider of information and advice</li> <li>- Advocacy role</li> <li>- Favourable interpersonal relationships</li> </ul>
<b>Challenges regarding aspects of continuous support during childbirth as perceived by the new mothers</b>	<ul style="list-style-type: none"> <li>- Undesirable attributes of support persons</li> <li>- Women’s and support persons’ knowledge deficiencies</li> <li>- Undesirable forms of supportive care</li> <li>- Unfavourable institutional practices</li> <li>- Undesirable support persons</li> </ul>

### 3.3.1 The roles and attributes of support persons as perceived by the new mothers

Support persons play a major role in rendering continuous childbirth support to women because without support persons continuous support during childbirth might be unfeasible. Childbirth support takes on various forms as discussed in the following sections of this dissertation.

#### 3.3.1.1 Conclusion: The type of support persons

- Husbands and female relatives provided support (Bakhta & Lee 2010:202; Sapkota *et al.*, 2011:427) though some women declined husbands’ or males’ support due to cultural restrictions (Bakhta & Lee 2010:202).
- Female or male relatives and friends (Banda *et al.*, 2010:939; Kungwimba *et al.*, 2013).

- Female relatives only, husbands not desired for support (Kabakian-Khasholian *et al.*, 2015).
- Doulas provided inclusive and individualised care (Akhavan & Edge, 2012:837; Berg & Terstad, 2006:332).
- Doulas and female relatives (Hunter, 2012:332; Lundgren, 2010:174).
- The doula was a valuable member of the support team (Berg & Terstad, 2005:333; Hunter, 2012:332; Lundgren, 2010:174).
- Nurses/midwives as primary support persons, husband plus a female supporter (Simpson 2008).
- Husbands, female relatives or friends plus own mothers were chosen (Price *et al.*, 2007).

### **Conclusion statement: The type of support persons**

Childbirth support can be provided by any person depending on a woman's choice. This choice might be influenced by relationships, past experiences or institutional practices. The support persons enabled women to have their needs met. The preferred support person was female. Some women chose their husbands as support persons while others had reservations about their husbands as support persons due to cultural influences.

#### **3.3.1.2 Conclusion: Physical presence**

- Mediated security and tranquillity aided women to endure childbirth (Banda *et al.*, 2010:939; Price *et al.*, 2007:187; Simpson, 2008:121; Lundgren, 2010:106; MacKinnon *et al.*, 2005:33).
- The husband's presence was valued as he provided intimate support (Sapkota *et al.*, 2011; Simpson, 2008:86; Price *et al.*, 2007:187).
- The doula's presence might be seen as interference by the midwife (Hunter, 2012:323).
- A discontinuous presence was acceptable and provided women some privacy and independence (Berg & Terstad, 2005:336; Lundgren, 2010:176; Simpson 2008:131; Price *et al.*, 2007, 188).
- Midwives' absence was a concern (Hunter, 2012:323; Lundgren, 2010:178; MacKinnon *et al.*, 2005:33).
- Husbands' presence caused anxiety according to Sapkota *et al.*, (2011:429) or was not desired at all (Bakhta & Lee, 2010:202).

### **Conclusion statement: Physical presence**

The mere presence of support persons gave women hope and courage. Both continuous and intermittent presence was acceptable to allow self-regulation. The continual presence of a support person was well received except in a few instances where the husband's presence was a source of discomfort due to cultural issues.

#### **3.3.1.3 Conclusion: Provider of emotional support**

- Emotional support comforted women (Kungwimba *et al.*, 2013:49; Sapkota *et al.*, 2011:427; Simpson, 2008:65) and
- Comprised praise, encouragement and empathy, (Kungwimba *et al.*, 2013:48; Banda *et al.*, 2010:939; Berg & Terstad, 2006:334; Akhavan & Edge, 2012:841; Kabakian-khasholian *et al.*, 2015:224; Simpson, 2008:68).

### **Conclusion statement: Provider of emotional support**

Emotional support comforted and gave women resilience to go on, it was offered through verbal communication or body cues. This was realised because the support person or midwife was gentle and considerate because childbirth itself is stressful and women do not need extra stressors.

#### **3.3.1.4 Conclusion: Provider of physical support**

- Giving water to drink (Berg & Terstad, 2005:334; Banda *et al.*, 2013: Kungwimba *et al.*, 2013:48; Hunter, 2012:322; Sapkota *et al.*, 2011:428) and assisting women to go to the toilet were appreciated (Banda *et al.*, 2013: Kungwimba *et al.*, 2013:48; Hunter, 2012:322).
- Physical support was provided through holding of hands (Kabakian-Kasholian *et al.*, 2015:225), as well as stroking the woman's hair (Hunter, 2012:322).
- Comfort measures ranged from back massages (Berg & Terstad, 2005:333; Kungwimba *et al.*, 2013:48, Lundgren,2010:177; Sapkota *et al.*, 2012:428; Simpson, 2008:108), cold compresses applied to the forehead (Berg & Terstad, 2005:335) and warm baths (Kungwimba *et al.*, 2013:48; Simpson, 2008:110).
- Other comfort measures included mobilisation and adoption of comfortable positions (Kabakian-Khasholian *et al.*, 2015:225; Kungwimba *et al.*, 2013:48; Sapkota *et al.*, 2012:428).

- Visualisation and distraction techniques, counter pressure, self-hypnosis and epidural (Simpson, 2008:110) or entonox (Berg & Terstad, 2005:335; Lundgren, 2010:178) techniques were also utilised.
- Breathing techniques and pushing techniques assisted women during the childbirth process (Akhavan & Edge, 2012:841; Hunter, 2012:323; Kungwimba *et al.*, 2013:48; Sapkota *et al.*, 2012:428; Simpson, 2008:108; Lundgren, 2010:177).

### **Conclusion statement: Provider of physical support**

Physical support involves assorted comfort measures that facilitate relaxation and relieve women's pain. Different techniques were applied to provide pain relief and relaxation depending on a woman's needs and preferences.

#### **3.3.1.5 Conclusion: Provider of information and advice**

- Education during the prenatal period about childbirth services (Akhavan & Edge, 2012:841; Banda *et al.*, 2010:939; Berg & Terstad, 2005:333; Simpson, 2008:55) was important to prepare women for childbirth.
- Women received information during the intra-partum period as well (Akhavan & Edge, 2012:840; Banda *et al.*, 2010:939; Kungwimba *et al.*, 2013:47; Lundgren, 2010:177; Mackinnon *et al.*, 2005:32; Price *et al.*, 2007:188; Simpson, 2008:67).
- Some women were self-empowered by reading available childbirth-related information independently (Simpson, 2008:52).

### **Conclusion statement: Provider of information and advice**

Preparation for childbirth involves the provision of information during both the prenatal and intra-partum periods to enlighten women about the birth process and about available services so that they can prepare themselves and make informed choices. Women can also empower themselves by reading available literature on childbirth on their own.

#### **3.3.1.6 Conclusion: Advocacy role**

- Open channels of communication enhanced women's feelings of security (Berg & Terstad, 2006:334; Lundgren, 2010:177; MacKinnon *et al.*, 2005:32; Akhavan & Edge, 2012:840).

- The support persons acted as mediators between women and midwives and relatives waiting outside the birthing rooms (Banda *et al.*, 2010:939; Berg & Terstad, 2006:333; Hunter, 2012:319; Akhavan & Edge, 2011:841; Price *et al.*, 2007:189; Simpson, 2008:83).
- Midwives informed women about the childbirth progress and about doctors' consultations (Simpson, 2008:73).

### **Conclusion statement: Advocacy role**

Due to the vulnerability of women during childbirth, support persons and midwives acted as their representatives ensuring that their needs were met. Through advocacy women felt safe and secure.

#### **3.3.1.7 Conclusion: Favourable interpersonal relationships**

- Intimate relationships with husbands were valued during childbirth phases by some (but not by all) women (Sapkota *et al.*, 2011:428; Simpson 2008:126; Price *et al.*, 2007:187).
- Close relationships with support persons permitted women to express themselves freely (Akhavan & Edge, 2012:842; Berg & Terstad, Lundgren, Hunter, 2012:321; Price *et al.*, 2007:187).
- Female relatives or friends put women at ease (Banda *et al.*, 2010:941; Berg & Terstad, 2005:334; Kabakian-Kasholian *et al.*, 2015:226; MacKinnon *et al.*, 2005:34; Price *et al.*, 2007:187).
- Women developed trust in the midwives because they were perceived as being gentle and genuine (MacKinnon *et al.*, 2005:31; Simpson, 2008:74).

### **Conclusion statement: Favourable interpersonal relationships**

Good interpersonal relationships promoted stability and boosted women's self-confidence and trust in the support persons, making the women calm and cooperative with their caregivers.

#### **3.3.2 Challenges regarding aspects of continuous support during childbirth as perceived by the new mothers**

In spite of the benefits of continuous support during childbirth reported by women, there were also aspects that were not appreciated by these women. Such aspects included undesirable qualities of the support person, women's and support persons' knowledge deficiencies, undesirable forms of supportive care, unfavourable institutional practices and undesirable support persons.

### **3.3.2.1 Conclusion: Undesirable attributes of the support persons**

- Some women were upset by their support persons' lack of empathy and gentleness (Akhavan & Edge, 2012:842; Banda *et al.*, 2013; Kungwimba *et al.*, 2013:48; Mackinnon *et al.*, 2005; Kabakian-Kasholian *et al.*, 2015).
- Some midwives were perceived as being detached because of their unfriendly demeanour (Lundgren, 2010:176).
- Some nurses' negative attitudes towards doulas unsettled some women (Berg & Terstad, 2005:335).
- Some support persons' inability to offer physical support left women feeling gloomy and disappointed (Akhavan & Edge, 2012:442; Sapkota *et al.*, 2011:428; Simpson, 2008:82).

### **Conclusion statement: Undesirable attributes of the support persons**

During childbirth women preferred someone who was gentle, caring and skillful. A rude or unfriendly support person or midwife could cause anxiety, fear, resentment and uncooperativeness.

### **3.3.2.2 Conclusion: Women's and support persons' knowledge deficiencies**

- There were instances where the woman or support person or both lacked knowledge (Akhavan & Edge, 2012:841; Banda *et al.*, 2013:944; Kungwimba *et al.*, 2013:50; Price *et al.*, 2007:188).
- Lack of information during pregnancy lead to ignorance about continuous support during childbirth (Akhavan & Edge, 2012:841; Banda *et al.*, 2013:944; Kungwimba *et al.*, 2013:50; Price *et al.*, 2007:188).
- Support persons who lacked knowledge and skills caused women to feel desolate (Akhavan & Edge, 2012:442; Simpson, 2008:82).
- Lack of information about childbirth support caused some women to come to the birth centre without any support person necessitating her to use the services of a 'nearby stranger' (Banda *et al.*, 2013:944).
- Due to lack of information husbands might stay for the births of their children despite uneasiness (Simpson, 2008:101).
- Some women were unaware about limitations on the number of allowed support persons, and brought too many support persons along (Price *et al.*, 2007:188).

### **Conclusion statement: Women's and support persons' knowledge deficiencies**

Lack of knowledge was frustrating for both the women and support persons as the care provided or received was not ideal. A lack of information about organisational norms could leave women disenchanted during childbirth. Knowledge could empower both women and support persons to comprehend childbirth.

