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Original Article

A qualitative study of childbirth fear and preparation among primigravid women: The blind spot of antenatal care in Lilongwe, Malawi

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ABSTRACT

Objectives: This study aimed to explore childbirth fear and childbirth preparation among primigravid women in the late pregnancy from 36 to 40 weeks gestation.

Methods: We purposively recruited 18 primigravid women into in-depth interviews, 21 birth companions, and 13 health workers into focus group discussions. Participants were recruited from two community hospitals' maternity waiting homes in Lilongwe, Malawi. Semi-structured interview guides were used to collect data that were analyzed using content analysis. NVivo11 computer software was used to organize the data.

Results: The four categories developed were: "ambivalent pregnancy feelings", "dependence on traditional childbirth counseling", "inadequate prenatal childbirth instruction" and "inconsistent roles of a birth companion". The findings suggest that primigravid women who were mainly exposed to traditional childbirth mentoring rather than professional care providers, experienced childbirth fear, and lacked proper psychosocial childbirth preparation.

Conclusions: Childbirth fear among primigravid women emanate from personal; family; ineffective traditional counseling; and inadequate antenatal childbirth instruction. Birth companions may increase childbirth stress. However, our findings highlight birth companions as readily available psychosocial support resources among primigravid women. We recommend that professional childbirth instruction during antenatal care should be strengthened to surpass traditional childbirth counseling. Appropriateness and effectiveness of birth companions need to be carefully assessed.

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What is known?

- Birth preparedness and complication readiness (BPCR) strategy has successfully invited pregnant women and their birth companions to give birth in health facilities evidenced by the increased health facilities' childbirth rates from 38% in 2000 to 53% in 2016 in Sub-Saharan Africa (SSA).
- Antenatal care in developing countries is often inadequate and not specific to prepare primigravid women for childbirth and

they experience high levels of childbirth fear during the late pregnancy period.

- Clinical based evidence has shown that the presence of a birth companion may influence positive pregnancy outcomes but in developing countries, birth companions are underutilized despite being present at a birthing facility.

What is new?

- The innovative approach of companion-integrated childbirth preparation (C-ICP) to effectively utilize a readily available evidenced-based psychosocial resource to effectively prepare primigravid women for childbirth in the late pregnancy period to reduce childbirth fear and a certain ensure first positive childbirth.

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- This innovative approach provides a platform to facilitate productive interaction between providers and consumers of maternal health care services to empower them and the community on childbirth-related issues to promote safe motherhood.

1. Introduction

Pregnancy is capable of invoking fear in women due to the increased vulnerability to childbirth complications and maternal death in low resource settings [1]. Childbirth fear in this context refers to feelings of uncertainty and anxiousness about the pregnancy and pending childbirth despite the woman desperately wanting a baby [2]. According to a study by Spice et al. [3], women described the prenatal period of childbirth as ‘a place of danger’ that could be harmful to themselves and the newborn. In Ghana, giving birth is perceived as a dangerous and vulnerable act in which pregnant women walk a thin line between life and death [4]. Literature has categorized this anxiety in pregnant women who have not given birth before as primary childbirth fear, whereas fear in pregnant women with previous childbirth experience is referred to as secondary childbirth fear [5]. Wijma et al. [6] described the origins of primary childbirth fear along social and personal dimensions. Furthermore, Fisher et al. [7] argued that the social dimension of childbirth fear originated from the fear of the unknown as primigravid woman do not know what will come of the pregnancy, while the personal dimension arises from the perceived excessive pain during childbirth, as well as a lack of confidence in knowing what to do during childbirth. Studies on maternal childbirth fear have shown that primary childbirth fear is more predominant and intense compared to secondary childbirth fear [8,9].

Primigravid women are novices and primary childbirth fear sets in as a reality late in their pregnancy. This was evident in a study that reported childbirth as the strongest factor associated with childbirth fear among Egyptian primigravid women who experienced higher levels of childbirth fear compared to women who had given birth before. The study concluded that the lack of knowledge and childbirth experience were the main factors that induced impending childbirth fear during the third trimester [10].

