

**FACULTY OF COMMUNITY AND HEALTH SCIENCES**

**DEVELOPING A CULTURALLY CONGRUENT CONTINUOUS  
LABOUR SUPPORT FRAMEWORK FOR WOMEN IN SOUTH-WEST  
NIGERIA**

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**A thesis submitted in fulfillment of the requirements for the degree of Doctor**

**Philosophiae in the School of Nursing, University of the Western Cape**

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**March, 2017**

**Declaration**

I, Olabisi Fatimo Ibitoye declare that this research study titled '*Developing a Culturally Congruent Continuous Labour Support Framework for Women in South-West Nigeria*' is my own original work. It has not been submitted before for any degree or examination at any other university and all the sources that I have used or quoted are indicated and acknowledged as complete references.

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...1<sup>st</sup> August, 2016.....

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Date

.....

## **Dedication**

This dissertation is dedicated to my loving and ever supportive husband Dr Rasheed Babatunde Ibitoye and my wonderful children (Basit, Kingfahd, Fathia and Shukur Ibitoye, Qudri and Qudus Oyelami).



## **Acknowledgements**

- I give glory and adoration to almighty Allah (the most glorious, most merciful) for his mercy and sustenance from the beginning of this programme till the end, despite irregular salaries and lack of financial assistance.
- I am highly indebted, and express special gratitude to my supervisor Professor Deliwe Phethlu for her constructive review and guidance from the conception of the project to its completion. You taught me how to believe in myself and I am really grateful for that.
- I thank all the women in antenatal care, as well as the nurse-midwives and policy-makers involved in this study for their active participation. Also, all the staff in all the hospitals used for both pilot and main study, for their cooperation and consent to use their facilities.
- I will forever remain grateful to my husband for his unstinting and unwavering support without which this dream would not have become reality. I am grateful, also, to MTU and his wife for upkeep of the family and spiritual support, to all my children for their endurance and show of love for mum.
- I am also grateful to the Ministry of Health and the School of Midwifery in Akure for granting me leave of absence to pursue the programme.
- Special gratitude goes to the Honourable Commissioner for Health Dr Dayo Adeyanju, the Permanent Secretary MOH Dr Taye Oni, the Director for Finance Mr. Jemilugba, Director of Nursing services Dr Solape Jemilugba, the Director of Nursing Services and Former Principal SOM, Akure Mrs.

Alice Ogundele and the current Principal Mrs. Bridget Oladele, for their support during the programme.

- To my mum Alhaja Musili Aduke Kolapo, I really appreciate all your prayers and am so very happy that you are with us to share this experience.
- Special regards to my siblings ( Mr. Ademola Costa, Mrs. Adebola Busari, Mr. Wasiu Kolapo, Mrs. Bolanle Esanju, Mrs. Opeyemi Oyegbule, Mrs. Bolanle Ogunmola Salewa Busari, Ademide & Adetunji Ogunmola and other family both at home and abroad for your encouragement and support during the programme.
- My heartfelt thanks and gratitude go to my professional colleagues at work, Mrs. Dupe Adamolekun, Mr. Idowu Olatubi, and Mrs. Kemi Adeola who willingly volunteered as research assistants throughout the period of data collection and other activities.
- I am also grateful to all Nigerian nursing students enrolled at UWC, especially Yinka Ishola, Dr Afemekhe and Dr Hanson, Mrs. Olanesi-Aliu ( Dr Doyin Iya-Ibeji), Rafiat Anakuru and Mr. Ogunyewo for their communal support.
- Finally, to everyone who has contributed to this success, I say a big thank you from the depths of my heart.

## **Abstract**

Childbirth is a multifaceted experience that is usually influenced by several factors that could result in an unsatisfactory or satisfactory childbirth experience. These factors include quality of support during labour of which Continuous Labour Support (CLS) is a part; it has been identified as a positive contributor to maternal health. Although CLS has been recommended by the World Health Organization (WHO), lack of a framework has also been an impediment to its implementation in Nigerian hospitals. The purpose of this study is to develop a culturally congruent Continuous Labour Support framework for women in Nigeria.

The study adopted a concurrent mixed method design to gain information from various dimensions for the study. The study populations included pregnant women, nurse-midwives and health policy-makers in Ondo state, Nigeria, who were selected through simple random sampling using computer-generated tables for the quantitative strand of the study. For the qualitative strand, participants were selected using a purposeful sampling method. The study was conducted in two phases. Phase 1 focused on the assessment of the perceptions, attitudes and preferences of all groups of participants. Collected quantitative data was analysed using descriptive and inferential statistics through the use of the Statistical Package for Social Science (SPSS) Version 21. Qualitative data was analysed using Tesch's Method of Content Analysis.

Findings the study shows that the pregnant women had positive perceptions and attitudes towards CLS from a familiar, close and trusted person, in public health facilities. Findings from the midwives revealed that pregnant women's family members are not usually involved in women's care during labour in public health

facilities. However, nurse-midwives expressed satisfaction with the few occasional/discretionary occasions on which the practice had been implemented, and the majority showed positive perceptions and attitudes to the introduction of CLS from a person of the woman's choice, in public health facilities. Findings from interviews with the policy-makers affirmed family support system during labour as a cultural expectation and a traditional practice at home but alien to the hospital. The policy-makers also expressed a positive standpoint on the introduction of CLS by persons of the woman's choice from her social network, in the public hospital.

Phase 2 of the study involved the development of the culturally congruent Continuous Labour Support framework for women in south-west Nigeria. The framework was developed using the Model Development Approach by Walker and Avant (2005, 2011). Findings from processes with all stakeholders in Phase 1 of the study were synthesised with literature review, using concept identification and classification. The concepts in this study were identified, described and developed through synthesis of data from questionnaire, the focus group and individual interviews of all stakeholders. Concept classification, description and validation was achieved through the six vantage points of surveying activity listed by Dickoff et al, (1968) in consultation the selected expert reviewers in maternal and child care. The developed framework was followed by a detailed description, and validation of the framework was done through consensus agreement with four experts.

**Key words: Attitude, Continuous Labour Support, Culturally Congruent Framework, Perception, Preference, Public health facility, Social support.**

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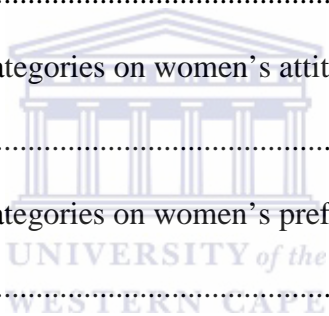
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## List of abbreviations

|         |   |
|---------|---|
| CLS     | Continuous Labour Support   |
| WHO     | World Health Organisation   |
| NPHCDA  | National Primary Health Care Development Agency                       |
| FMOH    | Federal Ministry of Health  |
| UNICEF  | United Nations International Children's Emergency Fund                |
| ICM     | International Confederation of Midwives                               |
| TFR     | Total Fertility Rate  |
| FCT     | Federal Capital Territory   |
| LGAS    | Local Government Areas  |
| UNAID   | United Nations Joint Programme on HIV/AIDS                            |
| PHC     | Primary Health Care   |
| SMOH    | State Ministries of Health  |
| NSHDP   | National Strategies Health Development Plan                           |
| DHS     | Demographic Health Survey   |
| UNFPA   | United Nations Population Fund  |
| SURE-P  | Subsidy Reinvested and Empowerment Programme                          |
| MSS     | Midwives Services Schemes   |
| LAS     | Labour Agency Scale   |
| BANSISQ | Bryanton Adaptation of the Nursing Support in Labour<br>Questionnaire |
| SPSS    | Statistical Package for Social Sciences                               |
| DNS     | Directors of Nursing Services   |
| QDA     | Qualitative Data Analysis   |
| FGDP    | Focus Group Discussion for Pregnant Women                             |
| FGDM    | Focus Group Discussion for Midwives                                   |

## CHAPTER ONE

### 1.1 Introduction

Childbirth is a crucial and significant event in the lives of women and their families and is usually influenced by cultural norms and expectations (Berkowitz, 2008). Although pregnancy and childbirth are normal physiological events, it is usually associated with great emotional, psychological and cultural significance for women and their families (Otley, 2013). The childbirth experience is influenced by several factors that could have an impact on the result that is either an unsatisfactory or a satisfactory childbirth experience. These factors include a sense of security, perceived control, experiences of prior deliveries, involvement in decision-making, the nature of organizational care and quality of support during labour (Dencker, Taft, Bergqvist & Lilja 2010; Hodnett, Gates, Hofmeyr & Salaka, 2009). Traditionally in all cultures across the globe, women usually gave birth surrounded by family members and with the support of other women, but with the movement of birth to the hospital, this valued tradition was lost and women became subject to and dependent on medical technology and hospital routines (Hodnett, Gates, Hofmeyr & Salaka, 2013). While several studies have documented the benefits of Continuous Labour Support (CLS), and the re-emergence of this concept in the hospital, CLS has remained the exception rather than the rule in most developing countries, particularly Nigeria (Sapkota, Kobayashi, Kakehashi, Baral, & Yoshida, 2012; Hodnett et al, 2013). Thus this study was designed to explore the perceptions of stakeholders to CLS, and to develop a culturally congruent Continuous Labour Support framework for women in South-West Nigeria.

The chapter focuses on the background and the rationale for the study, the significance of the study, research questions, objectives, paradigms, assumptions and the definitions of concepts.

## **1.2 Background and rationale for the study**

Worldwide, women share a common need and desire for continuous therapeutic support in labour (Mahdi & Habib, 2010). Historically and transculturally, childbirth usually took place at homes with trusted family and friends providing care and support for the labouring woman. This family ritual and traditional support during childbirth is valued by women and is associated with a positive childbirth experience. However, with the shift of childbirth from home to the hospital, this valued traditional childbirth practice has been subsumed by technological interventions (Hodnett et al., 2013). At modern maternity facilities, women are exposed to institutions' procedures and technology that may infringe on the natural progress of labour (Hodnett et al., 2011). Now, in the 21st century, with the depersonalization of women's birth experiences in hospitals, women have rediscovered the value of additional support during childbirth (Hodnett et al., 2012).

Culture is believed strongly to influence the beliefs systems of society, including childbirth practices and experiences (Esposito, 1999; Williamson & Harrison, 2010). Different cultures adopt different methods of caring for and supporting women during pregnancy and childbirth, and the kind of social support, as well as its significance for all stakeholders, varies according to women's cultural backgrounds (Bina, 2008). Currently, there is a growing need for maternity care providers to advocate culturally sensitive healthcare provision that meets the women's health needs. This is essential in creating optimal client-provider



communication, delivering high-quality, evidence-based services that bring about positive treatment outcomes, and ensuring client and family satisfaction (Gertner, 2012).

According to Lundgren (2007), the pivotal factor for a positive childbirth experience is support. Attending to a woman's psychological and social needs through therapeutic presence and Continuous Labour Support (CLS) improves maternal and infant health outcomes (Hodnett, Gates, Hofmeyr, and Sakala & Weston, 2011). CLS refers to non-medical continuous support without interruption, except for toileting, from shortly after admission to the hospital to the birth of the child (Hodnett et al., 2011). A woman who has had CLS from close family members and friends during labour feels protected. She also feels she is not being observed or judged by health care providers (Ngai, Chan, & Holroyd, 2011).

The benefits of CLS during childbirth have been studied over two decades and are still being studied. CLS has been associated with shorter labour, increased rates of spontaneous vaginal delivery, lower incidences of caesarian section, reduction in the use of pain medication, increased maternal feelings of control and positive childbirth experiences (Hodnett et al., 2009, 2012, Rosen, 2004). Based on the overwhelming benefits of CLS and the endorsement of the World Health Organisation, a parturient woman should be allowed to have a birth companion she trusts and with whom she feel at ease (WHO, 2009). Indeed it has become the norm since the 1980s for women to be accompanied through labour by their partners in most Western developed countries despite sophisticated maternal and child care facilities and technology. In the developing world however, CLS has been the exception rather than routine for women attending medical institutions to give birth.

This is especially true of Nigeria, which has among the worst maternal and child health indices, as well as limited health resources (Maimbolwa et al. 2001, Devries et al. 2001, Bruggeman et al. 2007, Morhason-Bello et al. 2008, Banda et al. 2010, Hodnett, 2013).

Currently, Nigeria's population is estimated to be over 170 million, but the last population census in 2006 put the population at 140 million people. This include women of childbearing age constituting about 31 million and children under five years old constituting 28 million (NPHCDA, FMOH, 2009; National Bureau of Statistics, 2010). Nigeria constitutes just 1% of the world population, ranking second after India on maternal mortality scale with the rate of 800 deaths per 100 000 live births, and thus accounts for 10% of the world's maternal mortality (Olusegun, Ibe, & Micheal, 2012). A woman's chances of dying from pregnancy and childbirth in Nigeria are 1 in 13. The Demographic and Health Survey (DHS) (2008) reported that about 62% of deliveries take place at home, 15% at private health facilities while less than 20% of women deliver their babies in public health facilities. Aside from direct causes of maternal mortality such as puerperal sepsis, abortion complications, pre-eclampsia/ eclampsia, prolonged obstructed labour, haemorrhage. Socio-cultural factors such as attitude to modern medicine, lack of social support, attitudes to social norms required to be observed during pregnancy and women's decision-making power has been linked to maternal mortality. Negative attitudes to professional health staff, and policies preventing relatives from being in the labour room to provide support at the public hospitals have been highlighted as key factors in the poor state of maternal and health care services in Nigeria (Chukuezi, 2010, Maternal Health in Nigeria Statistical Overview, Global

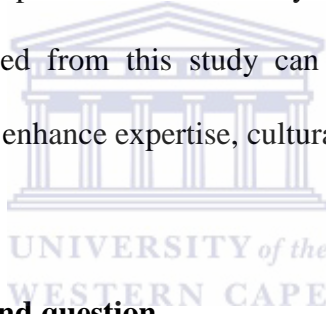
One 2015). Implementation of CLS from a woman's social network has been argued to be significant in developing countries like Nigeria where resources are limited. This is because the woman is more prone to feeling lonely in a birthing environment with a limited number of health workers, instead of with a number of women familiar to her, who could be involved in the delivery (Hodnett, 2011, Meyer et al 2001).

Several studies have also revealed Nigerian women's desire to have someone from the same cultural background with them during labour to provide social support (Dim, Ikeme, Ezegwui, & Nwagha, 2011; Morhason-Bello et al., 2008). Cultural expectations to the women are rites and rituals may serve as a guide and a means of support during pregnancy and birth and potentially aid their smooth transition to motherhood (Dike, 2013). Furthermore, the Morhason-Bello et al. (2008) study, on the effect of psychosocial support on birth outcomes, reveals that women who have had support experienced a shorter duration of the active phase of labour, are less likely to need a caesarian delivery, and have lower labour pain scores. For these women, the initiation of breastfeeding begins sooner, and there is generally a more positive labour experience – all of which signify the benefits of support during childbirth for Nigerian women. Hence, the researchers concluded that inclusion of the choice of Continuous Labour Support for Nigerian women, and a standardised framework for the protocols in the management of women in labour, may be justified.

### **1.3 Significance of the study**

The rate of maternal mortality can only be reduced when maternity services are rendered in an atmosphere that is culturally acceptable to the women in labour.

Hence, a culturally congruent framework for CLS during childbirth will ensure culturally adequate maternity health care, improve the therapeutic relationship between health providers, and women and their families, as well as enhance the positive birth experience in public maternity health facilities. This may also bring an increase in the utilisation of public health maternal health services and a reduction in the maternal mortality rate. The framework will be a point of reference for other researchers in maternal and child health and can also be transferred for use in other parts of the country with a similar cultural frame of reference. This study will also inform policy development on the involvement of women's families as a means to encourage the implementation of family-centered care in promoting CLS. The framework developed from this study can also be incorporated into the Midwifery curriculum to enhance expertise, cultural sensitivity and competency in midwifery practice.



#### **1.4 Research problem and question**

Worldwide, a woman dies every two minutes from pregnancy or childbirth-related causes, with Nigeria and India accounting for 14% and 20% of total global maternal deaths respectively (WHO, 2012). According to Say & Raine (2007), ethics, culture and religion form the basis for the diversity of factors affecting utilisation of maternal health services in Africa. Likewise in Nigeria, socio-cultural and ethno-religious factors rank among other reasons for under-utilization of maternal health services, which implies an association between sociocultural belief systems, tradition and childbirth practices on the one hand, and health-seeking behaviour on the other (Adegoke, 2007). Approximately two-thirds of all Nigerian women deliver outside of health facilities and without the medically skilled

attendants present. This has been linked to perceptions of unfriendly attitudes of health workers, but more importantly the lack of continuous labour support (CLS) in most public facilities in Nigeria (Harrison, 2009; Omoruyi, 2008; and UNICEF 2007). However, there is a dearth of information regarding CLS within the Nigerian cultural and health system's context.

WHO (2010) has endorsed the necessity of culturally congruent CLS processes for women during childbirth. A significant number of research studies have revealed the desire of Nigerian women to have CLS from their social networks (Oboro et al., 2011; Dim, Ikeme, Ezegwui, & Nwagha, 2011; Morhason-Bello et al., 2008; Madi et al, 1999 ;). However, this kind of practice is rare in Nigeria, especially in public health facilities. Implementation of CLS in public hospitals requires a standardised framework to influence policy, neither of which exists in Nigeria. Different CLS frameworks are used in the western world, but none has been found fit for the divergent cultural landscape of Nigeria. Hence, this study intends to work towards the development of a culturally congruent CLS framework for women in the South-West region of Nigeria so as to facilitate the implementation of WHO recommendations with regards to the need for CLS in reproductive health service delivery. The following research questions were developed in the quest to achieve the goal of this study:

1. What are the perceptions, attitudes and preferences of women towards Continuous Labour Support in the South-West region of Nigeria?

2. What are the perceptions and attitudes of nurse-midwives in government hospitals in the South-West region of Nigeria, to CLS from pregnant women's social networks?
3. What is the position of hospital policy-makers in government hospitals in the South-West region of Nigeria, to CLS from pregnant women's social networks?
4. How can a culturally congruent Continuous Labour Support framework for women in the South-West region of Nigeria be developed?

## **1.6 Paradigmatic Perspective**

A research paradigm is a set of fundamental assumptions and beliefs as to how the world is perceived, which then serves as a thinking framework that guides the behaviour of the researcher. Weaver and Olson (2006) view research paradigms as “patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished”. The paradigmatic perspective is the collection of meta-theoretical, theoretical and methodological assumptions that guide the research process.

### **1.6.1 Meta-theoretical assumptions**

Meta-theoretical assumptions are concerned with the reality that guides the researcher to understand how things are and how things work (Scotland, 2012). The researcher's worldview in this study is that of pragmatism. The proponents of pragmatism are “not committed to any one system of philosophy and reality” but advocate the use of “pluralistic approaches to drive knowledge about the problem” (Creswell 2014). Within this worldview, objective and subjective perspectives are

not mutually exclusive and therefore a mixture of approaches is acceptable to understand social phenomena (Wahyni, 2012).

Pragmatism advocates for the mixture of objectivist and subjectivist ontology and epistemology to understand a social phenomenon and give the researcher the freedom to choose methods techniques and procedures that suit the study's needs and purposes (Creswell, 2014; Wahyni, 2012). The ontological assumption of subjectivists is that the problem of reality is constructed by the researcher's involvement in the research circumstances which implies that the researcher, those individuals being researched and the reader interpret information differently (Creswell, 2009). In contrast, the objectivist advocates that the researcher adopts a distanced, detached, neutral and non-initiative position from the researched. However, in this study the researcher believed that the combination of the two world views would create room for better understanding and explanation of the phenomena in this study.

The Theory of Health Promotion in Nursing (University of Johannesburg, 2009) was the point of departure regarding the person as body, mind and spirit. The person functions in an integrated and interactive manner with the environment. The environment includes both the internal and external environments. The internal environment consists of dimensions of body, mind and spirit while external environment consists of physical and social dimensions.

The researcher believes that culture influences the pregnant woman's decisions and choices about where to seek maternity care as well as her expectations about the nature of that care, especially in the public health setting. Based on this the concept

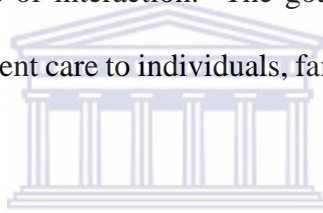
of person, environment, health and nursing in this study are assumed to be defined and understood as follows:

- i. The person in this study is a holistic being with sociocultural values and beliefs and expectations regarding maternal care in public health facilities. This comprises pregnant women, healthcare providers (nurse/ midwives) and hospital policy-makers. Each is viewed as a holistic being that functions in an interactive and integrative manner with the internal and external environments of an organisation.
- ii. The environment is viewed as the totality of geophysical and cultural internal and external environments. The environment in the context of this study refers to a public healthcare facility which utilises all the physical, ecological, spiritual, socio-political, cultural or technological structures available to it, to facilitate well-being in childbirth within a culturally affirmed context.
- iii. Health in this study is culturally defined and constituted as a state of affairs that helps pregnant women undergo the labour process in public health facilities, in a manner culturally acceptable to them, with positive outcomes for labour and childbirth.
- iv. Nursing is defined as a humanistic and scientific profession and discipline which focuses on human care phenomena and activities to assist, support and facilitate childbirth, and enable pregnant women to undergo the labour process in a manner culturally acceptable to them, with positive outcomes for labour and childbirth, in public health facilities.



### **1.6.2. Theoretical assumptions**

Based on the pragmatic world view, the researcher adopted culture-based theories as the theoretical foundation in this study. Transcultural nursing is defined as the area of study and practice which focused on comparing the differences in human-care and similarities in the beliefs, values, and patterned life-ways of cultures to provide culturally congruent care that is meaningful, and beneficial health care to people (Leininger and McFarland, 2002). Transcultural care denotes provision of care to members of different cultures or of a particular culture in which the healthcare provider takes into consideration the client's cultural background and differences in all aspects of interaction. The goal of Culture Care Theory is to provide culturally congruent care to individuals, families, groups, communities and institutions.



#### **1.6.2.1 Culturally congruent care**

Leininger (1995) refers to culturally congruent care as the cognitively based assistive, supportive, facilitative decisions that are tailored to fit with an individual's, group's, or institution's cultural values, beliefs, and way of life in order to provide meaningful, beneficial, satisfying care that leads to health and well-being" (Leininger,1995). According to Sainola-Rodriguez (2009), the interaction between health care personnel and the client can be viewed from the perspectives of the cultural background of the personnel, the patient and the cultural setting within which care is provided. Hence, health care services should be evaluated based on the capacity of staff to comprehend and respond positively to the cultural needs brought by the clients into their encounter with the health institution (Center for the Advancement of Health 2012).

The theoretical assumptions of the research regarding the matter of culture care include:

i. Cultural care concepts, meanings and expression, and patterns of care vary transcultural with diversity and universality.

ii. Culture has basic care knowledge and practices.

iii. Culture care is influenced by cultural values, beliefs, and practices. These values are embedded in cultural worldview, language, spirituality, kinships, politics and economics, education, technology and the environment.

iv. Beneficial, healthy, and satisfactory culturally based care influences the health and well-being of individuals, families, groups, and communities within the cultural context.

v. Culturally congruent care can only occur when individuals, groups, and communities' patterns are understood and used effectively.

vi. Culture conflicts, artificially-imposed practices, cultural stresses, and pain reflect the failure of professional care to provide culturally congruent care.

vii. For effective culturally congruent care, culture care theory suggests three primary modalities guiding nursing judgment, decision-making and actions. These include:

a. Cultural care preservation and maintenance: “refers to assistive, supportive, and facilitative or enabling creative care actions and decisions that help the culture to retain, preserve or maintain beneficial care beliefs and values”.

b. Cultural care accommodation and negotiation: Leininger & McFarland ( 2002) refers to cultural accommodation as "those assistive, accommodation, facilitative, or enabling creative care actions and decisions that help people of a designated culture to negotiate with, others for culturally congruent, safe and efficient care for their health".

c. Cultural care re-patterning and restructuring: "refers to those assistive, supporting, facilitative, or enabling professional actions and decisions that help to restructure their life ways and institution for better or beneficial health care patterns, practice or outcomes" (Leininger,1995; Leininger & McFarland, 2002).

### 1.6.2.3 Concept clarification

- **Culture**

Culture is defined as "the learned, shared, and transmitted values, beliefs, norms, and lifeway of a particular group that guide their thinking, decisions, and actions in patterned ways". (Leininger, 1995)

Culture in the context of this study refers to every symbol, ideology and value that flows through the institution and its individuals which might act as a facilitator of, or barrier against continuous labour support for women during childbirth in a public health facility.

- **Continuous labour support**

CLS refers to non-medical continuous support without interruption, except for toileting, from shortly after admission to the hospital up to and including the birth of the child (Hodnett et al., 2011).

CLS in this study refers to one-to-one non-medical provision of information, physical and emotional support offered by a preferred support person, or

preferred support persons, of a pregnant woman's choice from onset of labour to delivery in a public health facility.

- **Culturally congruent care**

Culturally congruent care is defined as “those cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are mostly tailor-made to fit with an individual's, group's, or institution's cultural values, beliefs, and life-ways in order to provide meaningful, beneficial, satisfying care that leads to health and well-being” (Leininger,1995; Leininger & McFarland, 2006).

Culturally congruent care in this study refers to the synergy of healthcare beliefs, organizational culture and childbirth practices that could enhance positive interaction and satisfaction between provider and client.

- **Conceptual framework**

Conceptual framework is a group of concepts that are broadly defined and systematically organized to provide a focus, a rationale, and a tool for the integration and interpretation of information on Continuous Labour Support during childbirth for women in Nigeria.

- **Labour support person**

Labour support person in this study refers to the pregnant woman's preferred support person from her social network, who will provide non-medical information, physical and emotional support to the pregnant woman from the onset of labour until delivery in a public health facility.

- **Policy-makers**

Policy-makers in the context of this study include people who make decisions regarding client management such as nurse managers, medical directors, chief

medical directors, directors of nursing services and permanent secretaries on the Hospital Management Board and in the State Ministry of Health.

- **A midwife**

A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is offered, and which is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education. This is an individual who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife', and who demonstrates competency in the practice of midwifery (International Confederation of Midwives (ICM), 2011).

In addition to the ICM definition, the midwife in this study is a registered midwife or nurse-midwife working at the maternity unit in public health facilities in Ondo state with at least 5 years' working experience.

- **Perception**

Perception is defined as the conscious recognition and interpretation of sensory stimuli through unconscious associations, especially memory, that serve as a basis for understanding, learning, and knowing, or for the motivation of a particular action or reaction (Mosby's Medical Nursing and Allied Health Dictionary 2002).

- **Attitude**

Attitude is the organization of beliefs, feelings and behavioural tendencies towards socially significant objects, groups, events or symbols or a general feeling or evaluation (positive/ negative) about some person, object or issue

(Vaughan & Hogg, 1995).

- **Preference**

Preference refers to an individual's attitude towards a set of objects, typically reflected in an explicit decision-making process (Lichtenstein & Slovic, 2006). Preference could also be described as the evaluative judgment in the sense of liking or disliking an object or a concept. (Scherer, 2005)

Preference in the context of this study refers to the evaluation of the pregnant woman's choice of continuous labour support person from her social network.

- **Position**

This refers to individual perceptions and attitudes of health policy-makers to the implementation of continuous labour support of a woman's choice in public health facilities in Ondo state.

- **Public health facility**


A public health facility in the context of this study is a government-owned secondary health facility offering maternal and child health care services in Ondo state.

### **1.6.3. Methodological assumptions**

Research method refers to set of procedures, tools and techniques together, as well as the data analysis approach that the researcher adopts in a study. An explorative concurrent mixed method research (MMR) involving collection of both quantitative and qualitative data was adopted for this study. Summary of the methodological process in Phase 1 is given in Table 1.1, while the detailed information is given in chapter 3.



**Table 1 Summary of methodological proces**

| <b>Research questions</b>  | <b>Population</b>  | <b>Methodology approach</b>   | <b>Data collection</b>                  | <b>Data analysis approach</b>         |
|--|--|---|---|---------------------------------------|
| What are the perceptions, attitude and preferences of women to continuous labour support in South West region of Nigeria?  | Pregnant   | Quantitative<br>Qualitative   | Questionnaire<br>Focus group discussion | Deductive and inductive data analysis |
| What are the perceptions and attitude of nurse- midwives to continuous labour support from women social network in government hospitals in South West region of Nigeria? | Nurse/<br>midwives   | Qualitative<br> | Focus group discussion                  | Inductive data analysis               |
| What is the position of hospital policy makers to continuous labour support from women social network in government hospitals in South West region of Nigeria?           | Policymakers :<br>Directors of nursing services<br>Chief Medical Directors<br>Head of Nursing Services | Qualitative   | Interview                               | Inductive data analysis               |



### **1.6.3.1 Phase 2: Framework development process**

The researcher adopted the Concept Synthesis approach of Walker and Avant (2011) to develop a culturally congruent CLS framework for women during childbirth in South-West Nigeria. Concept synthesis is used in generating novel ideas that add to theoretical development, and also bring together or order different concepts from a body of data or a set of observations, when the key dimensions are not clear or are altogether unknown (Walker & Avant, 2011). According to Walker & Avant (2011), the steps involved in concept synthesis are iterative. This means that the researcher does not always progress sequentially from step to step but rather, the researcher can go through the same steps many times, or back and forth between steps. The steps involved in concept synthesis are as follows:

1. Familiarization with the area of interest through the use of many resources to collect data.
2. Classification into categories of the data collected and clustering of the phenomena which appear to relate to each other or overlap substantially; that is, each category should be compared with every other category through visual inspection or doing a factor analysis using a computer.
3. Inspection of the clusters for any hierarchical structure and reducing clusters which appear very similar to a higher-order concept, and assigning a new name which accurately describes it and facilitates communication about it.
4. Empirical verification of the new concept and modification of it if necessary by returning to literature, field-notes, data collection and colleagues. This process should be continued until there is no new information being

received. The new concept is then considered adequate and should be described in a theoretical definition specifying its defining attributes.

5. Fitting the new concept developed into existing theory in the area.

### **1.5 Research aim and objectives**

The overall aim of the research was to develop a culturally congruent CLS framework for women in South-West Nigeria. In order to achieve the overall aim of the study, research objectives were formulated as follows:

1. To assess the perceptions, attitudes and preferences of women to CLS in the South-West region of Nigeria.
2. To explore the perceptions and attitudes of the nurse-midwives in public hospitals in the South-West region of Nigeria, to CLS by a person or persons from women's social networks.
3. To determine the position of hospital policy-makers in public hospitals in the South-West region of Nigeria, to CLS by a person or persons from women's social networks.
4. To develop a culturally congruent CLS framework for women in the South-West region of Nigeria.

### **1.7 Ethics**

Polit and Beck (2004) define ethics as a system of moral values concerned with the degree to which research procedures adhere to professional, legal and social obligations and concerns of the participants. This study was approved firstly by the Senate and Research Ethics Committee of the University of the Western Cape on the 9<sup>th</sup> April 2014. Ethical approval was also granted by the Ethical Review

Committee, Ministry of Health, Oyo State for the pilot study on 7<sup>th</sup> July 2014. For the main study in Ondo State, ethical approval for the use of state specialists and the general hospital was granted by the Ethical Review Committee of the hospital's management board, Akure, Ondo State, while permission for the use of two mother-and-child hospitals was given by the Ethical Review Committee of Mother-and-Child Hospitals, Akure. Permission letters and copies of the ethical approval documentation from these institutions were submitted to the gatekeepers of all hospitals used for the study and are attached to the thesis as appendices.

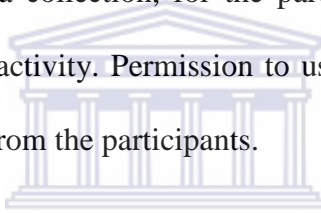
### **1.7.1 Researcher/ participant relationship**

Whenever participants arrived for focus group discussions and in-depth individual interviews, the researcher greeted them with a smile, demonstrating a warm welcome to build a mutual and trusting relationship. The researcher introduced herself to the different population groups and encouraged the members of each group to introduce themselves and get to know each other. The explanations regarding the title, nature and purpose of the study were also introduced to the participants. A conducive environment free from noise was provided for the focus group discussions and in-depth individual interviews. Active participation of all members was encouraged and efforts were made to ensure that no participant dominated discussion so that, as far as possible, each individual participant was able to express their experiences and perceptions. Field notes were taken to back up the audiotape recordings.

### **1.7.2. Informed consent**

According to Burns and Groove (2009) consent is the prospective participant's agreement to participate in the study as a subject after he/she has fully understood the essential information. Detailed information on the aims, objectives, voluntary participation, potential benefits and risks of the study and how data will be collected was given to the participants in print.

Participation in this study was voluntary and none of the participants was coerced to participate. All information about the study was also verbally explained to all participants and the information sheets and consent form were attached to all instruments used for data collection, for the participants to review before the commencement of each activity. Permission to use an audiotape and take field notes was also obtained from the participants.



### **1.7.3 Confidentiality and anonymity**

Confidentiality is the researcher's management of private information shared by participants (Burns & Groove, 2009). All participants were assured that the information they provided would remain confidential during and after the study. The participants were made comfortable and were encouraged to express their opinions and perceptions of the phenomena being studied without fear or embarrassment. The data gathered will be available only to the researcher, supervisor and statistician and all the responses to the questionnaire, all tape-recordings and transcripts from FGDs and interviews will be kept in a secure place under lock and key for five years after the results have been published. Data will be stored in a passworded folder on this researcher's personal computer.

#### **1.7.4 Privacy**

According to Brink (2010) privacy refers to the subject's right to determine the time, extent, and general circumstances under which his/her present information will be shared with or withheld from others. To ensure the participants' privacy, only data related to the aims and objectives of this study was collected. Participants were also assured of the confidentiality of their thoughts, behaviours and experiences during the study.

#### **7.5 Termination**

The participants were also granted the freedom to quit participation at any stage of the study without any consequence

#### **1.8 Thesis outline**

This thesis consists of eight chapters that give in detail the step-by-step process of what was done by the researcher and how the study was conducted.

Chapter 1: Background of the study and overview

Chapter 2: Literature review

Chapter 3: Methodology process

Chapter 4: Presentation of findings and discussion of quantitative results

Chapter 5: Presentation of findings and discussion of qualitative results

Chapter 6: Discussion and conclusion of Phase one

Chapter 7: Development of culturally congruent CLS framework

Chapter 8: Summary, conclusion and recommendations

## 1.9 Summary

This chapter has described the following: introduction, background and rationale for the study, statement of the problem, research question and objectives, the significance of the study and definition of concepts and theoretical paradigm.

Chapter 2 discusses the literature review



## **CHAPTER TWO**

### **LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK**

#### **2.1 Introduction**

The aim of the literature review is to critically appraise current knowledge about CLS practices to enable the development of an evidence-based culturally congruent CLS framework that will be applicable in the South-West Nigerian context. This review includes the historical background of childbirth and labour support, the concept of social support, the concept of culturally congruent care, the concept of labour support, and outcomes. Overview of Nigeria's general profile, the national health system, maternal health and various initiatives to promote maternal and child health are given and discussed. This is necessary in an attempt to provide the baseline information to understand the need for culturally congruent care, while also serving as a basis for the conceptual framework adapted for the study. Computer-assisted data-based and search engines searched include for literature include: MEDLINE (Medical Literature Online), Academic Search Premier, Nexus and CINAHL (Computer Index to Nursing and Allied Health Literature), Google scholar, Ebscohost, SpringerLink, Science Direct, and the University of the Western Cape library. Combinations of keywords and key phrases were used, namely: social support, one to one continuous labour support, continuous labour support, intrapatum care, Doula culturally congruent care and traditional childbirth practices.

## **2.2 Historical background of childbirth and labour support**

Childbirth has been a central part of the human experience throughout history and across all different societies and cultures. Childbirth practices vary in different parts of the world. Historically, throughout the world and in different cultures, assistance in childbirth was the responsibility of family members and friends. Women usually went through childbirth and the rigours of labour with the support of other women who were family members or women from the local community with experience in childbirth (Dunne, Fraser & Gardner, 2014; Etowa, 2012; Brodsky, 2006; Fahy, 2007). Before the late 1800s, birth belonged to women and pregnancy was a "collective experience" in which the woman was never alone Meyer's study (2001) on support during labour in non-medical settings revealed that the majority of women give birth with the support of at least one female companion throughout labour, in 127 of 128 non-industrialised societies (Meyer et al. 2001). However, with the advances in medical knowledge and technology as well as efforts to reduce infant and maternal mortality ratio, childbirth has moved from home to hospital for the convenience of caregivers (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011; Enkin, Keirse, Renfrew, & Neilson, 2000). This movement of childbirth from women's safe and comfortable home environment to the hospital results, in many countries, in women being isolated from the support of family and friends. Modern obstetric care frequently subjects women to institutional routines, which may have adverse effects on the progress of labour (Hodnett et al. 2012; Dunne, Fraser & Gardner, 2014).

Although the rates of maternal and neonatal mortality and morbidity have declined in developed countries with the use of modern obstetric practices during labour,



several studies have shown evidence of increased rates of caesarian section, use of intravenous oxytocin administration, epidural analgesia and continuous electronic foetal monitoring along with other forms of instrumental deliveries. This use of medical intervention has diverted caregivers from offering continuous support and has also led to the dehumanisation of women's birth experience (Hodnett et al. 2012; Behruzi, Hatem, Goulet, Frazer and Misago, 2013; Dunne et al., 2014; Cindoglu & Sayan-Cengiz, 2010). Compared to the medicalized model of care, a supportive human presence in the form of partner, female relative or doula has been found to be more beneficial to women's satisfaction with the birth experience (Sauls, 2002; Hodnett et al., 2003; Rosen, 2004).

A woman-centred care approach respects the values, beliefs, autonomy and choices of women, and considers their control over their bodies and births as key to humanised birth care (Misago et al., 2001). According to Kennell et al. (1991 cited in Ross-Davie, 2012), the exclusion of supportive companions in labour is detrimental to women's emotional and physical well-being both during and after labour.

Also, despite ongoing improvements in maternal health and reduced mortality rates, as well as technological advancements in obstetrical practices in most Western developed countries, it has become routine for women to be accompanied by a labour companion of their choice, to promote humanised care. In the USA, the practice of allowing female social support companions during labour was introduced from the 1970s and currently family involvement, including the husband, is routinely practised in most hospitals (Oboro, et al., 2011; Price, Noseworthy & Thornton, 2007; Modarres Nejad, 2005). Other high-income

countries also have the involvement of close relatives, husbands/partners, and doulas in maternal care. (Madi, Sandall, Bennett, MacLeod, 1999; Maimbolwa et al., 2001; Campbell et al. 2006; Pascali-Bonaro & Kroeger, 2004; Swiatkowska-Freund et al., 2007; Berg & Terstad, 2006). However, the involvement of family members in women's care and social support during labour has been very slow to catch on in most health facilities in majority of the African countries, particularly Nigeria despite harmful levels of maternal mortality and morbidity. There is ample evidence of the overwhelmingly positive benefits of social support for women in childbirth, through clinical trials in both developed and developing countries (see for instance, Dunne et al., 2014; Bruggeman et al. 2007, Morhason-Bello et al. 2008, Banda et al. 2010, Hodnett et al. 2012; Oboro, et al., 2011).

### **2.3 Nigeria profile**

Nigeria lies within latitudes 4° 1' and 13° 9' North and longitudes 2° 2' and 14° 30' East, and is bordered in the North by the Republic of Niger, in the East by the Republics of Chad and Cameroon, in the West by the Republic of Benin and in the South by the Atlantic ocean. The country occupies a total surface area of approximately 923,768 square kilometers and 800km of coastline. Nigeria's climate varies with an equatorial south, a tropical centre, savannah and arid north. Natural resources include natural gas, petroleum, tin, iron ore, coal, limestone, niobium, lead, zinc and arable land. Nigeria has southern lowlands which merge into central hills and plateaus; mountains abound in the southeast, and mostly plains dominate the north.

Nigeria is the most populous African country with an estimated population of 177,071,561 as at July 2013 and a Total Fertility Rate (TFR) of 5.5%. Nigeria's

annual growth rate is estimated to be 2.54% in 2013. The country has 36 states in addition to the Federal Capital Territory (FCT), with the states further divided into 774 Local Government Areas (LGAs). The states are grouped into six geopolitical zones based on geopolitical considerations: North-East (NE), North-West (NW), North Central (NC), South-West (SW), South-East (SE) and South-South (SS) with over 250 ethnic groups across the country. Each geopolitical zone is distinct in character with its own unique size, composition of population, ecology, language, norms, and economic settlement patterns. The languages include English (Official), Hausa, Yoruba, Igbo and over 500 other indigenous languages. The dominant ethnic group in the northern two-thirds of the country is the Hausa-Fulani, most of whom are Muslim. Other major ethnic groups of the north are the Nupe, Tiv, and Kanuri. The Yoruba people are predominant in the south-west. The Igbo (Ibo) are predominant in the south-east. Approximately 50% of the population live in urban areas with the rate of urbanization estimated at 3.75% annual rate of change (UNAID 2014).

**Table 2 : Zones and Their Constituent States of Nigeria**

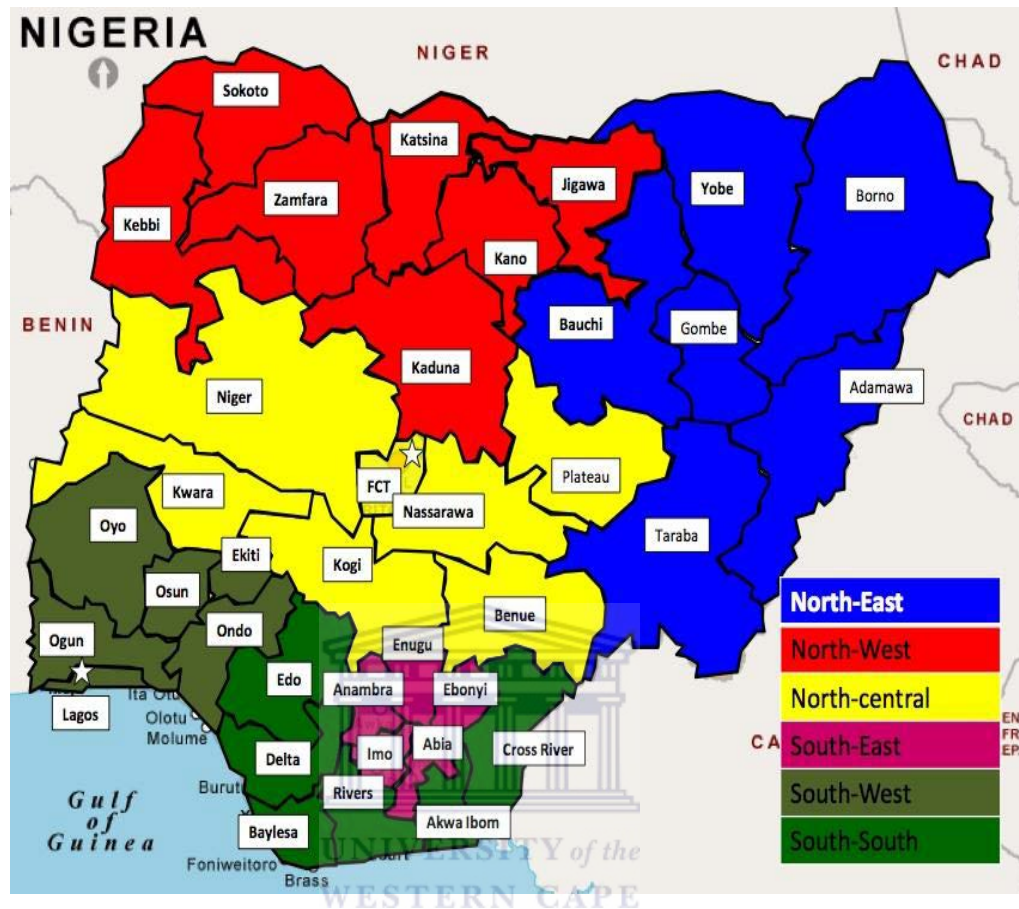
| <b>North Central</b> | <b>North-East</b> | <b>North-West</b> | <b>South-East</b> | <b>South-South</b> | <b>South-West</b> |
|----------------------|-------------------|-------------------|-------------------|--------------------|-------------------|
| FCT-<br>Abuja        | Adamawa           | Jigawa            | Abia              | Akwa<br>Ibom       | Ekiti             |
| Benue                | Bauchi            | Kaduna            | Anambra           | Bayelsa            | Lago<br>s         |
| Kogi                 | Borno             | Kano              | Ebonyi            | Cross<br>River     | Ogun              |
| Kwara                | Gombe             | Katsina           | Enugu             | Delta              | Ondo              |
| Nasara<br>wa         | Taraba            | Kebbi             | Imo               | Edo                | Osun              |
| Niger                | Yobe              | Sokoto            | -                 | Rivers             | Oyo               |
| Plateau              | -                 | Zamfara           | -                 | -                  | -                 |

**36 States and One Federal Capital Territory (FCT) Source: Maternal Health**

**in Nigeria Statistical Overview, Global One 2015 .Note: FCT is not a state**

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**Figure 1 : Zones and Their Constituent States of Nigeria**



## 2.4 National Health System in Nigeria

Health system is defined as activities whose primary purpose is to promote, restore or maintain health (WHO, 2007). Roemer (1991) cited in Alebiosu (2014) refers to the health system as the combination of resources, organization, financing and management that culminate in the delivery of health services to the population. The national health system is the “totality of government structure and plans for the mobilization of the public and resources in order to achieve an efficient and effective comprehensive physical, mental and social well-being for citizens in a state” (Alebiosu 2014). Nigeria’s health system operates three (3) tiers of health structure with responsibilities decentralized from the federal, to the state and local

government levels. All three tiers are involved in all the major health system functions such as stewardship, financing, and service provision. The Federal Ministry of Health (FMOH) is “responsible for policy and technical support to the overall health system, inter-national relations on health matters, the national health management information system and the provision of health services through the tertiary and teaching hospitals and national laboratories” (FMOH, 2004; WHO, 2000). The State Ministries of Health (SMOH) are responsible for secondary hospitals and for the regulation and technical support for primary healthcare services.

The local government is responsible for Primary Health Care (PHC) in all 774 Local Government Authorities in the country where health services are reorganized through wards and each local government is subdivided into 7-15 wards. A local government in Nigeria is the equivalent of districts in other countries and a typical local government in Nigeria may have a population in the range of 1-2 million people (some many more) compared to the wider international understanding of ‘district’, which will have a population in the range of 150-200,000 (WHO, 2005).