#### **3.3.2.3 Conclusion: Undesirable forms of supportive care**

- Having a support person during childbirth might be uncomfortable for some persons, especially husbands (Bakhta & Lee, 2010:202; Kabakian-Khasholian, 2015:224) particularly during 'actual birth' of the baby (Price *et al.*, 2007:188; Sapkota *et al.*, 2011; Simpson, 2008:80).
- Women who met the support person only during childbirth were apprehensive (Akhavan & Edge, 2012:842; Banda *et al.*, 2013:940).
- Lack of constant support from midwives made women feel forlorn (Lundgren, 2010:178; Mackinnon *et al.*, 2005:32).
- Refusal of assistance by support persons disappointed women (Kungwimba *et al.*, 2013:49).

### **Conclusion statement: Undesirable forms of supportive care**

Generally women wished to give birth in a tranquil environment that permitted them to have a 'natural birth' with the minimum 'medications' and 'interferences'. Women's preferences which do not pose risks for mother or baby should be considered in order to provide care that meets their wishes.

#### **3.3.2.4 Conclusion: Unfavourable institutional practices**

- Constraint on the number of visitors (Kabakian-Kasholian *et al.*, 2015:225; Price *et al.*, 2007:188).
- Unclear guidelines on support during childbirth (Banda *et al.*, 2010: 944).
- Women felt that the admission process robbed them of continuous support during childbirth (MacKinnon *et al.*, 2005:33).
- Imposition of unwanted medical interventions (Simpson, 2008:101).

### **Conclusion statement: Unfavourable institutional practices**

Women can only be afforded the experience they desired and wished for by institutions, through the implementation of approaches that embrace women's views. Women wished for engagement and not for decisions and interventions imposed on them.

#### **3.3.2.5 Conclusion: Undesirable support persons**

- It is traditionally intolerable in some cultures for husbands or male persons to witness childbirth (Akhavan & Edge, 2012:843; Bakhta & Lee, 2010; Banda *et al.*, 2013:941; Kabakian-Kasholian *et al.*, 2015).
- Private process - no need for spectators during childbirth except healthcare professionals (Bakhta & Lee, 2010; Banda *et al.*, 2013:939).
- Husbands barred from witnessing second stage of labour for privacy because women felt that if the husbands saw their genitalia in that state, it would affect their sex life in future (Sapkota *et al.*, 2011; Simpson, 2012:80).
- Mothers-in-law (Banda *et al.*, 2010:939) as well as own mothers (Hunter) and relatives (Banda *et al.*, 2010:939; Hunter, 2012:333; Simpson; 2008:95; Price *et al.*, 2007:187) were not desired support persons by all women due to emotional discomfort and interference.

### **Conclusion statement: Undesirable support persons**

Traditions and values influenced women's perceptions of continuous support during childbirth especially for the husband as support person. Education on cultural diversity could enable midwives and all other healthcare workers to utilise approaches that embrace cultural diversity.

#### **3.3.3 FINAL CONCLUSION**

Women are unique individuals whose preferences and opinions vary. Their perceptions were influenced by culture, traditions and values, relationships with specific support persons as well as institutional practices, forms of supportive care received and attributes of the support person. Evidently a familiar and caring person is preferred for support. Similarly the meta-synthesis by Bowers (2002) found that influences of women's perceptions of childbirth supportive care range from, the interpersonal relationship with healthcare professionals, prenatal education, cultural beliefs to qualities and skills of the midwife. It is evident that a synthesis on women's views and

experiences of continuous support during childbirth highlights aspects that are important to women according to women themselves.

The purpose and objectives of the study were attained, which were: to gather, appraise and synthesise evidence about women's views and experiences of continuous support during childbirth. These were addressed through exploration and synthesis of findings of the various studies that explored women's views and experiences of continuous support during childbirth. In this synthesis the sub-categories pertaining to the category; the roles and attributes of support persons as perceived by the new mothers, were similar to the seven categories (physical comfort, caring and emotional support, informational support, advocacy, the caregiver's interpersonal communication style, communication of information and instructions and professional competence) by Bowers (2002). Clearly women's perceptions of childbirth support are highly influenced by the main elements of continuous support during childbirth.

The synthesis provides a scientific evidence summary that can be used by care providers, policy makers and researchers. Thus the synthesis has implications for midwifery practice, nursing education as well as nursing research. The recommendations will contribute to the understanding and consideration of women's perceptions as the praxis of providing continuous support during childbirth.

### **3.4 LIMITATIONS**

The individual studies included in the synthesis had varying limitations. These limitations, as well as those that pertain to the current study itself, will be discussed.

#### **3.4.1 Limitations related to included studies**

##### **3.4.1.1 Selection bias**

Some studies (Akhavan & Edge, 2012:844; Berg & Terstad, 2005:336; Lundgren, 2010:178) had limitations in selecting participants because the doula organisation chose the participants. This might have resulted in selecting only women who were content with the doula support system to participate in these studies. Therefore, the risk exists that the women who were dissatisfied with doulas' services were not interviewed. Similarly in the study of Akhavan and Edge (2012) not all immigrants were interviewed, thus some immigrants might have had different views than those reported by these authors.

### **3.4.1.2 The sample**

- **Sample size**

Studies conducted by Berg and Terstad (2005:336), Lundgren (2010:178) and Price *et al.* (2007:191) utilised small samples and collected data in one setting only thereby limiting the extent to which the findings could be generalised to other populations.

- **Nature of sample**

Some studies (Banda *et al.*, 2010:992; Kungwimba *et al.*, 2013:50; Simpson, 2008:8) employed samples comprising primiparous women only. Another limitation in case of Simpson (2008) was the inclusion of only low risk women who gave birth normally to full term infants. Therefore, the results of these studies are not inclusive of women with high risks, being multiparous or giving birth to preterm babies as the nature of childbirth support might vary for these different categories of women and babies. Banda *et al.* (2010:992) excluded women from their study who had caesarean sections. This created a sampling limitation because caesarian sections were mostly performed on women from urban areas whose perceptions might have differed from those of women in the rural areas who did not have caesarian sections.

### **3.4.1.3 Setting**

Two studies, MacKinnon *et al.* (2005:33) and Simpson (2008:8) had the limitation of including only women from one health care institution. Hence the perceptions of these women might have been influenced by the nature of one institution's policies and standards. Thus these findings cannot be generalised to other birth settings.

### **3.4.1.4 Interpersonal relationships**

In the study by Hunter (2012:324), the limitation was the pre-existing close and personal relationship between the woman and her chosen support person which could have influenced the woman's perception of the support person and care. Hence the findings cannot be generalised to women without such pre-existing close and personal relationships with their support persons.

#### **3.4.1.5 Misinterpretations**

Studies conducted by Akhavan and Edge (2012:844) and Kabakian-Kasholian *et al.* (2015:226) used translators which could have resulted in misinterpretations of information or distortions giving different meanings to women's original stories.

#### **3.4.1.6 Investigator bias**

In the study by Bakhta and Lee (2010:203) the limitation was that the principal researcher was a native Russian speaker who had been medically trained in the United States of America. This might have influenced participants' eagerness to share their opinions with the rest of the world. Similarly for Simpson (2008:8), the limitation was that the women knew that the investigator worked as a midwife within the labour, delivery, recovery and puerperium (LDRP) unit. This might have influenced these women's responses.

#### **3.4.1.7 Level of education and income**

Limitations of the studies conducted by Akhavan and Edge (2012:844) and Bakhta and Lee (2010:203) included that the levels of education, literacy and economic class were not considered and could have influenced these women's understanding of continuous childbirth support.

#### **3.4.1.8 Changes in perceptions**

Another limitation in the case of studies by Bakhta and Lee. (2010:203) and Simpson (2008:8) was that women's perceptions of childbirth support were captured long after childbirth implying that these women's recollections might have changed over time.

#### **3.4.1.9 Critical appraisal of included studies**

Although the critical appraisal did appraise the ethical aspects of each included study, the reviewers were not able to ascertain whether the studies were indeed conducted ethically due to the limited evidence provided in the articles.

#### **3.4.2 Limitations related to the current study**

No South African studies were included as none met the selection criteria. Most included studies were from developed countries. Thus the context of the included studies might differ substantially from developing countries' settings and might not be generalisable to developing countries. Some relevant studies might have been missed due to unclear titles or poor indexing. Being a masters'

dissertation, most of the research was done by the student with limited research experience and expertise. Nevertheless the study's supervisors, who are experienced and published researchers, re-checked and verified what had been done.

### **3.5 RECOMMENDATIONS**

The recommendations will be discussed as pertaining to midwifery practice, education, policy and further research.

#### **3.5.1 Recommendations for midwifery practice**

Midwifery practice should:

- ensure that women's preferences regarding continuous support during childbirth is established upon entry into the labour ward.
- ensure that continuous support during childbirth is an integral part of intra-partum care by including it in birth plans.
- ensure that expectations of continuous support during childbirth are discussed by the midwife with the mother and stipulate her availability or commitment in this regard.
- ensure that women are informed about the meaning of continuous support during childbirth during the antenatal period through the use of posters, pamphlets and antenatal education.
- ensure that women, families and communities are aware of continuous support during childbirth and its significance in promoting autonomy through the dissemination of information using community awareness campaigns, local radio stations and printed media.
- provide and maintain a birthing environment that embraces, other support persons and different cultures by observing and implementing the Patient's Rights Charter and the Batho-Pele Principles in the South African context.
- be able to utilise suggestion boxes or patient questionnaires to evaluate care provided and to provide insight into women's perceptions regarding continuous childbirth support and consider these perceptions in formulating woman-centred policies.

#### **3.5.2 Recommendations for nursing education**

Nursing education should:

- sensitise aspiring midwives towards a women-centred and evidence-based approach of care with women as the focal point of care.

- include continuous childbirth support in basic and advanced midwifery curricula to bridge the existing knowledge and practice gaps.

### **3.5.3 Recommendations for policy makers**

Policy makers should:

- be aware of women's views and wishes regarding childbirth support and incorporate them when formulating guidelines, policies and standard operating procedures.
- be sensitive to the diverse nature of culture, religion, background and social values of women when formulating policies so that all women are treated with respect and dignity.

### **3.5.4 Recommendations for further research**

Further research could be conducted:

- regarding the synthesis of experiences of untrained support persons for continuous support during childbirth.
- to explore and synthesise both qualitative and quantitative studies on women's perceptions of continuous support during childbirth.
- to explore and describe midwives' perceptions of continuous support during childbirth.
- to formulate a user-friendly cost-effective model for providing continuous support during childbirth.
- to establish whether the presence of a doula is a benefit or an obstacle for the midwife towards rendering effective continuous support during childbirth.
- to identify essential fundamentals for the midwife-doula affiliation regarding provision of continuous support during childbirth.
- to explore women's views regarding continuous support during childbirth in South Africa due to fewer studies that have been done.

## **3.6 CONCLUSION REGARDING THE SIGNIFICANCE OF THE STUDY**

The research question was addressed by the systematic review as evidence demonstrated that women's views and experiences regarding continuous support during childbirth are multidimensional and influenced by various factors. Benefits of continuous childbirth support were reaffirmed and challenges revealed. Continuous support during childbirth is an essential aspect

of childbirth though the support persons may vary depending on a woman's preference, values or birth environment.

Women prefer midwives and support persons with positive attributes to achieve favourable outcomes. Midwives are also expected to provide continuous support during childbirth meeting a woman's personal and clinical needs. Thus health care workers should consider women's views in order to meet these women's needs. Health care institutions, policy makers, and professionals should recognise the significance of childbirth support. This should form part of antenatal education so that the women can make informed choices based on the best available information. In this way women, together with their chosen support persons, will be knowledgeable, adaptable and prepared for the actual childbirth experience.