Childbirth fear is strongly linked to undesirable pregnancy outcomes and delivery complications, such as prolonged labor, cesarean birth, birth traumas like fistulas, and weak emotional attachment in the postpartum period that affects maternal-infant interactions [11,12]. The results of childbirth fear, coupled with the unavailability of resources, actively influence the global discrepancies of pregnancy outcomes in low resource settings [13,14]. According to recent World Health Organization statistics, about 810 women died from pregnancy or childbirth-related complications around the world every day [13]. However, more than half (542) of these maternal deaths occurred in Sub-Saharan Africa, making it the only region with the highest maternal mortality rate [14]. In recent years, developing countries adopted the Birth Preparedness and Complication Readiness (BPCR) strategy to reduce childbirth complications, including maternal deaths, by inviting pregnant women to give birth in health facilities accompanied by their birth companions [15]. However, the maternal mortality rate in Malawi remains high at 439 deaths per 100,000 live births [16]. The increased risks of pregnancy and undesirable pregnancy outcomes in low resource settings make childbirth fear a reality for many women.

Currently, the first sustainable development goal 3 framework to end preventable maternal mortality highlights the importance of moving beyond the accessibility of care by emphasizing the need for quality care [14]. The literature on antenatal care services in

developing countries has indicated that less than 50% of pregnant women received adequate childbirth preparation counseling [17]. Additionally, most available routine antenatal care services do not include structured prenatal classes [17,18]. Being inexperienced, primigravid women require relevant, appropriate, and timely information to navigate positive experiences in the delivery room [19]. However, little is known about childbirth fear and childbirth preparation experiences among primigravid women before childbirth in low resource settings. Our study aimed to explore childbirth fear and preparation among primigravid women during late pregnancy (36–40 weeks gestation) in rural settings in Malawi.

2. Methods

2.1. Study design

A descriptive qualitative design was utilized in this study. This design was deemed appropriate for the study because it allowed researchers to explore the detailed, real experiences of the participants in the context of where the action occurred [20,21].

2.2. Study setting

The study was conducted at the Mitundu and Kabudula community hospitals in the south and west outskirts of Lilongwe district, Malawi. Approximately 2040 and 1800 primigravid women give birth each year at the Mitundu and Kabudula community hospitals, respectively. The two facilities were purposefully chosen for a larger quasi-experimental study to explore childbirth fear interventions among primigravid women because they were both in a rural setting, had similar maternal health care services, and had similar maternity waiting for home settings. According to the World Health Organization, maternity waiting homes are residential facilities located at the hospital where a pregnant woman can wait for labor and delivery late into her pregnancy (36–40 weeks gestation period) [22].

2.3. Participants

The participants consisted of 18 primigravid women (10 and 8 at the Mitundu and Kabudula community hospitals, respectively) who were purposely selected (Table 1). To be recruited in the study,

Table 1
Demographic characteristics of the primigravid women ($n=18$).

Characteristics	<i>n</i>
Age(years)	
17–20	16
21–25	2
Education level	
Primary	15
Secondary	3
Marital status	
Married	18
Type of marriage	
Pregnancy first	1
Marriage first	17
Women occupation	
Housewives	2
Farmers	16
Partners occupation	
Farmers only	16
Business	2
Number of antenatal visits	
Four visits	18

Table 2
Demographic characteristics of birth companions (n= 21).

Characteristics	n
Age(years)	
35–45	9
46–50	7
>50	5
Level of education	
None	7
Primary level	14
Relationship with a primigravid woman	
Own mother	12
Mother-in-law	9
Previous birth companion experience(s)	
None	12
Once	5
More than one	4

primigravid women had to meet the following criteria: i) to be late in their pregnancy from 36 to 40 weeks in the gestation period, ii) to have a singleton pregnancy without obstetric complications, iii) to stay at the maternity waiting home at the hospital while waiting for childbirth, iv) to have a birth companion, and v) to be fluent in either Chichewa (the local language) or English.

We also conducted four focus group discussions (FGDs). At each hospital, we conducted two FGDs: one with birth companions and the other with health care providers to allow a more in-depth understanding of childbirth fear and preparation at both the community and health facility levels. Therefore, we recruited 10 and 11 birth companions at the Mitundu and Kabudula community hospitals, respectively (Table 2). Birth companions had to meet the following criteria: i) a female birth companion accompanying a primigravid woman who is staying at the maternity waiting for a home, ii) staying at the maternity waiting for a home, and iii) having the ability to communicate verbally in Chichewa. Similarly, six health care providers at the Mitundu community hospital and seven health care providers at the Kabudula community hospital were recruited (Table 3). Health care providers who were recruited were providing direct maternal health care, either at the antenatal care unit or maternity ward and being able to speak both Chichewa and English.