Although the organization of the health sector in Nigeria seems well coordinated in terms of structure, the practical workings of the system are not as smooth as they appear to be. There is often a duplication and confusion of roles and responsibilities among the different tiers of government, which results in poor coordination and performance in meeting the target goal of health care for the populace. According to the 2009 communiqué of the Nigerian national health conference, the health care system in the country remains weak, as evidenced by

lack of coordination, fragmentation of services, dearth of resources, including drugs and supplies, inadequate and decaying infrastructure, inequity in resource distribution, access to care, and deplorable quality of care (cited in Welcome, 2011). All these factors have led to the lack of strategic direction and an inefficient and ineffective health care delivery system (National Strategic Health Development Plan (NSHDP), 2009).

The LGAs finance and administer PHC services under the supposed supervision of the National Primary Health Care Development Agency (NPHCDA). NPHCDA is a federal government parastatal responsible for the development and enforcement of guidelines on primary health implementation. Although LGAs' resources are normally independently allocated by the federal government, LGAs in the country are governed by locally elected chairmen who are usually answerable or beholden to the state governors. This puts LGA resources at the risk of being misused or diverted for other spending priorities at the state level rather than to the quality of service delivery, community outreach or response to constituent demand (Cooke & Tahir, 2013).

On the funding of health care in the country, the bulk of government's resources come from oil revenue into the Federation Account, which is shared among the federal, state and local government authorities, according to an allocation formula. Transfers from the Federation Account to the state and local governments are not 'earmarked'. That is, each state and each local government decide how they spend the funds that are allocated to them. In addition, they are not required to provide budget and expenditure reports to the federal government. This means that federal government does not have any significant

influence on funds allocated for secondary and primary health services except those funded through special agencies and programmes (FMOH, 2004; WHO, 2000).

Fluctuations in public funding, as well as poor management, political interference and poor coordination between the state and local governments limit the effectiveness of federal programmes, such as the National Programme on Immunization (NPI). Even when programmes are well-supported, they often contribute to fragmentation and duplication, with different programmes operating in the same local government under different administrative and reporting arrangements— all making different demands on the same health staff.

The lack of health care facilities has been identified as the leading cause of high maternal morbidity and mortality, as there is a significant disparity between rural and urban locations, with urban locations having more than twice as many deliveries taking place in health facilities (public and private), than those in rural areas.

## **2.5 Maternal Mortality in Nigeria**

Nigeria is the most populous country in Africa; women of childbearing age constitute about 31 million and children under five years of age are about 28 million of the population (FMOH, NPHCDA, 2009; National Bureau of statistics, 2010).

The country constitutes only 1% of the world population but accounts for 14% of maternal deaths worldwide. Maternal mortality in Nigeria ranks second after India with the rate of 630 – 800 deaths per 100,000 live births (DHS, 2008; Bankole, Akinrinola, Gilda Sedgh & Okonofua, 2009). Nigeria has also been identified as one of the 10 most dangerous countries in the world for a woman to give birth, as



an estimated 40, 000 Nigerian women die in pregnancy or from childbirth complications, and about 1 million to 16 million suffer serious disability from pregnancy and birth-related causes annually (DHS, 2008; WHO, UNICEF, UNPPA and World Bank, 2010; USAID, 2012).

The maternal mortality rate in Nigeria varies from region to region; it is purportedly higher in the northern region than the south, and according to survey reports, the average estimated rate of maternal mortality in the South-West is 165 per 100,000 live births while the North-East has the highest rate, of 1,549 per 100,000 live births (Abimbola, 2012; Onumere, 2010) with 62% of all births taking place at home (DHS 2008). The factors associated with maternal mortality, according to Olusegun et al. (2012) include poor socioeconomic development, a weak health care system and socio-cultural barriers to care utilization. Maternal Health in Nigeria Statistical Overview, Global One 2015, in 2012 summarized the major contributors to maternal mortality in Nigeria besides the known direct medical causes. The report asserts that the Health System Causes of maternal mortality include lack of staff, attitude of staff to patients, lack of funding (government priorities, political and/ or civil service corruption), lack of requisite skills by health staff, corruption at health facility level, non-availability of treatment, lack of health facilities (prohibitive distances), poor management, and user top-up fees (treatment delays). The Cultural Causes of maternal mortality, according to the report, are early marriage, birth spacing, attitudes to modern medicine, attitudes to social norms required in pregnancy, diminished decision-making powers for women, attitudes to professional health care, as well as number (parity) of pregnancies/ social expectations of number of births. Socio-political and economic factors are also

deemed to have direct effects on the health system. These include poverty, government priorities, the structure of government, education norms, government corruption, and civil service capability (Maternal Health in Nigeria Statistical Overview, Global One 2015 Report, 2012).

Despite a decline in maternal mortality reported from estimates of 1100 per 100,000 in 2005 (Hill et al, 2007) to an estimated 840 per 100,000 in 2008 (Nigeria Demographics Profile, 2011), maternal mortality remains high compared to other African nations and developed countries. A woman's chances of dying from pregnancy and childbirth in Nigeria are 1 in 29, compared with 1 in 35 in sub-Saharan Africa, a global average of 1 in 180 and 1 in 3800 in developed countries. Only about 40% of deliveries in Nigeria are attended to by skilled birth attendants (WHO, 2012; Okonofua et al, 2011).

A series of actions, intervention programmes and initiatives have been carried out to address the challenges of maternal health in Nigeria with a view to achieving goals four and five of the Millennium Development Goals (MDGs). These initiatives include but are not limited to the Midwives Service Scheme launched by NPHCDA in 2009 and the re-training of nurses and midwives in reproductive health-care and services. The Subsidy Reinvested and Empowerment Programme (SURE-P) sourced from the national accrued fuel subsidy money was intended to fund expansion of the Midwives Services Scheme (MSS) but currently most programmes supported through SURE-P have been put on hold as a result of a drop in oil subsidy money, owing to a fall in the global price of crude oil. Most of these programmes and policies, according to Mojekwu and Ibekwe (2012), do not seem to be adequately planned for and are consequently unsustainable. Recent evidence

shows that at current rates of progress, Nigeria cannot achieve this goal before 2040 (Harrison, 2012). According to Majiyagbe (2010), the maternal mortality situation in Nigeria is complex, the progress of intervention is slow, and many more women will die before, during or directly after childbirth due to conditions that are preventable (Majiyagbe, 2010).

Aside from the federal government initiatives to reduce maternal mortality, some states in Nigeria have also made concerted efforts to reduce women's deaths from childbirth-related causes. Of note is the world acclaimed Abiye programme in Ondo state in which the researcher's study is being conducted (Isola, 2013).

## **2.6 Basic components of social support**

There is much diversity in the interpretation of this concept. However, social support concepts can be organized into three broad categories: social embeddedness, perceived social support, and enacted support (Siedlecki, Salthouse, Oishi, & Jeswani, 2014).

### **2.6.1 Social embeddedness**

Social embeddedness refers to the connections or connectedness that individuals have to significant others in their social environments (Barrera, 1986; Granovetter, 1985, both cited in Siedlecki et al, 2014). Being socially connected is seen as a central element in one's "psychological sense of community" (Sarason, 1974 in Gottlieb & Bergen, 2010). Social embeddedness can be viewed in the form of social ties such as family, siblings, friends, participation in community organizations which serve as social support resources during a crisis period. Social embeddedness can also be explained in relation to social networks and social network analysis.

The term “social network” refers to a personal network or the web of social relationships that surrounds an individual. The social network comprises those people who give or receive support and provides the structural medium that forms the interactive field and process through which social support is provided (Glanz, Rimer and Viswanath, 2015).

The structure of social networks can be described in terms of dyadic characteristics which explain the specific relationships between the focal individual and other people in the network (House, Umberson, and Landis, 1988, all cited in Glanz, Rimer and Viswanath, 2015). Dyadic characteristics include: reciprocity, which is the extent to which resources and support are both given and received in a relationship; intensity or strength, which denotes the extent of emotional closeness in a relationship; formality, the extent to which a relationship is embedded in a formal organizational or institutional structure, and complexity, which explains the extent to which a relationship serves a variety of functions (Glanz, Rimer and Viswanath, 2015). Social functions of social networks include social influence, social control, social capital, social undermining, social comparison, companionship, and social support (Glanz, Rimer and Viswanath, 2015). Social network analysis involves structured procedures for identifying individuals who have important relationships with the focal subject. Social embeddedness is the depth and strength of the relational ties between the person and each member of the social network, without which some degree of social connectedness support cannot be achieved (Langford, Bowsher, Maloney & Lillis, 1997). Social integration refers to the number or range of different types of social relations. This includes marital

status, siblings, and membership of organizations such as churches, mosques or temples (Uchino, 2009).

### **2.6.2 Perceived Social Support**

Perceived social support is the individual's belief that social support is available, which is considered negative or positive depending on what the individual considers he or she needs (Norris and Kaniasty, 1996). Perceived social support expresses the individual's confidence that adequate support would be available if it was necessary, or to characterize an environment as helpful or cohesive in that it denotes availability and adequacy of support. Perceived support, also known as functional support, is the subjective judgment that family and friends would provide quality assistance with future stressors. People with high perceived-support believe that they can count on their family and friends to provide quality assistance during times of trouble (Wills & Ainette, 2012). This support may include listening to the stressed person talk about troubles, expressing warmth and affection, offering advice or another way of looking at the problem, providing specific assistance such as looking after the children, or simply spending time with the stressed person.

### **2.6.3 Enacted Support**

Enacted Support refers to the actions that others perform when they render assistance to a focal person. Measures of enacted social support involve assessment of what individuals do when they provide support (Wills & Filer, 2012).

## **2.7 The Abiye Programme in Ondo State**

Ondo state is one of the states in the Nigerian federation created out of the Old Western State on February 3, 1976. The state has 18 local government areas and is

located in the South-West region of Nigeria. The state is approximately 15,317 sq km which represents 1.66 percent of the entire region of Nigeria. The state's population, according to the National Population Census (2006) is 3,441,024 (1,761,203 males and 1,679,761 females). Statistics by DHS in 2008 declared Ondo state as the worst performer on maternal and child health in the south-west region of Nigeria. In 2009 the state governor, Dr Olusegun Mimiko, launched an "Abiye" initiative to combat the menace of maternal mortality in the state. "Abiye", which means "Safe Motherhood" in the Yoruba language, is a comprehensive strategy to address the four critical delays that contribute to maternal mortality and morbidity in the state. The Abiye initiative aims at ensuring that infant and maternal mortality rates are reduced and access to maternal health care service delivery is efficient and effective in the state. To address the maternal health challenge, the state conducted a study on maternal health by gathering statistical information and analysis of the methods and approaches maternal health care services and delivery had been using in the state. Findings from the study revealed high levels of illiteracy among the people and a lack of adequate information on maternal health related matters. The government launched an aggressive campaign and enlightenment programmes for women in the state, particularly pregnant women. The women were educated on maternal health issues, starting from the basics, and instructed on how they could locate and obtain allied maternal health care services in the state without any impediment. The women were also attached to Community Health Extension Workers (called Health Rangers) who were appointed, trained and posted to rural areas in the state to act as intermediaries between pregnant women and Abiye maternity health centres (Isola, 2013). Twenty-five pregnant women were assigned

to one health ranger who visits them regularly. The health rangers with a customised checklist, detect high risk, carry out a birth plan, embark on complications readiness, and carry out education and advice on family planning and the use of insecticide treated mosquito nets (Fajimbola, 2011).

Secondly, the use of telecommunications in the development of the health system and maternal health was also introduced. Every registered pregnant woman was given a toll free GSM (Global System for Mobile communications) handset to communicate with the health rangers and to facilitate the movement of women in labour to the hospital; transportation means such as motorbikes, tricycles and ambulances were also provided. Added to these measures was the establishment of two Mother-and-Child Hospitals (MCH) to handle all forms of referral on maternal health issues and emergencies free of charge.

Although the Abiye programme have yielded an impressive result in increasing antenatal attendance and births in the hospital free of charge, only these services available. Also, Abiye services are only available in Ifedore local government which is one out of 18 local governments in the state and the two hospitals are located in only one senatorial district out the three in the state. Unfortunately, scaling up of the programme in other local government areas has been impaired mainly due to inadequate funding and a shortage of qualified maternal health personnel, and the plan to establish mother-and-child hospitals in the other two senatorial districts has not been realised. Most of the other primary health care centres and secondary healthcare facilities in the state are not adequately equipped to render Abiye services, which has resulted in overstretching of resources of the only two mother-and-child hospitals in the state.

Most importantly, the Abiye programme in Ondo state has not considered addressing social and cultural barriers to the utilization of maternal health services, or factors contributing to a positive birth experience, as a driving force and a cost-effective way to health facility utilisation and user satisfaction. Social support during labour and woman-centered care has been shown to contribute to women's positive experience in labour, but family involvement and CLS have remained the exception rather than the rule in most states in Nigeria, and Ondo state in particular.

## **2.8 Social support as a theoretical foundation for culturally congruent care**

The notion of social support forms an important basis for understanding the need for a culturally congruent care framework because it is at the heart of communal cultures. Therefore, a discussion about how different authors define social support and the related concepts is germane. This will be done and subsequently followed by the theoretical linking of social support to health outcomes and in particular to labour practices.

### **2.8.1 Social support defined**

Over the last three decades, there has been a wealth of documented facts, on the concept of “social support” and its influence on physical and psychological health outcomes. Social support has been viewed from different angles by various scholars since the work of Caplan (1974, 1976), Cassel (1976), and Cobb (1976) cited in Turner & Brown (2010). Social support has been defined and viewed in its various dimensions and manifestations, depending on the issues being reviewed. The issues under discussion include the childbirth experience, psychological distress, mental health, chronic diseases and many others (see for example, Asher 1984, Callaghan



and Morrissey 1993, Vinokur, & Van, (1993), Vandervoort, 1999, Lakey and Orenek, 2011, Thoits, 2011). Social support has been defined as an intentional human interaction whereby assistance and protection are offered to those faced with a stressful life event, generally by significant others such as a family members or friends (Thoits, 2011). Shumaker & Brownell (1984) cited in Rini, Schetter, Hobel, et al (2006) expressed social support as "an exchange of resources between two individuals; the provider and the recipient which is perceived to be intended to enhance the well-being of the beneficiary." This definition established the fact that there must be a provider and a recipient for support to occur. Gottlieb (2000, cited in Thoits, 2011) views social support in relation to the resources that are exchanged between the provider and the recipient of social support. He posits that social support is an "interaction in a relationship which improves coping, esteem, belonging and competence through actual or perceived exchanges of physical or psychological resources". This view is also demonstrated in Wills & Ainette's (2012) definition of social support as the perception or experience that one is loved and cared for by others, esteemed and valued, and part of a social network of mutual assistance and obligations. Social support may come from a partner, relatives, friends, co-workers, social and community ties, or even a devoted pet (Allen, Blascovich, & Mendes, 2002 cited in Taylor, 2011).

In relation to childbirth, the concept of social support is difficult to define or measure as perceptions of support are highly subjective (McCourt, 2009). Psychological theories of social support focus on the perceptions, behaviours and feelings of an individual which determine their response to stress (McCourt, 2009). Sosa and Kennel (1980) cited in Ross-Davie, 2012) defined support in

labour as 'human companionship during labour and birth'. Simkin (2002, cited in Ross-Davie, 2012) also describes supportive care during childbirth as "non-medical care given to ease a woman's anxiety, discomfort, loneliness and exhaustion, to help her draw on her strengths and to ensure that her needs and wishes are known and respected. It includes physical comfort measure, emotional support, information and instruction, advocacy and support for the partner' (Simkin, 2002).

Labour support was also defined as "a repertoire of techniques the nurse can use to help women during one of the most memorable and personally challenging experiences of their lives". The goal of labour support is to help a woman achieve her wishes during labour, through offering companionship, attention to her emotional needs and active helping (Hodnett, 1996, 2011). Elements of social support from the existing literature include acceptance, reassurance, listening, assisting with problem-solving, showing attention and affection, and meeting physical needs for transportation and clothing (Hodnett et al., 2011; Ngai et al., 2011).

## **2.9 Types of social support**

There has been inconsistency in the formal descriptions of types of social support regarding childbirth. Social support has been defined and measured in numerous ways. House (1981) cited in Glanz, Rimer and Viswanath (2015) identified four broad types of supportive behaviours or acts. These are emotional support, instrumental support, informational support and appraisal support. Cohen and McKay (1984, cited in Glanz, Rimer and Viswanath, 2015) discuss three types of social support: tangible support, appraisal support and emotional support. Both definitions may be effectively applied to support during childbirth. However, the

consensus in the academic literature is that labour support consists of the three sub-categories of emotional, physical and informational support (Ross-Davie, Cheyne & Niven 2013). Adam and Bianchi (2008) describe the supportive behaviour in childbirth as falling into one of the following four groups: physical, emotional, instructional/informational, and advocacy.

### **2.9.1 Emotional support**

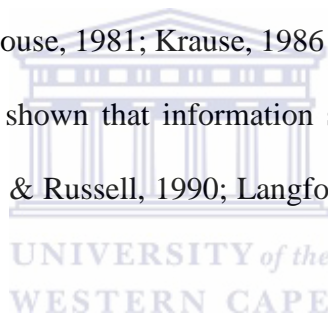
Emotional support involves the provision of empathy, love, trust, and caring and is ranked as the most important kind of social support (House, 1981; Gottlieb, 1978 cited in Glanz, Rimer and Viswanath, 2015). Emotional support is usually communicated in the form of information and non-verbal expressions which indicate that the individual is loved and cared for, is esteemed and valued, and also assumes that the individual belongs to a network of mutual obligation (Cobb, 1976 cited in Taylor, 2011). Emotional support emphasises the recipient's feelings and evaluation of themselves in the face of stressful events (Cohen & McKay, 1984 cited in Dlugosz, 2013). This means the provision of support that demonstrates that they are cared for, loved, respected, admired, appreciated, esteemed and valued, which in turn creates a sense of security (Tarkka & Paunonen, 1996). In childbirth, affective or emotional support is defined as expressions of love, admiration, liking, reassurance and respect, spending time with the client and making them feel cared for. This is important in helping the woman feel competent and therefore in control over her circumstances (Cohen & McKay, 1984; Green, Coupland & Kitzinger, 1990; Hodnett et al., 2011). This type of support may take the form of encouraging words offering strength to carry on.

### **2.9.2 Instrumental support**

Instrumental support involves the provision of tangible aid and services that directly assist a person in need (House, 1981; Tilden and Weinert, 1987 cited in Leahy-Warren, 2014). In childbirth, tangible support refers to comfort measures taking the form of practical support such as hand holding, wiping the brow, fetching drinks, massaging, roles often taken on by a partner (Tarkka & Paunonen, 1996 cited in Dlugosz, 2013).

### **2.9.3 Informational support**

Informational support is the provision of advice, suggestions, and information during a time of stress (House, 1981; Krause, 1986 cited in Chen, Simon, Chang, et al., 2014). Studies have shown that information support assists in the problem-solving process (Cutrona & Russell, 1990; Langford, Bowsher, Maloney & Lillis, 1997).



### **2.9.4 Appraisal support**

Appraisal support involves the provision of information which is relevant for self-evaluation (House, 1981; Glanz et al., 2008). Appraisal support serves as an affirmatory statement that proclaims the appropriateness of the acts or behaviours of others (Kahn & Antonucci, 1980, cited in Leahy-Warren, 2014). Appraisal support contributes to one's knowledge or cognitive structure with the aim of reducing the experience of stress by helping to alter an individual's assessment of threat, or assessment of their ability to cope with that threat (Cohen & McKay, 1984 cited in Dlugosz, 2013). For example, in childbirth, this type of support may be

information provided about a situation that would help redefine that situation as less threatening (Cohen & McKay, 1984; Dlugosz, 2013).

## **2.10 Theoretical linking of social support to health outcomes**

Social support plays a crucial role in the process of adapting to stressful life situations. Several scholars had studied the links between the provision and experience of positive social support, and the positive effects on physical and mental health (Asher 1984, Ganster and Vicker, 1988, Callaghan and Morrissey 1993, Vinokur and Van, 1993, Vandervoort 1999, Lakey and Orenek 2011, Thoits 2011). Social support provided by significant others is believed to help the individual concerned to exercise his or her mental resources as fully and effectively as possible in coping with the stressful situation (Caplan 1974, Caplan & Killilea, 1976). An individual copes better in a stressful situation if he or she has at least one support person (Kahn & Antonucci, 1980 cited in Leahy-Warren, 2014).

Studies on the relationship between social support and health have revealed three basic theoretical explanations. These are the stress and coping perspective, the social constructionist perspective and relationship perspectives.

### **2.10.1 Stress and Coping Perspective**

The stress and coping perspective has as its base stress and coping theory (Lakey & Cohen, 2000). Stress occurs when people interpret a situation negatively, leading to health problems, in part, insofar as people do not employ adequate coping responses in problem-solving and emotion regulation (Lazarus & Folkman, 1984; Folkman & Moskowitz, 2004).

Social support acts as a buffer to reduce the effect of stressful life events and circumstances on health by protecting people from the adverse effects of stress through the recipient's perception of availability of support, as well as supportive actions received (Cohen & Wills, 1985 cited in Feeney & Collins, 2014); Lakey & Cohen, 2000). They believe that support is available to promote positive appraisal of the threatening situation as less stressful. Consequently, this enhances the ability of the recipient of supportive action such as advice and reassurance, to cope more adequately with stressful situations (Lakey & Cohen, 2000). Another aspect of this theory is the stress support matching hypothesis (Cohen & Hoberman, 1983 cited in Mitchell, Evans & Hardy, 2014). This illustrates the link between supportive actions in meeting the demands of a stressful situation, and coping response. Each stressful situation places a specific demand on the affected individual. Therefore, supportive actions can only be effective in promoting coping and reducing the effects of a stressor if the assistance provided matches with the demand of the stressor (Lakey & Cohen, 2000; Lakey 2011). Social support in labour and childbirth is largely based on the 'buffer' theory of social support (Bryanton et al, 1994, Corbett and Callister, 2000 cited in Ross-Davie, 2012). It is believed that coping with the stress of labour can be enhanced by personal and environmental coping resources such as physical presence and can also be hindered by coping constraints such as the lack of supportive resources. Individual need for support will differ depending on personal circumstances and preferences, as well as factors that guide cultural and societal norms (McCourt, 2009). The perceived adequacy and appropriateness of social support will impact on its effectiveness (McCourt, 2009).

Furthermore, for support to be perceived as effective, it must match the support that is required (McCourt, 2009).

### **2.10.2 The social constructionism perspectives**

The social constructionism perspectives of social support are based on social cognition and symbolic interactionist theories. The basic assumption of this perspective is that “people construct a theory and concept about the world which reflects their social context.” (Dewey, 1997 in Lakey & Cohen, 2000). This perspective suggests no clear consensus on what constitutes supportive behaviour among individuals but expresses the link between self-perception and concomitant reflection of how one is viewed by others in the social world (Lakey & Cohen, 2000).

#### **2.10.2.1 Social-Cognitive Perspective**

The social-cognitive perspective under the broader heading of social constructive perspectives is related to cognitive models of emotional disorders (Lakey and Cohen, 2004). It explains the link between perceived support and mental health, and may be relevant to physical health, insofar as mental health is important for physical health (Lakey, 2011). This perspective is based on the assumption that the perception of social support is related to the recipient’s development of stable pre-existing beliefs about the supportiveness of others, self-evaluation and reaction to stress. Negative thoughts about social relations may stimulate negative thoughts about self, leading to emotional distress. People with high-functioning social support networks are more likely to have more positive memories of, and display greater attention to supportive behaviour, and also interpret the same behaviour as

supportive with greater ease and speed than people with low levels of perceived support (Lakey and Cohen, 2004; Baldwin, 1992). The social-cognitive perspective predicts that perceived support promotes self-esteem, which has direct consequences for health.

### **2.9.2.2 Symbolic interaction**

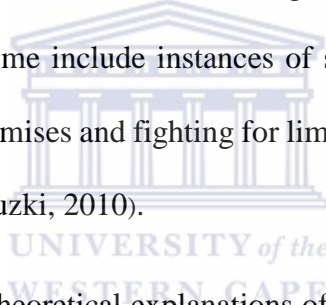
Another perspective under the umbrella of social constructive perspectives is the symbolic interaction perspective, which holds that regularization of social interaction contributes to the maintenance of general well-being; social environments directly promote the health and well-being of people in the appraisal of self and world surrounding them. This helps, according to the symbolic interaction perspective, to create and sustain identity and self-esteem. Identity is derived from the roles an individual occupies within society. It forms the foundation for the way people think about themselves. Individuals generally adopt a wide range of different roles, i.e. father, mother, husband, wife, mother, sister, etc. (Lakey and Cohen, 2004). Role concepts are shared among groups in the society to guide social interaction and provide a set of expectations about how people act in the different roles. According to the symbolic interaction perspective, social interaction predicts social role and support identity and this leads to positive health outcomes (Lakey and Cohen, 2004).

### **2.9.3 Relationship perspectives**

Relationship perspectives arise from an association of social support with relationship processes other than assistance during stressful situations. According to Lakey and Cohen (2004), social support is closely related to concepts such as



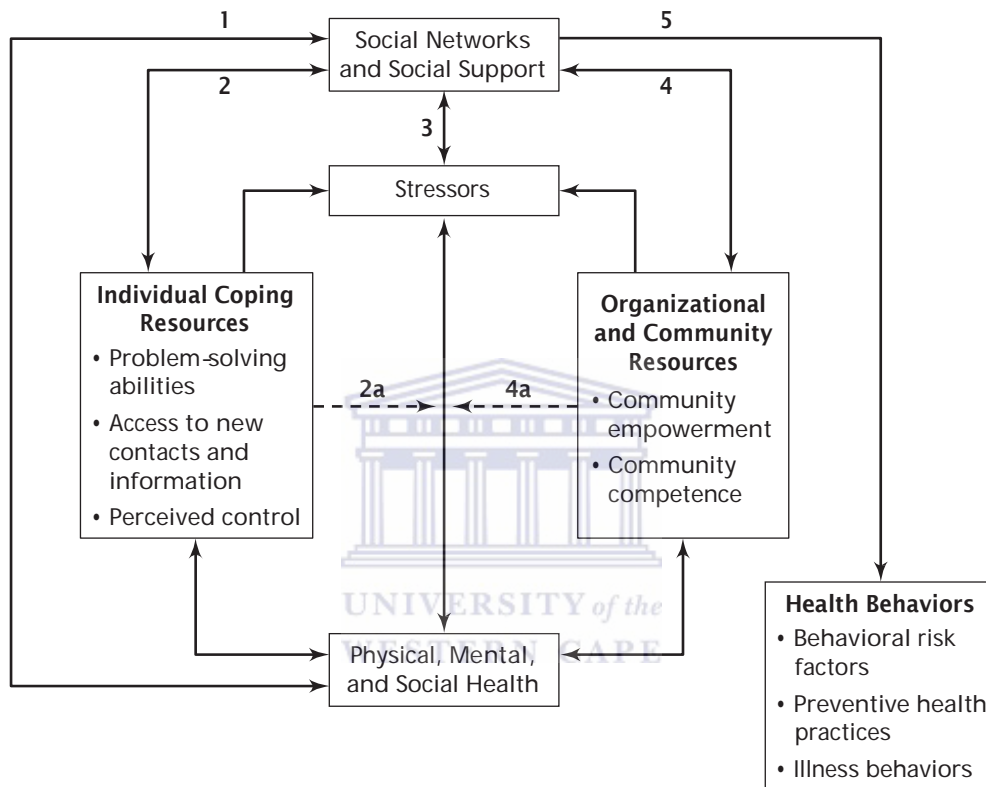
low conflict, companionship, intimacy and social skills which provide a strong link between the social network and social support. Social networking relationship concepts could be described in terms of positive and negative ties between people. Positive ties include companionship, relationship, satisfaction, and intimacy. Companionship is related to sharing leisure and other activities that are undertaken primarily for the intrinsic goal of enjoyment (Rook, 1987 cited in Bromell & Cagney, 2013). Relationship satisfaction is defined as “subjective evaluation of a relationship” (Hendrick & Hendrick, 1997) while intimacy is described as “bonded, connected and close feelings people have toward each other” (Barnes & Sternberg, 1997). Phenomena that have been linked to negative associations between social support and health outcome include instances of social conflict such as negative criticism, breaking of promises and fighting for limited resources (Pagel, Erdly and Becker, 1987, cited in Sluzki, 2010).



There are few adequate theoretical explanations of why companionship, intimacy, low incidence of conflict and attachment contribute to emotional and physical well-being. Nevertheless, this interaction has been linked with the same mechanisms that connect social support with the elevation of self-esteem and positive appraisal in active coping with stressful situations (Lakey and Cohen, 2004). Other theoretical explorations that link relationship factors to emotional and physical well-being include the view that positive, stable and secure relationships fulfil a basic biological need and are also a means of survival from isolation. This view is based on human history, which demonstrates that humans in isolation were commonly at risk of dangers such as death and maltreatment by other humans. Figure 2.2 and

Table 3 give graphic and pointers to the relationship between social network and social support to health:

**Figure 2 Conceptual model for the relationship of social networks and social support to health: (Heaney & Israel in Glanz, Rimer and Viswanath, 2015**



**Table 3 : Pointers for Conceptual Model for the Relationship of Social Networks and Social Support to Health**

| <b>Pointers for Conceptual Model for the Relationship of Social Networks and Social Support to Health</b>  |   |
|--|---|
| <b>Pathways</b>  | <b>Pointers</b>   |
| Pathway 1 represents a hypothesized direct effect of social networks and social support, on health.  | By meeting basic human needs for companionship, intimacy, a sense of belonging, and reassurance of one's worth as a person, supportive ties may enhance well-being and health, regardless of stress levels. |
| Pathways 2 and 4 represent a hypothesized effect of social networks and social support on individual coping resources and community resources, respectively. | Social networks and social support can enhance an individual's ability to access new contacts and information, and to identify and solve problems.  |
| Pathway 3 suggests that social networks and social support may influence the frequency and duration of exposure to stressors.                                | Presence of support person may reduce duration of stressor.   |
| Pathway 5 reflects the potential effects of social networks and social support on health behaviours.   | Through the interpersonal exchanges within a social network, individuals are influenced and supported in such health behaviours as help-seeking behaviour.  |

### **2.11 Social support and birth outcomes**

A positive birthing experience is an integral part of the mother and baby's well-being (Hodnett, Gates, Hofmeyr, Sakala & Weston, 2011; Price et al., 2007). Globally, the beneficial effects of labour support on childbirth outcomes have been reported in numerous research reports, reviews, and meta-analyses (Hodnett et al 2011, 2009, 2007, 2002; Campbell, Lake, Falk & Backstrand, 2006; Campbell, Scott, Klaus & Falk, 2007; Langer, Campero, Garcia & Reynoso, 1998; Scott, Berkowitz & Klaus, 1999; Scott, Klaus & Klaus, 1999; Zhang, Bernasko, Leybovich, Fahs & Hatch, 1996). Women who receive continuous support during labour rather than intermittent support are more likely to be satisfied with the

childbirth experience, have spontaneous vaginal delivery and shorter labour duration. They are also less likely to have maternal anxiety, intrapartum analgesia or epidural anesthesia, an instrumental birth, a caesarean birth and are less likely to have a baby that receives a low Apgar score (Hodnett et al, 2011; Hodnett, Gates, Hofmeyr & Sakala, 2007; Melender, 2006; Romano & Lothian, 2008; Sauls, 2002).

The presence of birth companions during childbirth also ensures that a woman is not left alone during this intensely stressful and frightening time in her life. Campero et al. (1998) have studied the effects of psychosocial support on mothers during labour in Mexico City. The study examines the experiences of mothers' psychological support from doulas compared to normal hospital routine. Sixteen in-depth interviews were conducted with women in the immediate post-partum period before they were discharged from the hospital. The study findings revealed that the women accompanied by a doula had a more positive childbirth experience. The researcher explained that the most significant differences between the two groups of participants was the way they expressed their feelings about their labour, their sense of control and their self-perception (Campero et al, 1998).

Essex and Pickett's (2008) cohort study in the four countries of the United Kingdom compared the characteristics of women who were unaccompanied in childbirth, with those had support. These experiences were analysed using the indicators for adverse maternal and infant health outcomes. The sample comprised 16,610 mother-infant pairs, and excluded women with planned caesarean sections.

The findings of the study revealed that women unaccompanied in childbirth were more likely to have a preterm birth, an emergency caesarean section, general

anaesthetic and low levels of satisfaction in life nine months postpartum (Essex & Pickett 2008). Their infants had a significantly lower birth-weight and were at a higher risk of delayed gross motor development. Women who were unaccompanied in childbirth were more likely also to have low scores on a measuring scale of maternal satisfaction with childbirth. In other words, labour support increased women's positive experiences and satisfaction with childbirth. This finding is significant because it is established that the childbirth experience can exert a powerful lifelong effect on women. Being unaccompanied at birth might, therefore, have some potential as a risk marker for women and infants who might benefit from close follow-up and support for parenting.

### **2.12 Types of support person**

Support during childbirth includes clinical care, physical care and emotional support that can be offered by a range of people, including professionals or the woman's spouse, relatives or friends (Dlugosz, 2013). A woman's experience of labour is dependent on the personality and attitude of the support person at the birth (Odent, 2005). The manner in which a woman perceives her support person will influence her experience of their support (Dlugosz, 2013). Her perception of support from someone she loves may be different from a professional whose knowledge and expertise she respects (Hodnett, 1996 cited in Dlugosz, 2013). The researcher examines the pros and cons of documented analyses, of different categories of support persons for women during childbirth ranging from the professional nurse-midwives to various relatives such as female relatives, and husbands or partner-companions during labour.

### **2.12.1 Support from professional Nurses/midwives during labour**

Across the world, midwives and nurses by virtue of their training and expected role are supposed providers of support to women during labour. Continuous presence during labour enables the midwife to provide emotional support, information, and guidance. Midwives' continuous presence and support for women if this is provided during labour may reduce the need for intervention during birth and promote a normal birth, as well as increase the woman's sense of control and coping (Hodnett et al., 2011). Also, women who have had access to the continuous presence of a midwife during labour are more likely to give birth spontaneously and the babies are more likely to have higher Apgar scores. They are less likely to have instrumental delivery, caesarean section, and continuous fetal monitoring, while the use of analgesia for pain relief is also reduced (Halldorsdottir & Karlsdottir, 2011; Hodnett et al., 2011; Howarth et al., 2011). The midwife's continuous presence is further believed to promote a positive birth experience, maternal attachment to the child, as well as the physical and mental well-being of the new family (Carlton et al., 2005; Rijnders et al., 2008; Howarth et al., 2011).

Various scholars have studied the supportive role of the health professional to women during labour for decades. Kashanian et al. (2010) studied 100 nulliparous women to assess the effects of continuous support during labour by midwives, on the duration of labour and the rate of caesarean delivery. This experimental trial involved two groups of nulliparous women, each divided into an intervention and a control group. In the intervention group (n=50), continuous support during labour was provided while the control group (n=50) did not receive continuous support. The study showed that the intervention group who had continuous support provided

experienced a shorter duration of the active phase and the second stage of labour, and a reduced rate of caesarean deliveries compared to the control group. The researchers concluded that continuous support provided by midwives during labour might reduce the duration of labour and the number of cesarean deliveries. They advocated for the implementation of this model of support to all women to improve the outcome and birth experience of women

The above exertion confirmed the benefits of CLS from the professional nurse/midwives. However, lots of studies have criticized the quality of support provided by the nurse /midwives. A study by Gagnon and Waghorn (1996) on supportive role of midwives during labour on over 3,367 random observations reveals that only 6.1% of the time was spent in supportive care while (74.9%) of the nurses' time was not spent in the labouring woman's room. Another study in Canadian hospital by Gale (2001) to examine the amount of labour support being provided by obstetric nurses and factors that influenced the provision of support also shows that nurses spent only 12% of their total time providing supportive care to labouring women. They identified barriers to providing support by midwives to include lack of time and insufficient staffing (Gale, 2001).

A comparative meta-analysis of intermittent and continuous support during labour was carried out by Scott et al. (1999). The focus of the study was to contrast intermittent and continuous support provided by doulas during labour and delivery on five childbirth outcomes: duration of labour, use of analgesia, oxytocin augmentation, forceps, and caesarean section. In the study, intermittent support was provided by experienced midwives or student midwives and the students while continuous support was provided by the lay woman (doula). The result of the study

revealed that the continuous presence of a doula during labour and delivery appears to have more beneficial effects than the support provided by the midwives on an intermittent basis. Women who had continuous support from a doula had a shorter duration of labour, a reduced need for any analgesia, oxytocin, forceps and caesarean sections. Women who received continuous social support had, on average, labour duration of 1 hour 38 minutes shorter than the average labour duration of women who received no additional support. The study findings emphasized the importance of a dedicated labour companion, but the researcher observed that the study results raise some questions about the relationship between labour support and childbirth outcomes.

The different results between the two groups of studies were believed to be influenced by the aspects of support depending on the level of training of the support attendants. Although the level of training was not statistically tested in the study, the study report suggested that the professional midwives were performing two tasks, namely, medical caregiving and the provision of social support and that their level of interest in providing support was low. Midwives and student midwives also stated that they felt devalued by the task of providing support and that their continuous presence was unnecessary.

Therefore, the researcher concluded that the quality of support offered by lay doulas may have been more beneficial to the women in labour than the support of the medically trained doulas because of a strong interest in the task, limited distractions, and the view that the provision of social support was a worthwhile activity. The continuous presence of a female lay person during labour and delivery can have



positive health and social outcomes with the possibility for lower hospital costs as well (Scott et al., 1999).

In their study Larkin et al. (2012) explored women's experiences in childbirth, in the Republic of Ireland. This involved 25 women who participated in five focus group interviews. The study demonstrated that women's feelings about their childbirth experiences were diverse but that childbirth was a great event about which women expressed strong emotions. Although some women were empowered by their childbirth experiences, others said they felt anxious, lonely and unsupported before the professional judgment that they were in labour. The feeling of loneliness and lack of support during labour was attributed to shortcomings in attention to staff shortages and a busy unit, in addition to organisational rules that did not allow partners to remain with them. Some of the study participants who had expressed 'explicit expectations' were disappointed and participants felt they had aimed 'too high'. Unlike Green et al. (1990) who found that having high expectations did not lead to feelings of failure, these women felt disappointed that their expectations had not been met, particularly concerning interventions. A few women had negative childbirth experiences which affected them greatly, in common with many others across the world (Fenwick et al., 2012, Olde et al., 2006).

There was a reluctance to criticise professionals, and a sense that, to them, having a live healthy baby was the ultimate goal and the experience of the process was secondary. Women accepted mostly what was done and what happened to them, believing it was the best that could be offered (van Teijlingen et al., 2003). The researcher concluded that midwives play a pivotal role in enabling or disempowering positive experiences and that being in control is an important

element of childbirth experiences. Therefore, the deficiencies of care caused by shortages of staff and the busy medicalised hospital culture in Ireland need to be addressed.

A qualitative study by Aune et al. (2014) investigated midwives' experiences of providing a continuous supportive presence in the delivery room during childbirth, and factors that may affect this continuous support at a maternity unit in Norway. In-depth interviews were conducted with ten midwives working in two different maternity wards. The midwives stressed the importance of continuous presence and support to the women and their families, as well as the customary midwife's concerns. Providing a continuous presence during labour fostered the midwives' perception of themselves as a 'good midwife' which was considered a feature of holistic care and health promotion. However, the professional standards and values of some midwives may be at variance with basic midwifery protocols and standards in some hospital settings. According to Halldorsdottir and Karlsdottir (2011) and Russell (2007), midwives often work with clinicians who have different orientations than theirs, which can be very challenging for the midwives. Bluff and Holloway (2008) suggest that in some hospitals there is a risk that midwives are expected to support the demands and values of the clinician rather than those of the woman in labour. The midwives experienced feelings of inadequacy when they felt that they had too little time available for the woman in labour. Hunter and Segrott (2008) point out that midwives often face a choice between being loyal to the institution where they work, or to the women they work with; they found that such dilemmas had a demoralising effect on midwives. Workload in the unit was also identified as a barrier to providing a continuous presence in the delivery room (Aune et al., 2014).

Moyer et al. (2014) investigated community and health-care provider attitudes towards maltreatment during delivery in rural northern Ghana. The cross-sectional qualitative study using in-depth interviews and focus groups was conducted among 128 community members including mothers with newborn infants, community leaders, traditional birth attendants, and formally trained health-care providers. Findings reveal that women delivering in facilities in rural northern Ghana experienced physical abuse, verbal abuse, neglect, discrimination, and denial of traditional customs. The researcher believed that maltreatment during labour and delivery might prevent some women from seeking facility-based delivery and advocated for health-care worker education and training to include modules addressing psychosocial elements of care provision. Also, policies that mandate women be allowed to bring a family member with them to the labour ward (which is not allowed at most facilities) will provide witnesses to the care that is being provided and may have a dampening effect on midwife maltreatment (Moyer et al., 2014).

These results are similar to the (limited) published research literature on maltreatment. Verbal abuse, other forms of abusive treatment, and negative and unfriendly staff attitudes as a barrier to seeking facility delivery have been reported throughout sub-Saharan Africa (D'Ambruso et al., 2005; Mills and Bertrand, 2005; Onah et al., 2006; Kruk et al., 2009). Also, fear of being shamed (Spangler and Bloom, 2010) or of being 'treated like a child or a fool' (Kyomuhendo, 2003) have been reported as barriers to facility delivery. Similarly, Thwala et al. (2011) conducted a study in Swaziland that reported on taboos associated with not keeping traditional practices which are often not allowed in facilities. This may lead to non

utilisation of public health facilities as some women may prefer to deliver at home. Maltreatment at the hands of providers in health facilities is a multifaceted problem that is likely to require multifaceted solutions.

### **2.12.2 Support from non – health professional**

Many studies have been undertaken to assess support in labour from a support person who is not a health professional. A qualitative study of 16 Canadian women's experience of social support in childbirth found that the women felt most comfortable in the presence of someone who "knew them best", offering a sense of personal connection in the birth environment (Price et al., 2007). Having someone who knew them well was also important as women wanted someone who could offer individualised support; support that focused solely on them (Price et al., 2007). A systematic review on continuous support for women during childbirth also revealed that continuous intrapartum support was associated with greater benefits when the provider was not a member of the hospital staff (Hodnett, Gates, Hofmeyr, Sakala, and Western, 2011b). These findings emphasised the benefits of social and family relations which are culturally focused. Analyses of a range of scholars on various non-professional support persons with respect to individual preference, as well as social and cultural expectations, were examined by the researcher.

Research indicates that male partners and female companions provide different types of support to women in labour (Bertsch, Nagashima-Whalen, Dykeman, Kennell, & McGrath 1990).

### **2.11.2.1 Husbands as support persons for women during labour**

The body of studies into father/ husband involvement in birthing experiences has been growing for decades (Cooper, 2005; Sengane & Nolte, 2012). In most western societies, the perception of father/husband involvement during labour has transformed from outlandish to normative and become universally accepted practice (Draper & Ives, 2013; Bruggeman et al. 2007, Morhason-Bello et al. 2008, Banda et al. 2010). However, there are mixed reports about whether the father's presence is a help or a hindrance (Blackshaw, 2009). Several researchers have highlighted the benefits of the husband's support during labour and childbirth (Kainz, Eliasson, & von Post 2010; Bondas-Salonen, 1998; Tarkka & Paunonen, 1996). The husband's presence and support during labour lessens stress and fears, promotes strength, endurance, comfort, and security, help divert attention from the pain, and in general, enhances the satisfactory birth experience (Kainz et al., 2010; Price et al., 2007). The partner's presence also assuages the woman's emotional distress related to childbirth. Three main regions in which the fathers were able to provide this support were acknowledged as offering comfort, providing security and promoting strength for the women in labour. Furthermore, partners' companionship also creates family bonding (Bondas-Salonen, 1998; Price et al., 2009; Kainz et al., 2010; Sapkota et al., 2012).

A study was conducted with low-risk primigravida women in a public maternity hospital in Kathmandu, Nepal in 2011. This study was done with women who gave birth with their husbands present, those who gave birth with a female friend present and women with mixed support for the birth. The Labour Agency Scale (LAS) was used to measure the extent to which women felt in control during labour (Sapkota,

Kobayashi, Kakehashi, Baral & Yoshida, 2012). This study revealed that women feel more in control during labour when their husbands are present at the birth, with higher LAS scores than the women who gave birth with female friends' support. Although having a female friend's company during childbirth was also related to the women's feeling of being in control during labour, the effect was less significant than for women who had their husbands' company (Sapkota, Kobayashi, Kakehashi, Baral & Yoshida, 2012). Before this study was conducted husbands were entirely prohibited from entering delivery rooms in Nepal, however, husbands are completely prohibited from entering delivery rooms. They are only allowed to make occasional visits to their wives inside the labour room or run errands for the medical supplies, food and drink. They are also contacted by the nurses and physicians only in emergencies. This attitude was sparked by the belief that a husband's presence will make labour pain worse and prolong the labour (Mullany, 2006; Sapkota et al. 2011).

In a meta-synthesis of fathers' experiences of their partner's labour and the birth of their baby involving 120 fathers, eight studies were conducted in England, Malawi, Nepal and Sweden (Johansson et al., 2015). Findings revealed that most men wanted to be actively involved in their partner's labour and be respected for what they can contribute. Although most men recognised that birth is a unique event that may be potentially challenging, and one which requires a level of preparation, there were those who felt pressured to attend. The men commonly expressed feelings of inadequacy to support their partner especially when they see their partner in labour pain. They affirmed midwives' position in making a significant difference in helping the men to have positive experiences of labour.

The researcher concluded that the expectant fathers' birth experiences were multidimensional. While many were committed to being involved during labour and birth, others felt vulnerable. Being prepared and receiving support was identified as essential elements of a positive experience, which may contribute adequately to supporting women in labour. The result in this meta-analysis is consistent with previous research, which expressed men's desire to participate in and support their female partner during the labour and birth process (Dellman, 2004; Eriksson et al., 2007; Gungor, 2007; Simbar et al., 2010; Abushaikha and Massah, 2012). Men wanted to be actively involved and be of some practical help to their partner. Arguably this could be the result of work that has consistently demonstrated that men feel left out or sidelined during a woman's pregnancy (Fenwick et al., 2012). Nevertheless, some men felt participation was an expectation of their partner and midwife rather than a free choice (Bartlett, 2004; Dellman, 2004; Eriksson et al., 2007).