## REFERENCES

- ADA (American Dietetic Association). 2012. Evidence analysis manual: steps in the ADA evidence analysis process. Chicago: Scientific Affairs and Research, American Dietetic Association. [https://www.andeal.org/files/Docs/2012\\_Jan\\_EA\\_Manual.pdf](https://www.andeal.org/files/Docs/2012_Jan_EA_Manual.pdf) Date of access: 30 March 2015.
- Akhavan, S. & Edge, D. 2012. Foreign-born women's experiences of community-based doulas in Sweden - A qualitative study. *Health care for women international*, 33:833-848.
- Albers, L.L. 2007. The evidence for physiologic management of the active phase of the first stage of labor. *Journal of midwifery & women's health*, 52: 207-215.
- Baker, K. 2010. The importance of effective support during childbirth. *British journal of midwifery*, 18(10):665-668.
- Bakhta, Y. & Lee, R. 2010. A survey of Russian women regarding the presence of a companion during labor. *International journal of gynecology and obstetrics*, 109:201-203.
- Banda, G., Kafulafula, G., Nyirenda, E., Taulo, F. & Kalilani, L. 2010. Acceptability and experience of supportive companionship during childbirth in Malawi. *British journal of obstetrics and gynaecology*, 117:937-945.
- Benoot, C., Hannes, K. & Bilsen, J. 2016. The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. *BMC medical research methodology*, doi 10.1186/s12874-016-0114-6.
- Berg, M. & Terstad, A. 2006. Swedish women's experiences of doula support during childbirth. *Midwifery*, 22:330-338.
- Berg, M., Olafsdottir, O.A. & Lundgren, I. 2012. A midwifery model of woman-centred childbirth care - In Swedish and Icelandic settings. *Sexual & reproductive healthcare*, 3:79-87.
- Bianchi, A.L. & Adams, E. D. 2004. Doulas, labor support and nurses. *International journal of childbirth education*, 19(4):24-30.
- Blackwell's Nursing Dictionary. 2005. 2nd ed. Cape Town: Juta & Co. Ltd.

BMC Pregnancy & Childbirth. 2016. Guidelines for Authors - BMC Pregnancy & Childbirth. <http://old.biomedcentral.com/bmcpregnancychildbirth/authors/instructions/researcharticle> Date of Access 8 August 2016.

Bowers, B. B. 2002. Mothers' experiences of labor support: Exploration of qualitative research. *Journal of obstetric, gynecologic, and neonatal nursing*, 31:742-752.

Brink, H., Van der Walt, C. & Van Rensburg, G. 2012. Fundamentals of research methodology for healthcare professionals. 3rd ed. Lansdowne, Cape Town: Juta.

Brown, H., Hofmeyr, G.J., Nikodem, V.C., Smith, H. & Garner, P. 2007. Promoting childbirth companions in South Africa: a randomized pilot study. *BMC Medicine* doi: 10.1186/1741-7015-5-7.

Burls, A. 2009. What is critical appraisal? <http://www.whatisseries.co.uk/what-is-critical-appraisal/> Date of access: 30 March 2015.

Burman, M.E., Robinson, B. & Hart, A.M. 2013. Linking evidence-based nursing practice and patient-centered care. *Nursing administration quarterly*, 37(3):231-241.

Byrom, S. & Downe, S. 2010. 'She sort of shines': midwives' accounts of 'good' midwifery and 'good' leadership. *Midwifery*, 26:126-137.

Callister, L.C., Holt, S.H. & West Kuhre, M. 2010. Giving birth: the voices of Australian women. *Journal perinatal neonatal nursing*, 24(2):128-136.

Campbell, D.A., Lake, M.F. Falk, M. & Backstrand, J.R. 2006. Randomized control trial of continuous support in labor by a lay doula. *Journal of obstetrical, gynaecologic and neonatal nursing*, 35:456-464.

CASP (Critical Appraisal Skills Programme). 2013. Making sense of evidence. 10 questions to help you make sense of qualitative research. [http://www.columbia.edu/~mvp19/RMC/M3/CASP\\_Qual.pdf](http://www.columbia.edu/~mvp19/RMC/M3/CASP_Qual.pdf) Date of access: 26 April 2015.

Chadwick, R.J., Cooper, D. & Harries, J. 2014. Narratives of distress about birth in South African public maternity settings: A qualitative study. *Midwifery*, (30):862-868.

- Chalmers, B. 2007. Let us not ignore women's concerns and wishes from developing countries. *Birth*, 2007; 34(1):51-52.
- Chan, C.Y.Z., Wong, S.K., Lam, M.W., Wong, Y.K. & Kwok, C.Y. 2013. An exploration of postpartum women's perspective on desired obstetric nursing qualities. *Journal of clinical nursing*, 23:103-112.
- Compact Edition of the Oxford English Dictionary. 2013. 3rd ed. London: Oxford University Press.
- Cooke, A., Smith, D. & Andrew, B. 2012. Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative health research*, 22(10):1435-1443.
- CRD (Centre for Reviews and Disseminations). 2009. Systematic reviews: CRD's guidance for undertaking reviews in health care. York: University of York. [http://www.york.ac.uk/inst/crd/pdf/Systematic\\_Reviews.pdf](http://www.york.ac.uk/inst/crd/pdf/Systematic_Reviews.pdf) Date of access: 31 March 2017.
- Cullum, N., Ciliska, D., Haynes, R.B. & Marks, S., eds. 2008. Evidence-based nursing: An introduction. London: Blackwell Publishing Ltd.
- Dixon-Woods, M., Fitzpatrick, R., & Roberts, K. 2001. Including qualitative research in systematic reviews: opportunities and problems. *Journal of evaluation in clinical practice*, 7(2):125-133.
- Downe, S. 2006. Engaging with the concept of unique normality in childbirth. *British journal of midwifery*, 14(6):352-356.
- Downe, S., Simpson, L. & Trafford, K. 2007. Expert intrapartum maternity care: a meta-synthesis. *Journal of advanced nursing*, 57(2):127-140.
- Eri, T.S., Bondas, T., Gross, M.M., Janssen, P. & Green, J.M. 2015. A balancing act in an unknown territory: A meta-synthesis of first-time mothers' experiences in early labour. *Midwifery*, 31:e58-e67.
- Etowa, J.B. 2012. Black women's perceptions of supportive care during childbirth. *International journal of childbirth education*, 27(1):28-32.

Fenwick, J., Staff, L., Gamble, J., Creedy, D.K. & Bayes, S. 2010. Why do women request caesarean section in a normal, healthy first pregnancy? *Midwifery*, 26:394-400.

Finfgeld-Connett, D. & Johnson, E.D. 2012. Literature search strategies for conducting knowledge-building and theory-generating qualitative systematic reviews. *Journal of advanced nursing*, 69(1):194-204.

Fraser, D.M., & Cooper, M.A. 2009. Myles textbook for midwives. 15th ed. Edinburgh: Elsevier.

Gibbins, J. & Thomson A.M. 2001. Women's expectations and experiences of childbirth. *Midwifery*, 17(4): 302-313.

Gough, D., Oliver. S. & Thomas, J. 2013. Learning from research: Systematic reviews for informing policy decisions. A quick guide. EPPI-Centre: Social Science Research Unit, Institute of Education. University of London.

Green, J. 2012. Integrating women's views into maternity care research and practice. *Birth*, 39(4): 291-295.

Green, J. & Hotelling, B.A. 2014. Healthy birth practice #3: bring a loved one, friend, or doula for continuous support. *The journal of perinatal education*, 23(4):194-197.

Grove, K.S., Burns, N. & Gray, J. 2014. The practice of nursing research: Appraisal, synthesis, and generation of evidence. 7th ed. Missouri: Elsevier Saunders.

Hannes, K., Lockwood, G. & Pearson, A. 2010. A comparative analysis of three online appraisal instruments' ability to assess validity in qualitative research. *Qualitative health research*, 20(12):1736-1743.

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.

Hatamleh. R., I Shaban, I.A. & Homer, C. 2013. Evaluating the experience of Jordanian women with maternity care services. *Health care women international*, 34:499-512.

Hodnett, E.D., Gates, S., Hofmeyr, G.J. & Sakala., C. 2012. Continuous support for women during childbirth. <http://www.childconnection.org.pdf/cochranedatabaseSyst Rev.pdf> Date of access: 8 April 2015.

Holly, C., Salmond, S.W. & Saimbert, M.K. 2012. Comprehensive systematic review for advanced nursing. <http://www.midwiferycollege.org/AcademicProgramme/Downloads/MSM/550Comprehensivesystematicreviewforadvancednursing.pdf> Date of access: 31 March 2017.

Honikman, S., Fawcus. S. & Meintjes. I. 2015. Abuse in South African maternity settings is a disgrace: potential solutions to the problem. *South African medical journal*, 105(4):284-286.

Hottenstein, S.E. 2005. Creating optimal birth experiences through theory-driven nursing care: continuous labour support. *AWHONN lifelines*, 9(3):244-247.

Hunter, C. 2012. Intimate space within institutionalized birth: Women's experiences of birthing with doulas. *Anthropology & medicine*, 19(3): 315-326.

Hyde, A. & Roche-Reid, B. 2004: Midwifery practice and the crisis of modernity: implications for the role of the midwife. *Social science & medicine*, 58:2613-2623.

ICM (International Confederation of Midwives). 2005. International definition of the midwife. <http://www.internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/.pdf> Date of access: 19 August 2015.

Jamas, M.T., Hoga, L.A.K. & Tanaka, A.C.A. 2011. Mothers' birth care experiences in a Brazilian birth centre. *Midwifery*, 27:693-699.

JBI (Joanna Briggs Institute for Evidence Based Nursing and Midwifery). 2001. Evidence-based practice information sheets for health professionals: an introduction to systematic reviews. *Changing practice*, 2(1):1-6.

Kabakian-Khasholian, T., El-Nemer, A. & Bashour, H. 2015. Perceptions about labor companionship at public teaching hospitals in three Arab countries. *International journal of gynecology and obstetrics*, 129:223-226.

Khan, K.S., Kunz, R., Kleijnen, J. & Antes G. 2003. Five steps to conducting a systematic review. *Journal of the royal society of medicine*, 96(3):118-121.

- Kitchenham, B. 2004. Procedures for performing a systematic review. [http://www.people.ucalgary.ca/~medlibrary/kitchenham\\_2004.pdf](http://www.people.ucalgary.ca/~medlibrary/kitchenham_2004.pdf) Date of access: 30 March 2015.
- Khresheh, R. 2010. Support in the first stage of labour from a female relative: the first step in improving the quality of maternity services. *Midwifery*, 26(6):e21-24.
- Kungwimba, E., Malata, A., Maluwa, A. & Chirwa, E. 2013. Experiences of women with support they received from their birth companion during labour and delivery. *Health*, 5: 45-52.
- Kritzinger, S. 2006. Why do women go along with this stuff? *Birth*, 33(2):154-158.
- Koumouitzes-Douvia, J. & Carr, C.A. 2006. Women's perceptions of their doula support. *Journal perinatal education*, 15(4):34-40.
- Lantz, P.M., Low, L.K., Varkey, S. & Watson, R.L. 2005. Doulas as childbirth paraprofessionals: results from a national survey. *Women's health issues*, 15:109-116.
- Larkin, P., Begley, C.M. & Devane, D. 2009. Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery*, 25(2):e49-59.
- Lavender, T., Walkinshaw, S.A. & Walton, I. 1999. A prospective study of women's views of factors contributing to a positive birth experience. *Midwifery*, 15:40-46.
- Leap, N. 2009. Woman-centred or women-centred care: does it matter? *British journal of midwifery*, 17(1):12-16.
- Lothian, J.A. 2004. Do not disturb: The importance of privacy in labor. *Journal of perinatal education*, 13(3):1-6.
- Lundgren, I., Karlsdottir, S. I. & Bondas, T. 2009. Long-term memories and experiences of childbirth in a Nordic context-a secondary analysis. *International journal of qualitative studies on health and well-being*, 4(2):115-128.
- Lundgren, I. 2010. Swedish women's experiences of doula support during childbirth. *Midwifery*, 26:173-180.
- MacKinnon, K., McIntyre, M. & Quance, M. 2005. The meaning of the nurse's presence during childbirth. *Journal of obstetric, gynecologic, and neonatal nursing*, 34:28-36.