2.4. Data collection

Data were collected from December 2017 to March 2018. All participants were recruited and interviewed by the researcher who was born in Malawi and fluently spoke the local language and English. With the assistance from the health care providers at each hospital's maternity waiting home, the researcher approached potential participants, both primigravid women and birth companions, and provided them with the participant information sheets with contact details for the researcher. One senior nurse at each hospital, who was briefed on the study inclusion criteria and study aims, assisted in the recruitment of health care providers. Semi-structured interview guides were used to conduct face-to-face, in-depth interviews, and FGDs in the Chichewa language in a private room at the antenatal clinic. The interview and FGD guides were developed in English and translated into the local Chichewa language. Two independent experts in maternal-child health checked the data collection tools for translation accuracy. Each in-depth interview lasted between 30 and 45 min, while each FGD lasted between 60 and 90 min. The researcher conducted in-depth interviews and moderated the FGDs while the research assistant aided the recording and capturing of the field notes. The first part of the data collection captured the demographic information of the

Table 3
Demographic characteristics of health care workers (n= 13).

Characteristics	n
Age (years)	
25–35	3
36–40	6
>40	4
Professional cadre	
Registered nurses	4
Enrolled nurses	9
Qualification level	
Degree	3
Diploma	10
Work experience(years)	
1–5	4
6–10	6
>10	3
Clinical placement	
Antenatal	7
Labour ward	6

participants. The other parts consisted of questions on pregnancy experiences, preparation for childbirth, and perceptions of childbirth preparation processes. Data collection continued until data saturation was reached. Subsequently, the data saturation determined the number of in-depth interviews and FGDs.

The age range of the primigravid women was 17–25 years. Most women had received primary education and were married to partners who earned a living from farming activities. Only one participant was impregnated before marriage. All the primigravid women attended the minimum of four required antenatal visits (Table 1).

2.5. Data analysis

The digital audio files were transcribed verbatim to Microsoft Word 97–2003 documents. The transcripts were then translated into English. To ensure translation accuracy, the bilingual language expert checked the translations. NVivo 11 computer software was used to aid the organization of data during the analysis [23]. The content analysis was used to identify, conceptualize, and interpret the inner meaning of childbirth fear and childbirth preparation among primigravid women [22]. The content analysis involved an overall reading of the transcripts, followed by a line-by-line initial coding [24]. Coding was mainly done deductively by primarily focusing on the study interview guide and inductively through the data. The initial coding was done independently by two researchers. The research team discussed differences that arose during the coding stage. A consensus was reached on the final code application. The codes were classified into subcategories with similar meanings which were further grouped into main categories [25]. Representative quotes were identified and summarized to support the categories from the findings. A sample of the condensation and abstraction process is shown in Table 4.

2.6. Trustworthiness

Rigor in a qualitative study demands the application of appropriate techniques and methods to ensure credibility [26]. To ensure rigor, the following techniques were implemented: i) Triangulation of in-depth interviews with primigravid women and FGDs with birth companions and health care providers, respectively, to collect converging evidence to verify or corroborate childbirth fear and childbirth preparation phenomena in primigravid women [27]; ii) Coding was mainly done deductively by focusing primarily on the

Table 4
The development of the category “ambivalent feelings”.

Subcategories	Open code	Meaning units
Being positive	Looking forward to having a baby	I want to have a baby. Looking forward to the day. I will manage to give birth. I am just waiting for the day to deliver. Why should I fail. I will be a mother soon.
	Knowing giving birth will please husband	My husband will be happy. He will be happy with me. My wife has done a good job. My husband wants a baby.
Suffering in silence	Feeling helpless and incompetent	What will happen. Feel sorry for myself. There is nothing we can do. I will just accept anything. I have no choice. Will I manage or not. I do not know what it means to give birth. It is a hard task. Will I manage to follow what I was advised?
	Given inadequate information to give birth	I hear people describing their experiences. You will toil when giving birth. What we were told by other women. What happens at the labour ward? Do not have any experience.
	Fearing the adverse pregnancy outcome	I have seen others dying. They say you should go for a caesarean section. Will I come out with my baby? Our friends had a ruptured uterus. I have seen others dying. Maybe I will die. I am concerned how things will come out when labour starts.
	Suspicious of husband infidelity	Husband is alone at home. I was told not to engage in extramarital sex. My husband sleeps with other women.
	You cannot say that you are scared	I don't share with anyone. Resolve on their own. I keep this to myself. You cannot say you are afraid. I put my trust in God. I feel shy to share. Better to be praying than praying than getting worried. I have left everything in the hands of God.

study interview guideline and inductively through the data; iii) The coding was done by two researchers. To ensure consistent application of the coding, codes were compared and examined at different times during the process. Differences were discussed by the research team, and a consensus was reached on the final code application to ensure the dependability and consistency of the findings; iv) The consolidated criteria for reporting qualitative research (COREQ) guidelines were used to report the findings [28].