In a similar study, Mullany (2005) researched barriers and attitudes in promoting husbands' involvement among men, women, and providers in Katmandu, Nepal. The study showed positive attitudes among pregnant women, husbands, and providers towards male involvement in maternal health. However, barriers to male involvement in maternal health, which were identified, include low knowledge levels, social stigma, shyness /embarrassment and job responsibilities. The health care providers in the study also projected obstacles to male involvement, such as hospital policy, manpower and space problems. The researcher concluded that the introduction of such health education services would be both feasible and well received. However, hospital policy needs to change to enhance couple-friendly

reproductive health services and male partner involvement in women's reproductive health.

Oboro et al. (2011) investigated the attitudes of Nigerian women toward the presence of their husband or partner as a support person during labour, at the Ladoke Akintola University of Technology Teaching Hospital, Osogbo, Nigeria. The qualitative cross-sectional study was done among 197 women, regarding the presence of a spouse /husband as a support person during labour. The findings revealed that more than one-third of pregnant women in the study declined social companionship in labour, and more than one-third of those who accepted such support did not have a preference for their partner/husband to be their companion during delivery. The main reasons expressed by the women for refusal of the husband as labour companion include personal embarrassment, fear of loss of sexual attractiveness, concern for their spouse/partner and lack of privacy. A large percentage of the women whose husband/partner accompanied them during labour, expressed satisfaction and willingness to repeat the experience in subsequent deliveries. They also indicated that they would recommend this partnering to other women. Only a few expressed dissatisfaction.

Due to the low levels of willing participants in the study involving husband companions during childbirth, the researcher believed that husbands' involvement during labour is a western cultural phenomenon only practiced in developed countries, one which should not be introduced in a Nigerian setting. However, the researcher noted that the study did not take into consideration the women's prior delivery experiences, which might well have influenced reservations expressed by the participants about partner/husband presence during labour. She expressed the



opinion that the women's refusal could have been the result of negative experiences in previous deliveries as well as the beliefs and attitudes of healthcare providers to husband support during labour, and hence advocated investigation into the traditional beliefs, attitudes, and practices among women and health workers, which is the focus of this study.

#### **2.11.2.2 Support from female relatives**

The effects of the supportive care of women in labour by mother/women have been established and replicated by researchers over the past several decades (Campbell et al, 2006). Reasons for the effects of support from female companions on women's experience during childbirth have been reviewed in different studies. Dick-Read (2005) explained that the presence and support of a female relative reduces maternal anxiety. In the escalating cycle of fear, tension, and pain experienced in labour, support of a female companion leads to lower levels of fear, which reduces anxiety which in turn leads to less intense labour pain (Dick-Read, 2005). Compared with other sources of labour support, the support provided by untrained lay women that begins during early labour and continues into the postpartum period provides the most consistent beneficial effect on childbirth outcomes (Hodnett et al., 2009; Rosen, 2004).

A randomised controlled trial was undertaken in Brazil, South America, at the Federal University of Santa Catarina, between February 2004 and March 2005 (Bruggemann, Parpinelli, Osis, Cecatti & Neto, 2007). The objective of the study was to assess the effectiveness and safety of the support given to women by a companion of their choice during labour and birth. A total of 212 women were recruited, with 105 allocated to the group in which support was permitted and 107

women assigned to the group where support was not given. The results showed there were no significant differences between the groups in the socio-demographic and obstetric features of women at the time of hospital admission (Bruggemann et al. 2007). Having a companion during labour and birth was strongly associated with higher satisfaction levels in the intervention group. The women in this group had more spontaneous vaginal births and were more satisfied with the care they received during labour and the medical guidance they received, than women in the control group. Largely, the women in the support group were more satisfied with labour experience (median 88.0 versus 76.0,  $p < 0.0001$ ) and delivery (median 9.1 versus 77.1,  $p < 0.0001$ ). The study reported no statistical difference between the two groups on any of the other variables (Bruggemann et al. 2007).

Another relevant study was a randomised controlled trial conducted in a Mexican public hospital by Langer, Campero, Garcia and Reynoso (2005). This trial evaluated the effects of psychosocial support by a female companion (doula) assigned to them during labour, birth and the immediate postpartum period. The outcomes included breastfeeding practices, duration of labour, medical interventions, women's emotional condition and the health of the newborns. Data was collected from the clinical records, and interviews were conducted with women in the immediate postpartum period while in the hospital and at their homes 40 days after the birth. The interviewers were unaware of the women's allocated group; that is, whether they were in the intervention group (support in labour) or not. The study found that the frequency of exclusive breastfeeding one month after birth was significantly higher in the experimental group, as were the behaviours which promote breastfeeding, such as a calm environment during breastfeeding sessions.

More women in the intervention group professed a high degree of control over their birthing experience, and their duration of labour was shorter than the women in the control group. There were no effects of medical interventions, mothers' anxiety or self-esteem, women's perceptions of pain and satisfaction, or in newborns' conditions between the groups. This trial, like many others, demonstrated that support in labour was also associated with the reduced use of narcotics for analgesia in labour.

Yuenyong, Brien, and Jirapeet (2012) conducted a study on the effects of a close female relative in labour support, on maternal satisfaction in a Thai setting. Findings from the survey show that support by a close female increased maternal satisfaction with the childbirth experience, promoted a positive effect that elevated maternal self-confidence and self-control, and shortened the active stage of labour. The researcher concluded that integration of a close female relative into the care of women in labour and birthing women was an important nurse-midwifery intervention that can become part of a comprehensive strategy to provide appropriate care to women and their families in hospitals.

A comparative study looked at the effect of the presence of a labour companion from the woman's social network, and also the effect of educating the companion in the giving of support to the parturient (Senanayake, Somawardana, Samarasinghe, 2014). The study was conducted with sixty women who were randomly divided into three groups. Women in the first group had female companions of their choice, and their labour companion was given the appropriate education. The women in the second group had companions who had not been provided with any such education. Group C included 30 women without a

companion and had routinely practiced. Women's perceptions of control during labour were evaluated with the validated version of the Labour Agency Scale (LAS-10) and perinatal characteristics were recorded. The Anova test and respective 95% confidence interval were used in statistical analyses. The study shows a significantly higher level of maternal satisfaction in group A with increased rates of breastfeeding in the first 12 hours in group B. There was a favourable result in the use of augmentation of labour, but no difference was demonstrated in the use of analgesics, delivery mode and the presence of meconium staining of liquor. The researcher concluded that a preferred female companion of the woman has a beneficial influence on the mother's experience of labour and perinatal events, with or without the companion receiving an education (Senanayake, Somawardana, Samarasinghe, 2014).

Campbell et al. (2006) conducted Randomized Control Trials to compare labour outcomes in women accompanied by an additional support person, with outcomes in women who did not have this additional support person. The study was conducted with six hundred nulliparous women carrying a singleton pregnancy in the low-risk category divided into two groups. The first group are women who had a female friend or family member as doula while the second group are women who delivered without doula. The women in the doula group were taught traditional doula supportive techniques in two 2-hour sessions and the effect of their support was assessed on the length of labour, mode of delivery, the time and use of analgesia/anesthesia, and Apgar scores. Findings from the study showed that women in the doula group had a shorter duration of labour, good cervical dilation at the time of epidural anesthesia, and higher Apgar scores at both 1 and 5 minutes.

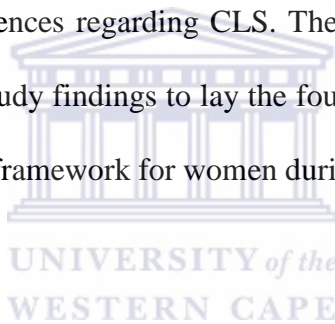
There was no significant statistic in the use and type of analgesia/anesthesia in caesarean delivery despite the lower cesarean delivery rates seen in the doula group. The researcher concluded that the use of female friends or relatives who were given lay doula training to assist during labour would be beneficial, especially for low-income women and resource-limited nations, considering the expensive cost of hiring a certified doula in the developed country. This result is highly valued for the research setting which is a country with limited resources and with diverse cultures, and perceptions about who is present with women during labour.



## **2.13 Theoretical framework**

A theoretical framework is the overall conceptual underpinning of a study and it allows the researcher to knit together observations and fact into an orderly scheme. To understand the perception and attitude to CLS, it is important to highlight the influence of the culture of support during childbirth. The structure of this study employs the culture-centred approach to understanding opinion on CLS among participants in South-West Nigeria.

The theoretical concept of a PEN-3 model was used as a tool to assess the perceptions of, attitudes to and preferences regarding CLS. The framework will also be used to facilitate analysis of the study findings to lay the foundation for the development of a culturally congruent CLS framework for women during childbirth in the south-west of Nigeria.



### **2.13.1 Culture Centred Approach**

Several researchers have studied the impact of culture on health behaviour, decisions and health outcomes (Airhihenbuwa, 2000, Dutta, 2007, Shaw et al., 2009). Culture, according to Airhihenbuwa (1999) refers to shared values, norms, and codes that collectively shape a group's beliefs, attitudes, and behaviour through their interaction in and with their environments (Airhihenbuwa 1999). Childbirth takes place within a cultural context in all countries, and childbirth practices are usually influenced by cultural norms and expectations (Berkowitz, 2008). To examine the effect of culture on individual health is to acknowledge that the group of people is more important than the individual person (Airhihenbuwa 1999). Studying the cultural context of the

community allows one to understand and appreciate the ways in which the person is shaped, as well as to explore the roles, connections, and relationships, whether positive or negative, that exist within the group (Singhal, 2003). These cultural intricacies are essential for public health interventions to be effective and sustainable.

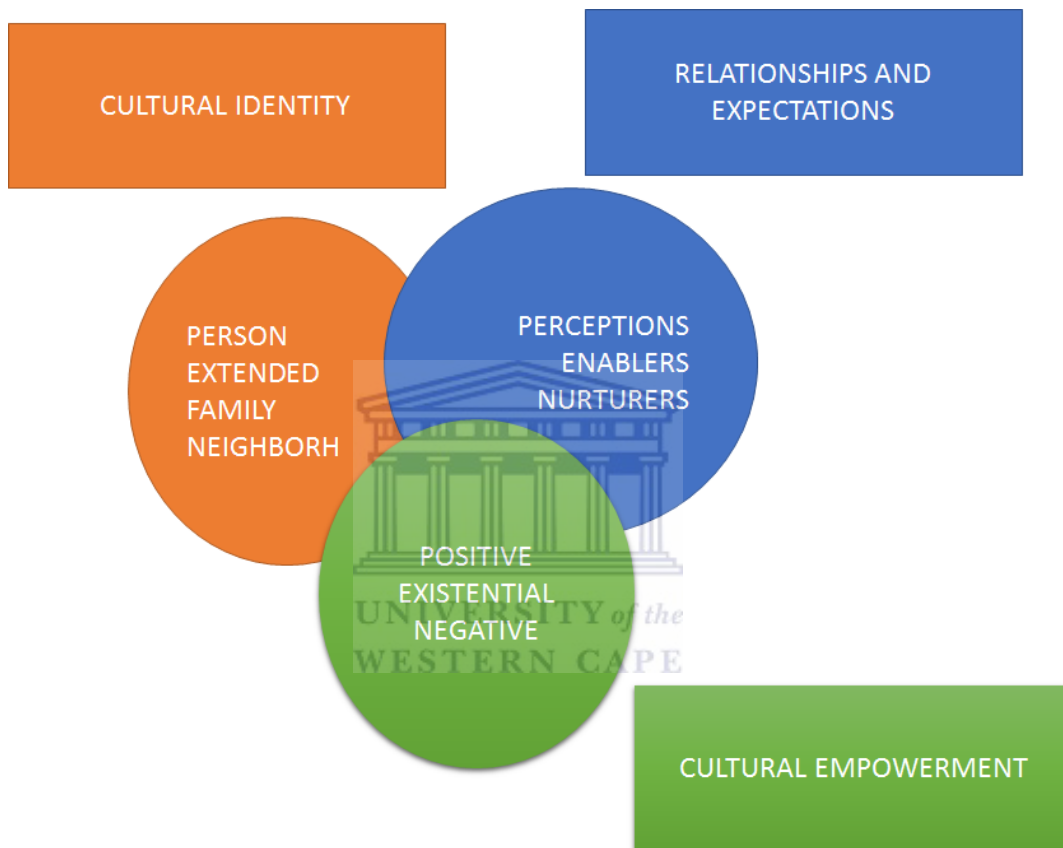
### **2.13.2 The PEN 3 cultural framework**

The PEN-3 cultural model was developed by Airhihenbuwa in 1989 to highlight the need for cultural relevance in developing, implementing and evaluating public health interventions. It has been applied in more than 100 studies worldwide to explore how cultural and social context affects the perception of health praxis to guide culturally focused health initiatives (Airhihenbuwa, 2013). The model examines cultural meanings, beliefs and values in health behaviour that play a central role in framing people's interactions with health in social and cultural contexts. The model also places culture at the core of the development, implementation, and evaluation of successful public health interventions (Airhihenbuwa and Webster 2004; Airhihenbuwa 1995, 2007a). It focuses on the role of culture as a connecting web by which individual perceptions and actions regarding health are shaped and defined (Airhihenbuwa 1995, 2007a, 2007b).

PEN-3 has three domains, and each domain has three dimensions. The three interconnected and interdependent domains are cultural empowerment (CE), relationships and expectations (RE), and cultural identity (CI) (Airhihenbuwa, 1995; Airhihenbuwa & Webster, 2004). The independent components are the person, extended family, and neighborhood for cultural identity (CI); perceptions, enablers,

and nurturers for relationships and expectations (RE); and positive, existential, and negative for cultural empowerment (CE).

**Figure 3 PEN-3 Cultural Model (Airhihenbuwa, 1990)**



**Cultural Identity:** This domain highlights the intervention points of entry and may occur at the level of persons (e.g. mothers or health care workers), extended family members (grandmothers), or neighborhoods (communities or villages).

**Relationships and Expectations:** This domain explores the perceptions or attitudes about the health problems, the societal or structural resources such as health care services that promote or discourage effective health seeking practices, as well as the



influence of family and kin in nurturing decisions surrounding effective management of health issues.

**Cultural Empowerment Domain:** This aspect of the model identifies the beliefs and practices that are positive, exploring and highlighting values and beliefs that are life-affirming and have no harmful health consequences, before identifying negative health practices that serve as barriers.

### **2.13.3 Application of PEN 3 model to the study**

Childbirth is a central part of the human experience throughout history and across all different societies and cultures. Culture is believed strongly to influence the beliefs systems of society, including childbirth practices and experiences (Williamson & Harrison, 2010). Different cultures adopt different methods of caring for and supporting women during pregnancy and childbirth, and the kind of social support, as well as its significance for all stakeholders, varies according to women's cultural backgrounds (Bina, 2008). The PEN 3 cultural model is suitable in this study to identify the culturally related factors regarding perceptions, attitudes, barriers, enablers and nurturers, from the different stakeholders' perspectives, with the overarching intention of laying the foundation for the development of a culturally congruent CLS framework for women during childbirth, as a guide in public health facilities in the south-west of Nigeria. While PEN 3 comprise of three domains: cultural empowerment (CE), relationships and expectations (RE), and cultural identity (CI), only two of the domains; the cultural identity and relationships and expectations will be adapted to the study. The perspectives of these domains to the study is explained as follows

**Cultural identity:** The cultural identity dimension of the PEN-3 model in this study identified the cultural practices regarding labour support from the study participant context. The participants in this context are pregnant women who were involved in focus group discussions in selected hospitals in Ondo state.

### **Relationships and Expectations**

**Perceptions:** An examination of perceptions involves the assessment of opinions and attitudes of all stakeholders in this study (pregnant women, nurse/midwives and policy-makers) on CLS in public health facilities. The pregnant women and the nurse/midwives were engaged in the study through focus group discussion while the researcher had one-to-one interviews with the key policy-makers. All participants used these opportunities to express their views on the issue of women's choice of labour support persons from their social networks in public health facilities.

**Enablers:** These include available and accessible resources that enable the incorporation and implementation of the family support system during labour, in public health facilities identified by the stakeholders in the study.

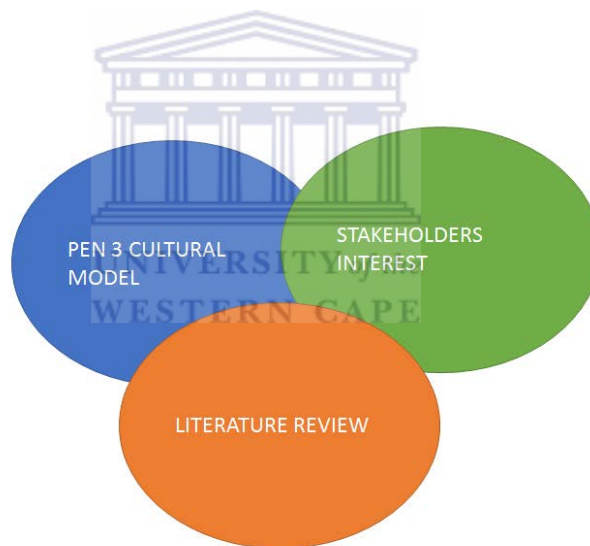
**Nurturers:** These are the reinforcing factors identified to promote culturally congruent continuous labour for women during childbirth in the hospital. The participants were encouraged to express cultural and religious expectations regarding family support during childbirth.

**Cultural empowerment:** The aim of this domain in the study context is to identify positive strategies in the effective development of a culturally congruent continuous

labour for women during childbirth, in the public health facilities. The domain also recognizes the risks and challenges to the concept.

The concepts identified through the application of the PEN 3 model in analysing the study's findings with concepts from literature review was adopted for the development of the culturally congruent continuous labour framework later in the study. Figure 2.4 below give graphic description of the domains as used in the study:-

**Figure 4 : Application of PEN 3 cultural model to the study**



## **2.14 Summary**

This chapter presents the literature review on the historical background of childbirth and labour support, the social support concept, the culturally congruent care concept, labour support and outcomes. There is an overview of Nigeria's general profile, the national health system, maternal health, and various initiatives to promote maternal and

child health as baseline information to understand the need for culturally congruent care. A conceptual framework for the study is also discussed. Chapter 3 presents the research methodology.



## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

The preceding chapter provided an appraisal of current knowledge about CLS practices as a foundation for the development of an evidence-based culturally congruent CLS framework that will be applicable in the South-West Nigerian context. The review also includes the historical background of childbirth and labour support, the social support concept, culturally congruent care concept, labour support and outcomes. The chapter also discusses an overview of Nigeria's general profile, the national health system, maternal health and various initiatives to promote maternal and child health.

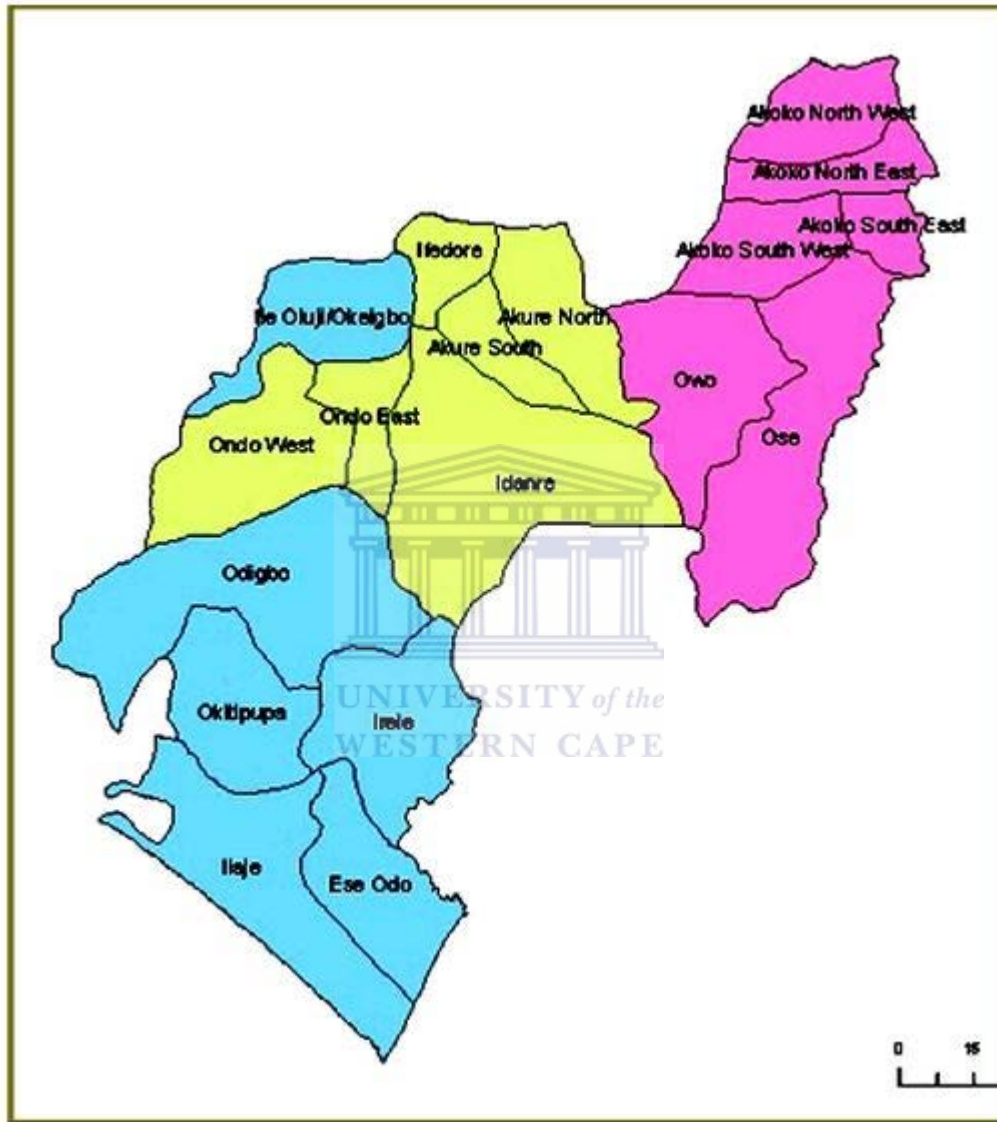
This chapter describes the research setting, research design and methods used in the study to achieve the study's objectives. The objective of the study was to explore the perceptions, attitudes, and preferences of pregnant women and nurse-midwives, as well as the positions of hospital policy-makers regarding CLS and women's choices in public health facilities, and also to develop a culturally congruent CLS framework for women in the south-west region of Nigeria.

#### **3.2 Research setting**

The study was conducted in Ondo state, one of the states in the south-west region of Nigeria. South-West Nigeria has six states: Ekiti, Lagos, Ogun, Ondo, Osun and Oyo. It is mainly a Yoruba-speaking area, although there are different dialects even within the same state.

Ondo state was created on February 3, 1976, with the State capital in Akure. Ondo State lies between latitude  $5^{\circ} 45'$  and  $7^{\circ} 52'$  North and longitude  $4^{\circ} 20'$  and  $6^{\circ} 05'$  East, an indication that the State lies entirely in the tropics. It is bounded in the North-West by Ekiti State, West-Central by Osun State, South-East by Ogun State, South-East by Delta State and in the South by the Atlantic Ocean. It occupies a land area of 14,798.8 Sq km with a current population of 3,640,877 people (National Population Census, 2006). Ondo state has eighteen (18) local government areas, three (3) senatorial districts: (i) Ondo North (ii) Ondo Central (iii) Ondo South. It has two hundred and three (203) wards. The people of the State are predominantly Yoruba. The major employers of healthcare providers in the state are Hospital Management Board (HMB) and the local government civil service commission. Ondo North Senatorial district has one (1) State Specialist Hospital (SSH) and six (6) General Hospitals, (GH). Ondo Central Senatorial district has one (1) State Specialist Hospitals (SSH) and six (6) General Hospitals and the two Mother and Child Hospital used for the Abiye programmes in the state while Ondo South Senatorial district has one (1) State Specialist Hospital (SSH) and six (6) general hospitals. Three state specialist hospitals (SSH), two Mother and Child Hospital and three general hospitals (GH) were selected for this study according to the senatorial district as follows:

Figure 5 : Map of Ondo state showing the senatorial districts and local government areas (<http://dailymail.com.ng/photos-maps>).



Key: Ondo central senatorial district (Yellow); Ondo south senatorial district (Blue) and Ondo north senatorial district (Pink)

### **3.2.1 Ondo central senatorial district:**

1. Mother-and-child hospital, Akure,
2. State Specialist Hospital, Akure
3. Mother-and-Child Hospital, Ondo town

### **3.2.2 Ondo south senatorial district**

4. State Specialist Hospital, Okitipupa
5. General hospital, Ore

### **3.2.3 Ondo north senatorial district**

6. State Specialist Hospital, Ikare
7. General Hospital, Owo



## **3.3 Research Design**

A mixed method research (MMR) approach following an explorative concurrent design was adopted for this study. Until about a decade ago, qualitative and quantitative research designs were the best known and used research methods. MMR came into being and is usually referred to as the “third methodology” (Lund, 2012; Venkatesh, Brown, & Bala, 2013).

### **3.3.1 Mixed method research as an approach**

MMR is defined as a research approach that combines all procedures of both qualitative and quantitative data collection and analysis in a single study (Creswell, 2012; Frels & Onwuegbuzie, 2013; Hong & Espelage, 2011). Quantitative research method involves



collection of numerical data, making observations and measurements of a phenomenon which can be subjected to statistical analysis and can be repeated and replicated by the same or other researchers under similar conditions. Qualitative researchers seek explanations and predictions that will generate to other persons and places, and the interest is to establish, confirm or validate relationships and to develop generalizations that contribute to theory (Leedy and Ormond 2001). MMR permits the researcher to combine both methods to explore concepts, requires contextual understanding from multilevel perspectives such as cultural, political and physical environments and perspectives as found in this study, rather than using one of the methods exclusively (Creswell, 2012; Frels & Onwuegbuzie, 2013; Hong & Espelage, 2011).

Venkatesh et al. (2013) identified seven benefits of MMR over other methodologies. These are: complementarity, completeness, development, expansion, corroboration/confirmation, compensation, and diversity. He described MMR as “complementing one method with another by obtaining mutual viewpoints about similar experiences or associations. It ensures that total representation of experiences or associations is attained in a study, and builds questions from one method that materialize from the implications of a prior method, or one method presents hypotheses to be tested in a subsequent method. It also elaborates on the knowledge gained from a prior method, evaluates the trustworthiness of inferences gained from one method, compensates to counter the weaknesses of one method by employing the other, and diversifies to obtain opposing viewpoints of the same experiences or associations in the same study”(Venkatesh et al., 2013).

This approach was considered appropriate for this study as the research intended to explore the perceptions of pregnant women, nurse/ midwives and policy-makers, regarding the CLS chosen from the women's social networks in public health facilities in Ondo State, for the purpose of developing a culturally congruent CLS framework which can be adopted for use during childbirth in the south-west region of Nigeria. Use of the explorative triangulation concurrent mixed approach allows different data collection strategies from all stakeholders in this study to confirm, cross-validate and corroborate findings (Creswell&Clark, 2007).

### **3.4 Research methods**

The study was conducted into two phases which will be discussed separately to ensure structural coherence. Phase 1 was concerned with objectives 1-3 with the aim of collecting empirical data that will inform the development of the framework. Phase 2 was the framework development of the culturally congruent CLS for women in south west Nigeria.

### **3.5 Study Phase 1**

This phase adopted an explorative concurrent design, which involved the collection of both qualitative and quantitative data simultaneously in two strands with equal weight to assess objectives 1-3 of the study. Each strand will be described separately for the purpose of clarity and simplification. Strand 1 explains the quantitative aspect of the study while strand 2 describes all the process adopted for the qualitative part.

### **3.6 Strand 1: Quantitative data**

The quantitative aspect of this study method involves the collection of data which in turn yielded numerical data from discussions with the pregnant women in all the selected public health facilities in Ondo state.

#### **3.6.1 Population**

Polit and Beck (2012) state that the target population includes all the members who are being studied, and who conform to a designated set of specifications. The study populations for this strand are pregnant women attending the antenatal clinic of the selected hospitals who will be the beneficiaries of the CLS framework when it is developed in Ondo state. Antenatal clinics in public health facilities were chosen for this study because these cater for women from different classes and backgrounds.

#### **3.6.2 Sample size**

Sample size was calculated based on prevalence of 50% based on population using Leslie Kish, 1965 sample size formula for proportions of in large population

$$n = \frac{Z^2 \times p \times (1-P)}{d^2}$$

d 2

n = the sample size

$Z\alpha$  = Level of significance

P = an estimated proportional of an attribute that represent the population Prevalence of outcome of interest, 50 %, 0.5

D = the acceptable sampling error or Level of precision which is usually standard of 5% or 0.05 (Leslie Kish, 1965)

$$n = 1.96 \times 0.5 \times 0.5$$

$$0.05^2$$

$$= 0.49$$

$$0.0025$$

$$= 196$$

To adjust for clustering (design effect)

$$196 \times 2$$

$$= 392$$



A total number of 392 respondents were selected using a table of random sampling. Samples from each selected hospital will be calculated according to the proportion of antenatal attendance of pregnant women in each hospital.

### 3.6.3 Sampling

Sampling has been defined as “the process of selecting a group of people, events, behaviours or other elements that represent the population being studied” (Burns and Grove,2014) and sample refers to the portion of the population selected for a study (Burns and Grove,2012). Pregnant women were selected through simple random sampling using the table of random sampling on computer, based on initial sample size

of three hundred and ninety two (392), which was calculated on the prevalence of 50%. This percentage was based on the population of those in monthly attendance, according to the antenatal records. The sample size for each of the selected hospitals was calculated according to the proportion of antenatal attendance of pregnant women. Table 3.1 below presents the proportional sample of pregnant women in all the hospitals selected for the study.

**Table 4 : Proportional sample of pregnant women**

| <b>Hospital</b>                      | <b>Location</b>                  | <b>Average Antenatal Attendance</b> | <b>Percentage</b> | <b>Sample</b> |
|--------------------------------------|----------------------------------|-------------------------------------|-------------------|---------------|
| Mother Child Hospital, Akure         | Ondo Central Senatorial district | 240                                 | 240/1340= 18%     | 71            |
| Mother Child Hospital, Akure         | Ondo Central Senatorial district | 240                                 | 240/1340= 18%     | 71            |
| State Specialist Hospital Akure      | Ondo Central Senatorial district | 220                                 | 220/1340= 16%     | 62            |
| State Specialist Hospital, Ikare     | Ondo North Senatorial district   | 180                                 | 180/1340= 13%     | 51            |
| General Hospital, Owo                | Ondo North Senatorial district   | 140                                 | 140/1340= 11%     | 43            |
| State Specialist Hospital, Okitipupa | Ondo South Senatorial district   | 180                                 | 180/1340= 13%     | 51            |
| General Hospital , Ore               | Ondo South Senatorial district   | 140                                 | 140/1340= 11%     | 43            |
|                                      | <b>Total</b>                     | <b>1340</b>                         | <b>100</b>        | <b>392</b>    |

A total number of three hundred and ninety two (392) were initially recruited for the quantitative aspect of the study, from all selected hospitals. Ten (10) pregnant women later declined to participate; fourteen questionnaires were not completed, and three hundred and sixty-eight (368) women completed the study.

### **3.5.2.1 Inclusion criteria**

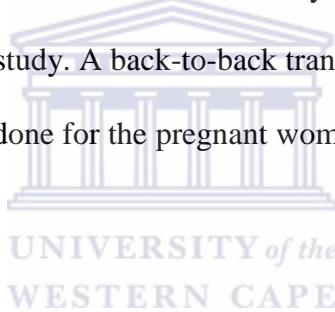
An eligible woman for this aspect of the study was selected based on at least one delivery experience in respect of the place of delivery. First-time pregnant women were purposely excluded due to the question on labour experience in the survey.

### **3.6.4. Data collection**

Data collection involves the process of gathering data from the studied participants (Brink, 2006; Burns & Grove, 2012). Data was collected from the pregnant women through the administration of the self-reported questionnaire. The questionnaire was developed by examining questions that would answer the objectives of the study, as indicated in the literature. The questionnaire consists of a total of sixty-six test items arranged in four sections (A-D). Section A assesses the demographic and cultural data of the women. Section B explores the perceptions of the women regarding CLS, Section C explores the attitudes of the women to CLS and Section D determines the preferences of the women regarding CLS. The attitudes of respondents to CLS were assessed using a five-point Likert scale (5=strongly agree, 4=agree, 3=undecided, 2=disagree, 1=strongly disagree).

### **3.6.5 Development of the questionnaire**

The questionnaire for quantitative data was developed in relation to existing related literature reviews and instruments used in previous studies on women's perceptions, attitudes and preferences in CLS. Some of the questions were also adapted from a standardized questionnaire that has been used in previous studies i.e. BANSILQ (Bryanton Adaptation of the Nursing Support in Labour Questionnaire), a social support questionnaire. The questionnaire was presented to a statistician, a research supervisor and an expert in maternal and child health for review and critiquing. The questionnaire was pilot- tested and the necessary corrections were made before proceeding with the main study. A back-to-back translation of the questionnaire into the Yoruba language was done for the pregnant women who could not speak or read English.



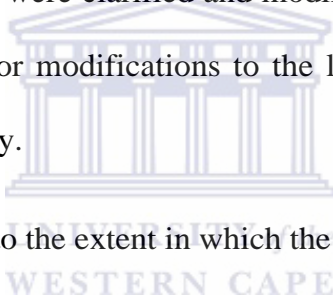
### **3.6.6 Validity**

This refers to the extent to which an instrument for data collection reflects the abstract construct being examined (Burns & Grove 2012). The basic ways to assess the validity of an instrument are criterion, content and construct validity.

The criterion validity is an approach that determines the extent to which the different instruments measure the same variable (Heale & Twycross, 2015). The questions on the instrument were, for the most part, adapted and reconstructed in line with the objectives of the study. There was documented evidence that most instruments adapted have been used in many other studies in different circumstances i.e. The BANSILQ has been used in a number of studies with women

from a range of cultural and ethnic backgrounds (Holroyd et al 1996, Corbett and Callister 2000, Ip 2000, Sauls 2004 and 2010, Mbye et al 2011).

Content validity refers to the ability of the instrument's items to adequately cover all the content that it should with respect to the variables (Heale & Twycross, 2015). To ensure content validity the questionnaire was given to some experts in maternal and child health, consulted in different parts of Nigeria, to examine the content in relation to the study objectives. The questionnaire was sent to the experts via email with an information sheet and the objectives of the study. Comments on items and the irrelevance were clarified and modified according to the comments from these viewers. Minor modifications to the layout and wording were made prior to its use in the study.



Construct validity refers to the extent in which the instrument can draw inferences about test scores related to the concept being studied (Heale & Twycross, 2015). The construct on the instrument was based on theory evidence that show similar behaviour to theoretical propositions of the construct measured in the instrument.

### **3.6.7 Reliability**

Reliability is a measure of consistency obtained in the use of a research instrument (Heale & Twycross, 2015). To address the issue of questionnaire reliability in this study, the test/retest method of reliability testing was used. Thirty pregnant women were asked to complete the questionnaire twice, with a two-week interval between the two sittings. The scores from both questionnaires were evaluated and the tool



assessed for consistency and reliability of answers. A comparison of tests scores was expressed by a Pearson correlation coefficient,  $r$ . The magnitude of the coefficient ( $r=0.85$ ) provided support regarding the stability of the questionnaire as a reliable tool. An  $r$  equal to or greater than 0.7 is considered an acceptable value for a tool to be viewed as reliable (Burns and Grove, 2007). Therefore, this result indicated that the questionnaire was a reliable tool. The questionnaire was corrected and edited based on the reliability test before application to the target population in the actual study.

### **3.6.8 Pilot study**

A pilot study was conducted at Adeoyo Maternity Teaching hospital in Yemetu Ibadan, Oyo state in South-West Nigeria with due ethical approval granted by the Ethical Review Committee, Ministry of Health, Oyo State. The questionnaire was pilot-tested with 30 pregnant women attending the antenatal unit of the hospital by the researcher and a research assistant. The aim of the pilot study was to assist the researcher to address the feasibility of the study objectives, resources, research populations, procedures of data collection, the data collection itself and also develop a contingency plan for errors that might occur in the main study. Some of the women expressed difficulty in describing as useful or not useful, the support received from the nurse-midwives during their last delivery in the health facility. Hence the researcher changed the options for the women's responses to Yes or No, to indicate that support was received or not received.

### **3.6.9 Data analysis**

Quantitative data collected from pregnant women was analyzed using descriptive and inferential statistics through the use of the Statistical Package for Social Science (SPSS) version 20. Data was presented as diagrams, frequency distribution and cross tables. Statistical tests such as Chi-square and binary logistic regression were used to test for associations and predictors of preference for continuous support, with the level of significance set at  $p < 0.05$ .

## **3.7 Strand 2: Qualitative data**

### **3.7.1 Population**

This part of the study had three target populations. The first population that was studied was pregnant women attending the antenatal clinic of the selected hospitals. The second group were registered nurse/ midwives working in public health facilities, who render care to women during pregnancy, labour and puerperium. The third group were hospital policy-makers in Ondo State who are responsible for standard management of hospital protocols and policy.

### **3.7.2 Sampling**

A purposive sampling method was adopted in selecting a sample from all three populations (pregnant women, nurse/midwives and policy-makers) for the qualitative part of the study. A purposive sampling in a qualitative study is a method of sampling in which typical cases are sought and selected for the study. The sample is usually composed of elements that contain the most characteristics, that are representative, and

that demonstrate attributes of the population that serve the purpose of the study best (Grinnell & Unrau 2008). The use of purposive sampling in the study allows the researcher to select participants who will give in-depth information to meet the objectives of the study. Since there are three research populations in this study, the purposive sampling process was implemented as follows:

### **3.7.2.1 Pregnant women**

The pregnant women were recruited at antenatal clinics of the selected hospitals after information regarding the study was given. The purpose and objectives were explained and voluntary participation in the study was sought. The antenatal clinical staffs also assisted the researcher to identify and invite women who showed an interest in the study, in no particular order. The names and contact details of the volunteer participants were collected and the researcher contacted each pregnant woman individually. A time, date and venue were arranged for a meeting. A total of eighty-eight (88) women who responded to the appointed dates of FGDs were used for 10 FGDs at the selected hospitals. All pregnant women irrespective of age, ethnicity, religion, socio-economic and educational status, who gave verbal and written consent, were allowed to participate in the study.

### **3.7.2.2 Nurse /Midwives**

The nurse/ midwives were recruited via meetings arranged through the Heads of nursing services in the selected hospitals. The purpose and the objectives of the study were explained at the meeting. The meeting was attended by nurse/ midwives who are working at the obstetrics and gynaecology units of the hospitals. The obstetrics and

gynecology units in most public health facilities in Nigeria and Ondo State, in particular, comprise the antenatal clinic, antenatal, labour and postnatal wards, as well as the Neonatal Intensive Care Unit (NICU) or the nursery as it is called in most hospitals selected for the study. Nurse/ midwives in most of these units usually work on yearly rotational posting within the units. These groups of nurses were recognized as a key informant in this study because of their training and skilled experience in maternal and child health care. A total of forty-five nurse/ midwives declared themselves available, gave written consent, and were involved in focus group discussions.

The inclusion criteria for nurse/ midwives was at least five years' experience working in the obstetrics and gynecology units, but the required number of years of experience was reduced to 2 years, because most of these facilities were grossly under-staffed, and some of the available staff were recruited less than 5 years ago.

The researcher had some challenges with the required number of women 6-8 nurse midwives for FGD due to staffing, and had to use only the available number of nurses on the ground that who were willing to participate in the study.

### **3.6.2.3 Policy-makers**

A total of fourteen (14) hospital policy-makers were involved in this study, comprising two (2) Directors of Nursing Services (DNS), five (5) Chief Medical Directors (CMD) and Medical Director (MD) and Seven (7) Heads of Nursing Services (HNS) at Ondo State Ministry of Health, Hospital Management Board and selected hospitals. The state

DNS are representatives of the Nursing and Midwifery Council of Nigeria at the state level and are responsible for the maintenance of standard nursing care. The CMDs and MDs are the heads of State Specialist Hospitals and General Hospital in Ondo State, and are responsible for the maintenance of standard medical and nursing care in the hospitals while the HNS maintain standard nursing care. The research had intended to involve the Permanent Secretaries in charge of the Ondo State Ministry of Health and Hospital Management Board in the study, but all efforts to conduct interviews with them were unsuccessful because of their busy schedules and responsibilities. Regarding the policy-makers, only people that make decisions on Maternal and Child Health issues in Ondo state hospital (Medical Directors, Heads of Nursing Services, Permanent Secretaries and Directors of Nursing Services) who had at least 20 years in government service and have been in their current positions of responsibility for at least six months were included in the study.

**Table 5 : Summary of study participants for strand 2**

| <b>Category</b>               | <b>Total number of participants</b> | <b>Number of focus group interviews</b> | <b>Semi-structured interview</b> |
|-------------------------------|-------------------------------------|---|----------------------------------|
| Pregnant women                | 88                                  | 10                                      | -                                |
| Nurse/ midwives               | 44                                  | 8                                       | -                                |
| Policy-makers:                |                                     |   |                                  |
| Directors of Nursing services | 2                                   |   | 2                                |
| Chief Medical directors       | 3                                   |   | 3                                |
| Medical Directors             | 2                                   |   | 2                                |
| Heads of Nursing Services     | 7                                   |   | 7                                |

### **3.8 Access to the sites**

Access to all the research settings was obtained from the gatekeepers who control access to the hospitals and people within them (Green & Thorogood, 2009). Every state specialist and general hospital in Ondo state is under the control of the Hospital Management Board and has a Research Ethical Review Committee that reviews any study that involves any of the hospitals under HMB control, except the two mother-and-child hospitals in the state, which have a joint Research Ethical Review Committee. The researcher obtained ethical review for the facilities used for the study from both Research Ethical Review Committees of the Hospital Management Board, and the Mother-and-child Hospital in Akure. A notification and request for permission to access the participants was also sent to the Chief Medical Directors and Heads of Nursing Services of all the facilities used for the study, with copies of the approval letters from Research Ethical Review Committees of Hospital Management Board and Mother-and-child Hospital, Akure attached. All copies of ethical approvals obtained for the study are attached to the paper as appendices.

### **3.9 Trial run for the focused group discussion and interview**

A trial run for the focus group discussions was conducted at Adeoyo Maternity Teaching hospital Yemetu Ibadan, Oyo state in South-West Nigeria, with due ethical approval granted by the Ethical Review Committee, Ministry of Health, Oyo State. One focus group discussion was done with midwives( n = 8) with the FGD guide developed by the researcher, while the interview guide for the policy-maker was pretested with the hospital Chief Medical Director and Head of Nursing Services in the

same hospital. The aim of the trial run was to assess the guide's accuracy and feasibility in clarity and understanding of the question, in relation to the study objectives. Modification and other necessary changes were done on the FGD and interview guides based on interaction with the pilot study participants.

### **3.10 Data collection methods**

Different data collection methods were used for the participants. These are focus group discussions for the pregnant women and nurse/ midwives, and interviews were conducted with the policy-makers. Data collection commenced in mid-September of 2014, but was interrupted by the Medical and Health Workers' Union industrial action, which paralyzed public health facilities services in Nigeria. Data collection was completed in April 2015. Data collection was discussed and analysed separately for each of the three populations.



#### **3.10.1 Population 1: Pregnant women**

Data was collected from the pregnant women through Focus Group Discussion. According to Burns and Grove (2009:513) and Polit and Beck (2012), focus groups are a carefully planned data collection method designed to access a rich store of information regarding the participants. This should be done in a setting that will not pose a threat to the participants, and will enhance group dynamics. The group dynamics help them to express and clarify their views in ways that are less likely to occur in in-depth individual interviews (Burns & Grove 2009:513). A total number of ten (10) FGDs were held with the pregnant women in seven hospitals, with a total number of eighty –eight (88) women as participants. One pilot focus group discussion

was conducted, two focus group discussions were done at each of the Mother-and-child hospitals in Akure and Ondo town, and one focus group discussion was done at each of the remaining hospitals. There was an average of 6-8 pregnant women participants in each FGD session lasting between 60 and 120 minutes. The researcher acted as the moderator for all the focus group discussions, while a colleague nurse-educator was co-moderator, and took detailed notes of proceedings and other non-verbal behaviours of the participants and the environment.

Before the beginning of the discussion, the researcher re-introduced herself and reminded all participants about the objectives of the discussion. Each woman also introduced herself and filled in a bio-data form. Written and verbal consent was collected for participation and audio recording of the proceedings. The researcher also encouraged the participants to engage actively in the discussion, pointed out that there were no wrong or right answers, and assured participants of their right to disengage from participation at any time, should they wish to do this. An FGD guide (Annexure K) was used. Probing questions were used to steer the discussion and the use of non-verbal responses was encouraged.

The researcher summarized all the main points at the end of the discussion and checked the summary against participants' assessment of its veracity. In conclusion, the researcher expressed her appreciation to all participants for their participation in the study.



### **3.10.2 Population 2**

Data from the midwives was also collected using Focus Group Discussion (FGD). A total of eight FGDs were conducted with an average of 6 midwives as participants in each of the seven hospitals used in Ondo state. Each FGD session lasted about 60 and 120 minutes and the proceedings were recorded with the permission of participants. A Focus Group Confidential Binding Form was filled in by each participant before the commencement of each FGD session.

Before the beginning of the discussion, the researcher re-introduced herself and reminded all participants about the objectives of the discussion. Each midwife also introduced herself and filled in a bio-data form. Written and verbal consent was collected for participation and audio recording of proceedings. The researcher also encouraged the participants to engage actively in the discussion, emphasised that there were no wrong or right answers, and assured participants of their right to disengage from participation at any time should they wish to do this. Probing questions were used to steer the discussion and the use of non-verbal responses was encouraged.

The researcher summarized all the main points at the end of the discussion and checked the summary against the perceptions of the participants. In conclusion, the researcher expressed her appreciation to all participants for their participation in the study.

### **3.10.3 Population 3**

Data from the policy-makers was collected using the in-depth interview to determine their positions regarding CLS in public health facilities in Ondo state. Burns & Grove

(2009:154) describes in-depth individual interviews as the tool that involves one-to-one conversation between the researcher and the participants and can be used to obtain good qualitative information, which contains deep insight into the perceptions and experiences of the participants. A semi-structured interview guide was used during interviews, with specific questions written down. Each interview session lasted between 45 and 60 minutes and was recorded on tape with permission.