- Maputle, M.S. & Hiss, D.C. 2013. Criteria to facilitate the implementation of woman-centred care in childbirth units of the Limpopo Province, South Africa (Part2). *Curationis*, 36(1):1-7.
- McGrath, S.K. & Kennell, J.H. 2008. A randomized controlled trial of continuous labor support for middle-class couples: Effect on cesarean delivery rates. *Birth*. 35(2):92-97.
- McNelis, M. 2013. Women's experiences of care during labour in a midwifery-led unit in the Republic of Ireland. *British journal of midwifery*, 21(9):422-431.
- Melender, H. 2006. What constitutes a good childbirth? A qualitative study of pregnant Finnish women. *Journal of midwifery & women's health*, 51:331-339.
- Melnyk, B.M. & Fineout-Overholt, E. 2012. Evidence-based practice in nursing & healthcare: A guide to best practice. Philadelphia: Lippincott Williams & Wilkins.
- Moher, D., Liberati, A., Tetzlaff, J. & Altman, D.G. 2009. PRISMA flow diagram. <http://www.PRISMA-statement.org/documents/PRISMA%202009%20flow%20diagram.pdf> Date of access: 31 March 2017.
- Mouton, J. & Marais, H.C. 1988. Basic concepts in the methodology of the social sciences. Pretoria: Human Sciences Research Council (HSRC) Publishers.
- Mouton, J. 2014. How to succeed in your master's & doctoral studies. A South African guide and resource book. Pretoria: Van Schaik.
- Muller, M. 1998. Nursing dynamics. 2<sup>nd</sup> ed. Sandton: Heinemann.
- National Aboriginal Health Organization (NAHO). 2008. Exploring the role of social support in labour and delivery by First Nations women and families. Celebrating birth. Ottawa: National Aboriginal Health Organization.
- New Zealand College of Midwives. 2015. About midwives. <http://www.midwife.org.nz/women-in-new-zealand/about-midwives.pdf> Date of access: 31 March 2017.
- Nicholls, I. & Webb, C. 2006. What makes a good midwife? An integrative review of methodologically-diverse research. *Journal of advanced nursing*, 56(4): 414-429.

NWU (North-West University). 2016. Manual for master's and doctoral studies. Potchefstroom: NWU.

NWU (North-West University). 2012. Referencing guide. Potchefstroom: NWU.

<http://library.nwu.ac.za/sites/library.nwu.ac.za/files/files/documents/quoting-sources.pdf> Date of access: 30 March 2015.

Papagni, K. & Buckner, E. 2006. Doula support and attitudes of intrapartum nurses: A qualitative study from the patient's perspective. *Journal of perinatal education*, 15 (1):11-18.

Pascali-Bonaro, D. 2003. Childbirth education and doula care during times of trauma, stress, and grieving. *The journal of perinatal education*, 12(4): 1-7.

Pascali-Bonaro, D. & Kroeger, M. 2004. Continuous female companionship during childbirth: A crucial resource in times of stress or calm. *Journal of midwifery & women's health*, 49 (4): Suppl. 1.

Page, L.E. & McCandlish, R. 2006. The new midwifery. Science and sensitivity in practice. 2nd ed. Philadelphia: Elsevier.

Payant, L., Davies, B., Graham, I.D., Peterson, W.E. & Clinch J. 2008. Nurses' intentions to provide continuous labour support to women. *Journal of obstetric, gynecologic and neonatal nursing*, 37: 405-414.

Polit, D.F. & Beck, C.T. 2012. Essentials of nursing research: appraising evidence for nursing practice. 8th ed. Philadelphia: Wolters Kluwer, Lippincott William & Wilkins.

Pope, R., Graham, L. & Patel, S. 2001. Woman-centred care. *International journal of nursing studies*, 38:227-238.

Price, S., Noseworthy, J. & Thornton, J. 2007. Women's experience with social presence during childbirth. *Maternal child nursing*, 32(3):184-191.

Puia, D. 2013. A meta-synthesis of women's experiences of a caesarean birth. *Maternal child nursing*, 38(1):41-47.

Rala, N., James, S. & Tshotsho, N. 2014. Opinions of labouring women about companionship in labour wards. *African journal of midwifery and women's health*, 8(3):123-127.

Ring, N., Ritchie, K., Mandava, L. & Jepson, R. 2011. A guide to synthesising qualitative research for researchers undertaking health technology assessments and systematic reviews. National Health System, Quality Improvement: Scotland. <http://www.Healthcareimprovementscotland.org/his/idoc.ashx?docid=04df262c-ec.pdf> Date of access: 01 April 2015.

Romano, A.M. & Lothian, J.A. 2008. Promoting, protecting, and supporting normal birth: A look at the evidence. *Journal of obstetrics, gynaecologic and neonatal nursing*, 37(1):94-105.

Rooks, P. 1999. The midwifery model of care. *Journal of nurse-midwifery*, 44(4):370-374.

Rosen, P. 2004. Supporting women in labor: Analysis of different types of caregivers. *Journal of midwifery and women's health*, 49:24-31.

Sandelowski, M., Docherty, S. & Emden, C. 1997. Focus on qualitative methods qualitative meta-synthesis: Issues and techniques. *Research in nursing & health*, 20:365-371.

Sapkota, S., Kobayashi, T. & Takase, M. 2011. Women's experience of giving birth with their husbands' support in Nepal. *British journal of midwifery*, 19(7):427-432.

Shimpuku, Y., Patil, C.L., Norr, K.F. & Hill, P.D. 2013. Women's perceptions of childbirth experience at a hospital in rural Tanzania. *Health care for women international*, 34:461-481.

Simkin, P. & Bolding, A. 2004. Update on non-pharmacologic approaches to relieve labor pain and prevent suffering. *Journal of midwifery and women's health*, 49:489-504.

Simpson, M.J. 2008. Women's perspectives on supportive care during labour and delivery. Vancouver: University of British Columbia (Dissertation-Master's degree).

Smith, H., Brown, B., Hofmeyr, G.H. & Garner, P. 2004. Evidence-based obstetric care in South Africa - influencing practice through the 'Better Births Initiative.' *South African medical journal*. 94:117-120.

The Royal Dutch Organisation of Midwives. 2012. Midwifery in the Netherlands. <http://www.knov.nl/fms/file/know.nl/knovdownloads/527> Date of access: 7 November 2015.

The Royal College of Midwives. 2014. High quality midwifery care. [http://www.rcm.org.uk/sites/default/files/High Quality Midwifery Care Final](http://www.rcm.org.uk/sites/default/files/High%20Quality%20Midwifery%20Care%20Final.pdf) Date of access: 31 March 2017.

Thomas, J. & Harden, A. 2008. Methods for the thematic synthesis of qualitative research in systematic reviews. EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

Wagner, E. & Wiffen, P.J. 2011. Ethical issues in preparing and publishing systematic reviews. *Journal of evidence-based medicine*, 4:130-134.

Walsh, D. & Downe, S. 2005. Meta-synthesis for qualitative research: a literature review. *Journal of advanced nursing*, 50(2), 204-211.

Wilde-Larsson, B., Sandin-Bojo, A.K., Starrin, B. & Larsson, G. 2010. Birthgiving: women's feelings and perceptions of quality of intrapartal care: a nationwide Swedish cross-sectional study. *Journal of clinical nursing*, 20:1168-1177.

WHO see World Health Organization.

World Health Organization. 2012. Nursing. <http://www.who.int/topics/nursing/en/2012> Date of access: 31 March 2017.

World Health Organization. 2015. Safe childbirth checklist implementation guide. [http://www.apps.who.int/iris/bitstream/10665/199179/1/WHO\\_HIS\\_SDS\\_2015.26\\_eng...](http://www.apps.who.int/iris/bitstream/10665/199179/1/WHO_HIS_SDS_2015.26_eng...) WHO Safe Childbirth Checklist Date of access: 31 March 2017.

# ANNEXURES

## ANNEXURE A: Results according to search engines and data bases

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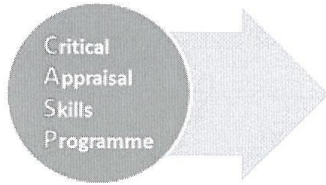
<b>SEARCH ENGINES AND DATA BASES</b>	<b>RESULTS</b>
<b>EBSCOHOST</b>	n=1545
<b>SA E PUBLICATIONS</b>	n=0
<b>JSTOR</b>	n=0
<b>PROQUEST</b>	n=0
<b>PUBMED</b>	n=14
<b>NEXUS</b>	n=0
<b>SCOPUS</b>	n=0
<b>GOOGLE SCHOLAR</b>	n=1
<b>NURSING @OVID</b>	n=0
<b>TOTAL</b>	n=1560

## ANNEXURE B: Detailed description of studies excluded for not meeting eligibility criteria

	Excluded studies	Reasons for exclusion
1	Chan, C.Y.Z., Wong, S.K., Lam, M.W., Wong, Y.K. & Kwok, C.Y. 2013. An exploration of postpartum women's perspective on desired obstetric nursing qualities. <i>Journal of clinical nursing</i> , 23:103-112.	Not women's experiences of labour support, but rather maternity care services.
2	Dunne, C.L., Fraser, J. & Gardner, G.E. 2014. Women's perceptions of social support during labour: development, reliability and validity of the birth companion questionnaire. <i>Midwifery</i> , 30:847-852.	Not about experiences of women. It is about the development of a measurement instrument.
3	Khresheh, R. 2010. Support in the first stage of labour from a female relative: the first step in improving the quality of maternity services. <i>Midwifery</i> , 26(6): e21-24.	Not women's experiences of labour support, but rather of maternity services.
4	Hatamleh. R., I Shaban, I.A. & Homer, C. 2013. Evaluating the experience of Jordanian women with maternity care services. <i>Health care women international</i> , 34:499-512.	No qualitative element
5	Rala, N., James, S. & Tshotsho, N. 2014. Opinions of labouring women about companionship in labour wards. <i>African journal of midwifery and women's health</i> , 8(3):123-127.	No qualitative element
6	McNelis, M. Women's experiences of care during labour in a midwifery-led unit in the Republic of Ireland. 2013. <i>British journal of midwifery</i> , 21(9):422-431.	Experiences about a midwifery-led unit not labour support
7	Melender, H. (2006). What constitutes a good childbirth? A qualitative study of pregnant Finnish women. <i>Journal of midwifery and women's health</i> , 51:331-33.	Pregnant women's perceptions of a good childbirth.