2.7. Ethical consideration

This study was approved by the Institutional Review Board of the Xiangya School of Nursing, South-Central University, China, and the National Committee on Research in the Social Sciences and Humanities in Malawi (REF.NO.NCST/RTT/2/6). Study participation was voluntary and depended strictly on the provision of informed consent and assent from participants younger than 18 years of age. Those who assented were required to provide parental consent from their immediate guardians.

3. Results

The four categories that emerged from the analysis of the data were: “ambivalent pregnancy feelings”, “dependence on traditional childbirth counseling”, “inadequate prenatal childbirth instruction”, and “inconsistent roles of a birth companion”. These categories were developed to explore the main theme of childbirth fear and childbirth preparation among primigravid women in late pregnancy in a rural setting (Table 5).

3.1. Ambivalent pregnancy feelings

The impending childbirth during the prenatal period provoked

mixed feelings among primigravid women. They were delighted to have become pregnant to fulfill their social expectations, but at the same time, the process of giving birth for the first time scared them.

3.1.1. Being positive

Many participants reported wanting to have a baby and looking forward to the day they would become a mother. The participants acknowledged the hard work involved in labor, but positive feelings about becoming a mother could temporarily suppress the stress of impending pregnancy and childbirth. One participant said:

“I will have my baby ... when I look at the impending childbirth, I do not have any feelings? I tell myself that I am ready for whatever will happen.” (Mitundu #9, 18 years).

The impending task of giving birth in the cultural context was also perceived as the fulfillment of a woman's duty of making her husband a father. One participant shared this feeling by saying:

“This is my first pregnancy; I wanted to have a baby. My husband will also be happy to see the baby with me. He will be proud of me that I have done a good job to give him a baby.” (Kabudula #1, 21 years).

3.1.2. Suffering in silence

Although most participants gave the impression that they were progressing happily in their pregnancies, they were quick to confess and acknowledge how the experience of childbirth struck fear in them. We observed participants expressing uneasiness while discussing their concerns about childbirth fear by turning their face away from the interviewer. Primigravid women often feel inexperienced and incompetent. Consequently, some primigravid

Table 5
Core category, categories and subcategories developed during content analysis.

Core category	Categories	Subcategories
Childbirth fear and childbirth preparation	• Ambivalent pregnancy feelings	• Being positive • Suffering in silence
	• Depending on traditional childbirth counseling	• Elderly women pregnancy counseling • Being warned not to shame parents
	• Inadequate prenatal childbirth instruction	• Unable to comprehend information on childbirth • Not given information
	• Inconsistent roles of a birth companion	• Blame game • Bearing witness • Cultural beliefs strains

women were scared of the impending childbirth experience. More commonly the childbirth fear emanated from inadequate information and lack of experience with childbirth. One participant reported:

“To be honest, I am afraid. This is my first experience. I do not know what it means to give birth. They say the task is enormous especially when the baby is coming out. One cannot manage. It is difficult.” (Kabudula #2, 19 years).

Other participants were scared of the approaching birth after overhearing fellow women crying wildly while giving birth in the labor ward. One participant had this to share:

“I think of what will happen when I hear a woman, who has given birth before, crying in the labor ward, I get scared, I ask myself that will I manage to give birth? This makes me be overwhelmed with fear.” (Mitundu #1, 17 years).

Echoing the sentiments raised by primigravid women, birth companions, and health care providers also pointed out that the proximity of the labor ward to the maternity waiting for home exposed the primigravid woman to some of the more frightening realities of going through labor. It was further reported that primigravid women were severely worried when they heard other women crying from intense labor pains. One birth companion pointed out that:

“The labor ward is not far from the maternity waiting for a home; hence primigravida can overhear someone crying. This instills fear among primigravid women.” (FGD, companion, Mitundu #2).

Some participants reported being afraid of childbirth complications and uncertain about pregnancy outcomes. The experience of seeing someone die during childbirth made them overly anxious. Expressing her fear, one participant said:

“I am always filled with fear when I think of childbirth ... others have died while giving birth or have given birth to a stillborn. This affects me psychologically.” (Mitundu #4, 19 years).

Furthermore, some participants were filled with childbirth fear because they were fearful of their spouse's sexual behavior during pregnancy. Culturally, a spouse having an extramarital affair while his wife is pregnant is believed to yield a curse that results in the woman experiencing difficulties during childbirth and/or having undesirable pregnancy outcomes. One participant stated:

“The husband should not have extramarital relationships when you are pregnant. In my culture, people say when the husband is having sexual relationships elsewhere; you will have problems when giving birth.” (Kabudula #7, 19 years).