### **3.10.3.1 Data collection tool**

The researcher developed an interview guide consisting of a set of predetermined questions (Annexure M). All policy-makers in the study were interviewed with the same guide, but the proceedings were also guided by responses from each participant.

### **3.11. Field notes**

Field notes refer to notes created by the researcher during the act of qualitative fieldwork to remember and record the behaviors, activities, events, and other features of an observation. Field notes are intended to be read by the researcher as evidence to produce meaning and an understanding of the culture, social situation, or phenomenon being studied (Schwandt, 2015). Field notes were made after each focus group discussion and individual interview. These included the data, time, seating arrangement and order in which participant spoke for each setting of the FGD and the interview, non-verbal and personal responses to fact and question; physical structure of the setting was also documented. Field notes were taken to enhance and complement the detailed record of all occurrences during an interview (Schwandt, 2015). The researcher and the co-moderator discussed the notes after each focus group discussion and the field notes

were also analyzed, since they contribute to concept development at the initial phase of concept analysis (Walker & Avant, 2005).

### **3.12 Measures to ensure trustworthiness**

The researcher adopted Lincoln and Guba's (1985) methods of credibility, transferability, dependability, and confirmability in this study to ensure valid and credible findings. Trustworthiness is described as an expression of the feeling that the findings of a study are "worth paying attention to" (Lincoln and Guba 1985:290). Polit and Beck (2012) have also described the five aspects of measuring trustworthiness as credibility, dependability, confirmability, transferability and authenticity.

#### **3.12.1 Credibility**

Credibility is an evaluation of whether or not the research findings represent a "credible" conceptual interpretation of the data drawn from the participants' original data (Lincoln & Guba, 1985). To ensure the credibility of the study findings, the researcher adopted prolonged engagement, persistent observation and triangulation, peer debriefing, and member checking (Creswell, 2014; Lincoln & Guba 1985:301).

#### **3.12.2 Prolonged engagement**

Prolonged engagement involves spending sufficient time in the study setting and with the participants. Prolonged engagement allows the researcher to develop an in-depth understanding about the details of the site and people to give credence to the phenomenon under study (Creswell, 2014). In this study, the researcher had a pre-visit to all the settings used for the study before the commencement of the focus group

discussions and interviews to get familiar with the setting and make arrangements for a conducive environment, and also to identify issues that might present a challenge during the focus group discussions and interviews.

### **3.12.3 Persistent observation**

Persistent observation involves identification of those characteristics and elements in the situation that are most relevant to the research problem or issue being pursued and focused on in detail. It provides depth to the research study. In this study, the researcher made field notes, observed, identified and assessed those salient factors and crucial, typical occurrences that were relevant to the development of a culturally congruent CLS framework for women during childbirth. The researcher also adopted probing questions and received rich and in-depth data from the participants. This encouraged them to generate more ideas, viewpoints, opinions, perceptions and attitudes about the labour support concept (De Vos, et al. 2007:351).

### **3.12.4 Triangulation**

Triangulation was used to improve the probability that findings and interpretations would be credible. According to Lincoln and Guba (1985:305), triangulation refers to the use of multiple and different sources, methods, investigators and theories. In this study data was collected through mixed methods from major stakeholders regarding maternal and child health care and was cross analysed for similarities and differences, the researcher also engaged the services of two experienced research assistants in

conducting the focus group discussions as well as an independent co-coder for data analysis.

### **3.12.5 Peer debriefing**

Peer debriefing refers to “the process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer’s mind” (Lincoln & Guba 1985:308). In this study, the researcher conducted nominal group discussion sessions with 12 expert reviewers for the data collected and model development.

### **3.12.6 Dependability**

Dependability refers to the stability (reliability) of data over time, over conditions and over occasions (Polit & Beck 2008:539). To achieve dependability the researcher submits the collected data to the expert co-coder for comparison of data and analysis.

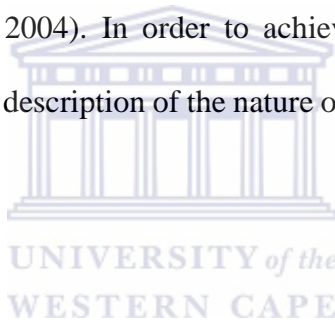
### **3.12.7 Confirmability**

Confirmability refers to objectivity, which has the potential for congruence between two or more independent people about the data accuracy, relevance, and how to interpret it (De Vos et al, 2007; Polit & Beck, 2008; Stommel & Celia, 2004). To achieve confirmability, the researcher used audit trails in which the approaches to data collection, decisions about which data to collect and about the interpretations of data were carefully documented so that another knowledgeable researcher could reasonably have arrived at the same conclusions about data as the primary researcher (Stommel & Celia, 2004). The researcher ensured that the findings reflected the participants’ voices

and the conditions of inquiry, rather than the biases, motivations or perspectives of the researcher (Polit & Beck, 2008). The researcher also ensured that there had been an internal agreement between the researcher's interpretation and the actual evidence (Brink 2006:125). There was a consensus among the researcher, the participants and the co-coder.

### **3.12.8 Transferability**

Transferability refers to the generalizability or the extent to which the findings can be transferred or have applicability to other settings and target populations (De Vos et al, 2007; Stommel & Celia, 2004). In order to achieve transferability, the researcher provided a comprehensive description of the nature of the study participants (Stommel & Celia, 2004).



### **3.12.9 Authenticity**

Authenticity refers to the extent to which the researcher has given a fair, faithful, honest and balanced account of social life from the viewpoint of someone who lives it every day, showing a range of different realities (Polit & Beck 2008:540). Authenticity emerged in a report when it conveyed the perception and attitude of all stakeholders to CLS from the woman's social networks, in public health facilities (Polit & Beck 2008:540).

### **3.13 Data management and analysis**

Qualitative Data Analysis (QDA) is the range of processes and procedures whereby the researcher moves from the qualitative data that have been collected into some form of

explanation, understanding or interpretation of the people and situations under investigation (Taylor and Gibbs, 2010). QDA is usually based on an interpretative philosophy to examine the meaningful and symbolic content of qualitative data through writing and the identification of themes (Taylor and Gibbs, 2010). Qualitative data analysis adopts the process of inductive reasoning. Trochim (2006) refers to two “broad methods of reasoning” as the inductive and deductive approaches and defines induction as moving from the specific to the general, while deduction begins with the general and ends with the specific. Research using the inductive reasoning approach usually “works from the ‘top down’ using the participants’ views to build broader themes and generate a theory interconnecting the themes” (Creswell and Plano Clark, 2007).

In this study, focus group discussions of the pregnant women and midwives and semi-structured individual interviews with the policy-makers were analyzed through thematic analysis. Data analysis procedure was done by the researcher and an independent data coder who is an expert on qualitative data analysis. The process of analysis involved:

- Organization and preparation of the data transcribing
- Developing a general sense of the data by reading and re-reading the transcripts, reflecting on the meaning of the data and writing notes
- Generating categories and coding the data
- Grouping categories into themes to generate descriptions of categories and themes

### **3.13.1 Transcribing Qualitative Data**

The audio recorded data from focus group discussions with the pregnant women and nurse/ midwives, and the interviews with the policy-makers with their field notes were transcribed verbatim by the researcher to ensure that transcriptions were accurate and reflected the totality of the focus group discussions and interviews. This also facilitated closer familiarity of the researcher with the data collected. To facilitate analysis during the transcription process, the researcher coded each individual speaker by assigning an alphabetical code. For example “I” meaning “interviewer” was used for the researcher, “FGDP” for pregnant participants and “FGDM” for midwives (Polit & Beck 2008: 509). The researcher had an independent co-coder and worked closely with the researcher’s supervisor, who confirmed the data from the audiotape to ensure the reliability of data coding (Brink 2006:185). Utterances such as sighs, laughter, the emphasis of words and repetitions were also indicated in the data transcription.

### **3.13.2 Developing a category scheme**

The researcher read, reorganized, and carefully transcribed the data to identify underlying concepts. This process assisted the researcher in determining the strategy for classification and indexing the data to develop a high-quality category scheme. The researcher converted the data into smaller and more manageable units that could be reviewed and retrieved. The category scheme was developed based on the scrutiny of the actual data (Polit & Beck 2008:510).



### **3.13.3 Coding qualitative data**

Correspondence from the data was coded to the categories by the researcher after reading the entire body of data. The researcher also read over the categories up to three to four times in order to fully understand the underlying meaning of each category. The data was grouped according to the findings from three different population groups. Themes were developed during analysis and interpretation of data. The detailed results from each population are described in Chapter Five.

### **3.14 Phase Two: framework development and description**

Framework development and description were based on the findings of Phase One objectives 1-3 regarding CLS from the woman's social networks in public health facilities. Conceptualization of the concepts identified during phase one was constructed into framework development using Walker & Avant (2005) concept synthesis. Concept synthesis is the process of using information based on observation, to construct a new concept through:

- i. Concept development
- ii. Concept classification
- iii. Framework development
- iv. Validation of the framework (Walker & Avant, 2005)

#### **3.14.1 Concept development**

A concept refers to “a mental image of a phenomenon, an ideal, or a construct in the mind about a thing or an action” (Walker & Avant, 2005). The concepts in this study

were identified, described and developed through synthesis of data from the focus group and individual interviews of all stakeholders. Walker & Avant (2005) describe the process of synthesis to involve examining raw data obtained from the focus group and individual interviews, to develop new insights or concepts to add to theoretical development. There are three approaches to concept synthesis, namely: qualitative, quantitative and literary approaches. Mixed method approaches to concept synthesis were found to be suitable in this study because the researcher combined quantitative, qualitative and literary approaches to identify similarities and differences in the data. Quantitative and qualitative data were classed into vertical categories while clustering and comparison of each classification was done by the researcher using visual inspection.

#### **3.14.2 Concept classification**

Concept classification is the process of identifying the relationships between two or more concepts from the concept development stage (Walker & Avant, 2005). Quantitative and qualitative data were put side by side for comparison, and vertical inferences were made from the data. Generalization from specific inferences to more abstract was facilitated by the qualitative and quantitative method process. Only statements derived from or supported by the empirical evidence were used for framework development (Walker & Avant, 2005). Expert review with skilled professionals in maternal and child health care were used at this stage, based on the results from the interpretation of the data for the process of the framework development. The group membership consists of 12 representatives including two

obstetricians, one Director of Nursing services, three Heads of Nursing Services, two principals of Schools of Nursing and Midwifery, one Chief Midwife Educator, one Principal Midwife Educator and one sociologist.

In the classification of concepts, the researcher made use of the six vantage points of surveying activity, together with the six aspects of activity as listed by Dickoff et al, (1968):

Agency – Who or what performs the activity?

Patiency or recipiency – Who or what is the recipient of the activity?

Framework – In what context is the activity performed?

Terminus – What is the end point of the activity?

Procedure – What is the guiding procedure, technique or protocol of the activity?

Dynamics – What is the energy source for the activity?

The steps above are used as a survey list when describing a particular situation or problem, and to give direction for the activities or strategies required to address the problem. The survey list was also used to identify the agent who carried out the strategies, who are the recipients of the strategies and in what context they were carried out. The survey list assisted the researcher in identifying what dynamics are required for activities to take place, as well as the procedures which are required to guide them. The terminus or the end point of the activity was the development of a one to one CLS framework during childbirth for use in public health facilities.

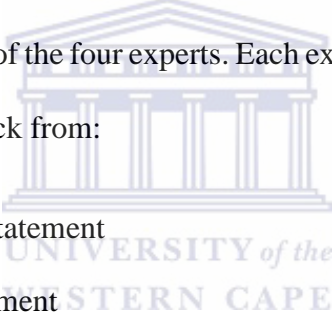
### 3.14.3 Description of the framework

The following questions were asked in order to describe a conceptual framework for culturally congruent CLS from women's social networks in public health facilities in Ondo state.

- What is the purpose of this framework? This question specifies the context and situations to which the framework applies.
- Why is this framework formulated?
- What are the concepts of this framework? This question identifies the ideas that are structured within the model. Concepts will be examined for quantity, character, emerging relationships and structure.
- How are the concepts defined? This question will clarify the meaning of the concepts based on the concepts from all stakeholders in the study.
- What is the nature of the relationships? This question addresses how concepts are linked together.
- What is the structure of the framework?
- On what assumptions does the framework build? This was built on values and relationships concepts that promote the implementation of a culturally congruent CLS from women's social networks in public health facilities in Ondo state. It also identified health beliefs and actions that are barriers and challenges to the implementation of the CLS framework.

### **3.15 Validation of the framework**

The developed culturally congruent CLS framework was validated through consensus expert review, which consists of four people selected previously as expert review group participants. The role of the experts was to consider and evaluate the suitability and applicability of the framework for its intended purpose in public health facilities in Ondo state. The evaluation of the framework was based on its content, components and structure, using the list of prescriptive consensus agreement statements. The consensus agreement form gave each expert the opportunity to decide on each of the statements of the framework. The final draft of the framework with the consensus agreement form was thereafter sent to each of the four experts. Each expert participant had the following options of statements to pick from:

- 
- A. = Agree with the statement
  - B. = Modify the statement
  - C. = Abstain ( No comment)
  - D. = Delete the statement

The results of the expert and suggestion exercise were worked on by the researcher in consultation with the research supervisor.

### **3.16 Summary**

Chapter Three has provided a detailed description of how the study was conducted in order to achieve the research objectives. This study adopted mixed methods, both quantitative and qualitative research approaches using exploratory, descriptive, and contextual designs to gain information from various dimensions as suggested by

Walker & Avant (2005). Phase one aimed at assessing the perceptions, attitudes and preferences of pregnant women, nurse-midwives and policy-makers, regarding CLS from women's social networks in public health facilities in South-West Nigeria. Phase Two aimed at development and description of a framework for incorporating "culturally congruent CLS for women during childbirth, using the concept synthesis method of Avant and Walker (2005).

Chapter 4 presents the results and discussion of a quantitative strand of Phase One of the study.



## CHAPTER FOUR

### QUANTITATIVE RESULT

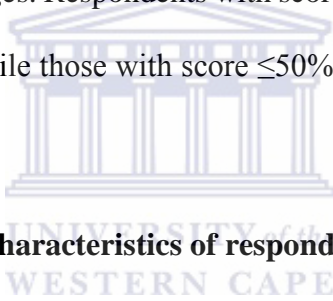
#### **4.1 Introduction**

This chapter presents the results and discussion of the questionnaires administered to pregnant women in seven (7) selected public health facilities in Ondo state. The objective of the questionnaire was to assess the women's perceptions, attitudes and preferences to CLS in the hospital. The perceptions of the women were assessed on their perceived support received from midwives during their last delivery experience in the hospital as well as their level of satisfaction with the care. The attitudes of the women to CLS by a person from their social network, as well as their perceived role of the support person in a public hospital were also measured. The pregnant women's preference of labour support person from their social network was assessed. Data was analysed using descriptive analysis of the Statistical Package for Social Science (SPSS) version 20, and generated data was presented in diagrams, frequency distribution and cross-tabulation tables. Statistical tests such as the Chi-square and the binary logistic regression were used to test for associations and predictors of preference for continuous support with the level of significance set at  $p < 0.05$ .

Satisfaction of respondents with women's perceived support of midwives' during their last labour experience was scored using a six-point Likert scale (6= very satisfied, 5= fairly satisfied, 4= somewhat satisfied, 3= somewhat dissatisfied, 2= fairly dissatisfied and 1= very dissatisfied) for each of the 10 questions on respondents' satisfaction, to make a total out of 60 points. The average of the scores was calculated and those below

average were categorised as respondents who were not satisfied, while those at the average and above average were categorised as those fairly satisfied, and satisfied with support rendered by the midwives during labour. The level of satisfaction of respondents was further categorised on the chi-square analysis with respondents who were not satisfied and fairly satisfied categorised as never satisfied.

The attitude of respondents to CLS was scored using a five-point Likert scale (5= strongly agree, 4= agree, 3= undecided, 2= disagree, 1= strongly disagree) for each of the 10 questions assessing respondents' attitudes, to make a total out of 60 points, which was converted to percentages. Respondents with score >50% were categorised as those with a positive attitude while those with score ≤50% were categorised as those with a negative attitude to CLS.



#### **4.2. Socio-demographic characteristics of respondents**

A total of 368 mothers were interviewed. As detailed in Table 4.2, the majority (68.8%) of the respondents were between the age group 26-35 years, followed by those below 26 years (19.0%) with a mean age of  $30.1 \pm 5.1$  years. Most (96.7%) of the respondents were married while 1.4% were single and/or separated. The majority of the respondents were educated, with 46.2% having a tertiary level of education, followed by secondary (40.2%), while 3.0% of them had no formal education. High proportions (87.0%) of the respondents were from the Yoruba ethnic group followed by the Igbo (9.5%). The result also showed that 85.1% of the respondents were Christians and 13.6% were Muslims. More than two-thirds (64.2%) of the respondents had more than one child, with 35.8% of them reporting having at least one child



**Table 6 : Socio-demographic characteristics of respondents**

|                           | Frequency<br>(n=368) | Percentage (%) | Mean±SD  |
|---------------------------|----------------------|----------------|----------|
| <b>Age group</b>          |                      |                |          |
| 15-25                     | 70                   | 19.0           | 30.1±5.1 |
| 26-35                     | 253                  | 68.8           |          |
| 36-45                     | 43                   | 11.7           |          |
| 46-55                     | 2                    | 0.5            |          |
| <b>Number of children</b> |                      |                |          |
|                           |                      |                | 2.0± 1.0 |
| 1                         | 132                  | 35.8           |          |
| 2                         | 122                  | 33.2           |          |
| 3                         | 74                   | 20.1           |          |
| ≥4                        | 40                   | 10.9           |          |
| <b>Marital status</b>     |                      |                |          |
| Married                   | 356                  | 96.7           |          |
| Single                    | 5                    | 1.4            |          |
| Divorced                  | 2                    | 0.5            |          |
| Separated                 | 5                    | 1.4            |          |
| <b>Educational status</b> |                      |                |          |
| No formal                 | 11                   | 3.0            |          |
| Primary                   | 39                   | 10.6           |          |
| Secondary                 | 148                  | 40.2           |          |
| Tertiary                  | 170                  | 46.2           |          |
| <b>Ethnicity</b>          |                      |                |          |
| Yoruba                    | 320                  | 87.0           |          |
| Igbo                      | 35                   | 9.5            |          |
| Others                    | 13                   | 3.5            |          |
| <b>Religion</b>           |                      |                |          |
| Christian                 | 313                  | 85.1           |          |
| Islam                     | 50                   | 13.6           |          |
| Traditional               | 5                    | 1.2            |          |

### **4.3 Pregnancy and delivery history of respondents**

As shown in table 7, 92.7% of the respondents have had more than one pregnancy while 99.4% of the pregnant women have had one or more delivery experience. About half (51.1%) of the respondents have had more than one delivery in the hospital, and about 91.0% of the women delivered their last child in the hospital. When asked about the total antenatal care sessions attended before delivery, 44.0% of the respondents indicated that they had attended more than 4 antenatal classes; while very few (3.3%) had had just one antenatal class. The nursing officers and midwives constituted (80.4%) of the total of main care providers to the respondents during the current pregnancy, followed by the physicians (18.5%) and relatives (1.1%). The majority (72.8%) of the respondents reported having had four hours' labour duration during the last delivery of their index child. About seventy-five percent (75%) of the respondents reported that family members were not allowed in the labour room during their last delivery while only 7.6% reported that family members were allowed unrestricted access to the labour room during delivery.

**Table 7 : Pregnancy and delivery history of respondents**

| <b>Variables</b>                                  | <b>Frequency<br/>n=368</b> | <b>Percentage<br/>(%)</b> | <b>Mean±SD</b> |
|---|----------------------------|---------------------------|----------------|
| <b>Number of pregnancies</b>                      |                            |                           |                |
| 1   | 27                         | 7.3                       | 3.0± 0.9       |
| 2   | 106                        | 28.8                      |                |
| 3   | 121                        | 32.9                      |                |
| 4 and above                                       | 114                        | 31.0                      |                |
| <b>Number of deliveries</b>                       |                            |                           |                |
| None  | -                          | -                         | 2.0± 1         |
| 1   | 125                        | 33.9                      |                |
| 2   | 135                        | 36.7                      |                |
| 3   | 66                         | 17.9                      |                |
| 4 and above                                       | 42                         | 11.4                      |                |
| <b>Number of deliveries in public hospital</b>    |                            |                           |                |
| None  | 36                         | 9.8                       | 2.0± 1         |
| 1   | 144                        | 39.1                      |                |
| 2   | 120                        | 32.6                      |                |
| 3   | 53                         | 14.4                      |                |
| 4 and above                                       | 15                         | 4.1                       |                |
| <b>Present Antenatal classes attendance</b>       |                            |                           |                |
|   | 12                         | 3.3                       | 3.1± 1         |
| 1   | 86                         | 23.4                      |                |
| 1-4   | 108                        | 29.3                      |                |
| 5-9   | 162                        | 44.0                      |                |
| 10 and above                                      |                            |                           |                |
| <b>Care provider during current pregnancy</b>     |                            |                           |                |
| Physician   | 296                        | 80.4                      |                |
| Nurse- Midwife                                    | 4                          | 1.1                       |                |
| Relatives   |                            |                           |                |
| <b>Delivery of the last child in the hospital</b> |                            |                           |                |
| Yes   | 35                         | 91.0                      |                |
| No  | 33                         | 9.0                       |                |
| <b>Last labour duration</b>                       |                            |                           |                |
| less than 4 hours                                 | 100                        | 27.2                      |                |
| 5-8 hours   | 94                         | 25.5                      |                |
| 9-11 hours  | 76                         | 20.7                      |                |
| 12-14 hours                                       | 59                         | 16.0                      |                |

|  |     |      |
|--|-----|------|
| 15-17 hours  | 13  | 3.5  |
| more than 18 hours   | 26  | 7.1  |
| <b>Allowed to have family member in the labour room during last delivery</b>     | 91  | 24.7 |
| Yes  | 277 | 75.3 |
| No   |     |      |
| <b>Allowed to have family member continuously in labour room during delivery</b> |     |      |
| Yes  | 28  | 7.6  |
| No   | 340 | 92.4 |

---

#### **4.4 Fear of delivery in the hospital experienced by respondents**

About a quarter (25.3%) of the respondents reported having had some fears of giving birth at the hospital with the last delivery. Among the main reasons given by the majority of the respondents for fearing delivery at the hospital, 38.7% reported the unfriendly attitude of health workers (38.7%), followed by labour pains (15.1%), being delivered by operation (delivery by caesarean section), and unfamiliar environment (11.0% each). Table 4.3 below gives the full details on this variable.

**Table 8 : Fear of giving birth in the hospital experienced by respondents**

|  | Frequency<br>n=368 | Percentage (%) |
|--|--------------------|----------------|
| <b>Had fear of giving birth at hospital</b>                    |                    |                |
| Yes  | 93                 | 25.3           |
| No   | 275                | 74.7           |
| <b>Reasons for the fear of giving birth at hospital (n=93)</b> |                    |                |
| No early question  | 2                  | 2.2            |
| Labour pain  | 14                 | 15.1           |
| Being delivered by operation                                   | 11                 | 11.8           |
| Being with unfamiliar people                                   | 8                  | 8.6            |
| Unfamiliar environment   | 11                 | 11.8           |
| Unfriendly attitude of health workers                          | 36                 | 38.7           |
| No reasons given   | 11                 | 11.8           |

#### **4.5 Perceptions of women of CLS**

The perceptions of the women were assessed on the perceived support received from midwives during their last delivery experience in the hospital, as well as their levels of satisfaction with the care received as a baseline for needs assessment for CLS during childbirth. The women's perceptions of CLS from a person from their social network in a public hospital, were also measured .

##### **4.5.1 Perceptions about support received from midwives during the last delivery**

Table 9 offers an assessment of perceived physical comfort measures, and emotional responses to instruction and advocacy support from midwives during respondents' last delivery. Physical comfort measures were rated slightly above average by the

respondents in this study. About 60 (6%) of the pregnant women reported having had assistance in bathing while 60.6% had their clothes/gown changed by the midwives. 60.3% of the women reported that midwives assisted by holding their hand and stroking their body during labour. 60.3% of the women were assisted in bathing or toilet while 60.3% had back massages and 59.5% had some form of therapeutic touching administered. 57.9% of the respondents were assisted in ambulation into, and 55.2% were assisted out of bed. 46.2% had their position changed for comfort.

On emotional support, the majority of the women in this study reported low emotional care from the midwives; only 35.6% of the women had midwives keeping them company, 30.2% had encouragement to verbalize fear, 30.2% of the women enjoyed midwives showing concern for their needs while 29.9% of the respondents reported that the midwives gave reassurance, encouragement and praise. The number of women who had social interaction/ conversation during labour from midwives was also below 50% (47.6%).

Instructional support received by women during their last birth experience was also low, as reported by the respondents, only 23.9% of the women reported having received antenatal teaching, which is the core aspect of antenatal care. 32.3% of the women reported being instructed on techniques to promote comfort and relaxation followed by coaching on breathing exercises and bearing down (32.1%), explanations and information about the progress of labour (28.5%) and monitoring procedures and foetal neonatal well-being (26.6%). Only 33.3% of the women had instruction on hospital routine, and getting information from patients.

On advocacy support, about 34.0% of the respondents had adequate pain management while 48.6% had midwives negotiating their needs with other team members.

**Table 9 : Respondents' Perceived Support received from midwives during the last delivery**

| <b>N=368</b>                               | <b>Yes n(%)</b> | <b>No n(%)</b> |
|--|-----------------|----------------|
| <b>Physical comfortmeasure</b>             |                 |                |
| Assistingin bathing                        | 223 (60.6)      | 145 (39.4)     |
| Antenatal teaching                         | 88 (23.9)       | 280 (76.1)     |
| Clothes/gown changing                      | 222 (60.3)      | 146 (39.7)     |
| Positioningfor comfort                     | 170 (46.2)      | 198 (53.8)     |
| Back Massage                               | 219 (59.5)      | 149 (40.5)     |
| Therapeutictouch                           | 213 (57.9)      | 155 (42.1)     |
| Holdinghandand stroking                    | 222 (60.3)      | 146 (39.7)     |
| Assistingin ambulationin and out ofbed     | 203 (55.2)      | 165 (44.8)     |
| Assistingin walkingto bath/toilet          | 222 (60.3)      | 146 (39.7)     |
| <b>Emotional support</b>                   |                 |                |
| Encouragingand verbalization of fear       | 113 (30.7)      | 255 (69.3)     |
| Showing concern for needs                  | 111 (30.2)      | 257 (69.8)     |
| Reassurance, encouragement and praise      | 110 (29.9)      | 258 (70.1)     |
| Keepingcompany                             | 131 (35.6)      | 237 (64.4)     |
| Engagingin socialconversation              | 175 (47.6)      | 193 (52.4)     |
| <b>Instruction information</b>             |                 |                |
| Givinginstruction andcoachingon            | 118 (32.1)      | 250 (67.9)     |
| Suggestingtechniques topromote comfort     | 119 (32.3)      | 249 (67.7)     |
| Explaining, providinginformation about     | 105 (28.5)      | 263 (71.5)     |
| Monitoringprocedures,foetal neonatal well- | 98 (26.6)       | 270 (73.4)     |
| Explaininghospital routine,                | 119 (32.3)      | 249 (67.7)     |
| <b>Advocacy</b>                            |                 |                |
| Listeningto myrequest forpainmanagement    | 125 (34.0)      | 243 (66.0)     |
| Negotiatingmyneeds withotherteam members   | 179 (48.6)      | 189 (51.4)     |

#### 4.5.2 Perceived Support received from midwives during the last delivery

Table 10 shows support received from midwives during the last delivery. According to the area of physical comfort measure, the mean score was  $19.37 \pm 10.20$  followed by emotional support ( $7.47 \pm 6.31$ ), the mean score of instruction information support was  $6.68 \pm 7.57$  and advocacy support was  $2.56 \pm 3.26$ . Hence, the mothers received the highest level of supportive care only on physical support while emotional, instructional information and advocacy support was low.

**Table 10 : Perceived Support received from mothers during last delivery**

| Support                  | Max score | Mean $\pm$ SD     |
|--------------------------|-----------|-------------------|
| Physical comfort measure | 36        | $19.37 \pm 10.20$ |
| Emotional                | 20        | $7.47 \pm 6.31$   |
| Instruction information  | 20        | $6.68 \pm 7.57$   |
| Advocacy                 | 8         | $2.56 \pm 3.26$   |

#### 4.5.3 Satisfaction of respondents with midwives' support during last labour

Table 11 shows respondents' satisfaction with support received from the midwives during the last labour. More than fifty percent of the respondents reported being very satisfied with the following: being given needed attention (55.2%), being made to feel, and being kept comfortable (53.3), being encouraged when they felt like giving up (52.2%), being encouraged to try new ways (51.1%) and being allowed to express their thoughts and feelings verbally (50.0%). Also, a low proportion of the respondents reported dissatisfaction with support such as: the assuming of a different position (3.3%), taking control of the birth process (3.0%), finding energy when about to give



up (3.0%), verbalizing their mind (2.4%), listening to complaints and paying attention (2.2% each), taking care of pain (1.9%) and feeling comfortable (1.6%).

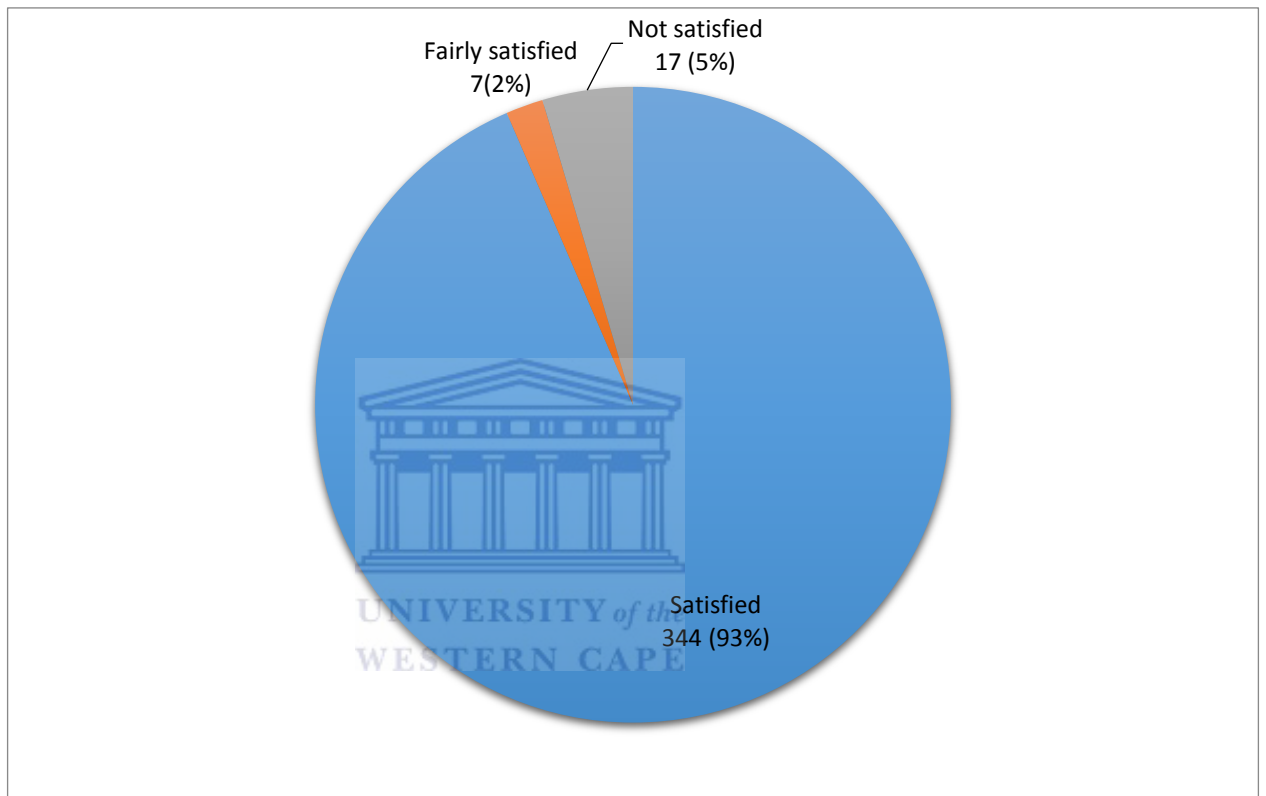


**Table 11 : Satisfaction of respondents with midwives' support during last labour**

| <b>N=368</b>  | <b>Very satisfied<br/>n(%)</b> | <b>Fairly satisfied<br/>n(%)</b> | <b>Somewhat satisfied(<br/>%)</b> | <b>Somewhat dissatisfied<br/>(%)</b> | <b>Fairly dissatisfied<br/>n(%)</b> | <b>Very dissatisfied<br/>n(%)</b> |
|---|--------------------------------|----------------------------------|-----------------------------------|--------------------------------------|-------------------------------------|-----------------------------------|
| Helping me to find energy when I wanted to give up            | 192<br>(52.2)                  | 98<br>(26.6)                     | 39<br>(10.6)                      | 16<br>(4.3)                          | 12<br>(3.3)                         | 11<br>(3.0)                       |
| Knowing instinctively what I wanted or needed at any one time | 166<br>(45.1)                  | 116<br>(31.5)                    | 41<br>(11.1)                      | 24<br>(6.5)                          | 13<br>(3.5)                         | 8<br>(2.2)                        |
| Making and keeping me comfortable                             | 196<br>(53.3)                  | 102<br>(27.7)                    | 33<br>(9.0)                       | 20<br>(5.4)                          | 11<br>(3.0)                         | 6<br>(1.6)                        |
| Encouraging me to try new ways of coping                      | 188<br>(51.1)                  | 97<br>(26.4)                     | 56<br>(15.2)                      | 11<br>(3.0)                          | 11<br>(3.0)                         | 5<br>(1.4)                        |
| Taking care of my pain  | 179<br>(48.6)                  | 94<br>(25.5)                     | 52<br>(14.1)                      | 19<br>(5.2)                          | 17<br>(4.6)                         | 7<br>(1.9)                        |
| Allowing me to verbalise my thoughts                          | 184<br>(50.0)                  | 98<br>(26.6)                     | 47<br>(12.8)                      | 20<br>(5.4)                          | 10<br>(2.7)                         | 9<br>(2.4)                        |
| Helping me to assume a different position                     | 182<br>(49.5)                  | 98<br>(26.6)                     | 45<br>(12.2)                      | 15<br>(4.1)                          | 16<br>(4.3)                         | 12<br>(3.3)                       |
| Allowing me to take control of the birthing process           | 155<br>(42.1)                  | 84<br>(22.8)                     | 74<br>(20.1)                      | 26<br>(7.1)                          | 18<br>(4.9)                         | 11<br>(3.0)                       |
| Listening to my complaints and concerns                       | 182<br>(49.5)                  | 113<br>(30.7)                    | 37<br>(10.1)                      | 19<br>(5.2)                          | 9<br>(2.4)                          | 8<br>(2.2)                        |
| Giving me needed attention                                    | 203<br>(55.2)                  | 93<br>(25.3)                     | 37<br>(10.1)                      | 18<br>(4.9)                          | 9<br>(2.4)                          | 8<br>(2.2)                        |

Hence in general, 93.0% reported satisfaction with all the support rendered by the midwives as depicted in Figure 6

**Figure 6 : Satisfaction of respondents with midwives' support during last labour**



#### **4.5.3.1 Mother's level of satisfaction of care in the last delivery**

Table 12 shows the proportion of respondents satisfied with each of the 10 items. Of the 10 items, a proportion of complete satisfaction above 50% was recorded for help finding energy when needed (52.2%), making respondents feel comfortable (53.3%), encouraging them to try new ways of coping (51.1%), giving them needed attention (55.2%). A lower proportion of complete satisfaction was reported for the following: knowing instinctively what they wanted (45.1%), listening to their complaints and

concern (49.5%), take care of their pain (48.6%), allow them to take control of the birthing process (42.1%). Making and keeping them comfortable (1.6%) and encouraging them to try new ways of coping (1.4%) recorded a very low dissatisfaction score.

**Table 12 : Mother's level of satisfaction during last childbirth**

| <b>Variable</b>   | <b>Completely satisfied (%)</b> | <b>Very dissatisfied (%)</b> |
|---|---------------------------------|------------------------------|
| Helping me to find energy when I wanted to give up            | 192(52.2)                       | 11(3.0)                      |
| Knowing instinctively what I wanted or needed at any one time | 166(45.1)                       | 8(2.2)                       |
| Making and keeping me comfortable                             | 196(53.3)                       | 6(1.6)                       |
| Encouraging me to try new ways of coping                      | 188(51.1)                       | 5(1.4)                       |
| Taking care of my pain  | 179(48.6)                       | 7(1.9)                       |
| Allowing me to verbalise my thoughts                          | 184(50.0)                       | 9(2.4)                       |
| Helping me to assume a different position                     | 182(49.5)                       | 12(3.3)                      |
| Allowing me to take control of the birthing process           | 155(42.1)                       | 11(3.0)                      |
| Listening to my complaints and concerns                       | 182(49.5)                       | 8(2.3)                       |
| Giving me needed attention                                    | 203(55.2)                       | 8(2.2)                       |

#### 4.5.4 Perceptions of women about CLS from social network

In table 13, the majority of the respondents felt that a family member can serve as a companion to provide supportive care during labour (74.5%) while 76.4% felt the hospital should allow a person known to the respondent in the labour room to provide continuous support (76.4%).

**Table 13 : Perceptions of women to CLS from social network**

|  | Frequency n=368 | Percentage (%) |
|--|-----------------|----------------|
| <b>Think a family member can serve as a companion to provide supportive care during labour</b> |                 |                |
| Yes  | 274             | 74.5           |
| No   | 94              | 25.5           |
| <b>Think hospital should allow a woman to have a person known to her for CLS</b>               |                 |                |
| Yes  | 281             | 76.4           |
| No   | 87              | 23.6           |

#### 4.6 Attitude of respondents to CLS

The attitude of the women to CLS by a person from their social network was assessed on the perceived role of the support person in the public hospital. Table 14 shows the attitude of respondents to an opinion about a family member providing CLS. More than half of the respondents strongly agreed that a family member can offer spiritual prayer support, and provide support such as physical comfort, human contact, praise for efforts, and companionship. The majority of the pregnant women also agree that the family member will reassure them and serve as a source of safety and security in the

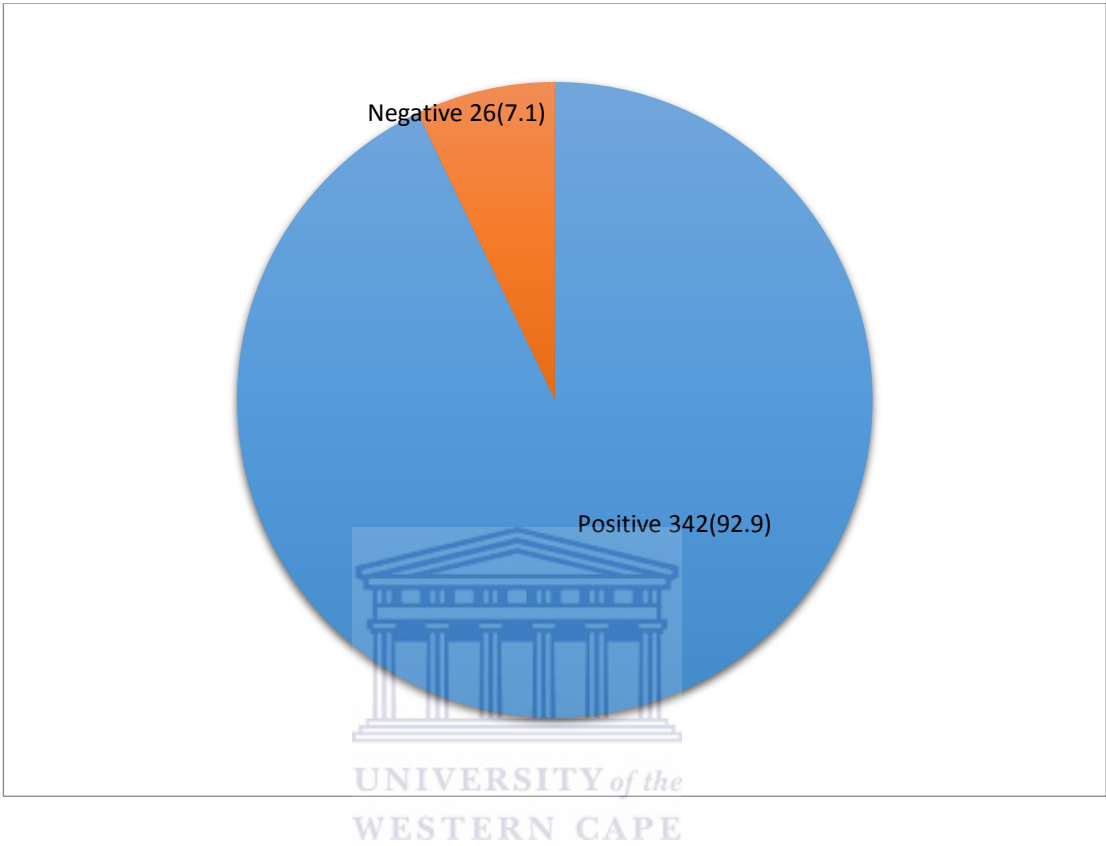
hospital. However some of the women disagree on the ability of the family labour supports to provide information on the progress of labour, coping techniques with the progress of labour, as well as helping with health decisions and choices. Generally the respondents showed a positive attitude to CLS from a family member. This is shown in Figure 7

**Table 14 : Attitudes of respondents to CLS**

| <b>Opinions about a family member providing CLS</b>                  | <b>SA<br/>n (%)</b> | <b>A<br/>n (%)</b> | <b>U<br/>n (%)</b> | <b>D<br/>n (%)</b> | <b>SD<br/>n (%)</b> |
|--|---------------------|--------------------|--------------------|--------------------|---------------------|
| Safety and security  | 189<br>(51.4)       | 98<br>(26.6)       | 13<br>(3.5)        | 39<br>(10.6)       | 29<br>(7.9)         |
| Reassurance  | 191<br>(51.9)       | 113<br>(30.7)      | 7<br>(1.9)         | 35<br>(9.5)        | 22<br>(6.0)         |
| Provision of information on progress of labour                       | 155<br>(42.1)       | 85<br>(23.1)       | 36<br>(9.8)        | 56<br>(15.2)       | 36<br>(9.8)         |
| Support on health decisions and choices                              | 145<br>(39.4)       | 125<br>(34.0)      | 36<br>(9.8)        | 36<br>(9.8)        | 26<br>(7.1)         |
| Physical comfort (touching, holding hand, back massage, wiping face) | 227<br>(61.7)       | 85<br>(23.1)       | 9<br>(2.4)         | 30<br>(8.2)        | 17<br>(4.6)         |
| Provision of coping techniques with labour progress                  | 147<br>(39.9)       | 112<br>(30.4)      | 33<br>(9.0)        | 43<br>(11.7)       | 33<br>(9.0)         |
| Consulting with health workers on health needs                       | 185<br>(50.3)       | 115<br>(31.3)      | 20<br>(5.4)        | 34<br>(9.2)        | 14<br>(3.8)         |
| Providing company  | 219<br>(59.5)       | 106<br>(28.8)      | 16<br>(4.3)        | 17<br>(4.6)        | 10<br>(2.7)         |
| Providing contact and praising efforts                               | 220<br>(59.8)       | 103<br>(28.0)      | 13<br>(3.5)        | 21<br>(5.7)        | 11<br>(3.0)         |
| Offering spiritual prayer  | 230<br>(62.5)       | 94<br>(25.5)       | 19<br>(5.2)        | 18<br>(4.9)        | 7<br>(1.9)          |

**SA** –Strongly Agree **A** –Agree **U**– Undecided **D** –Disagree **SD** – Strongly Disagree

**Figure 7 : Attitudes of respondents to CLS**



#### **4.7 Preference of CLS person among respondents**

This section shows the pregnant women's preference of labour support person from their social network, with the associating factors influencing the women's preference for CLS. Table 15 shows preference of CLS person among the respondents. The majority (75.5%) of the respondents preferred CLS from a familiar person. The main reasons given by the respondents for preferring CLS include: provision of company and help where necessary (61.9%), offering prayers/reassurance and support (22.7%), comfort/reduction of pain and fear of labour (6.5%), protection from maltreatment of health workers (4.7%) and previous experience of labour (4.0%). Among those that disagreed with a preferred/familiar person to continuously provide labour support, the reasons given for disagreeing were: this is not a necessity during delivery (43.3%), God is the only support during labour (26.6%), the fear of breaking confidentiality (24.4%), and not used to pampering during labour (4.0%). The majority (64.9%) of the respondents preferred their husband for CLS, followed by their mother (18.2%).



**Table 15 : Preference of CLS person among respondents**

|  | Frequency<br>n=368 | Percentage (%) |
|--|--------------------|----------------|
| <b>Preferred CLS from familiar person</b>        |                    |                |
| Yes  | 278                | 75.5           |
| No   | 90                 | 24.5           |
| <b>Reasons for agreeing to CLS (n=278)</b>       |                    |                |
| NoCLS  | 1                  | 0.4            |
| To provide company and help where necessary      | 172                | 61.9           |
| Protection from maltreatment of health workers   | 13                 | 4.7            |
| Comfort/reduction of pain and fear of labour     | 18                 | 6.5            |
| Prayers/reassurance and support                  | 63                 | 22.7           |
| Feel the experience of labour                    | 11                 | 4.0            |
| <b>Reasons for disagreeing to CLS<br/>(n=90)</b> |                    |                |
| Only God can support during labour               | 24                 | 26.6           |
| It is not necessary                              | 39                 | 43.3           |
| Not used to pampering during labour              | 5                  | 5.6            |
| Fear of breaking confidentiality                 | 22                 | 24.4           |
| <b>Preferred person for CLS</b>                  |                    |                |
| Husband  | 239                | 64.9           |
| Mother   | 67                 | 18.2           |
| Mother-in-law                                    | 30                 | 8.2            |
| Sister   | 25                 | 6.8            |
| Friend   | 2                  | 0.5            |
| Brother  | 1                  | 0.3            |
| Neighbour  | 4                  | 1.1            |

**4.7.1 Factors influencing preference for CLS from familiar person**

The associations of different variables were compared with the pregnant women's preference for CLS from a person in their social network, in public hospitals, using correlations and multivariate analysis.