<b>8</b>	Morhason-Bello, I. O., Olayemi, O., Ojengbede, O.A., Adedokun, B.O., Okuyemi, O. O. & Orji, B. 2008. Attitude and preferences of Nigerian antenatal women to social support during labour. <i>Journal of biosocial science</i> , 40:553-562.	No qualitative element
<b>9</b>	Moses, M.C., & Potter, R.H. 2008. The use of doulas for inmates in labor: continuous supportive care with positive outcomes. <i>Corrections today</i> , 58-73.	Not primary research
<b>10</b>	Papagni, K. & Buckner, E. 2006. Doula support and attitudes of intrapartum nurses: A qualitative study from the patient's perspective. <i>Journal of perinatal education</i> , 15 (1):11-18.	Explored the relationship between doulas and intra-partum nurses
<b>11</b>	Shimpuku, Y., Patil, C.L., Norr, K.F. & Hill, P.D. 2013. Women's perceptions of childbirth Experience at a hospital in rural Tanzania. <i>Health care for women international</i> , 34:461–481.	Not women's experiences of labour support, but rather maternity services.
<b>12</b>	Steel, A., Diezel, H., Johnstone, K., Sibbritt, D., Adams, J. & Adair, R. 2011. The value of care provided by student doulas: An examination of the perceptions of women in their care. <i>The journal of perinatal education</i> , 22(1):39-48.	Women's perceptions of care provided by student doulas studying towards a formal qualification as a support person.
<b>13</b>	Van der Gucht, N. & Lewis, K. 2015. Women's experiences of coping with pain during childbirth: a critical review of qualitative research. <i>Midwifery</i> , 31:349-358.	Not women's experiences of labour support, but rather coping with pain.
<b>14</b>	Wilde-Larsson, B., Sandin-Bojo, A.K., Starrin, B. & Larsson, G. 2010. Birthgiving: women's feelings and perceptions of quality of intrapartum care: a nationwide Swedish cross-sectional study. <i>Journal of clinical nursing</i> , 20:1168–1177.	Not women's perceptions of labour support but rather quality of intra-partum care.
<b>15</b>	Yuenyong, S., Jirapaet, V. & O'Brien B.A. 2008. Support from a close female relative in labour: The ideal maternity nursing intervention in Thailand. <i>Journal of the medical association of Thailand</i> , 91(2):253-60.	Not women's experiences of labour support but rather maternity services.

## ANNEXURE C: Critical appraisal tool for qualitative studies.



### 10 questions to help you make sense of qualitative research

#### How to use this appraisal tool

Three broad issues need to be considered when appraising the report of a qualitative research:

- Are the results of the review valid?
- What are the results?
- Will the results help locally?

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

There will not be time in the small groups to answer them all in detail!

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## Screening Questions

1. Was there a clear statement of the aims of the research?

Yes  Can't tell  No

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

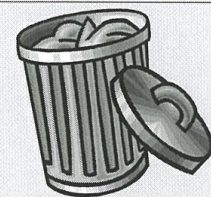
2. Is a qualitative methodology appropriate?

Yes  Can't tell  No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?



Detailed questions

**3. Was the research design appropriate to address the aims of the research?**

Yes     Can't tell     No

HINT: Consider

- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

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**4. Was the recruitment strategy appropriate to the aims of the research?**

Yes     Can't tell     No

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

**5. Was the data collected in a way that addressed the research issue?**

Yes     Can't tell     No

HINT: Consider

- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- If methods were modified during the study. If so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

**6. Has the relationship between researcher and participants been adequately considered?**

Yes     Can't tell     No

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during
  - (a) Formulation of the research questions
  - (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

**7. Have ethical issues been taken into consideration?**

Yes

Can't tell

No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

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**8. Was the data analysis sufficiently rigorous?**

Yes

Can't tell

No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

**9. Is there a clear statement of findings?**

Yes     Can't tell     No

HINT: Consider

- If the findings are explicit
  - If there is adequate discussion of the evidence both for and against the researchers arguments
  - If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
  - If the findings are discussed in relation to the original research question
- 

**10. How valuable is the research?**

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

## ANNEXURE D: Critical appraisal table

Authors/title/ bibliographic information	Type of study design, setting and language of data collection	Sampling, sample size and demographics	Data collection technique and analysis	Rigour
<b>Akhavan, S. &amp; Edge, D. 2012. Foreign-born women's experiences of community-based doulas in Sweden - a qualitative study. <i>Health care for women international</i>, 33:833-848.</b>	Design: Exploratory Setting: hospitals in the Vastra Gotaland region, Sweden Language: Arabic, Somali and Turkish.	Sampling: purposive Sample: 10 Age: 23–31 Parity: 4 multiparous Place of delivery: hospital Mode of delivery: NVD Post-delivery period: 3 and 6 weeks postpartum	Data collection: semi-structured interviews Venue: women's homes Data analysis: content analysis	<ol style="list-style-type: none"> <li>1. Statement of aims of research: clear.</li> <li>2. Methodology: appropriate and sufficiently discussed.</li> <li>3. Research design: appropriate to address aims.</li> <li>4. Recruitment: process sufficiently discussed.</li> <li>5. Data collection method: appropriate.</li> <li>6. Relationship between researcher and participants (reflexivity): Cannot tell .</li> <li>7. Ethical issues: sufficiently considered.</li> <li>8. Data analysis: sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> <li>10. Value of research: discussed and its contribution to practice and the need for further research indicated.</li> </ol> <p>C/A = 9/10 INCLUDED</p>
<b>Bakhta, Y. &amp; Lee, R. 2010. A survey of Russian women regarding the presence of a companion during labor. <i>International journal of gynecology and obstetrics</i>, 109:201-203.</b>	Design: qualitative survey Setting: Omsk County maternity and delivery hospital Language: Russian	Sampling: convenient Sample: 70 Age: 25.4 average Parity: 1.6 average Place of delivery: hospital Post-delivery period: 2 days post-partum (21 women)	Data collection: person-to-person interviews Venue: hospital Data analysis: content analysis	<ol style="list-style-type: none"> <li>1. Statement of aims: clear.</li> <li>2. Methodology: appropriate and sufficiently discussed.</li> <li>3. Research design: appropriate to address aims.</li> <li>4. Recruitment process: sufficiently discussed.</li> <li>5. Data collection method interviews were appropriate though women's narratives are few.</li> <li>6. Relationship between researcher and participants (reflexivity) sufficiently discussed regarding Russian speaking primary investigator.</li> <li>7. Ethical issues: considered.</li> <li>8. Data analysis: analysed by statistician.</li> <li>9. A clear statement of findings was provided.</li> </ol>

				<p>10. Value of research: discussed and its contribution to practice.</p> <p>C/A=8/10</p> <p>INCLUDED</p>
<p><b>Banda, G., Kafulafula, G., Nyirenda, E., Taulo, F. &amp; Kalilani, L. 2010. Acceptability and experience of supportive companionship during childbirth in Malawi. BJOG, 117:937-945.</b></p>	<p>Design: Cross-sectional surveys before and after introducing supportive companionship.</p> <p>Setting: Maternity facilities in Blantyre City, Malawi.</p> <p>Language: English and Chichewa</p>	<p>Sampling: variety of sampling methods</p> <p>Sample: 202 first study, 174 second study</p> <p>Age: ≤ 23-43 years</p> <p>Parity: primiparous and multiparous</p> <p>Place of delivery: hospital and health centers</p> <p>Mode of delivery: NVD</p> <p>Post-delivery period: while still in postnatal ward</p>	<p>Data collection: mixed methods using interviews using questionnaire with closed and open-ended questions.</p> <p>Venue: a private room at hospital</p> <p>Data analysis: content analysis for qualitative data</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: clear.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: appropriate to address aims.</li> <li>4. Recruitment process: sufficiently discussed.</li> <li>5. Data collection: method interviews were appropriate to get women's narratives though few.</li> <li>6. Relationship between researcher and participants (reflexivity) not discussed.</li> <li>7. Ethical issues: clear.</li> <li>8. Data analysis, content analysis was sufficiently discussed.</li> <li>9. A clear statement of findings was provided.</li> <li>10. Value of research: Recommendations for further research were made.</li> </ol> <p>C/A = 9/10</p> <p>INCLUDED</p>
<p><b>Berg, M. &amp; Terstad, A. 2006. Swedish women's experiences of doula support during childbirth. Midwifery, 22:330-338.</b></p>	<p>Design: Phenomenology</p> <p>Setting: 2 large Swedish cities.</p> <p>Language: Swedish and English</p>	<p>Sampling: purposeful</p> <p>Sample: 10 women (6 hospital delivery and 4 home)</p> <p>Age: 25-35 years</p> <p>Parity: primiparous and multiparous</p> <p>Place of delivery: 6 in hospital and 4 at home</p> <p>Mode of delivery: not specified</p> <p>Post-delivery period: 1-2 months</p>	<p>Data collection: open-ended interviews 40-70 minutes</p> <p>Venue: women's homes</p> <p>Data analysis: thematic analysis</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: is clear and relevant.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: appropriate to address aim.</li> <li>4. Recruitment strategy: appropriate and selection process discussed appropriately. Reasons for size of sample given.</li> <li>5. Data collection method was explicit and appropriate</li> <li>6. Relationship between researcher and participants (reflexivity): not considered.</li> <li>7. Ethical issues: considered sufficiently.</li> <li>8. Data analysis: sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> </ol>

				10. Value of research: More research was recommended. CA 9/10 INCLUDED
<b>Etowa, J.B. 2012.</b> <b>Black Women's Perceptions of Supportive Care During Childbirth.</b> <i>International Journal of Childbirth Education, 27(1):28-32.</i>	Design: qualitative (not specified) Setting: North End Community Health Centre located in the capital city of one of Canada's Atlantic provinces  Language: English	Sampling : purposive Sample:10 Age: 18-40 years Parity: 5 primiparous and 5 multiparous Place of delivery: healthcare institution Mode of delivery: not specified Post-delivery period: within 2 years and focus group interviews 6 weeks after interviews	Data collection: individual interviews and focus group interviews Venue: not specified Data analysis: thematic analysis	1. Statement of aims of research: clear. 2. Methodology: is relevant and applicable in addressing the research goal. 3. Research design: only qualitative. 4. Recruitment strategy: appropriate to some extent, reason for sample size not given. 5. Data collection method: was appropriate, discussed to some extent. 6. Relationship between researcher and participants (reflexivity): not considered. 7. Ethical issues: considered to some extent. Rights of participants not discussed. 8. Data analysis: sufficiently discussed. 9. Findings: Only one key finding was discussed. 10. Value of research: No reference to further research made. C/A = 6/10 EXCLUDED
<b>Hunter, C. 2012.</b> <b>Intimate space within institutionalized birth: Women's experiences birthing with doulas.</b> <i>Anthropology &amp; medicine, 19(3): 315-326.</i>	Design: Ethnography. Setting: birth education centre in a mid-sized homogenous Midwestern town in America Language: English	Sampling: purposive Sample: 9 doulas and 9 mothers Age: not specified Parity: not specified Place of delivery: hospital Mode of delivery: 8 had NVD of which 2 used pain medication, 1 caesarean section	Data collection: interviews Venue: birth education center Data analysis: ethnographic analysis using Atlas ti qualitative software	1. Statement of aims of research: clear. 2. Methodology: appropriate. 3. Research design: appropriate to address aims. 4. Recruitment strategy: snow ball technique was appropriate to address aim and process discussed. Reasons for size of sample given. 5. Data collection method: Data was collected over a long period and observations could be subjective. 6. Relationship between researcher and participants (Reflexivity): not discussed. 7. Ethical issues: considered.