Our study revealed that an unfavorable psychosocial environment forced primigravid women not to share their concerns. Consequently, primigravid women went into the labor ward with unresolved concerns that fueled their childbirth fears. To cope with childbirth fear, primigravid women used different strategies. Some kept their concerns to themselves while others shared their feelings with trusted persons, such as a mother or peer. However, a few primigravid women indicated that they had put their trust in God to help them overcome their childbirth challenges. Commenting on this, participants said:

“I keep all my worries to myself; I haven't told anyone.” [shying away from the interviewer by looking to the side] (Kabudula #3, 18 years).

“I don't share with anyone. I just keep the fears and concerns to myself (Laughing and shying away by looking to the side). I put my trust in God.” (Mitundu #2, 18 years).

To corroborate that primigravid women kept their childbirth fears to themselves, birth companions and health care providers shared similar sentiments. One birth companion said:

“Most of the times they (primigravid women) don't share what is bothering them unless you check with them. You can see that she is worried when you give her something to eat like porridge or tea. She will not take them. She will just sit quietly. Then you ask what is bothering her.” (FGD, companion Mitundu #5).

3.2. Dependence on traditional childbirth counseling

Primigravid women mainly received childbirth preparation advice from conventional systems. Most participants indicated that elderly women, grandmothers, mothers, and peers were their main sources of childbirth preparation information.

3.2.1. Elderly women pregnancy counseling

Most participants indicated having received childbirth information from elderly women from either their religious affiliation or the traditional social network in the community. Mostly, elderly women counseling was sanctioned by primigravid women's mothers and was conducted in their mothers' homes. One participant stated:

“I have not received any childbirth information from anyone else. It is only elderly women who came to talk to me on pregnancy and childbirth issues. [Elderly women] were invited by my mother.” (Kabudula #4, 18 years).

It was also evident from the perspectives of the birth companions and health care providers that elderly women's childbirth instruction was a prerequisite for the primigravid woman to start attending antenatal care. One birth companion expressed:

“When the woman is pregnant for the first time, we call elderly women in the village to talk to her before she starts antenatal care. Then after receiving the counseling, she can start attending antenatal care.” (FGD, companion Mitundu #2).

Another birth companion elaborated on this by saying:

“The primigravid woman cannot start antenatal visits and give birth without being counseled at home. She doesn't know anything for her to start antenatal care. She is allowed to start antenatal care after receiving counseling from elderly women at home.” (FGD, companion Kabudula #6).

The practice of waiting for traditional counseling was perceived as a contributing factor to late antenatal bookings by primigravid women. Commenting on this, one health care provider said:

“We advise primigravid women to start antenatal care soon after noting that they are pregnant. However, most primigravid women

start antenatal late because they wait for traditional counseling.” (FGD, care provider Kabudula #1).

Although it was claimed that primigravid women cannot start attending antenatal care, a few participants reported not receiving traditional counseling. The most common cited reasons for not receiving traditional counseling were the absence of a mother figure and financial challenges to host elderly women in the home. It is a tradition that after the counseling the elderly women should be given an honorarium in cash or kind. One participant stated:

“I was not given any advice on childbirth ... we do not have a mother, she passed away sometime back. Besides we are very poor ... I get a little childbirth information when interacting with others.” (Kabudula #6, 18 years).

3.2.2. Being warned not to shame parents

Most participants indicated that during elderly women counseling, they were encouraged to cooperate with health care providers during labor and delivery. They were also warned that any failures during the birthing process would shame their parents. Participants further stated that they were told not to cry during labor and delivery. Birth companions highlighted the need to cooperate with health care providers and not to cry. The following sentence illustrates why traditional counseling discourages women from crying during childbirth:

“We deliberately instill fear in her so that she should be terrified ... and what we want is that she should cooperate. She should not put us to shame as if we didn't counsel her at home” (FGD, companion Kabudula #2).

3.2.3. Unable to comprehend information about childbirth

Although most participants reported having received counseling at home, they felt uncomfortable giving birth based on the unclear and inadequate information they acquired during traditional counseling. Additionally, primigravid women tended to forget the instructions because the counseling was done quite early in the pregnancy. One participant stated:

“When I was being counseled, I did not know anything. They said a lot of things. I was just listening to what they were saying because I did not know anything. I just agreed to whatever they were telling me at that time ... I still have childbirth fear despite being counseled home.” (Kabudula #5, 18 years).