#### **4.8 Association between socio-demographic characteristics and preference for CLS from familiar person**

Table 16 shows the association between socio-demographic characteristics of respondents and preference for CLS from a familiar person. Statistically, none of the characteristics of respondents was found to be significantly associated with preference for CLS. A higher proportion (80.0%) of respondents in the age group  $\leq 25$  years had a preference for CLS compared to those between 26-35 years (74.7%) and  $>35$  years (73.3%),  $p=0.616$ . More (100%) of the respondents with no formal education had a preference for CLS compared to 64.1% of those who had had primary, secondary (73.6%) and tertiary (78.2%),  $p=0.064$ .

A slightly higher proportion (76.9%) of respondents from other ethnic groups such as the Hausa and Edo had a preference for CLS compared to the Yoruba (76.6%) and Igbo (65.7%),  $p=0.364$ . A higher proportion (76.4%) of respondents who were Christians had more preference for CLS compared to the Muslims (68.0%). However, all (100%) respondents practising local traditional religion had a preference for CLS (0.195). A slightly higher proportion (77.0%) of respondents with two children had a preference for CLS compared to those with one (73.5%) and more than two children (76.3%), (0.783).

**Table 16 : Association between socio-demographic characteristics and preference for CLS**

| Socio-demographic Variables | Preference for CLS |            | Total<br>N=368 | X <sup>2</sup> | P-Value |
|-----------------------------|--------------------|------------|----------------|----------------|---------|
|                             | Yes<br>n(%)        | No<br>n(%) |                |                |         |
| <b>Age in years</b>         |                    |            |                |                |         |
| ≤25                         | 56 (80.0)          | 14 (20.0)  | 70             | 1.0            | 0.616   |
| 26-35                       | 189 (74.7)         | 64 (25.3)  | 253            |                |         |
| >35                         | 33 (73.3)          | 12 (26.7)  | 45             |                |         |
| <b>Level of education</b>   |                    |            |                |                |         |
| No formal                   | 11 (100.0)         | 0 (0.0)    | 11             | 7.3            | 0.064   |
| Primary                     | 25 (64.1)          | 14 (35.9)  | 39             |                |         |
| Secondary                   | 109 (73.6)         | 39 (26.4)  | 148            |                |         |
| Tertiary                    | 133 (78.2)         | 37 (21.8)  | 170            |                |         |
| <b>Ethnicity</b>            |                    |            |                |                |         |
| Yoruba                      | 245 (76.6)         | 75 (23.4)  | 320            | 2.0            | 0.364   |
| Igbo                        | 23 (65.7)          | 12 (34.3)  | 35             |                |         |
| *Others                     | 10 (76.9)          | 3 (23.1)   | 13             |                |         |
| <b>Religion</b>             |                    |            |                |                |         |
| Christianity                | 239 (76.4)         | 74 (23.6)  | 313            | 3.3            | 0.195   |
| Islam                       | 34 (68.0)          | 16 (32.0)  | 50             |                |         |
| Traditional                 | 5 (100.0)          | 0 (0.0)    | 5              |                |         |
| <b>Number of children</b>   |                    |            |                |                |         |
| 1                           | 97 (73.5)          | 35 (26.5)  | 132            | 0.5            | 0.783   |
| 2                           | 94 (77.0)          | 28 (23.0)  | 122            |                |         |
| >2                          | 87 (76.3)          | 27 (23.7)  | 114            |                |         |

\* Hausa, Edo, Epira

#### 4.9 Association between pregnancy, delivery history and preference for CLS

Among the associations between pregnancy and delivery history of respondents, and preference for CLS from familiar person, the granting of permission of the hospital to allow family members into the labour room was statistically significant, as is shown in table 17. A higher proportion (91.2%) of respondents whose family members were allowed in the labour room during delivery had a preference for

CLS, compared to those whose family members were not allowed (70.4%),  $p < 0.001$ .

Furthermore, this study also shows that other delivery experiences among the respondents were not statistically significant with a preference for CLS among the respondents. The majority (76.7%) of respondents delivered by the nurses/midwives had greater preference for CLS, compared to those delivered by the physicians (72.1%) and those assisted by their relatives (50.0%),  $p = 0.355$ . This study also found that the preference for CLS from familiar persons increases with the number of deliveries a woman has had, where a slightly higher proportion (75.9%) of respondents with more than two deliveries wanted a companion to continuously provide support for them during labour, compared to those with two (75.6%) and one (75.2%) delivery,  $p = 0.992$ . A higher proportion (75.2%) of respondents who had attended four or more antenatal classes had a preference for CLS from family members, compared to those that had attended less than four classes (77.1%),  $p = 0.710$ . Most (87.0%) of the respondents who had had their last delivery outside the hospital had greater preference for CLS from a familiar person compared to those that delivered at the hospital (74.3%),  $p = 0.084$ .

This study also found that a higher proportion (79.0%) of respondents who spent four or fewer hours in labour had a preference for CLS from a familiar person, compared to those who spent between 5 and 11 hours (72.4%), and more than 11 hours (77.6%),  $p = 0.407$  in labour. However, these associations were not statistically significant.

**Table 17 : Association between pregnancy, delivery history and preference for CLS**

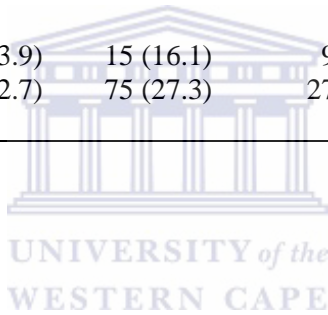
|  | Preference for CLS |            | Total<br>N=368 | X <sup>2</sup> | P-<br>Value |
|--|--------------------|------------|----------------|----------------|-------------|
|  | Yes<br>n(%)        | No<br>n(%) |                |                |             |
| <b>Care provider during current pregnancy</b>                                    |                    |            |                |                |             |
| Physician  | 49 (72.1)          | 19 (27.9)  | 68             | 2.0            | 0.355       |
| Nurse/Midwife  | 227 (76.7)         | 69 (23.3)  | 296            |                |             |
| Relatives  | 2 (50.0)           | 2 (50.0)   | 4              |                |             |
| <b>Number of deliveries</b>  |                    |            |                |                |             |
| 1  | 94 (75.2)          | 31 (24.8)  | 125            | 0.02           | 0.992       |
| 2  | 102 (75.6)         | 33 (24.4)  | 135            |                |             |
| >2   | 82 (75.9)          | 26 (24.1)  | 108            |                |             |
| <b>Number of antenatal classes attended prior to the last delivery</b>           |                    |            |                |                |             |
| <4   | 74 (77.1)          | 22 (22.9)  | 96             | 0.1            | 0.710       |
| ≥4   | 203 (75.2)         | 67 (24.8)  | 270            |                |             |
| <b>Delivered the last child in the hospital</b>                                  |                    |            |                |                |             |
| Yes  | 249 (74.3)         | 86 (25.7)  | 335            | 2.9            | 0.084       |
| No   | 29 (87.9)          | 4 (12.1)   | 33             |                |             |
| <b>Duration of last labour experienced (hours)</b>                               |                    |            |                |                |             |
| ≤4   | 79 (79.0)          | 21 (21.0)  | 100            | 1.8            | 0.407       |
| 5-11   | 123 (72.4)         | 47 (27.6)  | 170            |                |             |
| >11  | 76 (77.6)          | 22 (22.4)  | 98             |                |             |
| <b>Permission of family member to be in the labour room during last delivery</b> |                    |            |                |                |             |
| Yes  | 83 (91.2)          | 8 (8.8)    | 91             | 16.1           | <0.001      |
| No   | 195 (70.4)         | 82 (29.6)  | 277            |                |             |

**4.10 Association between fear of delivery at the hospital, and preference for CLS**

Significantly, a higher proportion (83.9%) of respondents who had a fear of giving birth in the hospital had a preference for CLS from a familiar person compared to those who did not have any such fear (72.7%),  $p=0.031$  in Table 18

**Table 18 : Association between fear of delivery at the hospital, and preference for CLS**

|   | Preference for CLS |            | Total<br>N=368 | X <sup>2</sup> | P-Value |
|---|--------------------|------------|----------------|----------------|---------|
|   | Yes<br>n(%)        | No<br>n(%) |                |                |         |
| <b>Had fear of giving birth at hospital</b> |                    |            |                |                |         |
| Yes   | 78 (83.9)          | 15 (16.1)  | 93             | 4.7            | 0.031   |
| No  | 200 (72.7)         | 75 (27.3)  | 275            |                |         |



#### 4.11 Association between perceptions, and preference for CLS

Table 19 shows that a significantly higher proportion (88.0%) of respondents who felt that the presence of a familiar person as a companion or support is essential during labour or delivery, had a preference for CLS, compared to those who disagreed to the presence of a family member as a companion (39.4%),  $p < 0.001$ . Most (91.8%) of the respondents who felt the hospital should permit a familiar person to provide support in the labour room had a greater preference for CLS from a familiar person, compared to those who disagreed with the granting of permission to a familiar person for labour support (23.0%),  $p < 0.001$ .

**Table 19 : Association between perceptions, and preference for CLS**

|  | Preference for CLS |            | Total<br>N=368 | X <sup>2</sup> | P-Value |
|--|--------------------|------------|----------------|----------------|---------|
|  | Yes<br>n(%)        | No<br>n(%) |                |                |         |
| <b>Think a family member can serve as a companion to provide supportive care during labour</b> |                    |            |                |                |         |
| Yes  | 241 (88.0)         | 33 (12.0)  | 274            | 89.5           | <0.001  |
| No   | 37 (39.4)          | 57 (60.6)  | 94             |                |         |
| <b>Think hospital should allow a woman to have familiar person for CLS</b>                     |                    |            |                |                |         |
| Yes  | 258 (91.8)         | 23 (8.2)   | 281            | 170.3          | <0.001  |
| No   | 20 (23.0)          | 67 (77.0)  | 87             |                |         |

#### 4.12 Association between attitude, and preference for CLS

A significantly higher proportion (80.1%) of respondents with a positive attitude had a preference for CLS from a familiar person compared to those with a negative attitude (15.4%),  $p < 0.001$  (Table 4.8.5).

**Table 20 : Association between attitude, and preference for CLS**

|                        | Preference for CLS |            | Total<br>N=368 | X <sup>2</sup> | P-Value |
|------------------------|--------------------|------------|----------------|----------------|---------|
|                        | Yes<br>n(%)        | No<br>n(%) |                |                |         |
| <b>Attitude to CLS</b> |                    |            |                |                |         |
| Positive               | 274 (80.1)         | 68 (19.9)  | 342            | 54.8           | <0.001  |
| Negative               | 4 (15.4)           | 22 (84.6)  | 26             |                |         |

#### 4.13 Association between satisfaction with support provided by midwives during labour, and preference for CLS

Table 21 shows that a higher proportion of respondents who were fairly satisfied (100.0%) and satisfied (75.3%) with support provided by midwives during labour, had a preference for CLS, compared to those who were not satisfied (70.6). However, the association was not statistically significant ( $p=0.286$ ).



**Table 21 : Association between satisfactions with support provided by midwives during labour, and preference for CLS**

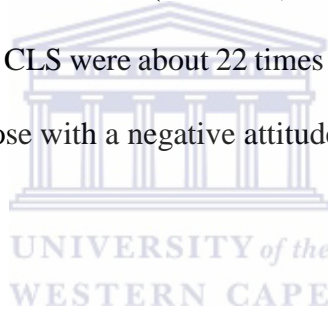
|   | Preference for CLS |           | Total | X <sup>2</sup> | P-Value |
|---|--------------------|-----------|-------|----------------|---------|
|   | Yes                | No        |       |                |         |
|   | n(%)               | n(%)      | N=368 |                |         |
| <b>Satisfaction with support provided by midwives during labour</b> |                    |           |       |                |         |
| Satisfied   | 259 (75.3)         | 85 (24.7) | 344   | 0.2            | 0.669   |
| Not satisfied   | 19 (79.2)          | 5 (20.8)  | 24    |                |         |

#### **4.14. Multivariate analysis of factors influencing preference for CLS**

Table 22 shows the multivariate analysis of factors influencing preference for CLS from familiar person among the respondents. After controlling for confounding variables using the logistic regression model, factors that significantly predicted preference for CLS among the respondents include: granting of permission for familiar person to provide support in the labour room, fear of giving birth at the hospital, the perceived need for the presence of a family member as companion during labour, the perceived need for hospital management to allow familiar person in the labour room for labour support, and a positive attitude to CLS.

Respondents whose families were granted permission to provide support during labour and delivery were about 4 times more likely to have a preference for CLS, compared with those whose family members were not allowed in the labour room during their last delivery (OR=4.4, 95% CI=2.0-9.4). The odds of having a

preference for CLS from a familiar person increases by about 2 times among respondents who had a fear of giving birth in the hospital, compared to those who had no fear of hospital delivery (OR=1.9, 95% CI=1.1-3.6). Respondents who perceived the need for the presence of a family member to provide supportive care during labour were 11 times more likely to have a preference for CLS, compared with those who felt that the presence of a family member is not required during labour (OR=11.3, 95% CI=6.5-19.5). Respondents who perceived that the hospital should allow a familiar person into the labour room were more likely to have a preference for CLS, compared with those who felt that hospitals need not allow a familiar person in the labour room (OR=37.6, 95% CI=19.5-72.5). Respondents with a positive attitude to CLS were about 22 times more likely to have a preference for CLS, compared to those with a negative attitude (OR=22.2, 95% CI=7.4-66.4).



**Table 22 : Multivariate analysis of factors influencing preference for CLS**

| <b>**Variables</b>   | <b>Odds ratio</b> | <b>95% Confidence interval</b> |              | <b>P-value</b> |
|--|-------------------|--------------------------------|--------------|----------------|
|  |                   | <b>Lower</b>                   | <b>Upper</b> |                |
| <b>Educational level</b>   |                   |                                |              |                |
| Tertiary   | 2.0               | 0.9                            | 4.3          | 0.067          |
| Secondary  | 1.6               | 0.7                            | 3.3          | 0.241          |
| * Primary  |                   |                                |              |                |
| <b>Religion</b>  |                   |                                |              |                |
| Muslim   | 0.7               | 0.3                            | 1.3          | 0.206          |
| * Christian  |                   |                                |              |                |
| <b>Delivered the last child in the hospital</b>  |                   |                                |              |                |
| No   | 2.5               | 0.9                            | 7.3          | 0.094          |
| * Yes  |                   |                                |              |                |
| <b>Permission to have family member in labour room during last delivery</b>                                |                   |                                |              |                |
| Yes  | 4.4               | 2.0                            | 9.4          | <0.001         |
| * No   |                   |                                |              |                |
| <b>Ever had a fear of giving birth at the hospital</b>   |                   |                                |              |                |
| Yes  | 1.9               | 1.1                            | 3.6          | 0.033          |
| * No   |                   |                                |              |                |
| <b>Think presence of a family member can serve as a companion to provide supportive care during labour</b> |                   |                                |              |                |
| Yes  | 11.3              | 6.5                            | 19.5         | <0.001         |
| *No  |                   |                                |              |                |
| <b>Think hospital should allow a woman to have familiar person for CLS</b>                                 |                   |                                |              |                |
| Yes  | 37.6              | 19.5                           | 72.5         | <0.001         |
| No   |                   |                                |              |                |
| <b>Attitude to CLS</b>   |                   |                                |              |                |
| Positive   | 22.2              | 7.4                            | 66.4         | <0.001         |
| * Negative   |                   |                                |              |                |

**\* Reference group\*\*Variables that were significant on the bivariate analysis**

**at p<0.2 were included in the logistic model**

#### **4.8 Discussion of quantitative result**

Continuous support of women during labour remains one of the most positive interventions during childbirth, particularly because of its impact on the results of obstetric treatment and on the health of the newborn baby (Hodnett et al, 2011). Support of women during labour has been shown to shorten the length of labour, lessen the use of oxytocin for augmentation, lower the rate of instrumental delivery and in some settings lower the rate of caesarian section (McGrath and Kennell, 2008; Morhason-Bello et al, 2009; Kashanian et al 2010; Hodnett et al, 2011). Information relating to all aspects of care are of vital importance and therefore fundamental elements. Hence this study provided information on perceptions of, attitudes to and preferences for CLS among women in Ondo state in the South-West region of Nigeria. The findings of this study make it clear that the information available to women needs to go far beyond what the institutions currently offer them.

The discussion is divided into four sections, according to the study objectives. The first section discusses the socio-demographic characteristics of the respondents. The other three sections discuss the women's perceptions and attitudes to CLS, and the preference for CLS, with the factors influencing preference for CLS among the respondents.

##### **4.8.1 Socio-demographic characteristics of respondents in Ondo state**

Similar to previous studies in Africa (Morhason-Bello et al., 2008; Ono et al., 2013), the mean age of respondents in this study was  $30.1 \pm 5.1$  years and the majority were

below 35 years of age. This age group indicated that the study population consisted of the younger and therefore more reproductive age group. This is to be expected, given that women in the younger age group are usually more engaged in delivery compared to other categories of women in the older age groups. Corresponding to previous studies in other parts of Africa (Kungwimba et al., 2013), the majority of the respondents in this study were married. This is also expectable since almost all of the women in this study were above the marriageable age in Nigeria, which was set at 18 years by the Child Rights Act in 2003.

The majority of the respondents in this study are from the Yoruba ethnic group. This may be explained by the fact that south-western Nigeria (where the study was conducted) is home to about 20-25 million people from the Yoruba ethnic group (United Nations University, 2015). The Yoruba ethnic group has also been reported to be the most urbanised and possibly the most industrialised in sub-Saharan Africa. This may also have accounted for the high proportion of respondents with a higher level of education (such as tertiary education) found in this study, as well as another study conducted in Ibadan, South-West Nigeria (Morhason-Bello, 2008). In addition, people in the south-western part of Nigeria tend to have a better attitude to education and learning compared to other parts such as the North, given that education has an empowering effect through the broadening of knowledge and creating of awareness of available opportunities (Ratsma and Malongo, 2009). In contrast with this study, a previous study in another part of Africa, namely Malawi,

found a lower proportion (5%) of women with a tertiary level of education (Kungwimba et al. 2013), as compared with this researcher's study.

On the respondents' history of the place of delivery, the majority (91.0%) of the respondents reported having delivered their index child in the hospital, while most (80.4%) of them reported being delivered by SBAs such as the nursing officers and midwives during their last delivery. The place of delivery and category of people assisting during delivery are essential factors in the reduction of maternal mortality (Koblinsky et al., 2006). In corroboration with this study's findings, Ono et al., (2013) also found that the majority (80.9%) of women in Kenya delivered in government health facilities. The previous study in Ile-Ife, Nigeria also found that the majority of pregnant women identified a health facility for delivery (Onayade et al., 2008). However, previous studies found a lower prevalence of delivery in hospitals in Nigeria and Kenya (42.6%) (Kenya National Bureau of Statistics and ICF Macro, 2010), and also in Nepal (31.0%) (Dhaka et al., 2011) in contrast with the findings of this study.

The higher prevalence of hospital delivery found in this study and respondents attended to by SBAs, compared to previous studies in Nigeria may be connected with the fact that this study was hospital-based and may also be attributed to the fact that the two mother-and-child hospitals that were among the 7 hospitals used for this study, are the major referral centers for the "Abiye" programme in Ondo state. A safe motherhood programme tagged "ABIYE" was introduced in the State in 2009 to ensure safe delivery of pregnant mothers, so as to achieve zero maternal

mortality. The programme serves as a symbiotic relationship between the Traditional Birth Attendants (TBAs)/Mission Home Birth Attendants (MHBAs), and the State Government, whereby the TBAs/MHBAs refer all pregnant women who visit their facilities (for a sum of money from the Government) to health facilities for delivery. The TBAs/MHBAs were also sponsored for the purpose of acquiring vocational skills e.g. bead making, soap making, catering services, hat making etc. and given micro-credit loans to start other businesses aside from the birth attendant business. Following three years after the commencement of the Abiye programme, health facility utilisation has increased by 70% as compared with the 60% targeted in 2012. Maternal mortality has also reduced by 30% in 2 years as compared with the 50% target for the state (Ondo State Primary Health Care Development Board, 2015). However, women in this study still express their desire to have CLS from their family network, as shown in later findings of this study. It is not in the Abiye policy of Ondo state for women to have CLS from their family network despite documented benefits and WHO endorsement of the concept.

#### **4.16.2 Perception of respondents to CLS**

Perceptions of support during labour are highly subjective (McCourt, 2009). The perceptions of a woman regarding support during labour can enhance her coping efforts and positive feelings about her labour experience (Tarkka and Paunonen, 1996). Individual needs of support during labour will differ depending on factors guiding cultural and societal norms, as well as personal circumstances and preferences (McCourt, 2009). Previous study indicates that the perceived adequacy

and appropriateness of social support will impact on its effectiveness (McCourt, 2009). In addition to this, research has shown that support that is given but not perceived as effective can in fact have counter-productive effects, which points to the fact that not all support is necessarily beneficial (McCourt, 2009). Support from someone a woman loves may be perceived differently from that of a professional whose knowledge and expertise the woman respects (Hodnett, 1996, 2011). This study shows that women greatly value the presence of someone whom they know and trust, and who will satisfy their need for empathy, to cope with labour. More than two-thirds of the respondents perceived the importance of labour companionship from a familiar person; similarly, the majority of them felt that the hospital should allow a woman to have a familiar person for support during labour. This finding is similar to what was reported in previous studies (Maimbolwa et al., 2001; Maimbolwa et al., 2003; Banda et al., 2010).

One of the issues that affects a woman's sense of herself as a competent mother is the extent of her satisfaction with her birthing experience (Bradley, 1996; Klaus, 1998; Teijlingen et al., 2003). Previous studies confirmed that a negative birthing experience can affect a mother's early interaction with her infant (Koniak-Griffin, 1993; Waldenstrom et al., 2004). One factor contributing towards birth satisfaction is experiencing personal and caring support (Teijlingen et al., 2003). Although the majority (80.0%) of the respondents in this study were very satisfied with the support rendered by the nurses and midwives during labour, 13% of them were only fairly satisfied with the support.



There is a profound need for support such as companionship, empathy and help for women in labour (Simkin, 1992; Szeverenyi et al., 1998). Previous descriptive studies of women's experiences during childbirth have suggested four major areas in which women can receive support during labour. These are: emotional, informational, physical, and advocacy (Midirs and the NHS Centre for Reviews and Dissemination, 2003). Findings of this study showed that more than half of the respondents received physical supports such as assistance in bathing (60.3%), clothes or gown changing (60.3%), holding hands (60.3%), assistance in walking to bath or to toilet (60.3%), back massage (59.5%), and therapeutic touch (57.9%). These techniques are meant to reduce painful stimuli and help the women manage pain during labour. However, a lower proportion (19.8%) of women in Jos, compared to this study, reported that they had received physical support such as massage from midwives during labour (Daniel et al., 2015). The low proportion of respondents that reported to have received body massage and therapeutic touch in this study and that of Jos may be related to the fact that most of the labour wards in Nigerian hospitals are understaffed, the midwife to patient ratio is usually low. Thus, carrying out physical activities such as massage for women in labour may take some of time to become standard practice, and midwives may not be available to offer such services for all women in labour.

Furthermore, information on the care strategies found to have been received by respondents in this study, is consistent with the study by Brown et al. (2001) on women's evaluation of intrapartum non-pharmacological pain relief methods used

during labour. The common methods found in this study include breathing (91.3%), relaxation (87%), position change (56.5%), and massage (59.5%). However, other studies have identified physical methods of support during labour such as movement and changes in position (77.3%), counter pressure (54.5%) and breathing exercises (63.6%) as methods known and commonly used by midwives and other healthcare professionals (Almushait and Ghani, 2014). Furthermore, similar findings have been found in previous studies in Sweden (Berg and Terstad, 2006; Lundgren, 2010), New York (Simkin, 2008), Malawi (Kungwimba et al., 2013) and Nigeria (Morhason-Bello, 2008).

Due to the neuroendocrine and biological changes that occur during pregnancy, women tend to experience some psychological changes such as nausea, fatigue, and anxiety during child birth (Cheung et al., 2007; Welch and Miller, 2008). These psychological changes may cause complications as a result of delivery. Such complications may include obstetric complications caused as a result of anxiety, of women in labour (Bewley & Cockburn, 2002; Johnson & Slade, 2002; Ryding et al., 2003). Thus, there is a need for continuous emotional support for women during labour in order to prevent these complications.

Morhason-Bello et al, (2008) in their study, discovered emotional support as the main rationale why women desired social support during labour. Despite the importance of emotional support for women during labour, less than half of the respondents in this study reported that they had received emotional support such as verbalization of fear (30.7%), reassurance, encouragement and praise (29.9%),

supportive company (35.6%) and engagement in social conversation (47.6%) from the midwives during delivery. This lack of emotional support from midwives may be the reason why women in Malawi described emotional support from their birth companions as useful and beneficial to their birth experience (Kungwimba et al., 2013). The birth companions reported by the women in Malawi were mainly relatives, compared to this study where emotional support from midwives was investigated.

Emotional support by a familiar person has been shown to be beneficial to women in helping them cope with the anxiety and worry the majority of them experienced during labour (Saisto et al., 2001; Waldenstrom, 2004). Also, the presence of a birth companion may make a woman feel safe, and interventions that encourage comfort during labour may allow the woman in labour to be actively involved in her labour, giving her confidence and strength (Schuiling & Sampselle, 1999). There is a need for birth companions to be prepared to provide continuous emotional support for women during delivery in order to support the nurses or midwives who may have coexisting responsibilities for more than one woman in labour. The midwives spend most of the time on extensive documentation or keeping records and may have little or no time to engage in labour support (Hodnett et al., 2007).

The inability of the midwives to provide emotional support may be attributed to the busy schedule and shortage of staff as observed in a previous study in Papua New Guinea, north of Australia. The midwives were unable to provide support because of the busy nature of their work and the limited staffing (Buasi, 2011). Another study

found that only 9.9% of nurses had spent the required period for supportive care for labour and delivery among women (McNiven et al., 1992).

Pregnant women and their families require basic, accurate, science-based instructional/information on preterm labour, including information on harmful lifestyles, and care, to focus on what to expect during labour and to know how to handle contraction pain and discomfort (Simpson, 2006). Explaining the terms of labour progress, coping methods, relaxation techniques, the treatment regimen, and the status of the fetus is important in reducing the anxiety associated with the risk of giving birth to a preterm infant. This study found that the majority of respondents were not given instruction information on breathing exercises and bearing down, hospital routine, techniques for promoting comfort and relaxation, the progress of labour, and monitoring procedures. This kind of support may help to build trust and strengthen the relationship between women and care providers as well as a feeling of safety, which helps in reducing anxiety and level of pain experienced by women during childbirth (Kungwimba et al., 2012). Contrary to this study, a descriptive cross-sectional study among birthing women observed that instructional/informative support was the most frequent kind of support given to women in Australia by midwives, and this accounted for 70% of the total support provided to the women (Buasi et al., 2011).

Advocacy for the woman in labour includes communicating the woman's wishes and offering information about the progress of labour, coping methods, or relaxation techniques (Payant et al., 2008). When advocating for the woman in

labour, the nurses or midwives must convey respect, acknowledge the mother's expectations, and resolve conflict (Adams & Bianchi, 2008). In corroboration with a previous study in Nigeria (Daniel et al., 2015), this study found that less than half of the respondents reported that the midwives listened to their request for pain management (34.0%), and negotiating needs with other team members (48.6%). This finding was not in line with a WHO report on standards for maternal and neonatal care, which stresses the need for information provision before birth given that intervention alone cannot address the main causes of maternal mortality (WHO, 2007). Providing information on pain management for women in labour will help them be prepared ahead of labour or delivery so they can cope with pain during labour. However, nurses or midwives in most Nigerian hospitals may find it unnecessary to provide this information for women before delivery, possibly due to their attitude to the pregnant women, which previous studies have reported as unfriendly (Mathole et al., 2004; Bazzano et al., 2008; Mrisho et al., 2009).

Similar to this study's findings, Daniel et al. (2015) in their study among women in Jos, also found that less than a quarter (22.2%) of the respondents reported that the nurses listened to them with care and attention, or reassured them that all would be well (Daniel et al., 2015). Another study showed that providing antenatal education that encourages avoidance of harmful traditional practices and teaches women how to identify problems that require immediate professional attention, could work towards improving maternal and neonatal outcomes (Onah et al., 2006).

Although, the pregnant women reported lack of core component of labour from the midwives in this study, the majority of the women still expressed a high level of satisfaction with the care received from midwives in almost all the facilities used for the study. Similar to this study's findings, a previous study in Benin, Nigeria also discovered that the midwives are highly appreciated by women and families (Fujita et al., 2012). Thus, a heightened sense of satisfaction may improve communication between a woman during labour and health workers, thus contributing to positive birth experience (Aune et al., 2014). The high level of satisfaction with labour support received from midwives expressed by the respondents in this study may be related to the hesitation of women to criticise, despite the extremely negative treatment they receive from health providers. According to van Teijlingen et al., (2003) there was a reluctance to criticise professionals by women, as having a live, healthy baby was usually their ultimate goal and the experience of the process was secondary. Women accepted mostly what was done and what happened to them, believing it was the best that could be offered (van Teijlingen et al., 2003).

#### **4.8.3 Attitude to CLS among the respondents**

Women's attitudes to health-related factors exert an important influence on maternal health care and practices (Ezeam and Ezeamah, 2014). In a situation where the attitude of the woman in labour's partner aligns more closely with hers than do the midwife's, partner support may be more highly valued than the medical staff's support. A previous study in Nigeria has found a high proportion of women with

the right attitude to CLS from a familiar person. For example, Oboro et al. (2011) found that the majority of women in Osogbo, Nigeria were willing to have a companion during subsequent labour, while more than half of them decided to recommend it to other women. A hospital-based cross-sectional study in Ibadan also found that seventy-five percent of respondents desired companionship during labour (Morhason-Bello et al., 2008). Previous studies in Russia (Bondas-Salonen, 1998; Callister et al., 2007) and Zambia (Maimbolwa et al., 2001) have also shared a similar view. In corroboration with studies mentioned earlier, this study found that more than two-thirds of the women interviewed had a positive attitude to CLS.

The high proportion of respondents with the right attitude to CLS in this study may be attributed to the high level of education attained by the majority of the respondents. Previous authors have identified higher educational level as a significant predictor of preference for labour support (Teshome et al., 2007; Morhason-Bello, 2008). Furthermore, previous studies found the need for emotional support to be the main rationale for women desiring support during labour. The lack of emotional support from midwives during labour as reported by the majority of the respondents in this study may be attributed to the reason the majority of them with the right attitude to CLS were found to desire, CLS from a familiar person.

The positive attitude to CLS from a familiar person expressed by participants in this study may also be attributed to the reason for fear of delivery identified in this study. The perception of pregnancy and birth as a risky and threatening experience

generates fear in many pregnant women. In several studies various women seeking care from health facilities reported pregnancy-related fear and anxiety as a common experience (Zar et al., 2001). However, the experience of childbirth ought to be a positive life-affirming event associated with minimal risk in the outcome (Geissbuehler & Eberhard, 2002). This study discovered that more than a quarter (25.3%) of the respondents had fears about giving birth at the hospital. Corresponding with this finding, another study reported a high prevalence of fear of giving birth at the hospital among Scandinavian women in Finland, Sweden, and the United Kingdom, with 65% of them found to be suffering from intense childbirth fear (Saisto & Halmesmaki, 2003). In studies in Western countries, fear of giving birth at the hospital were associated with pregnancy complications, increasing childbirth interventions, emergency and elective caesarean section (CS), postnatal depression (PND), Post-Traumatic Stress Disorder (PTSD) and impaired maternal–infant bonding (Bewley & Cockburn, 2002; Johnson & Slade, 2002; Ryding et al., 2003).

Furthermore, studies in developing countries identified several reasons why pregnant women do not make use of the health facilities for delivery, and these reasons include distance from the hospital (WHO, 2015; United Nations, 2015), lack of midwives (Kambala et al., 2011), and cultural and belief factors (Bazzano et al., 2008; Mrisho et al., 2009). Also, a study in rural Zimbabwe related women's non-use of health facilities for delivery to a local belief about increased vulnerability to witchcraft during early pregnancy, as against the use of alternative



forms of care (Mathole et al., 2004). This study found that the disposition and attitude of health workers was the main reason why a high proportion of the respondents refused to give birth at the hospital. In a situation where pregnant women saw no need of going to the hospital due to attitude of health workers, women give birth at home with family support, or sought help from unskilled birth attendants such as the TBAs/MHBAs, given that they are the only available option, particularly in Nigeria. This resulted hence, resulting in complications such as severe hemorrhaging, fresh still birth, neonatal and maternal morbidity and mortality. However, if health workers' attitudes towards service users continue to improve, this could have a positive effect on service utilization toward reducing maternal and child morbidity and mortality, as well as improve access to good reproductive health services (Love, 2013).

In line with this study, previous studies among women in Finland (Melender, 2002), Kenya (Centre for Reproductive Rights and Federation of Women Lawyers—Kenya, 2008), Ghana (Nakunda, 2007) and Nigeria (Ehiemere et al., 2011) also found that the unfriendly attitude of health workers was among the major reasons respondents refused to deliver in the health facility. D'Ambruoso (2005) study on women in labour in Ghana reported that mothers mentioned that midwives shouted at their clients, were rude, refused to offer assistance and in some cases threatened a woman in labour. More than a quarter of patients in a tertiary hospital in Nigeria concluded that the nurses are harsh, while an additional 37.5% reported dissatisfaction with the way the nurses addressed them. (Ehiemere et al., 2011).

Melender, (2002) reported that women in their study complained about how they are usually left alone, were made to feel silly, and were not involved in decisions by health workers in the hospital. All these factors may explain a preference for CLS from their family network despite care received from midwives during their childbirth experiences.

#### **4.8.4 Preference for CLS among respondents**

Although the majority of the respondents in this study were very satisfied with care received from midwives, more than two-thirds (75.5%) of them preferred CLS from familiar persons or relatives such as their husbands and mothers. This finding further highlighted the importance of CLS from familiar persons compared to support from midwives. The respondents' high level of satisfaction with care from midwives may not imply low preference for CLS from familiar persons. Social support from a spouse or partner and a social network of family and friends has the potential to influence women's decisions about obtaining prenatal care (Schaffer et al., 1997). Women traditionally relied on familiar persons for social support during pregnancy, childbirth and breastfeeding in some societies (Maimboiwa et al., 2001), and the presence of a female relative during labour has been associated with improved labour outcomes (Madi et al., 1999).

In corroboration with this study, a similar study in Ibadan, Nigeria found that more than two-thirds of antenatal patients studied wanted someone to be present to offer social support during the last labour experienced (Morhason-Bello, 2008). A systematic review of 15 studies summarizing the experiences of women in

Australia, Belgium, Botswana, Canada, Finland, France, Greece, Guatemala, Mexico, South Africa, and the United States on continuous labour support observed that the type of person who provides labour support had an impact on the outcome of labour. Also, it was found in this review that the positive effects of labour support were greater when continuous support was provided by a caregiver who was not an employee of the hospital studied (Hodnett, 2011). The father's presence has been reported to provide an important source of social support in previous studies (Klaus and Kennel, 1997) and this has been the norm in many countries. The father's presence during childbirth and the opportunity to interact with the baby at the earliest stage enhances father-baby bonding and also intensifies the husband's participation in early caretaking activities (Callister, 1995). In Nigeria, there is no law prohibiting the presence of husbands in the labour room. A previous study in Hong Kong reported that most husbands are routinely excluded from labour and delivery rooms (Yim, 2000). In corroboration with this study's findings, Bradley (1996) felt the father of the child was most qualified to provide support in labour because of the emotional connection he usually has with the mother. Corresponding with this study's findings, Bakhta and Lee (2009), found the husband to be the main source of companionship during labour, while previous studies in Africa found that women preferred female relatives as a companion or supporter during labour (Madi et al., 1999; Oboro et al., 2011). The small proportion of women who preferred not to have their husbands as companions during labour in the Oboro et al (2011) study was attributed to various reasons such as the feeling of being embarrassed

/depersonalized / de-individualised during delivery, the fear of losing sexual attractiveness and lack of privacy resulting in the loss of the perceived sacrosanct character of the childbirth process, as well as fear of loss of the seriousness with which their medical condition was regarded by healthcare personnel.

Contrary to this study, previous studies found a lower prevalence of mothers with a preference for social support during labour in Russia (17.5%) (Bakhta and Lee, 2010) and Nigeria (35.0%) (Oboro et al., 2011). Russian women often see childbirth as a medical process that should not involve social interactions and this might have accounted for low preference for CLS found among the women, as compared with this study. Bakhta and Lee (2010) also found that most of their respondents were convinced that no one could offer them better help in going through the stress and anxiety of labour, than a doctor or a midwife (Bakhta and Lee, 2010).

Among respondents who declined CLS in this study, the majority of them believed that CLS is not necessary, while about a quarter of them subscribed to the idea that only God can support a woman during labour. Hence they did not perceive any need for CLS. In most African countries including Nigeria, people usually attribute health practices to cultural and religious beliefs. For example, the taboos and practices that prevent women from taking appropriate decisions on where and when to seek medical attention during pregnancy and delivery, was reported in a previous study (Ezeama and Ezeamah, 2014). Also, there are taboos that emphasize traditional practices which negatively affect the well-being of women during pregnancy and delivery. The reasons given by respondents in this study were

different from those given by respondents in a study in Russia, for not wanting support during labour (Bakhta and Lee, 2010). The majority of the women in Bakhta and Lee's (2010) study reported that they wanted privacy, and feared that their husbands would not allow them to have a partner present during labour. A familiar person's involvement in labour was expressed in stereotypical terms by midwives, i.e. the likelihood of the support person fainting, panicking, behaving inappropriately or indulging in behaviour that detracted from support for the woman in labour (Blackshaw, 2009).

This study identified factors influencing and predicting a preference for CLS among the respondents. Identification of which contextual factors contribute to the success or failure of certain interventions has been reported to help in assessing their applicability in other countries, or the chances of replicating these successes in other regions (Rowe et al., 2005). This study found factors such as the fear of delivery at the hospital, the granting of permission for family members to be in the labour room during delivery, the perception of the need for the presence of a family member to provide continuous support during labour, and attitude to CLS to be significantly associated with preference for CLS among respondents on the chi-square analysis. Moreover, these factors were also found to predict preference for CLS among the respondents on the logistic regression model after adjusting for other confounding factors such as age and sex. The findings from the regression model are more reliable, as each predictor variable was handled independently while controlling for

the possible confounders which might have influenced the result obtained using the chi-square test (binary) of association.

The reduction in women's perception of pain and fear/anxiety are among the benefits identified for women who had companions during labour (Waldenstrom, 2004). Participation of a familiar person such as the husband during labour has been related to a reduction of anxiety and fewer reported feelings of pain in previous studies (Keinan and Hobfall, 1989; Yim, 2000). This study found that significant proportion of participants who reported fear of giving birth at the hospital had a preference for CLS, compared with those who reported an absence of fear. In previous studies, the fear of giving birth in the hospital had been attributed to the unfriendly nature of the health workers (Melender, 2002a; Ehiemere et al., 2011). Moreover, the unfriendly attitude of the health workers in the hospital may have accounted for the need for a familiar person as a companion during labour, as found among respondents in this study. Contrary to this study's findings, a previous study in Hong Kong found no significant effect of the husband's presence during labour on the obstetric outcomes of the mother's anxiety, perceived pain and length of labour (Yim, 2000).

Furthermore, this study found that the perception of the need for a familiar person during labour and the need to permit a familiar person to be in the labour room for support significantly influenced and predicted women's choice of or preference for CLS from a familiar person. Similar to this finding, previous meta-analysis and reviews found that the presence of a person specifically designated to provide

support positively influences the woman's perception of the birth experience itself (Zhang et al., 1996; Bruggemann et al., 2005).

Support from familiar persons such as family and friends may help to meet the needs of the mother in labour that the midwife may not be able to address, thus facilitating a positive birth experience (Melender, 2006). Despite the advantages of allowing a familiar person for support in the labour room, the practice of allowing relatives in the labour room during delivery is not common in some health facilities in Nigeria due to policies prohibiting relatives from being in the labour room, hence discouraging women from delivering at public hospitals (Morhason-Bello et al., 2008). As a result, many women rely on traditional birth attendants, who allow them to obtain social, emotional and other forms of support from family members or friends.

The attitude of women towards relatives such as the husband's participation in maternal care was identified as a factor in strongly opposing the physical presence of husbands in the labour room during delivery, in a previous study of trends in the Northern Part of Nigeria (Iliyasu et al., 2010). In addition, this study found that a higher proportion of respondents with a positive attitude to labour support had a preference for CLS from familiar persons compared to those with a negative attitude. Negative attitudes of women to labour support concluded in the study of Iliyasu et al. (2010) may be attributed to the strong cultural and religious effects of Islamic law applicable in the predominantly Muslim population in Northern Nigeria. This is different from Christian-dominated Southern Nigeria where there

is a high percentage of spouses inclined to spousal participation in antenatal, delivery and post-natal care (Olayemi et al., 2009; Morhason-Bello et al., 2009; Umeora et al., 2011).

Previous studies have emphasized the influence of characteristics of respondents on social support during labour. A study in Ethiopia found some characteristics of respondents to significantly influence preference for labour support among women (Teshome et al., 2007). Teshome et al. (2007) discovered that women in the older age group, unmarried, with a higher level of education and lower income wanted a companion during labour, compared to other categories of women. An earlier study in Ibadan, South-West Nigeria found that the proportion of women who wished to have support during labour was higher among respondents with a higher level of education, in older age groups and professionals with a higher level of formal education (Morhason-Bello, 2008). In addition to these factors identified by Morhason-Bello, (2008), a cross-sectional study conducted in Ibadan also found that the odds of wanting support during labour were higher among women having their first child, and those who were members of the minority ethnic group (Digest, 2008). Contrary to these studies in Ethiopia (Teshome et al., 2007) and Nigeria (Morhason-Bello, 2008; Digest, 2008), this study found that the highest proportion of respondents that had a preference for CLS was in the younger age group (age  $\leq 25$  and 26-35 years), who had no formal education, and were from the Yoruba ethnic group, with more than one child. However, these relationships were not statistically significant, either on the chi-square or logistic regression analysis.



Several studies revealed that women who were allocated to continuous one-to-one support in previous controlled trials were less likely to report dissatisfaction or a negative rating of their birth experience during labour, compared with those without CLS (Hodnett et al., 2012; Amorim MMR and Katz). Correspondingly, this study found that a higher proportion of women who were dissatisfied with the support rendered by the midwives and nurses had a preference for CLS from a familiar person compared with those who reported satisfaction with midwives support during labour. However, this association was not statistically significant. These differences in the satisfaction level among respondents may have been influenced by the woman's expectations and the way in which she perceived her care, and by having a companion in a setting.

#### **4.9 Summary**

Social support of women by familiar persons is indeed required by women during labour and it has to be legally recognized in Nigerian hospitals and health facilities because of the growing need for social support during labour, as confirmed by the responses of women in this study.

This study revealed that the majority of the women in Ondo state, south-western Nigeria have had previous deliveries in the hospital with skilled birth attendants, and that a significant proportion of them had a fear of delivery in the hospital mainly because of the unfriendly attitude of the nurses and midwives.

Also, various types of support was received from the midwives by the women in this study. These include physical, emotional, informational and advocacy support. Although more than half of the respondents received physical support relating to daily activities from the midwives, basic emotional, instructional/informational and advocacy supports required by the women in order to cope with the pain experienced during labour were reported to be lacking by the majority of respondents.

Furthermore, though respondents were very satisfied with the labour support received from midwives, the majority of them had a positive attitude to, and preference for continuous labour support from familiar persons. The importance of social support during labour was further shown in this study given that a high proportion of respondents had a preference for CLS from a familiar person, such as their husband, mainly because they needed companionship and help where necessary, as well as prayer support.

Factors found to significantly influence preference for CLS from a familiar person among the respondents were related mainly to anxiety or fear of delivery at hospital, and perceptions and attitudes to CLS from the familiar person. The study further shows that having a fear of delivery at the hospital, and having positive perceptions of, and attitudes to CLS from familiar person(s) increases the likelihood for preference for CLS among women.

## CHAPTER FIVE

### QUALITATIVE DATA

#### 5.1 Introduction

This chapter presents the results of the analysed data of all participants, namely focus group discussion with pregnant women and nurse/midwives as well as the semi-structured interviews with policy-makers in seven public health facilities in Ondo State, Nigeria. The presentation will be a discussion of the findings in conjunction with the literature which serves to recontextualize. These research findings represent step one using the Walker and Avant (2005) approach in developing a culturally congruent framework for CLS, for women in South-West Nigeria.

The inductive approach was used for data analysis as described by Tesch (1990), in Creswell (2004). Participants' transcribed responses were read and re-read, to enable the researcher to master the content. Numerous text units were developed during the coding process. These units were analysed in order to make sense of them and to form categories. As stated in Schurink, Fouche and De Vos (2011): category formation involves observing for categories that are internally consistent but distinct from each other. The next step was to organise the categories and attach meaning to them, in order to derive a thematic description for each of these search questions, for each participant group. Every category and theme is substantiated by citations from the raw data. Data is compared and contrasted with relevant current literature and research, to

determine the perceptions, attitudes and preferences of pregnant women regarding CLS, the nurse/midwives' perceptions of and attitudes to CLS by women chosen from pregnant women's social networks, and finally the positions of the hospital policy-makers in Ondo state to the implementation of CLS from those individuals who pregnant women selected from among people in their social network to support them, in public health facilities in Ondo state.

This chapter is organised into three sections which present and discuss the vertical themes that emerged during the data analysis process, derived from the categories of the three participant groups – namely the pregnant women, nurse/midwives and policy-makers.

Section One: presents the analysis results of transcripts of focus group interviews with pregnant women on their perceptions, attitudes and preferences to CLS in public hospitals in Ondo state.

Section Two: presents the analysis results of the focus group interview transcripts of the nurse/midwives on their perception and attitude to CLS by individuals selected by pregnant women from their own social network, in public hospitals in Ondo state.

Section Three: presents the analysis results of semi-structured individual interviews with hospital policy-makers on their position to CLS by individuals selected by pregnant women from their own social network, in

public hospitals in Ondo state. Table 23 gives a summary of the themes, sub-themes and categories from all the participants.