		Post-delivery period: not specified		8. Data analysis: sufficiently discussed. 9. Findings: a clear statement, provided. 10. Value of research: Further research suggested. C/A = 8/10 INCLUDED
<b>Kabakian-Khasholian, T., El-Nemer, A. &amp; Bashour, H. 2015. Perceptions about labor companionship at public teaching hospitals in three Arab countries. <i>International Journal of gynecology and obstetrics</i>, 129:223-226.</b>	Design: qualitative (not specified) Setting: three large public teaching hospitals in Beirut (Lebanon), Damascus (Syria), and Mansoura (Egypt). Language: Interviews in Arabic translated into English	Sampling: purposive Sample: mothers-69 Age: 18-38 years Parity: primiparous and multiparous Place of delivery: hospitals Mode of delivery: NVD Post-delivery period: immediate postpartum	Data collection: Semi-structured interviews Venue: private space in the hospital Data analysis: thematic analysis	1. Statement of aims of research: is clear. 2. Methodology: appropriate. 3. Research design: appropriate to address aims. 4. Recruitment: purposive; process discussed. 5. Data collection method: appropriate. 6. Relationship between researcher and participants (Reflexivity): No proof. 7. Ethical issues considered. 8. Data analysis sufficiently discussed. 9. Findings: a clear statement provided. 10. Value of research: valuable as it contributes to practice. CA 9/10 INCLUDED
<b>Koumouitzes-Douvia, J. &amp; Carr, C.A. 2006. Women's perceptions of their doula support. <i>Journal Perinatal Education</i>, 15(4):34-40.</b>	Design: only stated qualitative Setting: hospitals Language: English	Sampling: purposeful Sample: 12 Age: 30-37 years Parity: 11 primiparous and 1 multiparous  Place of delivery: hospital Mode of delivery: 10 NVD, 2 caesarean section Post-delivery period: 7 -16 weeks	Data collection: interviews Venue: homes of participants Data analysis: content analysis.	1. Statement of aims of research: is clear. 2. Methodology: appropriate. 3. Research design: are appropriate to address aims. 4. Recruitment: the process was prone to biasness as the recruiters were the doulas. 5. Data collection method: appropriate, but not sufficiently discussed. 6. Relationship between researcher and participants (Reflexivity): not discussed. 7. Ethical issues: not addressed. Moreover subjects were paid. 8. Data analysis: sufficiently discussed. 9. Findings: a clear statement provided.

				10. Value of research: Further research recommended CA 6/10 EXCLUDED
<b>Kungwimba, E., Malata, A., Maluwa, A. &amp; Chirwa, E. 2013. Experiences of women with support they received from their birth companion during labour and delivery. <i>Health</i>, 5:45-52.</b>	Design: descriptive Setting: public hospital Malawi Language: Chichewa and English	Sampling: Purposive Sample: 20 Age: 15-30 years Parity: all primiparous Place of delivery: hospital Mode of delivery: NVD Post-delivery period: immediate postpartum	Data collection: in-depth interviews using open-ended interview guide. Venue: postnatal ward Data analysis: content analysis-manually	1. Statement of aims of research: is clear. 2. Methodology: appropriate. 3. Research design: are appropriate to address aims. 4. Recruitment: process discussed. 5. Data collection method: appropriate. 6. Relationship between researcher and participants (Reflexivity): Not discussed. 7. Ethical issues considered. 8. Data analysis sufficiently discussed. 9. Findings: a clear statement provided. 10. Value of the research: Contribution and implications for practice is discussed. CA 9/10 INCLUDED
<b>Lundgren, I. 2010. Swedish women's experiences of doula support during childbirth. <i>Midwifery</i>, 26:173-180.</b>	Design: hermeneutic Setting: 2 maternity hospitals in Sweden Language: Swedish	Sampling: Purposive Sample: 9 Age: 15-40 years Parity: 7 primiparous and 2 multiparous Place of delivery: hospital Mode of delivery : 6 NVD, 1 planned, 2 emergency caesarean Post-delivery period: 1-8 months	Data collection: interviews Venue: woman's home or place of woman's choice Data analysis: thematic analysis	1. Statement of aims of research: clear. 2. Methodology: appropriate. 3. Research design: appropriate to address aims. 4. Recruitment strategy: purposive and process discussed. 5. Data collection method: appropriate. 6. Relationship between researcher and participants (Reflexivity): not discussed. 7. Ethical issues: considered to some extent. 8. Data analysis: sufficiently discussed. 9. Findings: a clear statement provided in relation to the research question. 10. Value of the research: contribution and implications for practice are discussed. CA 9/10 INCLUDED

<p><b>MacKinnon, K., McIntyre, M. &amp; Quance, M. 2005. The meaning of the nurse's presence during childbirth. <i>Journal of obstetric, gynecologic, and neonatal nursing</i>, 34:28-36.</b></p>	<p>Design: Hermeneutic phenomenological inquiry Setting: urban center in Canada Language: English</p>	<p>Sampling: purposive Sample: 6 Age: Not younger than 36 years of age Parity: 4 primiparous and 2 multiparous Place of delivery: hospital Mode of delivery type: NVD Post-delivery period: 6 months</p>	<p>Data collection: open-ended interviews Venue: not specified Data analysis: thematic analysis</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: is clear.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: is appropriate to address aims.</li> <li>4. Recruitment: purposive; process discussed.</li> <li>5. Data collection method: appropriate.</li> <li>6. Relationship between researcher and participants (Reflexivity): Not clear.</li> <li>7. Ethical issues: not clear on permission, only that each woman was given a pseudonym.</li> <li>8. Data analysis sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> <li>10. Value of the research: implications for practice discussed and further research recommended.</li> </ol> <p>CA 8/10 INCLUDED</p>
<p><b>Price, S., Noseworthy, J., &amp; Thornton, J. 2007. Women's experience with social presence during childbirth. <i>Maternal child nursing</i>, 32(3):184-191.</b></p>	<p>Design: naturalistic Setting: tertiary birth care Eastern Canada Language: English</p>	<p>Sampling: purposive Sample: 16 Age: 22-37 years Parity: 9 primiparous and 7 multiparous Place of delivery: tertiary care birth unit Mode of delivery: NVD Post-delivery period: immediate postpartum before discharge</p>	<p>Data collection: open-ended interviews Venue: postnatal ward Data analysis: thematic analysis</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: is clear.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: are appropriate to address aims.</li> <li>4. Recruitment: purposive; process discussed.</li> <li>5. Data collection method: appropriate.</li> <li>6. Relationship between researcher and participants (Reflexivity): Cannot tell.</li> <li>7. Ethical issues considered.</li> <li>8. Data analysis sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> <li>10. Value of the research: implications for practice discussed.</li> </ol> <p>CA 9/10 INCLUDED</p>
<p><b>Sapkota, S., Kobayashi, T. &amp;</b></p>	<p>Design: qualitative (not specified)</p>	<p>Sampling: purposeful Sample: 12 Age: 18 -28 years</p>	<p>Data collection: in-depth semi-structured interviews</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: is clear.</li> <li>2. Methodology: appropriate.</li> </ol>

<p><b>Takase, M. 2011.</b> <b>Women's experience of giving birth with their husbands' support in Nepal.</b> <i>British journal of midwifery</i>, 19(7):427-432.</p>	<p>Setting: Midwife led birthing center located within the tertiary care maternity and women's hospital in Kathmandu, Nepal. Language: Nepali translated into English</p>	<p>Parity: primiparous Place of delivery: birth centre Mode of delivery: NVD Post-delivery period: within 7 days</p>	<p>Venue: separate room within the birthing center Data analysis: thematic analysis</p>	<ol style="list-style-type: none"> <li>3. Research design: not discussed, only mentions qualitative in abstract.</li> <li>4. Recruitment: purposive; recruitment process discussed.</li> <li>5. Data collection method: appropriate.</li> <li>6. Relationship between researcher and participants (Reflexivity): discussed to some extent.</li> <li>7. Ethical issues considered to some extent.</li> <li>8. Data analysis: sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> <li>10. Value of research: discussed and its contribution to practice and further research recommended.</li> </ol> <p>C/A = 8/10 INCLUDED</p>
<p><b>Simpson, M.J. 2008.</b> <b>Women's perspectives on supportive care during labour and delivery. Vancouver: University of British Columbia.</b> (Dissertation-Master's degree).</p>	<p>Design: interpretive descriptive Setting: Labour, delivery, recovery and postpartum (LDRP) unit in a large metropolitan hospital Language: English</p>	<p>Sampling: Theoretical snowball Sample: 8 Age: 25-39 Parity: primiparous Place of delivery: hospital Mode of delivery :7 NVD(1 vacuum, 1 forceps), 1 caesarean section Post-delivery period: 7 weeks – 7 months</p>	<p>Data collection: semi-structured, open ended interviews Venue:women's homes Data analysis: thematic analysis</p>	<ol style="list-style-type: none"> <li>1. Statement of aims of research: clear.</li> <li>2. Methodology: appropriate.</li> <li>3. Research design: appropriate to address aims.</li> <li>4. Recruitment: purposive; recruitment process discussed.</li> <li>5. Data collection method: appropriate.</li> <li>6. Relationship between researcher and participants (Reflexivity): discussed.</li> <li>7. Ethical issues considered.</li> <li>8. Data analysis: sufficiently discussed.</li> <li>9. Findings: a clear statement provided.</li> <li>10. Value of research: conclusions contribute to existing knowledge and further research is recommended.</li> </ol> <p>CA = 9/10 INCLUDED</p>

## ANNEXURE E: Data extraction table of studies included in the synthesis

Reference	Focus of study	Study's findings	Findings relevant to this study
<p><b>Akhavan, S. &amp; Edge, D. 2012. Foreign-born women's experiences of community-based doulas in Sweden - A qualitative study. <i>Health care for women international</i>, 33:833–848.</b></p>	<p>To explore foreign born women's experiences of community based doula support</p>	<p>Three categories were identified in the study:</p> <p>(1) Foreign-born women's knowledge and expectations of doula support, (2) Satisfaction and dissatisfaction with doula support, (3) Finally, foreign-born women's perceptions of doula support.</p> <p><u>Knowledge and expectations of doula support</u></p> <p>Most of the women were new in Sweden. They learnt about the community based doula (CBD) services via the social services, midwives, interpreters, or doulas. Being in a foreign country made the women feel lonely, odd and outcast for which they used the term '<i>gharib</i>'. The language, rules, laws, and traditions were all unknown to these women. Nonetheless, meeting and getting to know the doulas before childbirth was reassuring and allayed their concerns and anxieties. Most importantly the women's expectations of "CBD" were to have someone they could communicate with in a language they both understood and having such a person (doula) was a wish come true for the women.</p> <p><u>Satisfaction and dissatisfaction with doula support</u></p>	<p>Supportive care was appreciated by the women, the companionship made them feel secure in a foreign country. Having met the doula prenatally enabled the women and doulas to get acquainted and to clarify their roles. Ignorance can lead to unrealistic expectations and demands. Supportive care proved was beneficial (Akhavan &amp; Edge, 2012:840-845).</p>

The majority of foreign-born women in the study were very positive about the role of doulas, though 2 mothers were not satisfied with their doulas due to two factors. Firstly the doulas lacked skills needed to fulfil their primary role of offering support, and secondly there was no prenatal meeting to establish a personal relationship.