Moreover, it was also evident that traditional childbirth instructions did not expose primigravid women to the realities of giving birth. Instead, counseling mainly focused on encouraging mothers to cooperate during labor and delivery. One participant lamented by saying:

“They confuse us [laughing] that is why I decided that I will do whatever I can when I go to the labor ward.” (Mitundu #5, 18 years).

3.3. Inadequate prenatal childbirth instructions

Our study revealed gaps in formal childbirth psychosocial

counseling. It is worth pointing out that almost all primigravid women who participated in this study attended the minimum of four required antenatal visits. Nonetheless, health care providers barely provided childbirth information to primigravid women during these visits. Unfortunately, primigravid women were blamed by health care providers for lacking childbirth information during labor and delivery.

3.3.1. Not receiving childbirth information

Information dissemination during antenatal care was suboptimal. Health care providers mostly concentrated on screening pregnant women for human immunodeficiency virus (HIV), conducting abdominal assessments, providing medications, and reminding pregnant women about items required for childbirth at the health facility. Almost all primigravid women denied receiving further childbirth preparation information during antenatal care. One participant shared:

“At the antenatal clinic, they do not tell us about childbirth ... I am sure they did not tell me anything about childbirth ... (laughing).” (Kabudula #8, 19 years).

Another participant, who attended antenatal care with her partner, reaffirmed that she did not receive any other information on childbirth apart from being reminded of the items required for childbirth at the facility:

“They asked my husband on requirements for childbirth. He said basin, four meters plastic paper, razor blade, cotton wool, torch or candle. The health care provider examined me on the abdomen. That is the only thing we were told.” (Kabudula #7, 19 years).

Echoing how health care providers hardly provided childbirth information, a birth companion said:

“Most of the time, health care providers do not take any part in giving primigravid woman information on childbirth. They only call us to go to the labor ward (pointing in the labor ward direction). When we get there, they ask us the information that we gave to the primigravid woman regarding labor and delivery. This clearly shows that health care providers do not even give childbirth information to primigravid women.” (FGD, companion Mitundu #5).

3.3.2. The blame game

The primigravid women who went to the labor ward with inadequate childbirth preparation predictably were subjected to shortcomings during labor and delivery. Sadly, primigravid women who were unprepared for childbirth were blamed for their ignorance. If a primigravid woman had a concern regarding childbirth they were referred to their birth companions to give them the information. One participant reported this by saying:

“When you ask them something, they will rebuke you ... they would say, ‘Were you not counseled at home? ... Why you did not ask your birth companion to assist you? Moreover, you are staying with them at the maternity waiting home.” (Kabudula #4, 19 years).

The blame for being ignorant about childbirth was also put on the birth companions. One birth companion shared the following:

“They will call you to the labor ward. When you are there, the first question would be, ‘Did you counsel your daughter on childbirth?’ She is failing to do what is expected of her. You should sit here and see for yourself what she is doing.” (FGD, companion Kabudula #2).

3.4. Inconsistent roles of a birth companion

Ideally, birth companions were required to accompany and support primigravid women during childbirth at the health facility. However, the involvement of the birth companions revealed professional and psychosocial challenges.

3.4.1. Being a primigravid women mentor

Most participants perceived their birth companion as someone with adequate childbirth experience to support them both during the delivery at the health facility and home after the child’s birth. Moreover, a birth companion’s understanding of their role was to support a primigravid woman to give birth to a live baby. One birth companion shared:

“We will do things together to make sure she is doing what she was told at home in case she has forgotten. We are here to remind her.” (FGD, companion Kabudula #3).

3.4.2. Bearing witness

Birth companions were only allowed into the labor ward when primigravid women failed to follow health care providers’ instructions. Health care providers commented on this by indicating that they invited birth companions into the labor ward to see how the primigravid women were failing to follow the instructions. Consequently, the birth companions were unknowingly bearing witness to the primigravid women’s failures to give birth and the potentially adverse pregnancy outcomes, like stillbirths. One health care provider reported:

“Birth companion is called into labor ward because she should see for herself that she [primigravid woman] has delivered a stillbirth ... We want her to witness what happened in case you need to write a report. The report should be exactly what she had witnessed.” (FGD, care provider Mitundu #1).

The failure of a primigravid woman giving birth to a live baby is a sign of being disobedient, and the woman could be labeled as a baby killer. One birth companion shared this sentiment by saying:

“If she goes into labor and comes out with a stillbirth, it means she was not following what she was advised. We call her ‘a killer woman.’ Everything that she was being advised did not mean anything to her.” (FGD, companion Kabudula #6).