**Table 23 : Summary of qualitative results**

| Objectives   | Themes                          | Sub-Themes  | Categories  |
|--|---------------------------------|---|---|
| <p>1. Assess the perceptions, attitudes and preferences of women to CLS in the South-West region of Nigeria.</p> | <p>1. Perceptions about CLS</p> | <p><b>Sub-theme 1</b><br/>Family as a traditional support system</p>                              | <ul style="list-style-type: none"> <li>• Intimate partner as a support system</li> <li>• Extended family and close friends as support system</li> <li>• Deprivation of family support means a lonely journey</li> </ul>                           |
|  |                                 | <p><b>Sub-theme 2</b><br/>Male involvement in women’s care during childbirth</p>                  | <ul style="list-style-type: none"> <li>• Sense of belonging</li> <li>• Increased value improves caring</li> <li>• Attitudinal change</li> <li>• More enlightened insights about family planning</li> </ul>  |
|  |                                 | <p><b>Sub-theme 3</b><br/>Family and healthcare workers roles</p>                                 | <ul style="list-style-type: none"> <li>• Supportive role of healthcare providers</li> <li>• More frequent facility utilisation</li> <li>• Enhanced cooperation with nurses’ procedures</li> <li>• Protection against nurses’ hostility</li> </ul> |
|  |                                 | <p><b>Sub-theme 4</b><br/>Congruence with childbirth practices guided by religion and culture</p> | <ul style="list-style-type: none"> <li>• Religious/ Traditionally accepted practices</li> </ul>   |

|  |                          |   |   |
|--|--------------------------|---|---|
|  | 2. Attitudes towards CLS | <b>Sub-theme 1</b> Positive attitudes         | Perceived benefits / role of family in CLS <ul style="list-style-type: none"> <li>• Source of information</li> <li>• Relaxing and comforting</li> <li>• Moral and emotional support</li> </ul>                  |
|  |                          | <b>Sub-theme 2</b> Negative attitudes         | Perceived challenges <ul style="list-style-type: none"> <li>• Structural deficiency</li> <li>• Lack of privacy/ confidentiality</li> </ul>  |
|  |                          |   | Resistance from healthcare providers <ul style="list-style-type: none"> <li>- Perceived negative attitudes from nurses</li> <li>- Nurses' occasional discomfort with too many people in labour ward</li> </ul>  |
|  |                          |   | Trust dynamics <ul style="list-style-type: none"> <li>- Personal fear/ mistrust</li> <li>- Secrecy of childbirth</li> </ul>   |
|  |                          |   | Role conflicts <ul style="list-style-type: none"> <li>- Conflict of interest between healthcare provider and support person</li> <li>- Relative's tendency to become too suspicious, or to overreact</li> </ul> |
|  |                          | <b>Sub-theme 3</b> Perceived enablers for CLS | Enhanced health facility structure <ul style="list-style-type: none"> <li>- Conducive environment for CLS (dedicated labour room for privacy and confidentiality; visitors' room)</li> </ul>                    |
|  |                          |   | Policy and legal back up <ul style="list-style-type: none"> <li>- Inclusion of CLS in hospital policy</li> <li>- Rules and regulations regarding CLS</li> </ul>   |
|  |                          |   | <ul style="list-style-type: none"> <li>- Training of health workers, clients and support persons, on CLS expectations and responsibilities</li> </ul>   |

|  |   |  |  |
|--|---|--|--|
|  |   |  | <ul style="list-style-type: none"> <li>• Advocacy <ul style="list-style-type: none"> <li>- Collaboration and public awareness programmes</li> </ul> </li> </ul>  |
|  | 3. Preference for CLS in public health facility | <b>Sub theme 1</b><br>Preferred support person   | <ul style="list-style-type: none"> <li>• Preference influenced by personal convictions , inter-relatedness, and childbirth experiences</li> <li>• Preference for close relatives based on “trust”</li> </ul> |
|  |   | <b>Sub-theme 2</b><br>Predictors for choice of support person                                    | <ul style="list-style-type: none"> <li>• Trust</li> <li>• Reliance</li> <li>• Availability</li> </ul>  |
|  |   | <b>Sub-theme 3</b><br>Gender and experience  | <ul style="list-style-type: none"> <li>• labour support person should be someone with experience in labour process, preferably a woman</li> </ul>  |
|  |   | <b>Sub-theme 4</b><br>Number of support person   | <ul style="list-style-type: none"> <li>• Preference for more than one support person for complementary assistance</li> </ul>   |
| 2. To explore the perceptions and attitudes of the nurse-midwives to CLS by person/s from pregnant women’s social networks, in | 1. Perceptions about CLS                        | <b>Sub-theme 1</b><br>Non-existence / intermittent practice                                      | <ul style="list-style-type: none"> <li>• Family involvement not part of current hospital policy and not routinely practiced</li> <li>• Occasional/discretionary practice</li> </ul>                          |
|  |   | <b>Sub-theme 2</b><br>Perceptions regarding introduction of family CLS in public health facility | Midwives’ perception that CLS can be introduced, tested and implemented at public health facilities  |

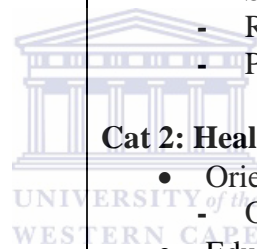


|  |                         |   |  |
|--|-------------------------|---|--|
| public hospitals in the South-West region of Nigeria                             | 2. Attitude towards CLS | <b>Sub-theme 1</b><br>Positive attitudes                | <b>Perceived benefits of CLS</b> <ul style="list-style-type: none"> <li>• Promotes love, sense of belonging and bonding</li> <li>• Psychological support</li> <li>• Improves patient cooperation and reduces nurses' stress</li> <li>• Enhances family planning</li> </ul>   |
|  |                         | <b>Sub-theme 2</b> Negative attitudes                   | <b>Perceived risks / challenges</b><br><b>i. Women-related challenges</b> <ul style="list-style-type: none"> <li>• Encroachment on women's privacy</li> <li>• Delay in delivery process</li> <li>• Misuse of opportunity by women's relatives</li> </ul>   |
|  |                         |   | <b>1. Facility-related challenges</b> <ul style="list-style-type: none"> <li>• Inadequate health facility infrastructure</li> <li>• Shortage of health personnel</li> <li>• Fear of breach of confidentiality</li> <li>• Religious exclusivity</li> <li>• Interference with nursing duties and routines/ delay in delivery process</li> <li>• Overcrowding and risk of contamination/ infection</li> </ul> |
|  |                         | <b>Sub-theme 3</b> Perceived intervening factors to CLS | <ul style="list-style-type: none"> <li>• <b>Trust and cultural dynamics</b> <ul style="list-style-type: none"> <li>- Midwives' observation of women's fear and mistrust of their relatives' presence during labour</li> <li>- Cultural exclusion of men in women's care during childbirth</li> </ul> </li> </ul>   |
| <ul style="list-style-type: none"> <li>• <b>Religious exclusivity</b></li> </ul> |                         |   |  |

|                                 |                      |   |  |
|---------------------------------|----------------------|---|--|
|                                 |                      |   | <ul style="list-style-type: none"> <li>- Some religions/ denominations prohibit men from attending births, for example, Islam</li> <li>- Issues of polygamy: men with many wives</li> </ul>  |
|                                 |                      |   | <ul style="list-style-type: none"> <li>• <b>Educational influence</b> <ul style="list-style-type: none"> <li>- Positive attitude of midwives to working with educated relatives rather than those without formal education</li> </ul> </li> </ul>  |
|                                 |                      | <b>Sub-theme 4</b><br>Enablers for CLS practice in public health facilities | <ul style="list-style-type: none"> <li>• Government involvement/ policy</li> </ul>   |
|                                 |                      |   | <ul style="list-style-type: none"> <li>• Health facility structure <ul style="list-style-type: none"> <li>- Resources (personnel, physical structure and equipment)</li> <li>- Sufficient medical equipment</li> <li>- Expansion of labour rooms</li> <li>- Adequate staffing</li> <li>- Organisational CLS concept</li> </ul> </li> </ul> |
|                                 |                      |   | <ul style="list-style-type: none"> <li>• Safety/ Security measures</li> </ul>  |
|                                 |                      |   | <ul style="list-style-type: none"> <li>• Orientation and training of CLS persons</li> </ul>  |
|                                 |                      |   | <ul style="list-style-type: none"> <li>• <b>Advocacy</b> <ul style="list-style-type: none"> <li>- Public awareness campaigns</li> <li>- Use of media</li> <li>- Visual aids</li> </ul> </li> </ul>   |
| 3. To determine the position of | Position of hospital | <b>Sub-theme 1</b><br>Perceptions about CLS                                 | <ul style="list-style-type: none"> <li>• CLS an alien concept in Nigerian health facilities</li> <li>• CLS should be evidenced-based</li> </ul>  |

|  |  |  |   |
|--|--|--|---|
| hospital policy-makers to CLS by person/s from pregnant women's social network in public hospitals in the South-West region of Nigeria | policy-makers to CLS<br><br>Attitude towards CLS | <b>Sub theme 2</b><br>Perceived CLS benefits   | <ul style="list-style-type: none"> <li>• Speeds up safe delivery process</li> <li>• Emotional support</li> <li>• Boosts women's confidence</li> <li>• Psychological care</li> <li>• Enhances women's cooperation with care</li> <li>• CLS benefits all stakeholders</li> </ul>            |
|  |  | <b>Sub theme 3</b> Perceived risks/ challenges   | <ul style="list-style-type: none"> <li>• Challenges for the hospital <ul style="list-style-type: none"> <li>- Lack of CLS policy and legal framework</li> <li>- Poor infrastructure. (Inadequate labour ward, lack of privacy, insufficient medical equipment)</li> </ul> </li> </ul>     |
|  |  |  | <ul style="list-style-type: none"> <li>• Challenges for healthcare providers <ul style="list-style-type: none"> <li>- CLS alien to healthcare providers</li> <li>- Professional gatekeeping (nurses)</li> <li>- Possible resistance to CLS by healthcare providers</li> </ul> </li> </ul> |
|  |  | <ul style="list-style-type: none"> <li>• Women-related challenges <ul style="list-style-type: none"> <li>- Belief systems and cultural misgivings</li> <li>- Mistrust</li> </ul> </li> </ul> |   |

|  |  |  |  |
|--|--|--|--|
|  |  | <p><b>Sub theme 4</b> Enablers for CLS</p> | <p><b>Cat 1: Hospital-related factors</b></p> <ul style="list-style-type: none"> <li>• Enabling law and political support <ul style="list-style-type: none"> <li>- Need for policy change</li> <li>- Need for CLS legal framework</li> </ul> </li> <li>• Collaboration with all stakeholders <ul style="list-style-type: none"> <li>- Involvement of women, healthcare providers, government and community in CLS concept</li> </ul> </li> <li>• Structure <ul style="list-style-type: none"> <li>- Modelling and trial of CLS concept in public health facilities</li> <li>- Finance</li> <li>- Sustainability</li> <li>- Recruitment of health personnel</li> <li>- Programme organisation</li> </ul> </li> </ul> <p><b>Cat 2: Healthcare provider-related factors</b></p> <ul style="list-style-type: none"> <li>• Orientation and training <ul style="list-style-type: none"> <li>- Orientation and re-training of all healthcare providers</li> </ul> </li> <li>• Educational curriculum <ul style="list-style-type: none"> <li>- Inclusion in midwifery training curriculum</li> </ul> </li> <li>•</li> </ul> <p><b>Cat 4: Women-related factors</b></p> |
|--|--|--|--|



|  |  |  |   |
|--|--|--|---|
|  |  |  | <p><b>Training</b></p> <ul style="list-style-type: none"><li>• Orientation and training of women and support persons</li><li>• Emotional preparation of CLS persons</li></ul> <p><b>Cat 5: Advocacy</b><br/>Awareness campaigns</p> |
|--|--|--|---|



## **5.2 Section One: Results of discussions with pregnant women**

This section captures the women's results pertaining to their perceptions, attitudes and preferences regarding CLS in public health facilities, as discussed in the focus group discussions. A total of eighty-eight (88) women who attended on the dates appointed for FGDs, were used for 10 FGDs at the selected hospitals. All pregnant women irrespective of age, ethnicity, religion, socio-economic and educational status, who gave verbal and written consent, were allowed to participate in the study with question guided by the interview guide (Annexure K)

### **5.2.1 Description of the demographics of the pregnant women**

A total of eighty-eight (88) pregnant women participated in the focus group discussions, with an age range between 18 and 45, and mean age of 30 years, with the majority being married (n=86). Most of the participants (n=77) were Yoruba, eleven of the participants were Igbo while the remaining three were of other tribes (Hausa, Igbira and Edo). The majority of the participants were Christians (n=77) while Muslims numbered eleven (11) and only one woman was an adherent of a traditional religion. More than 50% (n=60) of the participants had a tertiary education while 31% (n=27) had secondary or high school education, three (3) had only primary school education and five (5) of the women had never attended school.

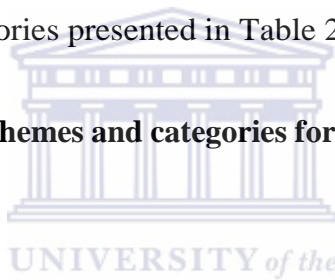
The results are presented according to themes and categories generated from the women's verbal and non-verbal responses, group interactions, field notes and

memos written from the data analysis process. The results are guided by the study objectives and elements of the PEN-3 cultural model (Airhihenbuwa, 1989) to identify perceptions, attitudes and preferences, as well as barriers and facilitators to the implementation of CLS from someone a woman has chosen from her social network, in public health facilities in Ondo state. The following themes emerged during inductive analysis.

### 5.2.2 Theme A1: Perceptions about CLS

Perceptions of pregnant women to CLS during childbirth generated four (4) Sub-themes and several categories presented in Table 24 below:

**Table 24 : Themes, Sub-themes and categories for pregnant women’s perceptions of CLS**

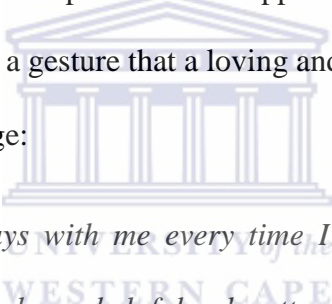


| <b>Themes A1 : Perceptions about CLS</b>   |   |
|--|---|
| <b>Sub-themes</b>  | <b>Categories</b>   |
| <b>Sub-theme 1</b><br>Family as traditional support system                               | Intimate partner as a support system<br>Extended family and close friends as support system<br>Deprivation of family support means a lonely journey               |
| <b>Sub-theme 2</b><br>Male involvement in women’s care during childbirth                 | Sense of belonging<br>Increased value improves caring<br>Attitudinal change<br>Enlightened insights about family planning   |
| <b>Sub-theme 3</b><br>Family and healthcare workers                                      | Supportive role to healthcare providers<br>Increased facility utilisation<br>Enhances cooperation with nurses’ procedures<br>Protection against nurses’ hostility |
| <b>Sub-theme 4</b><br>Congruence childbirth practices influenced by religion and culture | Religious/ Traditionally accepted practice<br>Ethnicity-defined traditions as a guide to practice   |

### 5.2.2.1 Sub-theme 1: Family as traditional support system

The women in this study described their family as a key traditional support system that should be involved in their care; most of these women had experience of family presence during birth either at home or in a private hospital or other alternative birth centre other than public health facilities, and shares their positive experiences with other participants. This traditional support was marked by the support of the intimate partners as well as that of extended family members and close trusted friends.

In most cases the participants expressed much appreciation of their husbands as part of the process and saw this as a gesture that a loving and supportive husband should give within a traditional marriage:



*“My husband stays with me every time I want to deliver in the hospital and he is always helpful as he attends to all my needs during labour.”*

The traditional support of family was not limited to intimate partners only, but included members of the extended family, and close friends, which is an accepted norm within most African cultures. This gesture was highly appreciated by participants, who felt that they were valued within their families:

*“When I wanted to give birth to my first born, my pastor’s wife stayed with me because my husband was not around and I really appreciate*



*what she did. She provided all the necessary assistance that I needed.” (FGDPG 2)*

This support from extended families was also valued, especially in uncertain circumstances, as described by another participant who related her unpleasant experience with her brother’s wife in a public health facility:

*“When my brother’s wife wanted to give birth and was taken to hospital X ....., the nurse examined her and confirmed she was in labour. She was admitted to the labour ward but I was not allowed in, she suffered the labour pain alone and requested to be operated when the pain was so unbearable and no relation was there to assist her. ....I was only allowed to enter and sign consent for her when she was being prepared for surgical operation which is not right, I believe the nurse should have allowed me to be with her to render assistance especially when she was in so much pain.”*

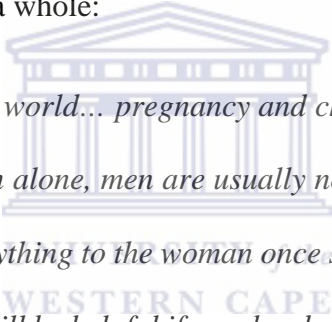
Some of the women described delivery without a family companion as being “lonely and boring”. Thus, being deprived of a family member to support them was perceived by women as being sentenced to a lonely journey. This was expressed by a participant in the following quote:

*‘If you are accompanied, you won’t feel lonely, like when you are just alone in the labour room without anybody and sometimes the way the nurses might treat you, you might not like it ,but with*

*one of your relatives with you ,it will be more lively, it won't be too boring.'* (FGDPJ 1)

#### **5.2.2.2 Sub-theme 2: Male involvement in women's care during childbirth**

Most of the women who are willing to have CLS from a family member, especially their husband, see it as an opportunity to get the husband involved in the pregnancy and labour experience, which has been grossly neglected in Nigeria and most African countries. The women in the study believed that the involvement of the husband/spouse would foster a sense of belonging and responsibility toward the woman and by extension to the family as a whole:



*'In this part of the world... pregnancy and childbirth programmes is left for the woman alone, men are usually not involved, which make men to leave everything to the woman once she is pregnant until she delivers..... It will be helpful if men has been in involved gradually and made to understand that they have important role to play from pregnancy to delivery.'*

Many of the respondents view the presence of their spouses during childbirth as a means to change the perceptions about the gender bias regarding the gender of the newborn, which is very common among men in Nigeria. They explained that some men perceived pregnancy and delivery as an easy task and always lose patience with their wives, especially when they are hoping for a male child and a girl is born instead. A participant describes a deplorable scene in which a husband who thought his wife was taking too long to deliver in the labour room (the woman had had only girl children

before) was eagerly waiting for a male child, and said he believed that the woman was “playing” or wasting time in the labour room. The narrator of this story believed that if husbands are allowed to stay with wives during labour, it would afford the man an insight into the labour process, and increase the wife’s value in her husband’s eyes:

*“They did not understand the pain that the woman undergo in labour so, if men are allowed to witness labour process and labour pain, they will value women more.”*

Furthermore, many of the respondents felt that husbands don’t give their wives the proper care and respect during labour and delivery, hence they felt that the presence of husbands during labour would change the non-caring attitude of the Nigerian men. Husbands, they believed, would care more for their wives if they went through the labour process together, and this would promote love and bonding:

*‘..... In developed countries, the husband is allowed to stay with his wife throughout labour, he will assist to rub her back and kiss her as she goes through labour pain. But here in Nigeria, our men are not that caring... I think if our husbands are allowed to stay with us throughout labour it may bring a change in their attitude.’ FGDP*

Furthermore, some of the women in this study also linked the importance of male involvement to the utilisation of family planning services. They believed that husbands would understand the need for child spacing and grant their wives permission to use family planning methods if they participated in the childbirth experience:

*‘The husband will understand the need for family planning and child spacing if he had followed the wife maybe during the first and second pregnancy and childbirth because he would have understood the effect of frequent pregnancy and childbirth on the woman’s health and the stress involved for the man.’ (FGDPG 3)*

### **5.2.2.3 Sub-theme 3: Family members and healthcare workers**

The women in this study perceived the inclusion of their family members as supportive to the healthcare providers’ work and public health facilities in general. They expressed the view that there are not enough doctors and nurses to care for the teeming population in the hospital. They observed that most times only one nurse was available to take care of many women in labour and the nurse might be busy with one woman when other women are also in need of assistance. Hence the relative may be of use in such circumstances. They also reasoned that some kinds of personal assistance can only be rendered by a female relative:

*‘I see this concept as a good one to allow relatives to stay with women in labour because most times the nurses and doctors are not enough to take care of women during labour....’ (FGDPG 5)*

*‘The nurses are with us to help but there is some assistance that we can request from our mother or mother-in-law that the nurses might not be able to render for us.’ (FGDPJ 8)*

The women also believed that the inclusion of family in women's care would boost women's confidence in hospital delivery, and increase the utilisation of public health facilities:

*'...it will also encourage people that are afraid to coming to the hospital to deliver, the concept will give the confidence to use the hospital since their relatives will be allowed to stay with them in the labour room.'*(FGDPA 1)

Family involvement during childbirth in health facilities is seen as supportive of the care providers, and also a means to promote cooperation between the client and healthcare providers, as can be seen in the statement below:

*'During my last delivery in the hospital, I came with my husband and he assisted in giving the necessary material I needed to the health workers, this assisted the nurses to conduct the delivery easily'*  
(FGDPJ 1)

Childbirth at public health facilities is believed to put women at risk of abuse and neglect by care providers. The respondents in this study recognize the benefit of social support from familiar persons or loved ones in reducing the risk of medicolegal hazards, and in preventing complications and misunderstandings that may occur after delivery. Some participants expressed their views as follows:

*'In addition to support that you should bring your loved ones to labour room, there are some scenarios .....you might deliver to a*

*male child, and they will exchange it with a female, but when you have a witness, maybe your husband....'(FGDPI 7)*

*'...and some situation whereby some babies will packed (dead) and they will say, it's your own that packed so all those kind of scenario or mix-ups will not be there when your witness is there, when your love one is there, the person will know what really transpired during the labour, so it will be transparent to everybody.' (FGDPI 7).*

The negative attitudes of nurses and midwives have been identified as the main reason why women have refused to give birth at the hospital, preferring labour support from relatives or familiar persons (Mathole et al., 2004; Bazzano et al., 2008; Mrisho et al., 2009). In line with previous studies, this study found that respondents were not satisfied with the attitudes and disposition of health workers, for example, the nurses, and felt that the presence of a family member during labour may help in curbing the physical and psychological assault and abuse from healthcare workers. This was emphasized by the following respondent:

*'...there are some nurses that are harsh, during that time of uttering harsh words, your mind will be scattered, you won't even compose yourself but when someone is there to encourage you, he will just say don't to mind them, just forget about their nagging attitude, you just concentrate on the delivery birth, this is our day of joy, you know they will be encouraging you and it will be easy.... (FGDPI 4)*

#### **5.2.2.4 Sub-theme 4: Congruence with religion and cultural practice**

The women in this study affirmed that having family support during childbirth is a cultural childbirth practice, especially in Yoruba culture in which this study is grounded, while the few participants from cultures other than Yoruba also confirmed family support as part of their cultural practice, as is the case for any culture in Nigeria.

*‘Our culture is not against it, a person may require assistance at any time especially during delivery, most time, the woman in labour may not have enough strength to do something that may be required or run around for something, but when you come with a trusted relative, he or she will assist where necessary.’ (FGDPB 5)*

*‘Yoruba tradition did not spell out a particular person should stay with woman during labour either man or woman, but when woman is in labour, it is compulsory for somebody to stay and support. It could be anybody from her family either senior or junior sister, her mother or mother-in-law; somebody must stay around and render assistance....’ (FGDPB 6).*

*‘...Igbo is not against the concept, a person can require assistance at any time....’*

*‘There is no religion is against a woman having a support person during labour....’ FGDPJ*

### 5.2.4 Theme A 2: Attitude towards CLS

Women’s attitudes to CLS from those of their social network, in public health facilities were influenced by what the women felt as the perceived benefits, risks, challenges as well as factors they believed could enhance the practice. The table below gives the summary description of the sub-themes and categories regarding the women’s attitudes to CLS.

**Table 25 : Themes and categories on women’s attitude to family members in CLS, in public hospitals**

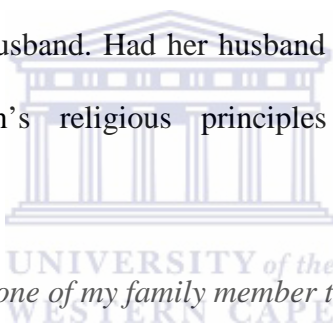
| <b>Theme A2: Attitude towards CLS</b>                  |  |
|--|--|
| <b>Sub-themes</b>                                      | <b>Categories</b>  |
| <b>Sub-theme 1.</b><br>Benefits/ role of family in CLS | <ul style="list-style-type: none"> <li>• Source of information</li> <li>• Production of relaxing and comforting environment</li> <li>• Moral and emotional support</li> <li>• Reduction of medicolegal hazards</li> </ul>  |
| <b>Sub-theme 2.</b><br>Perceived challenges            | <ul style="list-style-type: none"> <li>• Structural deficiency</li> <li>• Lack of privacy and confidentiality</li> <li>• Resistance from healthcare providers               <ul style="list-style-type: none"> <li>- Perceived negative attitudes from nurses</li> </ul> </li> <li>• Trust dynamics               <ul style="list-style-type: none"> <li>- Personal fear/ mistrust</li> <li>- Secrecy about childbirth</li> </ul> </li> <li>• Role conflicts               <ul style="list-style-type: none"> <li>- Conflict of interest between the healthcare provider and support person</li> <li>- Relative over-suspicious or tending to overreact</li> </ul> </li> </ul> |
| <b>Sub-theme 3.</b><br>Perceived enablers for CLS      | <ul style="list-style-type: none"> <li>• Enhancement of health facility structure               <ul style="list-style-type: none"> <li>- Conducive environment for CLS (dedicated labour room for privacy and confidentiality; visitors’ room)</li> </ul> </li> <li>• Policy and legal back-up               <ul style="list-style-type: none"> <li>- Inclusion of CLS in hospital policy</li> <li>- Rules and regulations regarding CLS</li> </ul> </li> </ul>  |



|  |   |
|--|---|
|  | <ul style="list-style-type: none"> <li>• Training of health workers, clients and support persons on CLS expectations and responsibilities</li> <li>• Advocacy <ul style="list-style-type: none"> <li>- Collaboration and public awareness programmes</li> </ul> </li> </ul> |
|--|---|

### 5. 2.3.1 Sub-theme 1: Perceived benefits/ role of family support

The FGD participants perceived support from people from their social network as a source of information for the healthcare providers, especially when the woman is in distress and unable to convey this information herself. A participant from one of the focus groups related an incident in which the importance of vital information was provided by a woman's husband. Had her husband not been on hand to convey this information, the woman's religious principles would have been seriously compromised.



*“I have followed one of my family member to deliver in this hospital before, although the woman's husband was not allowed to enter the labour room but he stood by the window. The woman was told she may not be able to deliver the child per vagina, she looked pale and may need urgent blood transfusion, the husband had to inform the nurses from where he was standing at the window that his wife cannot have blood transfusion because they belong to Jehovah Witness faith that forbids blood transmission.” (FGDPA 1)*

The findings of the FGD also showed that many of the respondents were in support of the presence of a companion during labour, preferably relatives because they believed

that the presence of a birth companion from their social network would assist them to manage pain and also provide comfort during labour:

*‘.....when you are in labour, you will be going through pain and when you see someone you trust close to you, the person with be comforting you, touching you and you will feel fine more than when you are alone.....’ (FGDPI2)*

Other participants believed family presence is necessary for “moral and emotional support” and sharing of the childbirth experience. The family also offer advice, counsel, reassurances and prayer for a successful delivery:

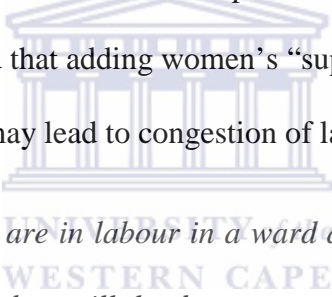
*“...for moral and emotional support the concept is good .....some women say bad words against themselves during labour pain, which is against the Yoruba tradition but if a relative is allowed to stay with them, the person will caution the woman against such words because the nurse might be too busy to notice.....The relative may advise the woman to sing or pray as a diversion from the pain and give moral support based on the person experience.” (FGDPI)*

#### **5.2.3.2 Sub theme 2: Perceived risk/ barrier**

Although the majority of women in this study expressed a positive attitude to CLS by persons of their choice from their close social network, the participants also discussed the factors perceived as risks and barriers to the implementation of a family support system during childbirth, in Nigeria society and in public health facilities in particular.

Women felt family CLS might not be convenient in public health facilities due to inadequate infrastructure. Some of the reasons cited by the women as potential risks/ barriers to the implementation of family-based I'CLS in public hospitals, include inconvenience for public health facilities, resistance from healthcare providers, personal fear and mistrust, and perceived conflict between support persons and healthcare providers. These factors were described in detail below.

The women decry the current structure in most public health facilities in which they give birth as inconvenient for the introduction of a family support system during childbirth. They explained that the women experience labour in an overcrowded single ward in most facilities, and that adding women's "support person" relatives in already over-crowded conditions may lead to congestion of labour wards:



*'When 20 women are in labour in a ward and there are 20 labour support persons that will lead to overcrowding in the hospital especially in a small labour ward.'*

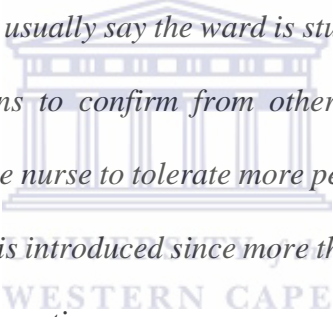
Another risk identified by pregnant women is the "privacy and confidentiality" issue. A woman might be reluctant to expose her body or express her feelings when a relative is around, especially where there are no individual rooms for labour:

*'The only challenge is that the concept might not be convenient in public health facilities for example a woman may not be comfortable with another woman's husband present during labour.'*

*'.....women may not feel free to expose themselves when relatives are around, she may also not be free to express herself especially if the mother-in-law is in the labour ward but when she is alone with the nurses she will feel free to ask for assistance.'* (FGDPJ 7)

The women in this study also discussed the possibility of unfavourable attitudes among healthcare providers, especially the nurses, to the family member's presence in the hospital during childbirth:

*'The nurses are not always comfortable with many people inside the labour ward, they usually say the ward is stuffy and ask people to go away (makes signs to confirm from other women). So the main challenge is for the nurse to tolerate more people in the labour ward when the concept is introduced since more than two women might be in labour at the same time.'*



Fear and ability to completely trust some labour support persons during labour and delivery, was a prominent issue discussed. They attributed fear of labour support to the religious belief that someone might want to harm them spiritually during the course of labour and delivery:

*'Although the government don't believe in evil spirit and witchcraft, but I think is very difficult to trust people whole-heartedly especially in Africa, some people may have evil intentions which may not be known to the woman.'* (FGDPJ 7).

*'One of the challenges can be the issue of trust, like the saying black people with black or evil intention. It might be difficult to trust some people because you are not sure of their intentions.'*

In corroboration with this finding, previous studies in Africa (Bazzano et al., 2008; Mrisho et al., 2009) also named culture- and belief-based anxieties as the main reason women refused to give birth in the hospital. In rural Zimbabwe, women related delivery to a local belief about increased vulnerability to witchcraft during early pregnancy, to the use of alternative forms of care (Mathole et al., 2004). The fear that someone may harm the woman or her new-born baby may be responsible for the secrecy surrounding information to the family and relatives when the woman is going to the hospital for labour, except for the most trusted relative of the expectant mother.

*'Many women don't like announcing to people when labour pain starts because of their fear about people's intentions in this part of the world.'*

*'...as for me, most times my husband is not around and I really don't like people following me to hospital during labour, my mother followed me once but was not allowed to enter the labour room and I don't like the idea personally. (FGDPJ 6)*

Women's fear and lack of trust may also be related to rumours from other people and also fuelled by the negative influence of social media:

*‘... We were told of an incident of a relative that followed the woman to the hospital and was also responsible for her delayed process of labour. She was said to have sat on a charm that obstructed the labour from progressing.’*

The fear and mistrust stated by the respondents in this study may be attributed to the norms and beliefs of people in some parts of Nigeria, where most people easily relate life experiences to religious and cultural practices (Ezeama and Ezeamah, 2014). For example, the taboos and practices that prevent women from taking appropriate decisions on where and when to seek medical attention during pregnancy and delivery have been reported in a previous study (Ezeama and Ezeamah, 2014). Also, there are taboos that emphasize traditional practices which negatively affect the well-being of women during pregnancy and delivery. Hence, women may be secretive about their delivery due to fear of being harmed during delivery and labour. The women felt that the involvement of family members in women’s care in public health facilities may also introduce a strain in the relationship between the woman’s support persons and the care providers:

*‘Some will even be over-suspicious of the nurse and say they ask me to stay because of the thing you people always do, so everything the nurse does, she’s putting her, she’s questioning her, overreaction and all that....’ (FGDPI 6)*

### 5.2.4.3. Sub-theme 3: Perceived enablers for CLS

Despite the risks and challenges identified by the women in the study, the majority of the participants believed the woman's preferred person from her social network can still be involved as CLS person in the public hospital if an enabling environment could be provided. The suggested enablers for CLS practice in public health facilities are discussed below. Poor infrastructure in most public health facilities leading to overcrowding, and lack of privacy and confidentiality were identified by the women in this study as barriers/ challenges to people from their social network providing support during labour. Thus, some of the respondents were of the opinion that the provision of individual compartments or a dedicated delivery room, visitors' room, equipment and adequate emergency drugs in the hospital are possible solutions:

*'Solution to overcrowding is the provision of an individual compartment for each woman and her labour support person.'*

*(FGDPJ 4)*

*'The labour room should be enlarged and they should screen for the woman in labour. The screen will be used to provide privacy so that only the nurses, doctors and relatives like the husband will have access to the woman; that will prevent the woman's husband from seeing the nakedness of the other women in labour.'* (FGDPA 2)

Currently, visiting policies in many hospitals, even for traditionally defined families are inappropriately restrictive. This puts patients at risk and contributes to emotional suffering for both patient and family (Lee et al., 2007). Hence, there is a need to have

a visitors' room to accommodate family members serving as companions during labour. In line with this, many of the respondents in this study suggested that a visitors' room should be provided to accommodate family members and to provide comfort for them:

*'I think the hospital should provide a visitors' room where they can rest because last year September I brought a patient here that had surgery done. I was out in the cold throughout the night even around one in the morning....' (FGDPF 3)*

In contrary to the above submission, some of the women felt that the provision of a visitors' room negates the purpose of family support in the hospital:

*'Is good if the government can provide visitors' room for relatives to rest but if the relative goes to sleep in a visitors' room there will be no point for your presence in the hospital. If the woman is in labour room and the support person in the visitor room sleeping because this concept is for the support person to assist the woman throughout labour. So I will suggest the hospital provide enough space and a chair for the support person to be with the woman.'*

Many of the respondents in this study were in support of the view that women should be allowed to choose whomever they want to serve as a birth companion during labour and delivery. They expressed the wish for a situation whereby there will be written policy, legal back-up and regulations to aid the practice of CLS from their social



network support persons. This may be attributed to the desire of the women to ensure the sustainability of the labour support system:

*'I prefer that channels should be created for relatives to be around when one is giving birth because if the concept is not welcome especially in state hospital, if the concept is not welcome, the nurses or the doctors or the management of the hospital will not allow any of the members of the families just enter into the hospital anyhow.'*

*'I will suggest that the concept become a law or part of hospital policy that the woman should bring a woman as labour support person while men will be exempted.'*

Some also suggested that the health facilities should have rules and regulations for CLS persons of the woman's choice:

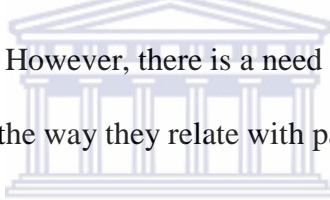
*'They should allow them to fill a form that says they are going to stand by the person that want to give birth.'* (FGDPF 7)

*'The nurse should ask the woman to identify her labour support person on admission into the labour room. The woman will confirm the identity of the person before the contraction becomes unbearable and the person should be allowed to enter the labour room and render necessary assistance.'* (FGDPA1)

Women also suggested that the hospital should design a tag as a form of identification for the support person:

*‘Maybe a tag or identification, maybe the nurse will ask where your identification is, let me know maybe you are truly the person that this woman in labour wants to stay with her or not, so the person should be able to present identification. The nurse will be satisfy that this is the true identification for security reason.’*

Many of the respondents in this study perceived that the level of awareness of labour support should be raised among the healthcare workers. They made mention of situations when health workers embarrassed their relatives providing support for them in the hospital. This behaviour of the health workers may be related to their attitude to patients and their families. However, there is a need to re-train health workers so as to improve their attitude and the way they relate with patients and their families:



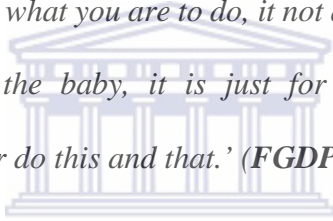
*‘The hospital officers or health workers should be homely, and every one of them should also have the understanding what we are talking about, of this particular thing.’*

*‘Everybody should be aware because of a situation when you ask somebody to stay with you and the nurse in question is looking at the person as a rival.’ (FGDPI 6)*

Besides issues related to health workers, many of the women in this study suggested the need to improve on the level of awareness of the familiar persons providing labour support for women, on various matters related to birth support. These awareness

interventions need to focus more on educating birth companions on the emotional, physical, informational, spiritual and advocacy needs of women in labour:

*'...during this course of antenatal, the nurse should try and enlighten those that come because is not everybody that will understand that this is the minimum number of persons that can go in with you, only one person and even the person that will come in, I think before coming in, the nurse should enlighten him or her on what the person want to do inside and not just say come inside. The nurse on duty should say, this is what you are to do, it not as if you are the one that want to deliver the baby, it is just for you to give words of encouragement or do this and that.'* (FGDPI 6)



Some the women suggested that the CLS should start during antenatal preparation and that support persons should be encouraged to come with the woman:

*'The husband should attend the antenatal clinic with the wife at least once during pregnancy for counseling, maybe when the pregnancy has reach the advanced stage, maybe 7/ 8 months, then the form should be introduced. The person the pregnant woman comes with must know ahead of time so he or she can be ready on the day.'* (FGDPF 1)

The women participants recommended collaboration and comprehensive country-wide/ state-wide public awareness programmes to enlighten the public about the CLS

concept, which they believe will go a long way in enhancing successful implementation.

### 5.2.5 Theme A3: Preference for CLS

Although all the showed preference towards CLS however, the women preference for support person was influenced by individual conviction, interrelatedness and childbirth experience. Most of the participants in this study preferred the support person to be a close relative either husband, mother or mother-in-law, sister in law or anybody the woman can “trust”. The table 26 below presents the detail Sub-themes and categories on women preference to CLS in public health facilities.

**Table 26 : Themes and categories on women’s preference for CLS in public health facilities**

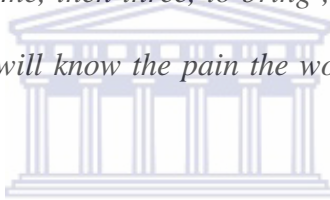


| <b>Theme A3 : preference for CLS in public health facilities</b> |  |
|--|--|
| <b>Sub-themes</b>  | <b>Categories</b>  |
| <b>Sub theme 1</b><br>Preferred support person                   | Preference influenced by personal conviction , inter-relatedness, and childbirth experience<br>Preference for close relatives based on “trust” |
| <b>Sub-theme 2</b><br>Predictors for choice of support person    | Trust<br>Reliance<br>Availability  |
| <b>Sub-theme 3</b><br>Gender and experience                      | Labour support person should be someone with experience in labour process, preferably a woman  |
| <b>Sub-theme 4</b><br>Number of support persons                  | Preference for more than one support person for complementary assistance   |

### 5.2.5.1 Sub theme 1: Preferred support person

The women expressed divergent preference for support person. They felt the woman should be given the opportunity to choose her support person based on her personal convictions about the role of the person, and also trust and availability. The women who preferred to have their husbands as support person believed that the husband is the closest person to the woman and is responsible for the pregnancy and the family:

*'I prefer my husband, why because one, he's the father of my unborn child or my children; he's the father of my children , two, he knows everything about me, then three, to bring ,to create more love and care because he will know the pain the woman is passing through during labour.'*



However, some of the participants contest the above assertion, they maintain that the supportive role during labour is best done by female relatives due to the feminine nature of caring and the fact that the woman who has undergone labour herself will understand what it feels like for another woman to be in labour. They also explained that the husband may not be able to stand the sight of his wife in labour:

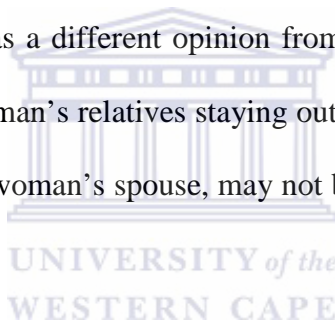
*'I prefer my mother because my mother knows how to take care of someone.'* (FGDPF 5)

*'My mother usually follows me to the hospital during labour because my husband has a phobia and cannot stand labour process. I trust and believe in my mother more than other people.'* (FGDPJ 8)

*'...will prefer my elder sister because she's of great experience and she knows me better than my husband....' (FGDPF 1)*

*'I prefer my sister to stay with me, the reason is this, what my sister can do for me, my husband may not be able to do it for me. The only thing I may need my husband for there is to stay around and be praying for me. But my older sister I can ask, please come and rub my back, put powder for me, I can even use my head to knock her if she is not cooperating so I prefer my sister to be there.'* (FGDPF 2)

One of the participants has a different opinion from the majority. She opted for the current practice of the woman's relatives staying outside the labour room because the relatives, particularly the woman's spouse, may not be able to bear seeing the woman in pain.



*'I prefer the way they have been doing it before, they were asked to stay outside because is not everybody that will be bold and have confidence to withstand labour experience especially the husband, some men might be afraid and may not be able to withstand the wife going through pain.'* (FGDPJ 6)

#### **5.2.5.2 Sub-theme 2: Trust, reliance and availability**

The women in the study expressed the need for the support person to be someone that is trustworthy, reliable and available to render support at the time required. The issue of trust emerged with resounding emphasis.

*'I believe the support person should be the person that the woman trusts and will be willing to assist during labour.'*

*'...is not necessary it should be husband, or the mother or mother-in-law or senior or junior sister, but a person that is willing to render assistance and ready to cooperate.'*

*'Sometimes the trusted relative may not be around when the women fall into labour and just anybody assists the woman to the hospital. I think the nurse should confirm from the woman if the person that accompany her to the ward is her trusted labour support person.'*

*(FGDPA 2)*

### **5.2.5.3 Sub-theme 3. Gender and experience**

Many of the respondents felt that an experienced person who has undergone the labour process before will be the best one to provide support during labour. They felt that an experienced mother will be able to provide all the required labour support during childbirth, based on personal understanding of the labour process.

*'The support person should be women in respect of religious belief either Christians or Muslims, as we all serve and believe in one God. Women will always be comfortable with other women and women who have compassion will readily assist other women even if they are not related.'* (FGDPA 6)

Some of the women added that labour support is not mere presence of a family, or running errands, but is somebody who can give support morally, spiritually, and emotionally, and be with the woman during labour. They also raised the point that some men may not be able to take the experience of labour and thus supported the preference for an experienced female support person:

*'I believe the woman should have the person that can give support morally, spiritually, emotionally with her during labour and not necessary the husband. Labour support is not to run errands and just physical presence, some men have phobia and will only be shaking if you force them to stay ...so the labour support person should be someone that is ready to render all assistance in labour from being a companion to offering prayers, giving useful advice and assurance for the woman in labour.'*

#### **5.2.5.3 Sub-theme 4: Number of support persons**

Some of the women expressed the desire to have more than one labour support person at a time, for complementary assistance. This argument was based on the need to have somebody continuously around the woman in labour, in case one was sent on an errand.

### **5.3 Section Two: Results of Nurse/Midwives**

This section captures the results of the focus group discussions of the nurse/midwives on their perceptions and attitudes to CLS, and the pregnant women's choice of support person from their social network, in public health facilities. A



total of forty-five nurse/ midwives were available and gave written consent to be involved in focus group discussions. The inclusion criteria for nurse/ midwives was originally at least five years' experience working in the obstetrics and gynecology units, but the stipulation for years of experience was reduced to 2 years because most of these facilities were grossly under-staffed, and some of the available staff were recruited less than 5 years ago. The discussion was guided by the interview guide (Annexure L).

### **5.3 1 Descriptions of the demographics of the Nurse/ Midwives**

A total of forty-five (45) nurse/ midwives participated in the focus group discussions with an age range between 22 and 57, and a mean age of 38 years, composed of mostly married participants (n=40). Most of the participants (n=44) were Yoruba, with only one Igbo. The majority of the nurse/ midwives were Christians (n=43) while only two were Muslims. Most of the participants (n=40) are registered nurse/ midwives while the remaining participants have Bachelor of Nursing (BSc) degrees. Eight of the nurses are Chief Nursing Officers (CNO) by rank, ten are Assistant Chief Nursing Officers (ACNO), five are Principal Nursing Officers (PNO), and fourteen are Senior Nursing Officers (SNO) and the remaining eight are of the lowest Nursing Officer (NO) cadre.

**Table 27 : Themes and categories on nurse-midwives’ perceptions regarding the practice of CLS in public health facilities**

| Theme B1 : Perceptions about CLS  |   |
|---|---|
| <b>Sub-theme 1:</b> Non-existence/intermittent practice                                     | <ul style="list-style-type: none"> <li>• Family CLS is not part of current hospital policy and not routinely practised</li> <li>• Occasional/ discretionary practice</li> </ul> |
| <b>Sub-theme 2</b> Perceptions about introduction of family CLS in public health facilities | <ul style="list-style-type: none"> <li>• Midwives perceived that CLS can be introduced, tested and implemented in public health facilities</li> </ul>                           |

### **5.3. 2 Theme B1: Perception and practice of CLS**

The nurse/ midwives in this study discussed the current practice in most hospitals, and also expressed their perceptions about family as a source of CLS in public health facilities, based on personal belief and experience in the public service.