It was alluded that the dissatisfaction by the two women could have been due to greater exposure to western culture and hence they expected more from the doulas. One of the women had more than 10 years of Swedish residence and was fluent in Swedish while the other had a 14 year education and had been resident in Germany for a lengthy period of time before migrating to Sweden.

#### Foreign-born women's perceptions of doula support

All of the 10 foreign-born women were happy about the CBDs. The doula was inspiring and the idea of CBDs represents "human rights and dignity". Even the two who were dissatisfied with their doulas thought CBDs were important and useful for women who are single and alone or new in the country and those with minimum education from rural areas. However they felt doulas need to be educated about labour support. Another view was that women should be well informed in order to differentiate between a doula who is constantly present and an interpreter who is not.

For women whose husbands could not be present the doula was a good replacement.

		<p>The authors concluded that a doula can provide support before, during, and after childbirth. Hence there is need for the CBD program to continue training doulas so to that woman get acquainted with the programme and doulas to enhance positive birthing and parenting experiences.</p> <p>Another conclusion was that newly arrived refugee women should be supported by maternity support groups in order to meet both their emotional and medical care needs. More so, midwives' and doulas' experiences of CBD should be investigated. Further extensive quantitative and qualitative research needed to measure the impact of CBDs and the possibility of expansion (Akhavan &amp; Edge, 2012: 840-845).</p>	
<p><b>Banda, G., Kafulafula, G., Nyirenda, E., Tauro, F. &amp; Kalilani, L. 2010. Acceptability and experience of supportive companionship during childbirth in Malawi. BJOG, 117:937-945.</b></p>	<p>To explore women's perceptions of companionship during labour.</p>	<p>The authors found that supportive companionship was highly acceptable to most participants. Women were satisfied with the different forms of care received from their companions, they also appreciated having a constant presence of someone to whom they could verbalise their fears and having a witness to the birth process. The companion was the connection between the women and the midwives. Of all the supported women only one was not happy about having a companion who happened to be her mother-in-law whose presence she saw as a burden.</p> <p>When it came to the choice of companions, 40% indicated that they would have preferred another</p>	<p>Supportive care includes different forms of care which women valued. Traditional beliefs play a major role in women's preferences of a support person. Good interpersonal relations cannot be over emphasised. Clear guidelines and enlightening women about the maternity care services contributes towards women's realistic perceptions of labour support (Banda <i>et al.</i>, 2010:839).</p>

		<p>companion as opposed to the one they had, despite knowing the support person. Only one woman had a companion she had never met before, she took someone she had just met at the hospital.</p> <p>The companions comprise a variety of female relatives, male partners or fellow female religious congregation members. Only 2.6% wanted a doctor as a supportive person and 3% a male partner. Two women, who had their male partner as companion, wished they had a mother or sister. Nonetheless 99.5% of the supported women were satisfied and wished that labour companionship would continue.</p> <p>The authors concluded that supportive companionship for women during childbirth is valuable and greatly acceptable amongst mothers, health professionals and community members in Malawi. However women require information about the necessity for a supportive companion and their expected role prenatally. Such information will permit the pregnant woman to identify a compatible companion. In this way both woman and companion will be prepared beforehand. Therefore it is imperative to have clear guidelines to follow that embrace and facilitate positive perceptions of continuous childbirth support (Banda <i>et al.</i>, 2010:839).</p>	
<p><b>Bakhta, Y. &amp; Lee, R. 2010. A survey of Russian women regarding the presence</b></p>	<p>A survey of Russian women regarding the</p>	<p>Most women (n = 48) did not want to have continuous support during childbirth, only 22 wanted a support person, whereas only 13 women were not aware of continuous support during childbirth. However, out of</p>	<p>Women's preference for continuous support during childbirth are influenced by traditions and values. The husband's presence might not be desired during</p>

<p><b>of a companion during labor. <i>International journal of gynecology and obstetrics</i>, 109:201-203.</b></p>	<p>presence of a companion during labor.</p>	<p>these 13 women, eight did not want to have a support person even after information had been provided. The reasons for not wanting a support person varied from 'concern for their husband, embarrassment and others felt that their husbands' presence would have a negative effect on their sex life'. Others did not wish for a support person because it was a 'private experience' for a woman which does not need an audience.</p> <p>Ultimately only 12 women out of the 22 were able to have a support person during childbirth of whom 11 had their husbands and one had her own mother. The reason for not having a support person included; family members lived out of town, husbands were working or refusing not having the necessary laboratory blood investigations and only one woman had no reason (Bakhta &amp; Lee, 2010:201-203).</p>	<p>childbirth. Some women might not want any support person. Thus not all women will accept continuous support during childbirth - an aspect of which midwives should be aware. Every woman is a unique individual and should be treated as such (Bakhta &amp; Lee, 2010:201-203).</p>
<p><b>Berg, M. &amp; Terstad, A. 2006. Swedish women's experiences of doula support during childbirth. <i>Midwifery</i>, 22:330-338.</b></p>	<p>Women's experiences of having a doula present during childbirth.</p>	<p>In this study the presence of a doula was seen as symbolic of the missing piece that was needed to complete the childbirth "puzzle." The "puzzle" consisted of five pieces: the partner, prenatal midwife, intra-partum midwife, children's clinic nurse and the doula who was missing. The doula had multiple roles "adviser, fixer, mediator, affirmative person, guarantor and an accessible presence." (Berg &amp; Terstad, 2006:333).</p> <p>The relationship between the woman and the doula was established prenatally which allowed the doula to familiarise herself with the woman or couple's perspective. This was founded on sharing of childbirth</p>	<p>Continuous support is an essential aspect of childbirth. It is through the birth companion's supportive role that women's needs are met. Women need someone who can support them unconditionally throughout the emotional turbulent experience of giving birth and the support person should thus not be an emotional distracter (Berg &amp; Terstad, 2006:332-335).</p>

and associated experiences The doula, being familiar with the birthing practices, was able to share valuable information and also facilitated communication between the woman and her family as well as between the woman and the midwife. The doula provided fair guidance and counselling to both the woman and partner.

As an 'affirmative' person the doula reassured the woman and reaffirmed their relationship by providing emotional support. Through this interaction the woman developed confidence and self-esteem. Consequently a collaborative team spirit was established.

As a 'guarantor' the doula was dependable for providing emotional stability.

When it came to other tasks the doula was seen as 'a fixer' who ensured that everything runs smoothly.

Authors concluded that it is natural for women to have both a midwife and a birth companion. Currently many women in Sweden have their partners as support persons, though others opt for doulas. The women in the study, greatly appreciated the doula as she functioned as a pillar of support. In as much as the roles of the midwives and doula differ, the midwife should ensure good interpersonal relations with the woman and all her chosen support people for maintaining agreeable interactions. Midwives' attitude towards doulas vary, some accept the presence of a doula while others see her as someone who interferes with their role which

		negatively affects the woman's care. Hence more research is needed to determine the connotation of a doula's presence for the midwife (Berg & Terstad, 2006:332-335).	
<b>Hunter, C. 2012.</b> <b>Intimate space within institutionalized birth: Women's experiences birthing with doulas.</b> <i>Anthropology &amp; medicine</i> , 19(3): 315-326.	Mother-doula relationship during the birth experience.	In this study one theme pertaining to the women's perceptions of doulas emerged:  <u>Creating and maintaining intimacy</u>  The women saw the doulas as 'mothers' because of the close relationship they developed. Some felt that their own mothers would not be able to witness the process without interfering. One woman had developed a close relationship with the doula such that she could not even tell the doula's touch from her husband's. The care rendered by the doulas was acknowledged more often than the care of nurses. Nurses perceived that their primary role of caring had been completely taken over by the doulas, hence they felt threatened.  The authors concluded that doula care might address the intra-partum loneliness through the provision of meaningful, familiar and cultural sensitive supportive care (Hunter, 2012:321-324).	Doulas are valuable in that they render and uphold care that is therapeutic and acceptable to the women. They create close relationships that are unique. The care provided by doulas directly conforms to the needs and desires of the women. Women will opt for (and appreciate) a birth companion to whom they are close and with whom they are comfortable (Hunter, 2012:321-324).
<b>Lundgren, I. 2010.</b> <b>Swedish women's experiences of doula support during</b>	Women's experiences of doula support during childbirth.	The study revealed that the women experienced the doula both as a support and a professional person. A doula was found to provide care that was 'sisterly'. The doula's care includes the professional side and the supportive side. Professionally the doula was the director that aided the woman to participate in the birth process.	A doula is more than just a support person for a woman, but also a provider of different forms of care and provides a bridge between herself, the midwives and the women's families. However, the doula's role should be clearly defined

<p><b>childbirth. <i>Midwifery</i>, 26:173-180.</b></p>		<p>Another important aspect was the perception of a doula as a 'coach' who restored belief in the woman's capacity to give birth.</p> <p>However, the midwife's supporting role was unable to offer continuity of care in terms of continuous support during childbirth compared to doulas. Doulas offered both information and physical support to women. The women wished the midwives had been present a bit longer despite the doula being present (Lundgren, 2010:179).</p>	<p>otherwise a doula might encroach on the midwives' territory. The presence of a doula should not influence the midwife's execution of her professional duties (Lundgren, 2010:179).</p>
<p><b>Kabakian-Khasholian, T., El-Nemer, A. &amp; Bashour, H. 2015. Perceptions about labor companionship at public teaching hospitals in three Arab countries. <i>International journal of gynaecology and obstetrics</i>, 129:223-226.</b></p>	<p>Perspectives of women, female relatives, and health care providers on labour companionship.</p>	<p>The study's findings show that women expected their companions to be knowledgeable about childbirth support. For emotional support the women desired someone who shared their spiritual beliefs. The companion also had to be the mediator for the women.</p> <p>Another finding was that some women had prior knowledge about the hospital policies which they found restrictive concerning the number of people allowed to support a woman compared to previous places of delivery including clinics and private hospitals. Consequently women did not have high expectations from the public institutions due to vagueness of a labour companion's role.</p> <p>Women preferred their mothers and sisters for support as these people knew them well and they could depend on them. Others opted for their husbands as support</p>	<p>Institutional births are usually guided by policies which might have undesirable implications. Women and their families should be given pre-childbirth information about institutional policies to reduce fear and uncertainty. Caregivers should consider a woman's perspective in order to meet her unique needs (Kabakian-Khasholian <i>et al.</i>, 2015:224-226).</p>

		<p>persons which happened to be culturally unacceptable to some women.</p> <p>Childbirth was associated with isolation and fear of the unknown. Thus advocating for childbirth support would enlighten women and their families and address the negative perceptions about childbirth (Kabakian-Khasholian <i>et al.</i>, 2015:224-226).</p>	
<p><b>Kungwimba, E., Malata, A., Maluwa, A. &amp; Chirwa, E. 2013. Experiences of women with support they received from their birth companion during labour and delivery. <i>Health</i>, 5:45-52.</b></p>	<p>Participant's knowledge regarding birth companionship.</p>	<p>Both birth companions and women need to be educated about their different roles and expectations during childbirth. Women depend on birth companions for support. Some women did not receive the desired support by not being escorted to the toilet or turned, not given food or back massages. Some women received incorrect advice such as being instructed to push at an inappropriate time during the first stage of childbirth. Some birth companions, and some women, lacked knowledge which prevented the birth companions from providing effective support. Nonetheless some women felt safe and secure by the constant presence of a birth companion</p> <p>Midwives' lack of support for birth companions impacted negatively on the quality of support rendered to the women by the birth companions. Primiparous women and their birth companions need to be educated about childbirth during the antenatal period so that the midwife's and birth companion's roles can be clarified..</p>	<p>Women have great expectations from birth companions, but these might be unrealistic if they lack knowledge about the roles of companions and midwives. Prenatal education, especially for primiparous women, could avert many anxieties and misunderstandings. Clarifications of the respective roles of doulas and midwives should specify the boundaries of each group. Supportive care from the support persons was valued especially in the absence of a midwife's constant presence (Kungwimba, 2013:47-50).</p>