A birth companion who witnesses the birth of a dead baby subsequently shares the primigravid woman’s ordeal with the community. Such a primigravid woman would be labeled as “a killer woman” and may face social consequences, such as divorce. One birth companion said:

“When she comes out with a dead baby, her husband is encouraged to leave her and marry another woman because she does not have the strength to give birth.” (FGD, companion Mitundu #5).

Therefore, coming out of the labor ward with a dead baby was a

source of childbirth fear among primigravid women waiting at the maternity waiting for homes for labor and delivery. The excerpt below demonstrates the fear that primigravid women have of losing the baby:

“I fear working hard in the labor ward. My main fear comes when I see someone coming out of the labor ward without a baby. So, I ask myself several questions, one of which being ‘Will I come out with a baby?’.” (Kabudula #1, 18 years).

3.4.3. Cultural belief strains

It was revealed that both primigravid women and health care providers had reservations about engaging birth companions on childbirth activities. Most primigravid women reported being inadequately supported by the birth companions due to sociocultural issues, especially when the birth companion was a mother-in-law. One participant said:

“I cannot share information with my mother-in-law. I do not chat with her freely [while turning aside and laughing to herself].” (Mitundu #6, 18 years).

Health care providers reported that the presence of a birth companion facilitated the cultural practice of giving primigravid women labor enhancing herbs (local Pitocin) that exacerbated the primigravid labor process. One health care provider shared:

“We noted that there were a lot of asphyxiated babies. We strongly suspect that some of the birth companions give primigravid women local herbs to precipitate labor and delivery.” (FGD, care provider Mitundu #4).

4. Discussion

This study explored childbirth fear and childbirth preparation during late pregnancy from the perspectives of primigravid women, birth companions, and health care providers in rural settings in Lilongwe, Malawi. Although the study revealed that primigravid women were looking forward to being mothers, they also suffered silently by being uncertain of pregnancy outcomes and fearful of the childbirth experience. The study further revealed that primigravid women mainly received childbirth information from traditional sources rather than health care providers. However, the function of traditional childbirth information was questioned when the primigravid woman could not cooperate during delivery or experienced undesirable pregnancy outcomes.

A pregnant woman looks forward to the time when she will carry her baby in her hands. However, we found that primigravid women had mixed feelings while waiting for childbirth; their desires to become mothers were challenged by feelings of pregnancy distress. Primigravid woman became overly anxious, not only when they thought about the labor process, but also the outcomes of the pregnancy, thus suggesting a build-up of childbirth fear in primigravid women. Childbirth fear has been reported in other studies and they have recommended that health care providers should listen to pregnant women and respect their perspectives to provide holistic care [29]. The provision of holistic care is critical because, according to Haines et al. [30], childbirth may compromise the emotional wellbeing of a pregnant woman and consequently influence the occurrence of an adverse pregnancy outcome. Moreover, primigravid women have no experience with childbirth and need effective

psychosocial support to overcome childbirth fear [11]. Therefore, we suggest that health care providers should properly screen for childbirth fear among primigravid women during the prenatal period. This will ensure that primigravid women receive appropriate individualized and effective psychosocial support during their pregnancies. It is further argued that making the first childbirth a positive experience for a pregnant woman will prevent the escalation of secondary childbirth fear and increase the chances of women utilizing health care facilities for childbirth in their future pregnancies in low resource settings [31].

In this study, it was evident that sociocultural beliefs aggravated childbirth fear. The most reported belief related to childbirth fear was husband infidelity. Similarly, some authors have reported that extramarital affairs by a partner can contribute to experiencing difficult labor.

[32] and the occurrence of stillbirth [33]. Moreover, with the introduction of the maternity waiting homes, Barta & Kiene [34] argued that the practice of leaving young men at home presents an increased opportunity for infidelity. Furthermore, in most societies in Malawi, male infidelity is socially acceptable [35] and this leaves a woman helpless to suffer in silence. We assert that primigravid women in Malawi live in a hostile sociocultural environment and require concerted efforts to manage their fears. Hence, the need to develop culturally sensitive interventions to support such vulnerable pregnant women. Again, to ensure positive childbirth experiences, we suggest that health care providers should meaningfully involve a primigravid woman's partner throughout the childbirth preparation cycle to address sensitive sociocultural issues that unnecessarily instill childbirth fear.