#### **5.3 .3.1 Sub-theme 1: Non- existence/intermittent practice**

The midwives in this study affirmed that CLS is not part of the current hospital policy and therefore not routinely practised in the hospital. They established that women’s families are not usually involved in care, or allowed to stay to offer supportive care during labour:

*‘It’s not been in practice in this hospital since its inception.’*

*(FGDMA1)*

*'It is not in practice but the patients' relatives can be allowed to hang around the facility if their assistance is needed, they can be easily called upon.'* (FGDMA 2)

*'We don't allow them to stay inside the ward with them. We don't allow them to stay beside them, we allow them to stay around and so when we need them, we will call them for anything the patient needs.'*  
(FGDMA 4)

The midwives explained further that occasionally the woman's relatives may be called upon for assistance, at the nurse/ midwife's discretion, depending on the situation in the ward, and the level of pain, and sometimes based on the woman's request:

*'Is not part of the hospital policy but, is just using one's discretion to judge what is happening at any time, for instance if we are having a woman who is not cooperating on the labour couch in the labour room we can invite the husband or the parent in to come and talk to her and give her some psychological support, the person she can trust anyway.'* FGDM 3

### **5.3.3 Sub-theme 2: Perceptions about CLS being introduced in public health facilities**

Many of the midwives perceived the concept of birth support from familiar persons as a good and evidence-based practice in developed countries that can be implemented on a trial basis, and incorporated into standard practice in Nigeria. Participants in one of

the FGDs expressed satisfaction with the occasional practice in which a woman's relatives were invited to assist with an uncooperative woman in labour:

*'...with the few we have done here, you will see the joy in the husband....that see the way the baby is coming out and everything...you know they are doing everything together, the husband and the wife, they are doing everything.'* (FGDMG 5)

However, the midwives felt the concept can only be successfully implemented if adequate resources are provided in the hospitals and clinics:

*'...the policy is a good idea if government can make provision in terms of the instruments and staff too because we have shortage of staff and at the same time the instruments we have is inadequate for us to make use of....'* (FGDME4)

#### **5.3.4 Theme B2: Attitude towards CLS**

The nurse/ midwives' positive attitude to family members as part of the CLS system in public health facilities, is defined by their perceived benefit, while a negative attitude was influenced by the perceived risks/ challenges that could come with CLS in a public health setting. Table 28 highlights the sub-themes and categories relating to the midwives' attitudes to CLS as well as the enablers for CLS practice in public health facilities.

**Table 28 : Themes and categories on nurse-midwives' attitudes to introduction of CLS in public health facilities**

| <b>Theme B2 : Attitude toward CLS</b>                      |   |
|--|---|
| <b>Sub-theme 1</b><br>Positive attitude                    | <p><b>Perceived benefits of CLS</b></p> <ul style="list-style-type: none"> <li>• Promotes love, sense of belonging and bonding</li> <li>• Psychological support</li> <li>• Improves patient cooperation and reduces nurses' stress</li> <li>• Enhances family planning</li> </ul>   |
| <b>Sub-theme 2</b><br>Negative Attitude                    | <p><b>Perceived risks / challenges</b></p> <p><b>i. Women-related challenges</b></p> <ul style="list-style-type: none"> <li>• Deprivation of women's privacy</li> <li>• Delayed delivery process</li> <li>• Misuse of opportunity by women's relatives</li> </ul> <p><b>Facility-related challenges</b></p> <ul style="list-style-type: none"> <li>• Inadequate health facility infrastructures</li> <li>• Shortage of health personnel</li> <li>• Fear of breach of confidentiality</li> <li>• Religious exclusivity</li> <li>• Interference with nursing duties and routines/ delay in delivery process</li> </ul>  |
| <b>Sub-theme 3</b><br>Perceived intervening factors to CLS | <ul style="list-style-type: none"> <li>• <b>Trust and cultural dynamics</b> <ul style="list-style-type: none"> <li>- Midwives' observation of women's fear and mistrust of their relatives' presence during labour</li> <li>- Cultural exclusion of men in women's care during childbirth</li> </ul> </li> <li>• <b>Religious exclusivity</b> <ul style="list-style-type: none"> <li>- Some religions prohibit men from attending births, for example, Islam</li> <li>- Issues of polygamy : men with many wives</li> </ul> </li> <li>• <b>Educational influence</b> <ul style="list-style-type: none"> <li>- Midwives expressed positive attitude to working with educated relatives rather than those without formal education</li> </ul> </li> </ul> |

|   |  |
|---|--|
| <p><b>Sub-theme 4</b><br/>Enablers for CLS practice in public health facilities</p> | <ul style="list-style-type: none"> <li>• Government involvement/ policy</li> <li>• Health facility structure <ul style="list-style-type: none"> <li>- Resources (personnel ,physical structure and equipment)</li> <li>- Sufficient medical equipment</li> <li>- Expansion of labour rooms</li> <li>- Adequate staffing</li> <li>- Organisational CLS concept</li> </ul> </li> <li>• Safety/ Security measures</li> <li>• Orientation and training of CLS persons</li> <li>• <b>Advocacy</b> <ul style="list-style-type: none"> <li>- Public awareness campaigns</li> <li>- Use of media</li> <li>- Visual aids</li> </ul> </li> </ul> |
|---|--|

#### 5.3 .4 .1 Sub-themes 1: Positive attitude

Many of the midwives expressed a positive attitude to CLS and see the concept as beneficial to the woman during labour. The FGD participants believed that the involvement of the woman’s relatives in care during labour could promote love and a sense of belonging, and bring about psychological support during labour:

*‘...of course it promote bonding, it makes the woman feels emotional support with the family members, and maybe the husband is there, some women says they want their husband to be there to feel the measure of pain they feel.’ (FGDMB 1)*

*‘It’s really good psychologically, when your husband or somebody is beside you it makes you feel relaxed. (FGDMG 5)*

It is also believed that family support to the woman during labour may reduce the stress midwives may experience during childbirth, through enhancement of cooperation with the woman, for care and other forms of assistance during labour:

*'...it even reduces the stress that the nurses or the care-givers pass through during this period.'*(FGDMB 2)

*'Many of this women when they see their husband and their relative that they can trust when they see them around they cooperate more.'*  
(FGDMB 2)

Furthermore, the husband is believed to be a key factor in the utilisation of family planning; midwives view the involvement of the woman's spouse during childbirth as an avenue to reach out to the man as the decision-maker in the traditional family in Nigeria, to promote the use of family planning:

*'Another thing is that when we invite husband, it does work because in family planning sometime if the husband and wife come together, even you too will enjoy the counseling.'* (FGDME 2)

#### **5.3 .4 .2 Sub-themes 2: Negative attitude**

The nurse/ midwives' negative attitude was influenced by the risks/ barriers that could be challenges to the implementation of family members as support in the CLS system, in public health facilities. The identified challenges were discussed below in relation to women-related and facility-related challenges as stated by the participants.

Deprivation of privacy for the pregnant women was identified as a risk due to the current structure of the labour ward in most health facilities, and the nature of the individual woman's reaction to pain. The midwives pointed out that women are usually

naked during labour and may be exposed to the visitors in the ward infringing on their privacy:

*‘When you have one or two people or more women in labour in the same ward, you know, the attitude or the way pain reception differs from women to women and occasionally you can find them stripping off naked; such women will not be happy to have visitors around.’*  
(FGDMA 1)

*‘We don't have a private ward, we have many patients, many women in the ward and in a case when you invite maybe the husband to stay inside, there are many naked women there, also that won't be able to expose due to the husbands' presence there.’* (FGDMA 6)

Some of the midwives also believed that the family members' presence may obstruct or delay the delivery process due to “pampering” of the women by the relatives in the ward:

*‘They may feel reluctant to do most of the things you ask them to do which may lead to delayed second stage of labour and some other things.’*

They also recognized the fact that a familiar person from the social network of a woman in labour may sometimes “misuse the opportunity” given to them by some health facilities to assist in childbirth. They reported that the labour support person can either administer an unorthodox method of treatment to the woman, or infect the new-born



child if they are present during childbirth, or contaminate medical equipment if they are not well-guided:

*'...at times many of these relatives they do more harm than good, most cases you see many of these relatives coming into labour ward with herbal concoction, with local Pitocin, they will try to give to that patient in labour maybe at a time the nurse is somehow busy, they will just give it to the patient in labour, and that may cause more harm to the patient.'* (FGDMA 2)

*'If they sneeze inside the labour room while the child is being delivered, the child can easily have such infection the individual is suffering from.'* FGDME 1

'In general hospital as example, in the same ward we have antenatal ward, labour ward, postnatal ward, post-surgery ward, everything is there, so we have like four patients in labour and th The midwives also identified the inadequate state of the structure of the health facilities as an impediment to the concept. They reported that most of the labour wards could barely contain the pregnant women and healthcare providers, and may not be able to accommodate the family support person:

*ey are bringing their relatives one after the other....'* (FGDME 2)

*'...if we are having fourteen patients in the ward and allowing fourteen relatives to stay, where will the nurses pass? Even to carry out procedures will be like a war zone.'* (FGDME)

Besides poor infrastructure, the midwives also raised the issue of shortage of staff as another challenge to the concept. The midwives in this study felt that conditions might not be optimal for divulging information to women during childbirth, due to lack of privacy and confidentiality in the labour room. They felt that the presence of the birth companions may hinder them from disclosing some important information to the women before, during and after delivery, especially if the woman does not want the relative to know about confidential aspects of her health status:

*'You will not be free to divulge any information and they won't be free to open up, especially to doctors when they come.'* (FGDMA 1)

*'Culturally, there are some things you have to tell the woman, maybe there are some things the woman might not want the relatives to know about, maybe her status, her HIV status or many things like that, and you invite them, the presence of the relative there won't allow the woman to open up, or tell you some things that would even benefit her due to the presence of outsiders there.'* (FGDMA 6)

The midwives also perceived potential for conflict between them and the woman's support person; they envisage that some of the support persons might be difficult to handle. They also believed that some of the relatives interfere with nursing duties/routines:

*'So some of patient's relatives will not cooperate with the nurses on duty.'*

*'...in some cases these women when they hang around they tend to interfere like asking the nurse, ... saying, please this woman is crying come and attend to her, do this do that, trying to tell us what to do and forgetting that the pain that the woman is having at that particular time, the pain threshold differs from one woman to another.'* (FGDMA 1)

The midwives in this study admitted that it will not be easy dealing with some categories of birth companions during childbirth, such as those from the Hausa ethnic group and those who practice the Islamic religion in Nigeria; this feeling was based on their cultural and religious practices. For instance, Islamic law applicable in the predominantly Muslim population in Northern Nigeria opposed the physical presence of husbands in the labour room during childbirth (Iliyasu et al., 2010). Thus, delivery of high quality care to Muslim patients may involve having adequate awareness of the ramifications of these Islamic beliefs and practices. The midwives need to understand the implications of spiritual and cultural values for clinical practice. This could prevent the midwives from accepting labour companions during child birth, particularly when delivering women from the Hausa ethnic group or those who are practicing Muslims:

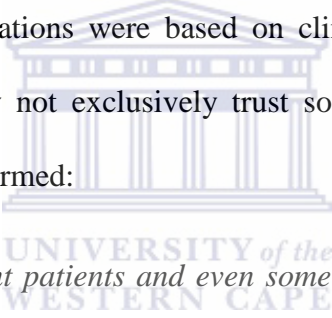
*'One won't have free hand in dealing with the patient because of the cultural belief of some women, you understand what I am trying to put across, like the Hausa and the Muslims, if they are around you won't be free handling them, especially the people that, what do you*

*call them, (somebody interjected Eleha , meaning women in purdah).... (FGDMA 1)*

### **5.3 .4 .3 Sub-themes 3: Intervening factors**

The midwives discussed factors that could influence the implementation of CLS either positively or negatively. These include cultural and religious beliefs and expectations, trust, and level of education of the client and the support persons.

The midwives in this study are concerned with issues of “fear /mistrust”; they explained their observation of women’s fear of the unknown and about trusting relatives as birth companions; these observations were based on clinical experience. The midwives reported that women may not exclusively trust some people as birth companions because of fear of being harmed:



*‘We have different patients and even some patients will tell you, I don’t want any relative, they will say please, I don’t want any relative to come in, just leave them alone, they don’t trust anybody that is around them and some trust people around them, so those people that trust people around them, it does come out well when we allow them in to stay around.’ (FGDME 1)*

The fear of the unknown among women in labour, as reported by midwives, may be attributed to the conventional cultural and religious beliefs that the birth companions such as relatives and friends may hurt them and their child. Similar to this belief, some cultures in other countries have traditional methods of giving birth and choosing a

labour support person. For instance, men have been mainly viewed as the providers, while pregnancy support is regarded as a female role in some cultures in Africa (Kwambali et al., 2013; Chongo and Ngoma, 2014). Furthermore, in Zimbabwe, women were found to relate delivery to a local belief about increased vulnerability to witchcraft during early pregnancy (Mathole et al., 2004):

*‘Our people here in Ondo state so much believe in their culture and religion and so many things they heard during pregnancy affect their behaviour, what they hear during period of pregnancy determines what they will say when in labour, some will prefer their relative with them and some will say they don't anybody around them.’ ((FGDME 3)*

*‘They believe in their own practice, their own cultural practice and they want to come and do it here...some men believe that going after or following their wife everywhere, the family or friend may think that she has used his head (bewitched the man) or something like that.’ (FGDMG 5)*

Differences in religious belief may also serve as a factor militating against labour support from familiar persons in the hospitals. A religion such as Islam, in Nigeria, has different views as regards childbirth. For instance, Islamic law prohibits the man from attending the delivery of the woman (Iliyasu, 2010). Similar to the view of the women in this study, the midwives also perceived that religious differences may serve as a barrier to accepting the concept of labour support from familiar persons in the hospitals.

*'We consider the patient's religion...and when we are saying it is the right of our patient, they have the right to their religion...when a woman in purdah is in labour, even they don't want, how will I put it, beside the health care giver that is attending to them...it is not that they want something, that is what their religion is saying about what you can and cannot expose them to, so somebody's husband cannot just come in, even a pastor may say he is not feeling comfortable with this. Even if she is not a woman in purdah but her husband may not feel comfortable that another man coming in sees his wife nakedness.'* (FGDMB 2)

*'Look at this issue of polygamy, when the man has about 2 to 3 wives, if he doesn't go with the first wife, and maybe the younger wife is the one he likes most and he has to follow the younger one, that will generate a kind of hatred.'* (FGDMB)

The midwives in this study viewed the communication gap as a major challenge for the provision of childbirth support by family members of women in labour, in this study. The gap in communication between caregivers and patients has resulted in lowering the quality of care, poor outcomes, and dissatisfaction with the health care system (Bonds et al., 2003). In addition, the midwives believed that educated relatives may be more inclined to listen and heed, and that they were therefore easier to direct than those with little to no formal education. Hence, efforts to orientate the labour support person in the language they understand may enhance their ability to support during labour:

*‘The majority of the patients we attend to here, the majority of them are illiterates, so if it is somebody that is learned and you feel will understand the language you are speaking, when you explain to them that ah this, this, this and this is not good for your wife or your relative, some of them do understand when they are educated but those people that come from the, you know, we have people that come from the different farms and them, all those villages....’ (FGDMG 5)*

#### **5.3 .4 .4 Sub-theme 4: Enablers for CLS practice**

To encourage the practice of labour support in the hospitals, the midwives in this study shared their views about some facility-related factors that may encourage CLS practices. The provision of health care in Nigeria remains the function of the three tiers of government: the federal, state, and local government (Adeyemo, 2005). Due to the fact that the various tiers of government are involved in health policy-making in the country, and the fact that they also support most health facilities financially, there is a need to inform them of various health policies, with a view to adequate budgeting.

The midwives in this study felt that there is a need to involve the different levels of government in any policy related to childbirth care in the hospitals:

*‘Our government also has a role to play because I don't think this policy can really come to reality without bringing in the government, that is if it will be acceptable to them, because all this public hospitals we are talking about that we want this policy to take place, they are owned by the government, so both federal and state*

*government, even local government if they can review the maternity section, if they can do it like private, something like private hospitals, where is going to be a cubicle to a patient, where we can really practice this so the patient will feel it is home away from home where the relation, or the husband or whosoever the patient prefer to stay with her, will be.” (FGDMB 5)*

According to the 2009 communique of the Nigerian national health conference, Nigeria’s health care system is weak, and this has been attributed to a lack of coordination, fragmentation of services, dearth of resources, including drugs and other supplies, an inadequate and decaying infrastructure, inequity in resource distribution, limited access to care, and the deplorable quality of care (Nigerian National Health Conference, 2009). In line with the finding, that Nigeria has a weak health system (identified in this national conference), the Ondo State Strategic Health Development Plan also found the lack of infrastructure as an existing gap in the health care system in Ondo state (Ondo Ministry of Health, 2010).

Furthermore, corresponding to these reports, the midwives in this study felt that there is a need to improve the infrastructure in the state hospitals, which includes of the provision of dedicated labour rooms, as well as the provision of more equipment, to improve childbirth practices in the hospital:

*‘The labour ward has to be made more private, as in: you have to have a private room for each patient.’ (FGDMA 1)*

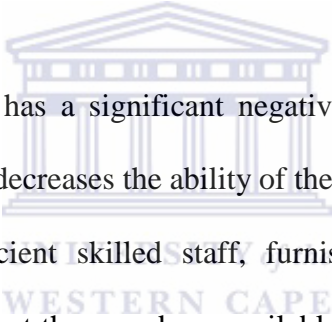


*'If there are more buildings and we have antenatal wards, postnatal wards and labour room separate it can help, and more staff.'*

*(FGDME 4)*

*'If we have to go about the policy there should be a column that will be signed by the pregnant woman, the column will ask the question that when you want to deliver, who do you want to be there with you, so the woman will write and put the signature and if there will be any changes during antenatal period, she can choose a different person.'*

*(FGDME 3)*



Inadequate staff numbers has a significant negative impact on maternal outcomes (Gerein et al., 2006). This decreases the ability of the health system to maintain a state of readiness where sufficient skilled staff, furnished with the proper supplies, equipment and resources that they need are available and ready to respond to women 24 hours a day, 7 days a week (Gill et al., 2005). In situations where the proportion of patients in the labour ward is considerably higher than the number of available nurses and midwives who have to provide support during childbirth, patients might not receive all the required support during the childbirth process, except for the support received from their labour support person.

The midwives in this study felt that there is a need to employ more personnel to enhance policy to implement CLS to women during labour:

*'If they employ more staff, they can assign one nurse to a patient so that the nurse will stay permanently with the patient.'* (FGDMA 4)

*'It is not easy to carry out this policy when we have shortage of staff and we have twenty patients in the labour room at the same time.'*  
(FGDME 1)

The midwives also advocate the need for security measures to prevent the potential risk of misuse of opportunities, and interference with hospital routines and procedures by the clients and their relatives. They suggested the need for a monitoring system using CCTV cameras in order to monitor the activities in the labour rooms:

*'When such concept is being introduced each room can be secured using CCTV cameras so that at least the nurses at the nursing stations can be able to monitor each room right from the nursing station.'* (FGDMA 2)

The CCTV cameras will enable the hospital management to monitor any misconduct that may occur during childbirth, as well as the health status of the birthing women. Similar to the findings of this report, the need for the nurses/midwives to monitor the patient/service user, document the nursing/midwifery action and communicate her/his actions to other members of the health care team, consistent with the health service provider's policies and the patient's/service-user's overall plan of care, has been documented in the Guidance to Nurses and Midwives on Medication Management (2007) (Altranais, 2007).

The midwives also suggested the need for adequate training for support persons, to equip them with information about their role during labour in order to ensure effective service delivery and interaction with healthcare providers. They stressed the point that the support person needs to be knowledgeable about hospital procedures:

*'Relative that are to stay with patient need to be well health educated prior to labour especially during antenatal clinic.'* (FGDMA 4)

*'They will know their limit, where to touch and where to go within the labour room....They have to be well informed of all my procedures.'*

Besides training of the labour support person in how to be an effective birth companion, the midwives in this study also felt that there is a need to raise the level of awareness of the people using either the electronic media or board system through other means of communication:

*'Maybe through media, they can introduce to people and tell them the consequence so that if anybody comes with any concoctions or any other thing that is contraindicated to medical care, the person would be dealt with.'* (FGDMA 1)

*'This policy, first of all, there should be general awareness, it should go round the state, it should go round the country, let the entire people know that the women are very unique and they need other people's support especially during childbirth and if they are coming*

*into the labour room they need individual, they need everybody to be there for them during the period of pregnancy, labour and so on.'*

*(FGDME 1)*

The midwives suggested the need to further extend the birth companionship messages to the community as a whole so that people can be aware of their role as birth companion before being involved in childbirth. Massive public awareness campaigns may go a long way in reaching as many people as possible in order to prevent ignorance and lack of knowledge about birth companionship.

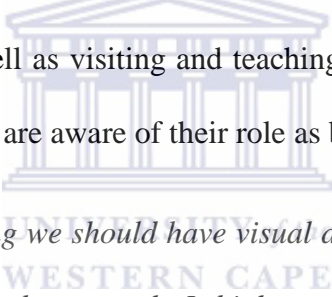
*'There should be a massive public awareness, we should create, you know, there is one thing in this our country, we don't listen, we don't really want to change and before you can make people to change from old habits, it is going to take a lot of time, it may take years, so there should be a kind of awareness program, radio, television, posters, everywhere, even if we can create a kind of public crusade about it, hand bills, it will make people to change.'* (FGDME 3)

*'Then maybe in the churches and mosques. Caregivers could be sent there to sensitize them and train them.'* (FGDMA 4)

Companions from a woman's social network, such as husbands/ partners and female relatives, usually have little experience in providing labour support and are themselves in need of training and education on their role as a labour support person. As they are frequently available to assume the labour support role, often without extra cost to

families or health systems, it is important to understand their effectiveness and better orientate them as providers of CLS.

The electronic media has been one of the most efficient means of communicating health messages to people in most parts of Nigeria. Previous studies in Nigeria have also found the media to be an effective means of communicating health information to large numbers of people (Omolase et al., 2009; Akodu, 2014). Many of the midwives in this study were in support of the view where women bring whomever they feel comfortable with and trust to be their birth companion. They supported the idea where the selected labour support persons are trained or educated on birth companionship using audio-visual teaching aids, as well as visiting and teaching people in places of worship, in order to ensure that people are aware of their role as birth companion:



*'I think in teaching we should have visual and audio teaching aids. If we are to train these people I think we should have some video clips and audio talks that could be played to them.'* (FGDMA 1)

*'There can be a notice board in which we can write and paste the policy in either Yoruba or in English so that everybody would see. We should pass the message across in the way they can understand.'*  
(FGDMA 4)

#### **5.4 Section Three: Findings from interview with policy-makers**

This section presents valuable insights into policy-makers' position on CLS by the person of the pregnant woman's choice, from her social network, in public health

facilities in Ondo State. The total number of fourteen (14) hospital policy-makers was involved in this study comprising of two (2) Directors of Nursing Services (DNS), five (5) Chief Medical Directors (CMD) and Medical Director (MD) and Seven (7) Heads of Nursing Services (HNS) at Ondo State Ministry of Health, Hospital Management Board and selected hospitals. The following themes were derived from the data analyzed.



**Table 29 : Themes and categories of policy-makers’ perceptions and position regarding CLS of a person chosen from the pregnant woman’s social network, in public health facilities**

| Theme C1 : Policy-maker perceptions and position on CLS |  |
|---|--|
| Sub-themes  | Categories   |
| Sub-theme 1<br>Perception and position on CLS           | <ul style="list-style-type: none"> <li>● CLS is an alien concept in Nigerian health facilities</li> <li>● CLS should be evidence-based</li> <li>● CLS could be implemented and is practicable</li> </ul>   |
| Sub theme 2<br>Perceived CLS benefits                   | <ul style="list-style-type: none"> <li>● Speeds up safe delivery process</li> <li>● Provides emotional support</li> <li>● Boosts women’s confidence</li> <li>● Provides psychological care</li> <li>● Enhances women’s cooperation with carers</li> <li>● CLS benefits all stakeholders</li> </ul>   |
| Sub theme 3<br>Perceived risks/<br>challenges           | <ul style="list-style-type: none"> <li>● Challenges for the hospital               <ul style="list-style-type: none"> <li>- Lack of CLS policy and legal framework</li> <li>- Poor infrastructure( inadequate labour ward, lack of privacy, insufficient medical equipment)</li> </ul> </li> <li>● Challenges for the healthcare providers               <ul style="list-style-type: none"> <li>- CLS alien to healthcare providers</li> <li>- Professional gatekeeping (nurses)</li> <li>- Possible resistance to CLS by healthcare providers</li> </ul> </li> <li>● Women-related challenges               <ul style="list-style-type: none"> <li>- Belief system and cultural misgivings</li> <li>- Mistrust</li> </ul> </li> </ul> |
| Sub theme 4<br>Enablers for CLS                         | <p><b>Cat 1. Hospital-related factors</b></p> <ul style="list-style-type: none"> <li>● Enabling law and political support               <ul style="list-style-type: none"> <li>- Need for policy change</li> <li>- Need for CLS legal framework</li> <li>- Collaboration with all stakeholders</li> <li>- Involvement of women, healthcare providers , government and community in CLS concept</li> </ul> </li> <li>● Structure               <ul style="list-style-type: none"> <li>- Modelling and trials of CLS concept in public health facilities</li> <li>- Finance</li> <li>- Sustainability</li> <li>- Recruitment of health personnel</li> <li>- Programme organisation</li> </ul> </li> </ul>                                |

|  |   |
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|  | <p>Cat 2 : Healthcare provider-related factors</p> <ul style="list-style-type: none"> <li>• Orientation and training</li> <li>• Orientation and re-training of all healthcare providers</li> <li>• Educational curriculum</li> <li>• Inclusion in midwifery training curriculum</li> </ul> <p>Cat 3 : Women-related factors</p> <ul style="list-style-type: none"> <li>• Training</li> <li>• Orientation and training of women and support person</li> <li>• Emotional preparation of CLS persons</li> <li>• Advocacy</li> <li>• Awareness campaigns</li> </ul> |
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#### **5.4.1 Theme C1: Policy-maker perceptions and position on CLS**

The policy-maker and healthcare providers play a crucial role in determining access to, and ensuring the quality of reproductive health services (Shelton, 2001). Hence the views of these groups of people, on any new concept introduced into the hospital setting is very important for easy operation and sustainability. Sub-themes and categories were developed based on the policy-makers' perceptions and position, perceived benefits/risks and challenges as well as enablers for the implementation of CLS by person/s from the woman's social network in public hospitals in the south-west region of Nigeria.

##### **5.4.1.1 Sub-theme 1: Perceptions about CLS**

The majority of the policy-makers interviewed in this study affirmed that family social support during childbirth is an accepted traditional/ cultural practice throughout Nigeria and the Yoruba ethnic group in particular, but the concept is not being practiced in most public health facilities. They described the concept of a family system of CLS



as alien to the healthcare worker and facilities despite it being an evidence-based intervention in developed countries:

*'In our traditional setting, pregnant women deliver within the family, in the family house among their family members in the comfort of friends and family mothers-in-law and so on, sometimes even with the husband there, but now in the hospital, we don't practise in the hospital.'*

*'I think that with modern medicine we have tried to jettison some of this very important traditional practices that actually aids the birth process, we have literally jettison many of these, but we have seen it that a client should have only the trained medical practitioners, what they need is just the nurse and maybe the doctors and I think it is a great error on the part of the medical workers. We just feel that we don't need them to be there.'*

The policy-makers also attested to CLS as an evidence-based practice that should be incorporated into the public health facilities.

*'For us practitioners, as care givers we favour evidence-based and the evidence today is that support in labour is beneficial, that is the evidence and as a practitioner, that is my opinion. I feel that women should have support in labour because that gives a better outcome.'*

*‘Quite a lot of papers have been written and the evidences a quiet clear that when you have support in labour, the outcome is better and the experiences on the woman perspective is equally more positive.’*

#### **5.4.1.2 Sub-theme 2: Perceived benefits**

The policy-makers described the family support system during childbirth as a fundamental part of traditional midwifery practice that contributes to the successful delivery process within the community:

*‘If we go back to the traditional way, we talk about the traditional midwives and the way things were done from then, if you look at the concept, if it was actually developed from there you know it was a system where relatives were there with the “Iya Agbebi” (Native Midwives), you know there are trusted members of the family that stays with “iya agbebi” with the person to deliver, that was how our midwifery was.’*

The policy-makers recommend CLS with emotional support. They explain that women in labour are more satisfied with the emotional support (distraction from pain) provided by family or relatives, than they are with the support they get from midwives. They referred to the midwives as being strangers to the women, who may not be able to provide all the necessary support needed. This further showed the importance of emotional support from familiar persons as discussed in previous studies (Gale et al., 2001; Tumblin and Simkin, 2001):

*‘When someone is in labour,.....I have gone through the experience, you have somebody close, somebody that you have a tie with consoling you, speaking nice words to your ears, not that the pain would not be there, but like a distraction, it makes the labour less painful compare to the stranger that is the midwife you have never met before.’*

The policy-makers also underline the fact that the women in labour are always scared of the midwives, and many of them do complain about the midwives’ and nurses’ negative attitudes during childbirth. Hence, they felt the women would benefit more from labour support from a person from their social network. This served to confirm previous study findings, where the midwives were deemed to offer inadequate emotional support for women in labour, compared to familiar persons or relatives (Tumblin and Simkin, 2001):

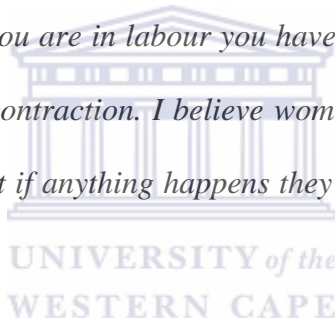
*‘I am sure the woman in labour would benefit more because my significant person is here, some people are scared about how the midwives treat them while in labour. They are not sure who you are going to meet, they are not sure of the words the midwives will speak to them and so on and so forth.’*

Furthermore, the policy-makers believed that the presence of a family labour companion gives the woman psychological support.

*‘Actually, psychologically a woman will want somebody that is very close to her to be around during labour like the husband, the mother-in-law, her mother, and it helps them psychologically to have a quick and safe delivery.’*

The presence of a familiar person during labour has been found to enhance the cooperation of women in labour during childbirth, according to the policy-makers in this study:

*‘When they have a significant person, they will be more relaxed and you know when you are in labour you have to be more relaxed like when they have contraction. I believe women will cooperate better in labour, at least if anything happens they will know that someone is there.’*



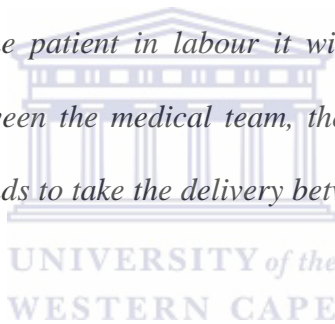
Aside from the benefits of the family CLS system to the women, the policy-makers in this study highlighted the benefits of the concepts to the healthcare providers and the health facility as a whole. The policy-makers recognize the fact that a labour support person can also help to relieve the burden of childbirth on the midwives. This was attributed to the lack of personnel in the hospitals or health centres.

*‘You know if a woman or a relative is standing by a woman in labour and as it is now because of shortage of personnel, we have about a nurse to about 4, 5 patients in labour, if you have relatives to help you to stay, the woman is going to empty her bowels in labour, or if*

*she notices excessive bleeding, she may alert staff on time and prompt intervention could be done to save the woman's life and the baby's.'*

The policy-makers in this study also believed that the CLS from family members promotes a positive labour experience and may increase hospital utilization and effect a positive image of the public health facility.

*'If somebody is closer to the patient stay with her and that person is trustworthy to the patient in labour it will actually promote the relationship between the medical team, the midwives, the doctors and whoever stands to take the delivery between the patient and the relative.'*



Due to the supportive role a labour support person engages in during the childbirth process; the policy-makers felt that there is a need to enhance the quality of care among women in labour in the hospital:

*'Care in the hospital is not only about the physical, it is psychological, it's spiritual, hence, you need people that are very close to them, to be able to give this part. When you are running to give the medical care to look for somebody to solve the physical, somebody is around to solve the psychological aspect and somebody should be also there solving the spiritual aspect and you know what,*

*as human beings, that whole is talking about the physical, if you know what health is all about, you will get to know of the physical, spiritual, mental encompasses all health is all about and no one can do all, so we need team work and in this team work we need these significant others to be able to play this role which is very important.'*

#### **5.4.1.3 Sub-theme 3: Perceived risks / challenges**

Engaging with policy-makers highlighted the barriers to the incorporation of a family CLS system in Nigerian health facilities, with a particular reference to Ondo state where this study was conducted. Some of the barriers were discussed as facility-related, staff-related, and others were the challenges with the pregnant women and the support persons.

Some of the policy-makers discussed the current structure in most public health facilities in the state as unfavourable to the implementation of CLS. Due to inadequate structure, lack of private rooms for the patients, the policy-makers felt the presence of the labour support person could serve as an intrusion on the privacy of the women in labour. A similar report has been made in the Ondo state strategic Health Development Plan (Ondo State Ministry of Health, 2010):

*'For many parts of our nation, in many hospitals the way the labour ward is designed and constructed has a lot of negative implications for this kind of practice.'*

*‘...labour ward is constructed in a manner that did not allow other persons aside from nurses and doctors to be in the labour ward.’*

The policy-makers were of the view that health care workers, particularly midwives and doctors might not be comfortable with the support from non-skilled birth attendants such as labour support persons from the family or relative. They alleged that family CLS is particularly alien to most healthcare providers in Nigeria.

*‘Mainly, the challenge will be to actually sensitize our nurses and midwives and maybe the obstetricians because it’s a new thing and it’s of course alien to the medical culture. In the traditional setting, yes, but to modern medical culture it’s alien.’*

*‘80 % of current midwives in Nigeria are not attuned with CLS.’*

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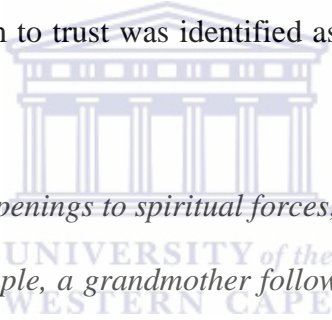
The policy-makers also alleged that the use of labour support from a familiar person might face some resistance or challenges from the health workers if the policies were to be instituted in the hospitals or health facilities.

*‘The challenges like I have stated will be the environment to practice this, you know and then the resistance that you get from, you know change...it is not palatable to everyone and so if you want to leave what you are doing currently, to adopt another one, you certainly expect some form of resistance from the health workers.’*

The policy-makers also felt that the concept of labour support from those in a woman's social network will disrupt the work of the midwives and nurses:

*'The midwives will think about it, will it disturb our job? Will the relatives allow us to do our profession in this? All those things, you have to deal with them.'*

The policy-makers interviewed also highlighted the challenge relating to the pregnant women's belief systems, and misgivings arising from cultural norms. Fear of the unknown relating to whom to trust was identified as a potential risk to the woman's choice of support person:



*'We attribute happenings to spiritual forces; we are a very religious society. For example, a grandmother follows her granddaughter to the labour room, if there is delayed labour, if there is bleeding maybe due to placenta previa, if there is anything at all, people will attribute it to the presence of the mother-in-law. In fact, if the mother-in-law is too agitated and so on, they will say "She followed her from home she must be a witch" and all that.'*

The policy-makers also postulated that childbirth practices are usually influenced by religious and cultural beliefs. They supported the view that there are different beliefs and cultural norms surrounding childbirth. For this reason they felt there is a need to take extra precautions when making the policies regarding the presence of family



during labour and delivery. For instance, according to Islamic belief and tradition, the man has not been allowed to serve as a labour support during the labour and delivery of a woman. (Iliyasu et al, 2010).

*'In the home setting and because of their immediate family and so on, they don't think about all those negative religious feelings. But once it comes to public health institutions it is another kettle of fish.'*


#### **5.4.1.4 Sub theme 4: Enablers for CLS practice**

The policy-makers suggested a possible modus operandi for the implementation of CLS in public hospitals in Ondo State. This was discussed in relation to hospital-related, health worker-related facilitators and women-related factors.

The policy-makers saw the need to create policies and take legal measures that will back up the CLS concept in the health facilities. This may involve legal documentation or written statements as suggested by the policy-makers in this study and in a previous study (Sweidan et al, 2008). This may help guard against any misconceptions about CLS provided by family members, and also ensure the sustainability of the concept in health facilities.

*'Let there be a legal framework to formally allow patients, I mean, allow relatives or support personnel to stay with a woman in labour. So, legal framework is very important. The state has to draw a legal framework that allows it to be formal.'*

Lack of effective policy-making and practices have been recognized as key challenges to public health in most developing countries (Bowen and Zwi, 2005). The WHO in 2008 reported that strong and effective health systems that are evidence-based in their operations are necessary to achieve continued improvement in health outcomes, in an efficient and equitable manner (WHO, 2008). In 2003, the WHO supported the process of contextualizing evidence and translating it into policy in many developing countries, including Nigeria (WHO, 2003). Similar to the view of the WHO, the policy-makers in this study also felt the need to inform and engage the government and policy-makers first in the decision-making about the CLS concept before practising it in various facilities:



*'You want to introduce this new concept in Ondo State, first of all is the policy-makers, they must accept it first.'*

*'... it starts with the law makers, they must accept, you must be able to sell it to them, how about this, how about that, what are the consequences. The government will see if it will give a positive or negative image, you know the political aspect of it, that's their own.'*

The policy-makers understand the need to plan and strategise in order to incorporate the concept of CLS into the healthcare system. They voiced the need to plan and involve all parties such as the women, skilled birth attendants, governments and the society at large in making decisions concerning the concept in order to ensure that it is widely accepted. This may also ensure the sustainability of the concept in health facilities:

*'If we are going to introduce it, we need to do a lot of groundwork because any concept introduced must be accepted not only by our pregnant women, by nurses and midwives themselves and by the society at large. We must all be on the same page. It is something that can be introduced once people understand the concept and why it will be easy once they understand it...because our people are already doing this at home, but they limit it to the home setting.'*

Lack of infrastructure has been widely identified as an existing gap in the healthcare system in Ondo state (Ondo state Ministry of Health, 2010). Hence, the policy-makers in this study felt that there is a need to make greater provision for equipment and infrastructure in health facilities. Provision of infrastructures in health facilities will reduce overcrowding in the labour ward/room, a problem common to most health facilities in Nigeria:

*'In terms of equipment that we have to use in the labour room, now that we are using the labour ward we can say this one instrument and can still wait, let me make use of this instrument, after using you disinfect, sterilize and wash. But when it comes to that single room, in terms of equipment, in terms of personnel, in terms of bedding and all other things, supplies have to be increased.'*

Provision of different cubicles for the women in labour and their families will also enable privacy and confidentiality in the labour room:

Financing and budgeting have been identified as two of the main challenges facing the health care sector in Nigeria (Popoola, Irinoye, & Oginni, 2014). These challenges must be overcome if quality and effective health care services are to be made available to the people. Similar to this report, the policy-makers in this study felt there is a need to finance and make provision for adequate budgeting if the CLS concept is going to be effective and functional in the health facilities:

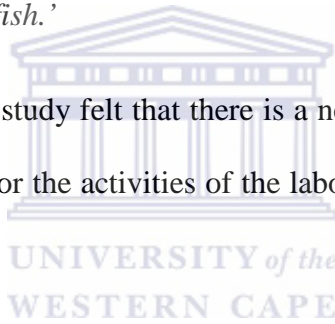
*'In any new program, you need money, money comes in because if you are going to... for example do advocacy in the media. In fact you need a lot of money because if you are going to do advocacy, it is not just by announcement. It will be a drama presentation, presenting two scenarios where somebody has a CLS and somebody doesn't have a CLS. So if you want to develop jingles, it will need money in order to... promote an idea, you have to budget for it. So it needs budgeting by policy-makers to actually drive this concept home. We have to budget for it and you need people who are educators who will promote the concept, those who would do the training, the advocacy and that is where the money comes in.'*

Non-sustainability of the health care programmes has been identified as one of the main constraint affecting the healthcare system in Nigeria, with policy-makers having challenges in how to allocate limited resources across the range of preferences (Eneji et al., 2013). Hence, this may result in government quitting some programmes in order to utilize the limited funds for other programmes. The policy-makers felt there is a need

to ensure that the CLS concept is sustainable. One of the means of ensuring the sustainability of the concept may involve engaging the Non-Governmental Organizations (NGOs) and international agencies in order to ensure that adequate funding is available to fund the CLS concept and to make sure that all the required infrastructure, equipment and personnel are available in facilities across the country:

*‘What we want to do is not something that will happen today, maybe another government would come and scrap it, or the leaders in the hospital will accept it today and if they change the leadership it’s another kettle of fish.’*

The policy-makers in this study felt that there is a need to employ more personnel in the labour rooms to monitor the activities of the labour support persons in each room of the labour ward.



*‘We need to put in place the personnel, you know, the advantage of using the labour ward now. When it comes to personnel you can make use of just two midwives looking after 5 people, because she is sitting and she is seeing all of them at the same time, but if we adopt this concept of labour room, having a separate room for each patient, then we will need more hands because somebody cannot be in a room and we would say we leave the care to the husband that is there, no, the midwives must be there.’*

The policy-makers believed that the concept needs to be properly planned before it can be executed in public health facilities. They suggested that the concept be started as a trial in a model hospital over some time and be evaluated for effectiveness:

*‘When you want to start a new concept you start it in a smaller unit, so that you can monitor the challenges and correct it and even if it is not perfect, near perfection would do and at least once they know that it is a success story they will begin to demand for it.’*

#### **5.4.1.4 .2 Health worker-related facilitators**

The policy-makers felt the need to orientate the health worker who might not be aware of the existence of labour support from familiar persons in the hospital. Orientation of the health workers may improve the health worker-client relationship. This may further influence the attitudes of the health workers towards the relatives of the women in labour, and obviate incidents in which the familiar labour support person is embarrassed by a health worker:

*‘I think that we have our clients in the centre of all these. We have the nurses, we have the obstetricians and we also have these significant others, we need to bring all of them together and of course the policy-makers, to bring everything together since we are satisfied that it’s going to benefit them we need to bring them together and actually sensitize them especially the health workers, we need to sensitize them and that’s why the issue of training comes in because*

*most of the workers were trained in the era where this concept was not in use.’*

Furthermore, the policy-makers discussed the need to incorporate birth companionship training into institutions’ curricula in order to orientate healthcare providers about the concept of the CLS right from basic training and after:

*‘We should start from the training school because that is where the orientation comes. What our midwives have been used to, as in, they are not attuned to this concept. In fact if you say it today, 80% of the midwives would say no based on the fact that they were not trained to have that mind-set.’*

*‘It must be in the curriculum...you have to bring in the nursing and midwifery council of Nigeria because it’s something they have to accept because they are the ones responsible for our curriculum.’*

#### **5.4.1.4 .3 Women-related facilitators**

The policy-makers felt that there is a need to orientate and train the labour support person in birth companionship. This is required because families, or relatives engaged as labour support persons may not have the experience and knowledge needed to support women during childbirth. This means that there may be some misunderstanding between the labour support persons and the women in labour:

*‘The support person ought to have been prepared emotionally that the role you are going to play....’*

The policy-makers felt the need to take the concept into the community through public awareness campaigns so that people will have proper orientation before coming to the hospital:

*'It needs a lot of public enlightenment, reorientation and education because remember that in our culture we have so many needs.'*

### **5.5 Discussion of qualitative result**

The discussion of the findings across all participant groups (the pregnant women, nurse-midwives and policy-makers) was done using the Pen-3 cultural model as guide. Computer-assisted data-based bibliographies searched include: MEDLINE (Medical Literature Online), Academic Search Premier, Nexus and CINAHL (Computer Index to Nursing and Allied Health Literature), Ebscohost, SpringerLink, Science Direct, and the University of the Western Cape library. Combinations of keywords and key phrases were used, namely: social support, one to one continuous labour support, continuous labour support, culturally congruent care and traditional childbirth practices. Most of the keywords and key phrases were linked to literature on pregnant women, nurses- midwives, policy-makers and childbirth. The literature accessed has been integrated into the results and discussions across all the participant groups. The discussion is described in three section bases of groups of participants:



## **5.6 Section 1: Discussion of findings from focus group discussions of pregnant women**

This section contains a detailed discussion of the perceptions, attitudes and preferences of women to CLS in the south-west region of Nigeria.

### **5.6.1 Perceptions of the pregnant women to CLS**

The perceptions of the women in this study are represented by four themes that emerged from the collected data. These were: family as the traditional support system, male involvement in women's care during childbirth, family and healthcare workers, and congruence with religious beliefs and cultural practices.

The women in this study acknowledged that the family support system is given within the traditional/ cultural setting, when a woman is in labour at home which is lacking in the public health facilities. They said that their relatives are usually sent away once they were admitted in most public health facilities. The majority of the participants expressed the opinion that delivery without family involvement is usually boring and lonely, hence the demand to have a familiar person to render support for the woman during labour, especially in public health facilities. In line with the study's findings, transculturally, across the globe, childbirth usually took place at home, with trusted family and friends providing care and support for the woman in labour. This family ritual and traditional support during childbirth is valued by women but has been lost with the shift of childbirth from home to the hospital (Hodnett et al, 2013). This explains the desire of the participants in the study to have family support during birth as a cultural expectation. Predictably, the prohibition of a positive traditional practice

such as family support during childbirth has been linked to low utilisation of health facilities by women (Thwala et al. 2011).

Although nurses are generally considered an essential support for women during labour, contrary to this, women in this study described the support from nurses-midwives in public health facilities as grossly inadequate. This assertion conforms to the findings of previous studies on the supportive role of midwives during labour. Gagnon and Waghorn (1996) cited in Banda, (2010) found that only 6.1% of time was spent in supportive care while (74.9%) of the nurses' time was not spent in the labouring woman's room. Another study in a Canadian hospital examined the amount of labour support being provided by obstetric nurses, and factors that influenced the provision of support, also showed that nurses spent only 12% of their total time providing supportive care to women in labour. They identified barriers to support provided by midwives to include lack of time and insufficient staffing (Gale, 2001).

Similarly, a qualitative study by Aune et al (2013) which investigated the midwives' experiences of providing a continuous supportive presence in the delivery room during childbirth, and factors that may affect this continuous support, at a maternity unit in Norway. The midwives in the Norway study believed their continuous presence and support during the process of labour was of great importance for the woman and her partner, the family's future well-being, and the midwife's sense of being able to work in harmony with her ethics and principles. However, their intention to support women in labour may be overridden by or at variance with hospital protocols and policy. According to Halldorsdottir and Karlsdottir (2011), and Russell (2007), midwives often

work with clinicians who have a different ideology, which can be very challenging for the midwives. Bluff and Holloway (2008) submit that in some hospitals there is a risk that midwives are expected to support the demands and values of the clinician rather than those of the woman in labour. In the same vein, Hunter and Segrott (2008) point out that midwives often face a choice between being loyal to the institution where they work, or to the women they work with; they found that such dilemmas had a demoralising effect on midwives. Also, workload in the unit was identified as a barrier to the midwife continuous presence in the delivery room.