		Despite these shortfalls birth companions play an important role during childbirth thereby improving birth experiences since midwives cannot be continuously present during the childbirth process (Kungwimba, 2013:47-50).	
<p><b>MacKinnon, K., McIntyre, M. &amp; Quance, M. 2005. The meaning of the nurse's presence during childbirth. <i>Journal of obstetric, gynecologic and neonatal nursing</i>, 34:28-36.</b></p>	To develop new understandings of what it means for a nurse to be present during childbirth.	<p>Women appreciated the nurses' presence. The women wanted nurses to be continuously present to offer emotional support and create a special and memorable moment. The nurse was seen as an advocate between the family and doctors and someone dependable for providing emotional support, besides the technical aspects. Knowing the nurses enhanced the women's experiences as mutual respect and trust were established. The provision of information on the progress of labour made the women feel at ease and respected.</p> <p>Institutional practices affected women's childbirth experiences. For example, obstetric triage implied that women had to wait to be checked by a medical specialist before being assessed by nurses. Women found this to be unrealistic since nurses were also skilled to perform assessments. Subsequently women felt frustrated and disempowered as they missed the opportunity of establishing good intra-partum relations with the nurses. The obstetric triage was also perceived as a way of imposing medicalised care on women. Institutional values and norms influenced how nurses executed their</p>	<p>Nurses have supportive functions to perform besides their professional functions. The women expect nurses to meet both their physical and emotional needs. Good intra-partum relations enhance women's confidence in the nurses. Advice and constant communication about the progress of the childbirth process reassure the women. Unpleasantly unknown institutional norms might present obstacles if not communicated to women. Hence a woman's voice needs to be heard in order to understand her perspective (Mackinnon <i>et al.</i>, 2008:31-35).</p>

		<p>supportive roles. Women valued the role nurses play with skilfulness and confidence.</p> <p>The authors highlighted the need for further research to shed more light on the meaning of nurses' presence during childbirth (Mackinnon <i>et al.</i>, 2008:31-35).</p>	
<p><b>Price, S., Noseworthy, J., &amp; Thornton, J. 2007. Women's experience with social presence during childbirth. <i>Maternal child nursing, 32(3):184-191.</i></b></p>	<p>The meaning and significance women attach to family and friend presence during childbirth within a tertiary care birth unit.</p>	<p>Sixteen women wanted to have one or more support person present. The primary support person for 13 women was the partner and for 3 a female friend or female relative during the pushing stage.</p> <p>Women described their birth experiences under four main categories that influenced their choices: (1) <u>Who the women chose</u>: "Partner first; knows me best", (2) <u>Why they chose</u>: "Individualised support; family bonding". (3) <u>How they chose</u>: Not a social event, it is her 'birth' so she chooses and (4) <u>Consequences of the choice</u>: "team work" and "comprehensive support". Overall, the women appreciated social support during childbirth. The women chose who "knew them best" and this often implied their partners with whom they were comfortable. Others had more than two birth companions because they were not aware of limitations on the number of visitors.</p> <p>The authors concluded that midwives need to ensure that during the antenatal period women are educated about childbirth support, including related policies. Policies should consider individual women's desires and circumstances. Birth plans should be compiled in</p>	<p>The choice of a supportive person is influenced by various factors. Firstly childbirth support is appreciated by women, secondly childbirth preparation education should start during the prenatal period for the women and all relevant persons to lay a foundation for the process of childbirth (Price <i>et al.</i>, 2007:187-191).</p>

		partnership with the women. Therefore, nurses should fulfil their advocacy on behalf of the women to ensure a gratifying birthing experience (Price <i>et al.</i> , 2007:187-191).	
<b>Sapkota, S., Kobayashi, T. &amp; Takase, M. 2011. Women's experience of giving birth with their husband's support in Nepal. <i>British journal of midwifery</i>, 19(7):427-432.</b>	To explore women's experiences of giving birth with their husband's support.	<p>Three identified themes described the women's experiences: (1) Feeling in control during the labour progress, (2) Concern for husbands, (3) Emotional discomfort.</p> <p><u>Feeling in control of the labour process</u></p> <p>Some women were comfortable with their husbands' presence. In Nepal women do not receive one-to-one midwifery care during early labour, hence husbands were invaluable in offering support especially for women without female relatives. Women acknowledged their husbands' presence and support. However, during delivery, the midwife's presence was more desired than that of the husbands'.</p> <p><u>Concern for husbands</u></p> <p>The women were aware of their husbands' apprehension making them feel uncomfortable. No women had attended birth preparation classes with her husband which could have averted this unpleasantness.</p> <p><u>Emotional discomfort</u></p> <p>Husbands' inability to offer adequate physical support irritated one woman, who wished she had an experienced female who would be more effective. Some</p>	Women appreciate having someone they value and with whom they are comfortable with during labour either a husband or female relative. However, some women experienced their husbands' presence as a source of discomfort. (Sapkota <i>et al.</i> , 2011:427-431).

		<p>women felt embarrassed because it was against their culture for their husbands to handle a woman's soiled garments during childbirth.</p> <p>Women had both positive and negative experiences, so measures should be taken to reduce the negative experiences by encouraging husbands to be present during the birth of their children, provided that this is acceptable to the husbands and wives. This can be addressed during prenatal education classes. Midwives should be sensitive about women's religious and cultural beliefs.</p> <p>There is need to further investigate the needs and expectations of couples when husbands are birth companions in health care facilities. Further research will expedite a wider coverage of childbirth support for health care facilities in Nepal (Sapkota <i>et al.</i>, 2011:427-431).</p>	
<p><b>Simpson, M.J. 2008. Women's perspectives on supportive care during labour and delivery. Vancouver: University of British Columbia. (Dissertation-Master's degree).</b></p>	<p>Women's perceptions of the support that they received during labour and delivery.</p>	<p>Complexities surround the types and degrees of supportive care that women require and receive during childbirth, and meaningful support is multifaceted. Supporting women during childbirth is complex, as each woman and her supportive team are unique and come to the labour delivery recovery and postpartum (LDRP) unit with their own distinctive dynamics. Prenatal preparation will ease the woman's and support person's nervousness, and help them to prepare for childbirth with realistic expectations. During the early stages of labour some women might prefer to be at home with family for peace and privacy, concurrently avoiding 'unnecessary'</p>	<p>Different support persons bring different aspects of care which the women acknowledged. Supportive team work and collaboration ensure a satisfactory experience for the woman and the family. Caregivers should meet women's unique needs and preferences because their attitudes influence women's childbirth experiences (Simpson, 2008:117-153).</p>

interventions. Women's preferences of a birth companion differed. The support persons included husbands, mothers, sisters or female friends. Generally the husbands were considered the most appropriate companions with whom to share experience. This choice was influenced by the stage of labour. For example, during the 'active stage' the preferred support person was the midwife not the husband. Nurses were professional in their demeanour which women appreciated. Forms of emotional support were diverse, ranged from words of encouragement, small gestures, and praise from their companions. Comfort measures such as visualisation, breathing, and diversion therapy were used as well as sitting on birth balls and being massaged. Self-support was also valued by some women.

Negative aspects included nurses acting in superior manners towards women and doctors treating childbirth as a medical condition that needed to be cured.

Circumstances like the history of own mother's experiences, being well informed, having the choice to choose and reading about childbirth during pregnancy influenced the woman's experiences. Some women preferred a 'natural birth' and not a 'medicalised one.'

Various forms of supportive care might have contributed to positive birth experiences. Prenatal preparation increased awareness and emotional stability. The nurses enhanced women's resilience by demonstrating

		sensitivity and confidence. The husband's presence was appreciated though not all husbands were skilled in providing supportive care. A female supporter was appreciated by most women but some women wanted to be left alone at times for privacy and to regain composure (Simpson, 2008:117-153).	
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# ANNEXURE F: Ethics approval certificate of project



NORTH-WEST UNIVERSITY  
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2016/03/31

## ETHICS APPROVAL CERTIFICATE OF PROJECT

Based on approval by Health Research Ethics Committee (HREC) at the meeting held on 10/02/2016, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby approves your project as indicated below. This implies that the NWU-IRERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

<b>Project title:</b> Women's views and experiences of continuous support during childbirth: a meta-synthesis																														
<b>Project Leader:</b> Prof CS Minnie																														
<b>Student:</b> P Lunda																														
<b>Ethics number:</b> <table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td><td>-</td><td>1</td><td>6</td><td>-</td><td>A</td><td>1</td></tr><tr><td colspan="3">Institution</td><td colspan="6">Project Number</td><td colspan="2">Year</td><td colspan="4">Status</td></tr></table>	N	W	U	-	0	0	0	0	2	-	1	6	-	A	1	Institution			Project Number						Year		Status			
N	W	U	-	0	0	0	0	2	-	1	6	-	A	1																
Institution			Project Number						Year		Status																			
<small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small>																														
<b>Application Type:</b> Full Single (Systematic Review)																														
<b>Commencement date:</b> 2016-03-18	<b>Expiry date:</b> 2017-03-17	<b>Risk:</b> <table border="1"><tr><td>Minimal</td></tr></table>	Minimal																											
Minimal																														

### Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

### General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HREC:
  - annually (or as otherwise requested) on the progress of the project, and upon completion of the project
  - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
  - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the HREC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-IRERC via HREC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-IRERC and HREC retains the right to:
  - request access to any information or data at any time during the course or after completion of the project;
  - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.
  - withdraw or postpone approval if:
    - any unethical principles or practices of the project are revealed or suspected,
    - it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented,
    - the required annual report and reporting of adverse events was not done timely and accurately,
    - new institutional rules, national legislation or international conventions deem it necessary.

Please note: HREC can be contacted for further information or any report templates via [Carolien.VanZyl@nwu.ac.za](mailto:Carolien.VanZyl@nwu.ac.za) or 018 299 1206.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the IRERC or HREC for any further enquiries or requests for assistance.

Yours sincerely

Prof LA  
Du Plessis

Digitally signed by Prof LA Du Plessis  
DN: cn=Prof LA Du Plessis, o=North-West University, ou=Campus Rector, email=Linda.DuPlessis@nwu.ac.za, c=ZA  
Date: 2016.04.01 09:13:01 +0200

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

## ANNEXURE G: Declaration by language editor

**Valerie Janet Ehlers**

Nurse Consultant and Researcher

**Emeritus Professor and Research Fellow: University of South Africa**

**Associate Editor: International Nursing Review**

(B Soc Sc (University of Natal), Honours B Soc Sc, BA Cur, Honours BA Cur, MA Cur, D Lit et Phil, Diploma in Development Administration, TAALKU-F for Diploma in Translation- Unisa))

### CONFIRMATION LETTER: EDITING OF A DOCUMENT

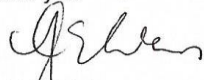
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8 December 2016	I hereby certify that I have edited Ms P Lunda's master's dissertation titled: <b>WOMEN'S VIEWS AND EXPERIENCES OF CONTINUOUS SUPPORT DURING CHILDBIRTH: A META-SYNTHESIS</b>
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Thank you

  
Prof VJ Ehlers