Our study has shown that traditional childbirth counseling was the main source of childbirth information and was regarded as an effective tool to help primigravid women cooperate with health care providers. Previous studies have consistently found that informal sources of childbirth information strongly influence the confidence of pregnant women and how they respond to the childbirth process [17,28]. However, Malata and Chirwa [36] warned that informal childbirth information is sometimes detrimental to a pregnant woman's well-being and childbirth preparation. This assertion by Malata and Chirwa [36] is true considering that, in our study, informal preparation was perceived as confusing and untimely, leaving mothers psychologically unprepared, and hence provoking intense childbirth fear. Incorrect and insufficient knowledge provided during a woman's pregnancy may lead to childbirth fear [37].

Additionally, as evidenced in the current study and elsewhere [38,39], traditional childbirth counseling is a potential threat to the adequate utilization of antenatal care services among primigravid women. Malawi's current guidelines recommend that pregnant women start antenatal care early in the first trimester to achieve at least four visits before giving birth [40]. Unfortunately, a comparative analysis of maternal health care utilization between young mothers and elderly women in the Sub-Saharan Africa region found that 80% of young women start antenatal late [41]. We assert that late antenatal booking in some settings could partly be attributed to the fact that primigravid women wait for traditional counseling; thus, furthering the understanding that traditional counseling affects service utilization. Therefore, we suggest that primigravid women receive adequate formal practical childbirth preparation information throughout the antenatal care period, as well as, at the maternity waiting homes to minimize the detrimental effects of traditional counseling.

However, as evidenced in the study, primigravid women receive little or no childbirth preparation information despite attending the required antenatal care visits. For example, a national service provision assessment in Malawi reported that 39% of pregnant women

did not receive any advice from care providers on childbirth during the antenatal care visit at the health facilities [42]. Previous studies have also reported that most health care providers in Sub-Saharan Africa rarely provide childbirth information to pregnant women during antenatal care and this affects their response to childbirth and pregnancy outcomes [43–45]. Current maternal care best practices advocate for a positive first experience during childbirth that requires care providers to give adequate pregnancy and childbirth information to primigravid women [46]. Nonetheless, our study highlights some important gaps in antenatal care, and we suggest the adoption and use of educational tools to enhance information transfer.

Although birth companions were regarded as primigravid mentors, they were passively involved in the childbirth preparation and care. Mostly, birth companions were used to witness adverse pregnancy outcomes and were blamed for failing to prepare the primigravid woman for childbirth. Empirical evidence has shown that birth companions provide effective psychosocial support to pregnant women [47,48]. Interestingly, birth companions joined health care workers in condemning the primigravid woman to allow health care workers to run away from their professional responsibility and accountability. Consequently, the ordeal becomes more of a social stigma that could cost a pregnant woman her marriage. Previous studies support this finding that a stillborn baby causes primigravid women to be socially stigmatized, isolated, and valued less by society [49,50]. This provokes great childbirth fear in ill-prepared primigravid women. Therefore, we emphasize the need for health care providers to maintain their professional integrity and effectively support both birth companions and primigravid women to minimize childbirth fear.

5. Study strengths and limitations

To our knowledge, this is the first study to explore childbirth fear in primigravid women during late pregnancy at a birthing facility in a low resource setting. Although this study included birth companions and health care providers' perspectives to guarantee the robustness of our findings, there were a few limitations. First, the findings were based on a relatively small geographical area and cannot be generalized to other populations. Second, the recruitment of primigravid women staying in the maternity waiting home at a health facility may have influenced their response to childbirth fear after being exposed to the stressful environment of the labor ward.

Future studies should explore innovative interventions to minimize childbirth fear in a sociocultural context by utilizing birth companions to strengthen BPCR strategy implementation. Additionally, our study findings provide additional justification to explore the effectiveness of traditional childbirth information in the prenatal period.

6. Conclusion

This study has revealed that primigravid women experience childbirth fear late in pregnancy. Health care providers hardly give primigravid women sufficient childbirth information due to the perceived function of birth preparation that comes from traditional sources. However, a primigravid woman can be labeled as a 'killer woman' and sometimes face divorce when adverse pregnancy outcomes occur. Therefore, we suggest giving primigravid women adequate formal practical childbirth information and psychosocial support during the third trimester to effectively reduce childbirth fear.

CRedit authorship contribution statement

Berlington M.J. Munkhondya: Conceptualization, Methodology, Investigation, Software, Writing - original draft. **Tiwonge Ethel Munkhondya:** Visualization, Investigation. **Gladys Msiska:** Investigation, Data curation. **Ezereth Kabuluzi:** Validation, Resources. **Juqin Yao:** Funding acquisition, Writing - review & editing. **Honghong Wang:** Conceptualization, Methodology, Writing - review & editing.

Declaration of competing interest

The authors declare that they have no competing interests with respect to the research, authorship, and publication of this article.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijnss.2020.05.003>.

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