The women also complained about the attitudes of the nurses or doctors, and the dismal nature of the support they received from professional staff during delivery. As found in this study, negative attitudes of nurses and midwives has been established as the main reason why women refused to give birth at the hospital and preferred labour support from relatives or familiar persons (Mathole et al., 2004; Bazzano et al., 2008; Mrisho et al., 2009). More than a quarter of patients in a tertiary hospital in Nigeria concluded that the nurses are harsh, while an additional 37.5% reported they are not satisfied with the way the nurses address them (Ehiemere et al., 2011). Melender, (2002) also found the women in their study complained about how they are usually left alone, are made to feel insignificant and are not involved in decisions by health workers in the hospital.

Moyer et al (2014) investigated the community and health-care provider attitudes towards maltreatment during delivery in rural northern Ghana. Findings reveal that women delivering in facilities in rural northern Ghana experienced physical abuse,

verbal abuse, neglect, and discrimination, and were denied the practice of traditional customs. The researchers believed that maltreatment during labour and delivery may prevent some women from seeking facility-based delivery, and advocated for health-care worker education and training to include modules addressing psychosocial elements of care provision. In addition, policies that allowed women to bring a family member with them into the labour ward will ensure witnesses to the care that is being provided, and may effect a reduction of incidents of midwife maltreatment (Moyer et al, 2014).

On the women's perceptions regarding the introduction of CLS in public health facilities, the majority were in favour of introducing CLS by persons of the woman's choice in public health facilities. They gave unequivocal assent to the involvement of their extended family, closest friends and intimate partners as support system during labour. Similar to this study's finding supportive companionship by the women's family and friends was favoured by mothers in Malawi (Banda et al, 2010). The women vehemently expressed the desire for their husbands' special involvement in their care during labour. They believed this will serve as a means to promote a sense of belonging, increase value and appreciation and care for women, promote attitudinal change and enhance insight and utilisation of family planning and child spacing. Since 1994, the International Conference on Population and Development has advocated for the active inclusion and shared responsibility of men in reproductive health, and WHO has also recognized the importance of male involvement in improving maternal and

child health service as a means to achieve the Millennium Development Goal 5, i.e. the reduction of the maternal mortality rate, especially in developing countries.

Studies conducted in developed countries showed that women who had continuous spousal labour support are reassured, comforted and emotionally encouraged to overcome the pain associated with labour and delivery (Somers-Smith, 1999; Hodnett et al., 2007). Other studies have also demonstrated that husbands' role in prenatal care is the most crucial factor required to promote care and the health of pregnant mothers, and to reduce maternal and infant mortality during pregnancy and delivery periods (Nwokocha, 2008), and this makes men critical partners in the improvement of maternal health, and the reduction of maternal mortality. Furthermore, a similar review also showed that women with continuous support from spouses, experience shorter duration of labour, reduced need for oxytocin, anesthesia, instrumental deliveries, and decreased by 50% their chances of being admitted to a cesarean section (Hodnett et al., 2007). In developing countries such as Nigeria, which is known to be a patriarchal, male dominated society where pregnancy and childbirth are regarded as exclusively women's affair, spousal participation in labour and delivery has also been found to be exceptionally low. This was shown in the Iliyasu et al study of 2010. et al which reveals that traditionally, men do not accompany their wives for antenatal care and are mostly absent from the labour room during delivery, leaving their support roles to relatives and midwives.

Most women in this study also believed that the presence of their spouses during childbirth may change men's perceptions and attitudes about the gender bias common

to most men in Nigeria. Male offspring are mostly desired by husbands in order to ensure their sons inherit their property, carry on the family name, and provide support for parents in old age (Edewor, 2006). Thus, men often value their wives more if they know that the sex of the unborn child is male. However, the women felt that the presence of their spouse during labour and delivery would enable the spouse to value them more, irrespective of the sex of the child delivered, because their spouse would witness the pain they experience during childbirth. In corroboration with this study's finding, other studies have found an increasing desire among women for their husbands' involvement in labour (Miller, 2012; Brunson, 2010; Sapkota et al., 2012). Mumtaz and Salway (2009) suggest that there is a need to move away from seeing men as "oppressors" and instead recognize them as partners in this realm.

The increased desire for husband involvement in labour and delivery among the women in this study may also be attributed to the respondents' perception that husbands lack the knowledge of women's experiences in labour and delivery. Previous studies in South Asia also found that there are low levels of knowledge and experience among men, regarding maternal health (Dolan and Coe, 2011; Singh et al., 1998). Thus, lack of knowledge regarding complications and danger signs during pregnancy and delivery has been found to prevent husband involvement during delivery (Mullany, 2006) and this might eventually affect maternal health outcomes. Brunson's (2010) study shows that despite the fact that the husband may not be knowledgeable about childbirth, in emergencies men control the situation through their decision-making. Thus, strategies that involved educating the husbands on the physical, emotional and socio-economical

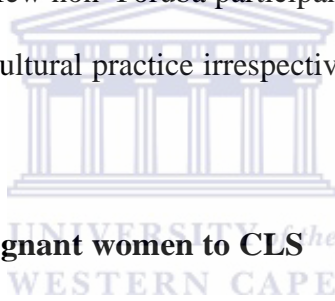
needs of the pregnant woman, emergency obstetric conditions, and engaging them in birth preparedness and complications readiness have been suggested in a previous study (Iliyasu et al., 2010).

Furthermore, the women felt that the presence of husbands during labour and delivery will improve pregnancy outcomes as a direct result of the quality of care received from their spouses. In line with this study, Nwokocha (2007), found that most research in the field of male involvement in reproductive health in Africa has shown a significant improvement in pregnancy outcomes when women were supported by their husbands during pregnancy, labour and delivery. Similarly, some studies concluded that both partners felt their relationship had improved following their shared experiences, irrespective of mode of delivery (Dragonas, 1992; Chan & Peterson-Brown, 2002).

As an indication of positive perceptions about CLS, the women also felt that inclusion of their family member would be of assistance to the healthcare providers. They all attested to the current shortage of healthcare personnel available to render care to the growing numbers of women in the hospitals. In situations where the proportion of patients in the labour ward is considerably higher than the number of available nurses and midwives expected to provide support during childbirth, patients might not receive all the support required during the childbirth process, except that from their labour support person. There have been reports that skilled birth attendants such as nurses and midwives are unable to provide all the required support women need during labour and delivery (Zwelling, 2008). In support of this finding, women in Saudi Arabia expressed their concerns about the diminished possibility of health workers rendering one-to-one

nursing care to women in labour because of staff shortages. Women usually go through labour alone, especially in the first stage of labour (Al-Mandeel et al, 2013). This helped to explain why women in these situations desire the presence of a relative or familiar person during labour, to offer assistance to skilled birth attendants such as nurses and midwives. The women added that personal assistance can be rendered only by a female relative.

The women in this study affirmed that having family support during childbirth is a cultural childbirth practice especially in Yoruba culture, the context in which this study was conducted, while the few non-Yoruba participants also confirmed their view that family support is part of cultural practice irrespective of tribe or tribal affiliations, in Nigeria.



### **5.6.2 Attitude of the pregnant women to CLS**

The women's attitude was influenced either positively or negatively depending on the perceived benefits and perceived challenges that can arise with the introduction of CLS in hospitals. Participants' attitudes were demonstrated by their expression of benefits and challenges with regard to the CLS concept. Most of the women participants in this study expressed a positive attitude to the introduction of CLS in public health facilities. Women's positive approach to CLS was seen in several other studies as well, (TO, 2015; Elfeshawy et al, 2015 ; Dodou et al, 2014; Alexander et al., 2014 ; Al-Mandeel et al, 2013; Kungwimba et al, 2012; Banda et al 2010). The group of women who were favourably disposed to CLS in public hospitals believed that choice of familiar labour support person from their social network would serve to provide companionship,



emotional comfort, psychological support, physical and moral support for the woman during delivery, preventing what the woman described as a “lonely and boring” labour process in public health facilities. Previous descriptive studies of the birth experience of women have suggested four main areas women can benefit from CLS (CLS) during childbirth (Dodou et al, 2014; Midirs and the NHS Centre for Reviews and Dissemination, 2003; Hodnett et al, 2007). These areas are: emotional (continuous presence, reassurance and praise), informational, physical or comfort (comforting touch, massage, warm baths/showers) and advocacy support (helping women articulate wishes to others). The presence of a companion also promotes confidence, strength, relief from pain and the feeling of loneliness, and generating emotional and physical welfare during labour (Dodou et al, 2014).

In line with the women’s view in this study, the World Health Organization and the Cochrane Pregnancy and Childbirth Group also recommended the presence and the active participation of a companion in labour and delivery (WHO, 1996, Enkin et al, 2000). Also, the vast majority of women interviewed in a previous study in Brazil (Diniz et al, 2014) and Thailand (Chunuan et al, 2010) recognized the fact that labour support from a birth companion is a major step towards greater personal control, and that this practice is highly beneficial for women in order to have a better and calmer birth experience. Similar studies among women in Malawi further revealed that mothers wanted companions so that they could provide company, help the midwife, provide verbal reassurance, give emotional security and monitor the progress of labour, and conduct deliveries (Banda et al, 2010). Likewise, the women and their partners in

Hong Kong demonstrated a positive attitude to labour support by highlighting the benefits and elements of support. They considered emotional support, inclusion in making decisions, physical support and cutting the umbilical cord as the major elements and benefits of support. The women's partners, in the study, also added that being part of women's care during labour offered them the opportunity to take photographs/ videos as memoirs of the joyous occasion, aside from their role as companions (TO, 2015).

This study further showed that respondents were more delighted and satisfied with the labour support received from birth companions such as relatives, compared to that received by the nurses and midwives. Similar to this investigation, another analysis conducted in Brazil, focusing on women's satisfaction with regard to women's experience of abusive treatment during childbirth care, found that the presence of a birth companion significantly inhibited the occurrence of all forms of violence against women attending publicly funded care. That is, if a woman had a birth companion present, she was less vulnerable to violence in a public facility, and going into labour (Diniz et al, 2014). The women in Malawi also demonstrated a positive attitude to labour support with the view that the labour support would serve as protection against verbal abuse from midwives and that their babies would also be safer (Banda et al, 2010). The presence of acquaintances of the women, during labour, was also found to enhance freedom of expression, since loneliness in unfamiliar environments with unfamiliar people, during labour makes women feel threatened and vulnerable (Elfeshawy et al, 2015 Oliveira, Rodrigues 2010).

Although many of the women participants in this study support the introduction of a woman's choice of CLS person from her close social network in public health facilities, some of the women expressed a negative attitude to the concept in voicing their concerns regarding the barriers and challenges to CLS practice in the public health setting. Some of the challenges identified include: structural deficiency, lack of privacy and confidentiality, resistance from healthcare providers, personal fear/ mistrust, and possible role conflict between the support person and healthcare providers. They described the deplorable conditions in which women undergo labour, in the company of other women, due to lack of space in the hospitals. In support of the women's view of inadequate structure in public health facilities, Ondo state Strategic Health Development Plan also reported that the physical components (including infrastructure and capital equipment) are lacking in some health facilities in the state, particularly the secondary health facilities and primary healthcare centers, and that this affects the quality of service provided in most of the health facilities (Ondo State Ministry of Health, 2010).

In discussion, the women expressed the view that labour support from a familiar person other than a skilled birth attendant might face some resistance or challenges from the health workers, if the policies were to be instituted in the hospitals or health facilities. They felt that the midwives might not be comfortable with the support from non-skilled birth attendants such as a labour support person such as a relative. In support of this view, previous studies (Sleutel et al, 2007; Davies and Hodnett, 2002) reported the negative attitudes of other staff, the physical environment, and lack of management

support as factors preventing labour support. They found that these factors created fear in women and thus fostered a negative attitude in the women themselves.

The women also expressed personal fear and mistrust of the very people who may serve as support persons during labour. They explained that it might be difficult to trust people completely in an African setting because of possible dubious intentions on the part of the support persons, and voiced the fear that people might want to harm them spiritually during the course of labour and delivery. The fear and mistrust stated by the respondents in this study may be attributed to the norms and beliefs of people in some parts of Nigeria where people easily relate aspects of life to religious and cultural practices (Ezeama and Ezeamah, 2014). For example, the taboos and practices that prevents women from taking appropriate decisions on where and when to seek medical attention during pregnancy and delivery was reported in an earlier study (Ezeama and Ezeamah, 2014). Also, there are taboos that emphasize traditional practices which negatively affect the well-being of women during pregnancy and delivery. Hence, women may be secretive about their delivery due to fear of being harmed during delivery and labour.

In terms of encouraging the practice of labour support in the hospitals, the women in their focus group discussions shared their views on factors that could enhance the introduction and practice of CLS from persons chosen by women from their social network in public health facilities. They suggested an enabling birthing environment for the practice of CLS in the form of individual rooms for privacy and confidentiality. In line with the recommendation of the respondents in this study, Ulrich (2003) also

found that it is easier to accommodate family members in private single rooms than in semi-private rooms (Ulrich, 2003). Other than the convenience that a single-occupancy hospital room provides during labour, an earlier study also found lower rates of hospital acquired infection in private rooms with proper design and ventilation systems (The Center for Health Design, 2003).

Similarly, current visiting policies in many hospitals, even for traditionally defined families, are inappropriately restrictive, putting the patients at risk and contributing to emotional suffering for both patient and family (Lee et al., 2007). Hence, there is a need to have a visitors' room to accommodate family members who may serve as companions during labour. In line with this, many of the respondents in this study suggested that a visitors' room should be provided to accommodate family members and provide comfort for them. The lack of a visitors' room in health facilities, as reported by respondents in this study, may be attributed to the fact that most health facilities, particularly those in the rural areas of the state, lack the basic infrastructure and equipment, thus there might not be enough space for a visitors' room.

The women advocated for the inclusion of CLS as part of the hospital policy and encouraged formulation of rules and regulations regarding CLS practice. Several studies in developed countries have found that hospital policy permitted women to be accompanied by their husbands/ partners or other family members during labour (McGrath, 2008; Dickinson, 2002; Gagnon, 1997; Campbell, 2006). Hence the need for the inclusion of CLS in hospital policy, for effective practice, as suggested by the women in the study. The women also suggested training for the healthcare providers

and the support persons regarding expected roles and responsibilities. In line with the opinion in this study, Banda et al, (2010) in their study on the acceptability and experience of supportive companionship during childbirth, by mothers, health professionals and supportive companions in Malawi, also suggested the formulation of clear guidelines on CLS for effective practice. They believed that the women require information concerning the need for a supportive companion, as well as information on their expected role before they present in labour at a health facility (Banda et al, (2010). In addition, the persons providing the labour support intervention may vary in experience, qualifications and their relationship to the women in labour. Thus, there is a need to orientate and train them on ANC services and childbirth support and processes. The training of women in the childbirth process has been reported in previous systematic reviews to be most beneficial (Hodnett, 2012). Trials of different models of training providers of labour support have been reported to have helped to inform decision-makers about the most effective models in the context of their settings (Hodnett, 2012).

### **5.6.3 Preference of the pregnant women for CLS**

The presence of a companion during labour and childbirth is generally promoted and encouraged (Davis-Floyd et al 2009). The birth companion can be a husband, female family member, friend, or a doula depending on individual preference. There was mixed reaction from the women in this study regarding the best person from their social network to serve as the woman's birth companion. In conformity with women's preference for mother, sister, grandmother, aunt, mother-in-law, friend, male partner,

other unspecified person in earlier studies (TO, 2015; Alexander et al, 2014; Al-Mandeel et al, 2013; Banda et al, 2010). The women in the study expressed preference for husband, mother/mother-in-law, sister or friend as preferred labour support person, in order of priority.

But contrary to the findings of the Malawi study (Banda et al, 2010) which showed women's low preference for husband as companion during labour, but similar to the Hong Kong study's results (TO, 2015), most women in this study wanted their male partner as a companion. The women who preferred their husband as sole companion believed that the husband is the most trustworthy and therefore the most suitable one to accompany them to the health facility during labour and delivery. They held that since the husband is responsible for the pregnancy, he would be brave enough to stand by the wife during labour. This may also be related to the fact that men have decision-making power within the household, and influence the decision to seek medical help and make arrangements for transporting a woman in labour. In line with this finding, several other studies have also found the majority of women in their study to have a high preference for the husband to provide support during labour (Bakhta and Lee, 2009; Backstorm, 2009; Digest, 2008; Bruggemann et al, 2007). Different from the reports of the respondents in this study, studies conducted in Zambia (Mullick, 2005) and South Africa (Chongo and Ngoma, 2014) found that some women want their partners to participate in antenatal clinic visits, to accompany them to hospital during delivery, but to stay out of the delivery room.

In contrast to wanting their husband as labour support, many of the women who preferred a female as birth companion felt that a person experienced in labour support is best equipped to provide support during labour. They felt that a woman with previous childbirth experience will be able to provide all the required labour support during childbirth. In line with this belief, some cultures in other countries have traditional methods of giving birth and choosing labour support persons. For instance, men mainly have been viewed as the providers while pregnancy support is regarded as a female role in some cultures in Africa (Kwambali et al, 2013; Chongo and Ngoma, 2014). Other studies have also indicated women's preference for mothers and sisters as labour support persons (Elfeshawy et al, 2015; Alexander et al, 2014; Al-Mandeel et al, 2013).

Issues of continuous presence or availability of the support person were also raised by the women. Some of the women in this study preferred persons who would be available throughout the course of the labour and delivery, to provide support. Situations may occur where the husband may not be available throughout the duration of labour and delivery, hence respondents felt that their relatives or friends could also assist them during labour instead of their spouses. Similar to the reports of the respondents in this study, the majority of respondents in a study among Nigerian women also indicated that they would be happy to have their mother or another relative with them, while few preferred siblings, friends or someone else (Digest, 2008). Respect for the woman's choice of labour companion is a useful practice that must be encouraged.

Some of the women want more than one support person present during their labour for complementary assistance. This request was based on the belief that when one support



person is sent on some kind of errand, the other support person will be available. The study of Price et al (2007) on women's beliefs, values, perceptions and experiences of childbirth, involved 16 post-partum women, of which 13 had more than one support person. The primary support person was the woman's husband while the other support person was a female friend or a relative. The women chose their husband as the primary source of support and comfort while also holding the belief that birth should be shared with other significant people. According to the Price et al (2007) report, some women added other relatives out of a sense of compassion and benevolence, while others relied on the additional support person because they recognized that their husband could not meet all their support needs. Women in the study also looked on the other women as a source of support due to their experiential knowledge of the birth process.

However, Kettlei & Perkins (2006) revealed that the presence in the labour room of too many people can create communication problems, with too many directives being given to the woman from too many sources. Also, the presence of multiple support people may cause tension between the women and the support people, which may in fact result in a lack of support. In addition, women accompanied by a large number of support persons were seen to be unsupported, and the labour and birth process was treated as a "viewing", a spectacle (Maher, 2004). These challenges may dictate the need to regulate the number of support persons, as suggested by the participants in this study. Spear's (2006) investigation on policy, practice and associated rationale regarding the mother's options during childbirth in the south-eastern region of the USA revealed that hospitals allowed two or more support persons during vaginal birth.

However, he points out that the nurses were given the leeway to exercise their professional judgement in deciding how many people could be present at a birth, regardless of the unit policy (Spear, 2006). He also cited instances where the nurse asked the support people to leave if their presence was deemed detrimental to the health and welfare of the women in labour. However, Price et al caution against too strict a policy about the number of persons attending a birth. They reason that an inflexible adherence to policy on number of support persons may create confusion and stress for the women, as some people may be prevented from participating in the birthing experience. However, the presence of multiple people during a birth can also be a source of conflict or hindrance rather than support (Dunne, 2012).

Although the majority of the women desire a family member as labour support person, a few of the women said they would rather deliver quietly without the attendance of birth companions, and some preferred no relative other than their spouse to be around during childbirth. Similar sentiments have been recorded among women in Bawku Municipality in Ghana, where respondents perceived pregnancy, labour and delivery as secret and private activities and preferred to deliver alone, without the knowledge of familiar persons due to a fear of being bewitched.

### **5.7 Section 2: Discussion of findings from nurse-midwives**

This part contains discussion of the perceptions and attitudes of the nurse-midwives to CLS by person/s from the women's social network in public hospitals in the south-west region of Nigeria.

### **5.7.1 Perceptions of nurse-midwives to CLS**

Based on data collected from the nurse-midwives, two themes were generated: the non-existence / intermittent practice of CLS, and positive perceptions regarding the introduction of family CLS in public health facilities. The nurse/ midwives pointed out that CLS is not part of current hospital policy, hence the woman's family members are not usually involved in women's care or allowed to offer support during labour. This result confirmed the submission that CLS remained the exception rather than the rule in most developing countries, particularly Nigeria (Sakoda, 2012; Hodnett, 2013). Also, the absence of policy on the practice of CLS in public health facilities has been cited as an obstacle to effective implementation of CLS, especially in developing countries (Hodnett, 2013). Similarly, the absence of a standardized policy in most government hospitals, on permission for a companion to be with the mother during labour in the United Arab Emirates was given as a reason why healthcare givers are not advocating the practice in public health facilities (Al-Mandeel et al, 2013). However, the nurse/ midwives in the current study attested to occasional/ discretionary practices; especially when the woman was uncooperative in care, nurse-midwives invited the relatives to intervene, thus giving credence to the importance of family involvement in women's care despite the absence of policy to that effect in public health facilities.

Most of the nurse-midwives in the study demonstrated positive perceptions regarding the introduction CLS by persons of the woman's choice from her social network. They expressed the view that the concept can be introduced and implemented in public health

facilities; this was based on their having witnessed the beneficial effects of CLS on very few occasions. Likewise, the majority of midwives in the study of Banda et al (2010), on the acceptability and experience of supportive companionship during childbirth, in Malawi, accepted the introduction of companionship during labour in the hospital. The midwives in that study also emphasised the importance of a woman in labour to have a supportive companion (Banda et al, 2010). Consistent with the current study's findings, a significant percentage of healthcare providers in Egypt and Nigeria supported companionship for women during labour (Elfeshawy et al, 2015; Morhason-Bello et al., 2009).

In support of the midwives' assertion of the benefits of supportive care to women during childbirth, continuous labour support is acclaimed as best practice during labour, and the beneficial effects of labour support on childbirth outcomes have been reported in numerous research reports, reviews, and meta-analyses (Hodnett et al 2011, 2009, 2007, 2002; Campbell, Lake, Falk, & Backstrand, 2006; Campbell, Scott, Klaus, & Falk, 2007; Langer, Campero, Garcia, & Reynoso, 1998; Scott, Berkowitz, & Klaus, 1999; Scott, Klaus, & Klaus, 1999; Zhang, Bernasko, Leybovich, Fahs, & Hatch, 1996). Women who received continuous support during labour rather than intermittent support were more likely to be satisfied with the childbirth experience, have spontaneous vaginal delivery and a shorter labour length, and are less likely to have maternal anxiety, intrapartum analgesia or epidural anesthesia, an instrumental birth, a caesarean birth, and are less likely to have a baby that received a low Apgar score

(Hodnett et al, 2011; Hodnett, Gates, Hofmeyr, & Sakala, 2007; Melender, 2006; Romano & Lothian, 2008; Sauls, 2002).

### **5.7.2 Attitudes of the nurse-midwives to CLS**

As established in the women's discussion, the nurse-midwives' attitude to the introduction of CLS by persons of the women's choice in public health facilities was also influenced either positively or negatively by their professed benefits and perceived challenges. The midwives who are in support of the concept praised the benefits that could be derived, and those with negative attitudes expressed the risks/ challenges of the practice.

The nurse-midwives demonstrated positive attitudes to the introduction of CLS in public health facilities. This positive disposition was also found among midwives in Malawi who emphasised the importance for a woman in labour to have a supportive companion, and expressed the willingness to allow the women at their health facilities to benefit from the CLS concept (Banda et al, 2010). The midwives, just like the women in this study, were convinced that CLS would be beneficial in terms of promotion of love, a sense of belonging, and bonding within the family. They added that the support person would offer the woman psychological support, might improve the woman's cooperation with care routines, and reduce the nurses' stress. In support of this study's findings the Malawian midwives also highlighted the benefits of women companions as the reason for their positive support for CLS in health facilities in Malawi. They explained that the woman companion would provide pain relief, give assistance to labour ward staff, explain the progress of labour to the woman in labour,

and provide reassurance and company to her. They also believed that the companions would help the midwives to verbally discipline ‘uncooperative’ women in labour (Banda et al, 2010). Similarly, Morhason-Bello et al. (2009) reported that health professionals stated that companions can provide emotional and spiritual reassurance to parturient women during labour.

In corroboration of the view of the midwives about the benefits of labour support from familiar persons, earlier systematic review studies also found birth companions to significantly assist the birthing women and the midwives in initiating spontaneous vaginal birth, reduce intrapartum analgesia use, reduce birthing women’s dissatisfaction about the birth experience, facilitate shorter labour duration, promote normal delivery and enable women to give birth to babies with a low 5-minute Apgar score (Hodnett et al., 2011). Subgroup analyses in the systematic review study also suggested that continuous support was most effective when it was provided by a woman who was not part of the hospital staff (Hodnett et al., 2011).

Furthermore, nurse-midwives, in agreement with the pregnant women’s opinion, affirmed that husband involvement in labour and delivery would promote family planning. In most parts of the country, family planning is often regarded as the woman’s responsibility. There is, however, a growing recognition of the need to involve men in family planning programmes as a means of achieving reproductive health objectives. Similar to the reports of the midwives, the International Conference on Population and Development (ICPD) in Cairo also made an explicit call for programmes and policies to educate and enable men to play an active role in

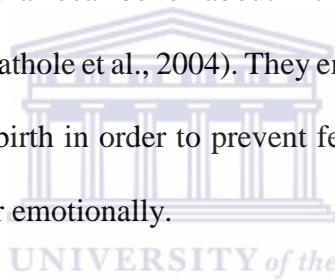
reproductive decisions, including contraceptive method choice and use (Boender et al., 2004; Gribble, 2003). The midwives in Malawi also view the involvement of males as labour companions, as a means to enhance uptake of contraceptive methods and make provision for transport in case of referral to another facility if emergencies arise (Banda et al, 2010).

The midwives who expressed negative attitudes in this study felt that CLS might not be practicable in the public health setting due to inadequate infrastructure, and lack of privacy and confidentiality in the labour room. They felt that the presence of the birth companions may hinder them from disclosing some important information to the women before, during and after delivery. Similarly, some of the midwives who expressed negative attitudes to the introduction of CLS in Malawi health facilities felt that midwives are the only source of expertise to care for women in labour. They also expressed the view that the presence of a companion may be a hindrance to their professional duties, because the companion might make the woman in labour stubborn and unwilling to follow the midwife's instructions, which might lead to delayed progress of labour and other feto-maternal complications (Banda et al, 2010). Healthcare providers, in the Elfeshawy et al (2015) study, also expressed negative attitudes to CLS due to their concern for overcrowding in the labour unit, stress caused to women by companions, related to the inability of medical staff to deal with the woman in the presence of her relatives, and fear that companions may transfer negative pictures about healthcare providers to others.

Midwives also discussed sociocultural phenomena, such as the fact that in certain regions, value is attached to religious beliefs that may serve as factors militating against labour support from familiar persons in the hospitals, especially regarding spousal companionship during labour. Aside from men's perceptions regarding childbirth as an exclusively female concern, in most cultures in Nigeria, male involvement is viewed as a kind of taboo or a weakness in a man, a sign of his inability to exercise control over his wife. The midwives cited the situation in which a husband who follows his wife around is a sign to most mothers that their son has been bewitched by his wife. Similarly, some groups such as the Muslims in Nigeria have different views on childbirth. For instance, Islamic law prohibits the man from attending the delivery of the woman (Iliyasu, 2010). In similar vein, some women are skeptical about a husband's involvement in women's care and said they felt that the support person should be a female relative. The Oboro et al (2011) study also found that the fear of losing sexual attractiveness was given as a reason by women for not wanting their husband as labour support person. Also in concert with these findings, Malawian midwives said that there are cultural hindrances to male involvement in women's care. They reported that there was anxiety that companions would gossip about the women in labour and that the Malawian culture does not encourage 'spectators' for the childbirth experience, which would be the case if husbands were birth companions (Banda et al, 2010). There are also sociocultural and religious barriers in Eastern societies for the presence of males, even husbands, during the intimate period of labour and delivery, when the mother's body is continuously exposed (Al-Mandeel et al, 2013).



The midwives further talked about their patients' fear of the unknown, regarding women's ability to trust people as birth companions. This fear of the unknown may be attributed to the conventional cultural and religious belief that birth companions such as relatives and friends may hurt them and their child. Similar to this attitudinal belief, some cultures in other countries have traditional methods of giving birth and choosing labour support persons. For instance, men mainly have been viewed as providers while pregnancy support is regarded as a female role in some cultures in Africa (Kwambali et al., 2013; Chongo and Ngoma, 2014). Furthermore, in Zimbabwe, women were found to relate delivery to a local belief about increased vulnerability to witchcraft during early pregnancy (Mathole et al., 2004). They emphasized the need for the spouse to be present during childbirth in order to prevent fear of the unknown, which might affect the woman in labour emotionally.



Some of the midwives in this study recognized the fact that a familiar person from the social network of a labouring woman may sometimes misuse the opportunity given to them by some health facilities to assist in childbirth. They reported their concern that the labour support person might either give the woman some unorthodox method of treatment, or infect the newborn child if they were present during childbirth. Incorrect labour support practices reported among birth companions may be attributed to lack of knowledge of the required support they ought to provide for women during labour. An earlier study confirmed this observation by concluding that birth companions do have inadequate knowledge of the support women needed during childbirth (Kungwimba et al., 2013). Furthermore, people in the south-western part of Nigeria, the ethnic

character of which is Yoruba, often attached a lot of importance to child-bearing and often times they related the birth process to spiritual beliefs and taboos, for example, that a witch or sorcerer can cause harm to the mother and the baby (Awolalu and Adelumo, 2005). Hence, herbal medicines are mostly prescribed by the traditional healers for preventing the negative effects of the childbirth process on the mother and the baby.

Aside from the misconduct of birth companions, there is a possibility that they can be infected by, or infect others during the process of childbirth. According to the United States Center for Disease Control and Prevention (CDC), hospital-acquired infections now affect one in 25 patients (CDC, 2015). Also, a study conducted in a prominent tertiary hospital in South-West Nigeria found the prevalence of Hospital Acquired Infection (HAI) to have increased from 2.4% in 2005 to 3.1% in 2008. A decline was, however, noted in 2009 with a rate of 2.3% (Adesanmi and Asuzu, 2011). Hence, efforts directed towards the allocation of separate rooms for birth companions or visitors was recommended.

The midwives in this study viewed the communication gap as a major challenge to the provision of childbirth support by family members of labouring women in this study. The gap in communication between caregivers and patients has resulted in lower quality of care, poor outcomes, and dissatisfaction with the healthcare system (Bonds et al., 2003). In addition, the midwives believed that the educated relative may listen more carefully, and be easier to direct than those with no formal education. An effort should be made to accommodate the mother tongue of the labour support person. The

reasoning is that this may enhance their ability to support during labour. Poor knowledge and lack of proper education or adequate reading materials for pregnant women and their families about the role of companions during childbirth, was also identified as a barrier among healthcare providers in Saudi Arabia (Al-Mandeel et al, 2013).

To encourage the practice of labour support in the hospitals, the group of midwives in this study shared their views on factors that could enhance the introduction and practice of CLS from a person/ persons of the women's choice from their social network, in public health facilities. The midwives expressed the need for overhauling and rehabilitation of public health facilities to enhance implementation of CLS. This, they suggested, was necessary to ensure the provision of a conducive environment, infrastructure, and equipment, as well as the requisite healthcare personnel. According to the 2009 communique of the Nigerian national health conference, Nigeria's healthcare system is weak and this has been attributed to lack of coordination, fragmentation of services, dearth of resources, including drugs and supplies, inadequate and decaying infrastructure, inequity in resource distribution, access to care and a deplorable quality of care (Nigeria National Health Conference, 2009).

In line with the weak health system of Nigeria, identified in the Nigerian national conference, the Ondo State Strategic Health Development Plan also found that lack of infrastructure constituted a gap in the healthcare system in Ondo state (Ondo Ministry of Health, 2010). Furthermore, corresponding to these previous reports, participants in this study felt that there is a need to improve the infrastructure in state hospitals. Areas

that need improvement include dedicated labour rooms and the provision of additional equipment to improve childbirth practices in these hospitals. The improvement of infrastructure in health facilities will reduce overcrowding in the labour ward/ room, which is a problem in most health facilities in Nigeria. The provision of separate compartments for women in labour and their families will also enable privacy and confidentiality in the labour room.

Corresponding to the view of pregnant women in this study, midwives also felt that there should be legal back-up when making decisions about the selection of CLS persons from women's social network. Corresponding to this report, Sweidanetal (2008) reported in Jordan that the majority of hospitals have adopted formal written policies regarding childbirth, breastfeeding and the care of mothers. In addition, a report on birth and emergency preparedness in antenatal care also stated that among the requirements for birth preparedness, the health system should ensure that pregnant women are able to discuss and review their written birth and emergency plan with skilled attendants at each antenatal assessment, and that intercultural skills should be put in place, in order to support the woman in preparing a birth and emergency plan (Integrated Management of Pregnancy and Childbirth, 2015).

Inadequacy of staff numbers and resources has a significant and negative impact on maternal outcomes (Gerein et al., 2006). This compromises the capacity of the health system to maintain a state of readiness where sufficient skilled staff, furnished with the supplies, equipment and resources that they need are available and ready to respond to women 24 hours a day, 7 days a week (Gill et al., 2004). In situations where the

proportion of patients in the labour ward is considerably higher than the number of available nurses and midwives that are required to provide support during childbirth, patients might not receive the required support from professional staff during the childbirth process; it may be that they then rely on support received from their labour support person. Nurse-midwives in this study expressed the need to employ more personnel or staff to enhance policy in order to implement CLS for women during labour.

The midwives in this study also saw the need for a monitoring system using CCTV cameras in order to monitor the activities in the labour rooms. The CCTV cameras will enable hospital management to monitor any misconduct that may occur during childbirth, as well as the health status of the birthing women. Similar to this report, the need for the each nurses/midwife to monitor the patient/service user, document the nursing/midwifery activities and communicate her/his actions with other members of the healthcare team, consistent with the health service provider's policies and the patient's/service-user's overall plan of care, has been documented in the Guidance to Nurses and Midwives on Medication Management (Altranais, 2007).

### **5.8 Section 3: Discussion of findings from the policy-makers**

This section discussed the findings on the position of hospital policy-makers to CLS by person/s from the women social network in public hospitals in South West region of Nigeria

### **5.8.1 Position of policy-makers regarding CLS**

In line with the view of the women in this study, policy-makers affirmed that family support during labour is a traditional/ cultural childbirth practice at home, but maintained that the concept is alien to public health facilities and healthcare but is being practiced in a few private hospitals in Nigeria. This confirms anecdotal reports that some institutions still retain rigid policies regarding the labour and birth support options of women despite the long-standing trend for family-centered maternity care and the recommendations of WHO and the Mother-Friendly Childbirth Initiative, that mothers should have “unrestricted access to the birth companions of their choice, including fathers, partners, children, family members, and friends” (Hodnett et al 2012; WHO, 2010; Spear, 2005; Coalition for Improving Maternity Services, 1996). In line with this study, Al-Mandeel et al, (2013) also revealed the impact of the lack of clear policy, on the presence (or absence) of a supportive companion in government hospitals in Saudi Arabia.

Similar to the opinion of pregnant women and nurse-midwives in this study, policy-makers also believed that CLS by a person of the woman’s choice could be introduced into public health facilities. They attested to the concept being an evidence-based care strategy, especially in developed countries, and felt it could be trialled in the Nigerian health setting. They confirmed that some private hospitals in Nigeria have already put the concept into practice.

Some of the policy-makers also demonstrated a positive attitude to CLS in public health facilities. This approach was based on the conviction that CLS would be beneficial to

the woman, the healthcare provider and the hospital. They think that CLS will speed up the delivery process, enhance women's cooperation with care practice, and boost women's confidence, hence promoting a positive labour experience. This will promote a positive image of the public health facilities and may increase hospital utilization. Similar observations have been made in earlier studies in Russia (Bakhta and Lee, 2009) and other African countries (Madi et al., 1999; Oboro et al., 2011).

The policy-makers were optimistic about the introduction of a support person of a woman's choice, from her close social network, for CLS in public health facilities. They did, however cite some factors that may hinder practicability in Nigerian society, and particularly in the public health setting. They highlighted the current lack of policy and legal framework as well as structural deficiencies, as impediments in the health facility setting. They explained that the current set up of health facilities might not foster the development of the CLS concept in the hospitals. Given that there are no private rooms for patients, the policy-makers felt that the presence of labour support persons for some women would be an intrusion on the privacy of other women in labour.

In corroboration with the views in this study about space in the labour ward, healthcare providers in a study conducted in Syria and Egypt also identified crowding in the labour room as among the main barriers that might prevent adoption of a hospital policy that institutionalizes labour companionship (Khasholian et al., 2015). The health workers in the Khasholian et al. (2015) study reported situations where labour rooms

are shared by four to ten women, in addition to the presence of nursing and medical students.

The policy-makers also expressed the fear that the CLS concept might face some resistance to or challenges from health workers if CLS were to be instituted in hospitals or health facilities. They felt that midwives might not be comfortable with support from unskilled birth attendants such as labour support persons from the family. Similarly, the nurse/ midwives in this study also expressed reservations about working with the woman relatives in the labour ward. They felt the concept of labour support from someone in a woman's social network would disrupt nursing routines and procedures and that some of the relatives might be difficult to handle. This suggests perceived conflict of interest, as also expressed by the women in this study. In support of this view, previous studies (Sleutel et al., 2007; Davies and Hodnett, 2002) reported the negative attitudes of other staff, the physical environment, and lack of management support as factors preventing labor support.

The policy-makers added that there was a need to take extra precautions when making the policies regarding the presence of family members during labour and delivery. They suggested that the inclusion of CLS in hospital policy should take into consideration the role of cultural and religious beliefs.

The policy-makers expressed understanding of the need to plan strategies to incorporate the concept of CLS into the healthcare system. They suggested a change in the current arrangements in labour wards; they put forward the idea of separate



compartments for women in labour, each with her own birth companion, to ensure privacy and dignity for clients. Joffe et al. (2003) showed the importance of privacy and dignity for patients. They found that the perceptions of respectful, dignified treatment correlated most closely with high satisfaction with the hospital. The privacy of the labouring women, they suggest, is better achieved through improved infrastructure in the hospitals, which was reported to be lacking in various facilities. They also voiced the need to plan and involve all parties such as the women, skilled birth attendants, governments and the society at large in decision-making about the concept, in order to ensure that it is widely accepted. This may also ensure the sustainability of the concept in health facilities.

Non-sustainability of healthcare programmes has been identified among the major constraints affecting the healthcare system in Nigeria; with policy-makers experiencing challenges regarding how to allocate limited resources across the range of preferences (Eneji et al., 2013). Hence, this may result in government terminating certain programmes in order to utilize the limited funds for other programmes. The policy-makers felt there is a need to ensure that CLS is sustainable. One of the means of ensuring the sustainability of such a programme may involve engaging the Non-Governmental Organizations (NGOs) and international agencies in order to ensure that sufficient funds are available to finance CLS, and to make sure that all the required infrastructure, equipment and personnel are available in facilities across the country.

Financing and budgeting was also identified as one of the main challenges facing the healthcare sector in Nigeria (Popoola, Irinoye et al., 2014). These challenges must be

overcome if quality and effective healthcare services are to be made available to the people. In line with the findings of this report, the policy-makers in this study felt there is a need to ensure access to adequate finance, and budget appropriately if the CLS concept is going to take root and become functional in health facilities. Reference to the constitution of Nigeria is germane here. The constitution states, in section 17(3) (c) and (d) that “the state shall direct its policy towards ensuring that the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused and that the state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons.” (Popoola, Irinoye et al., 2014).

Similar to the views of the women in this study, on orientating nurses and midwives on CLS, the policy-makers also saw the need to train health workers who might not be aware of the existence of labour support from familiar persons in the hospital, as a concept and practice. Re-training of health workers may improve the worker-client relationship. This may further influence the attitude of health workers towards the relatives of the women in labour, and avert occasions where the labour support person is embarrassed by a health worker. In line with this view, Payant et al. (2008) also found that 40% of the nurses who completed a survey were unaware of research evidence that supports the benefits of continuous labour support, thus underlining the need to upgrade health workers’ professional knowledge in this area. This includes nurses and midwives.

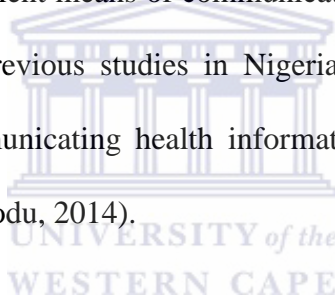
Aside from adequate training for healthcare providers, the policy-makers, like the nurse-midwives in the study, suggested the need to train the labour support person in

matters related to birth companionship. Companions from a woman's social network, such as husbands/ partners and female relatives, usually have little experience in providing labour support and are themselves in need of education and training on their role as a labour support person. The midwives added that labour support persons could be trained or educated for birth companionship using audio-visual teaching aids as well as visiting and teaching people in places of worship in order to ensure that people are aware of their role as birth companion. It is important to understand their effectiveness and better orientate them as providers of CLS.

Similar to the above submission, developed countries such as those in North America have provided special training for women so as to enable them to render childbirth services effectively. These categories of trained women are most commonly referred to as doula (a Greek word for 'handmaiden') in these countries. This new member of the caregiver team may also be called a labour companion, birth companion, labour support specialist, labour assistant or birth assistant. Some hospitals in developed nations have begun to sponsor trained birth companion services. Previous national surveys of childbearing women in the United States found that about 3% to 5% of respondents indicated that they had used trained birth companion services during their most recent labour (Declercq, 2006). However, this type of model may be too expensive for most developing nations including Nigeria. On the other hand, the family member chosen by the woman can be given orientation and training on expectations of the companionship, after which they could assume the labour support role without extra cost to families or health systems, as suggested by the participants in this study.

Furthermore, the policy-makers felt that there is a need to incorporate birth companionship training into the curricula of institutions in order to orientate people about the concept of CLS right from the basic training for the healthcare providers.

All participants also expressed the need for collaboration of all stakeholders, including the community, to promote culturally congruent CLS for women during childbirth in public health facilities, as the nature of support within the community will be different in a public health setting. The participants suggested the need for advocacy and public awareness using all means, including the electronic media. The electronic media has been one of the most efficient means of communicating health messages to people in most parts of Nigeria. Previous studies in Nigeria have also found the media an effective means of communicating health information to large numbers of people (Omolase et al., 2009; Akodu, 2014).



### **5.5 Summary**

This chapter has looked at the following: themes, sub-themes and categories as well as the detailed discussion of results derived from the analysis of the focus group discussion with the antenatal women and the nurse-midwives, as well as the interview with the policy-makers on their perceptions, attitudes, preferences and positions regarding CLS in public health facilities in South-West Nigeria. The next chapter gives the summary and conclusion statement of findings across all participants in both quantitative and qualitative stands of the study.


## CHAPTER 6


### CONCLUSIONS AND SUMMARY OF PHASE ONE OF THE STUDY

#### 6.1. Introduction

The previous two chapters (chapter 4 and 5) presented the two different data set from both the quantitative and qualitative data strands. As a mixed method approach using a concurrent design intended to broadly explore the phenomenon under study was adopted for this study, it was thus imperative to highlight a mixed data set that present the broad conclusions. The chapter will first present the researcher's conclusion statements from findings across all participants in both quantitative and qualitative strands of this study based on the detailed discussion of both strands in chapters four and five followed by final conclusions based on the mixed data which was the intention of the study. The concluding statement will be the foundation for the framework development in Chapter 7. Table 6.1 below show the integration of findings from both strands of the study.

| <b>Table 30 : Summary of discussion of findings based on pen 3 model</b> |   |  |   |   |
|--|---|--|---|---|
| <b>PEN 3 MODEL</b>   | <b>PREGNANT WOMEN</b>   | <b>MIDWIVES</b>  | <b>POLICY-MAKERS</b>  | <b>CONCLUDING STATEMENTS</b>  |
| <p><b>Relationship/ expectation</b></p> <p>1. Perception of CLS</p>      | <p>-Women acknowledged family as traditional support system that should be involved in their care during childbirth in public health facilities. They would be present as support during labour. This is an acceptable and expected cultural practice across Nigeria, especially among the Yoruba</p> | <p>• The midwives expressed that CLS is not part of current hospital policies; and is occasionally but not routinely practised based at healthcare provider's discretion, and the situation in the ward.</p> | <p>•Policy-makers perceived family support during childbirth as accepted traditional and cultural practice throughout Nigeria, but an alien concept to healthcare providers in public health facilities, as it was never practiced in that manner before.</p> <p>- The policy-makers believed CLS is an</p> | <p>- Family support during childbirth is an accepted traditional practice across Nigeria.</p> <p>- Family support during labour is not a routine practice in the public health setting.</p> <p>- .There is an absence of policy and legal framework for CLS practice in public health facilities.</p> |


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|  | <p>-Women's savowed attitude to midwives was negative and they believed the presence of family members as labour support person would prevent the women from midwives' abuse and neglect due to their advocacy role.</p> |  <p>UNIVERSITY of the WESTERN CAPE</p>  | <p>evidence-based practice that should be incorporated into public health facilities based on the beneficial outcomes reported in the developed countries.</p>      | <p>-Negative attitude of midwives to women during labour influences desire of women for CLS</p> <p>- All stakeholder agreed to the introduction of CLS in public health.</p> <p>- CLS is not in high standing among healthcare providers.</p> <p>-Inadequate infrastructure and resources for practice of CLS in public health facilities.</p> <p>-Need for government support and involvement regarding CLS.</p> |
| <p>2. Enablers</p> <ul style="list-style-type: none"> <li>• Facilitators for CLS practice in public health facilities</li> </ul> | <p>- Women suggested renewal of physical structures to provide conducive environment for CLS through inclusion of CLS in hospital policy, rules and regulations</p>  | <p>•Midwives suggested government involvement through issuing a policy statement about CLS, reorganization and rehabilitation of existing structures, orientation and</p> | <p>The policy-makers agreed that enabling law and political support, facility structural change/rehabilitation, collaboration with all stakeholders, resources,</p> |   |

|              |   |  |  |   |
|--------------|---|--|--|---|
|              | <p>regarding CLS; training of health workers, clients and support persons on CLS expectations, responsibilities and collaborations; and public awareness programmes in order to facilitate the practice of CLS system while ensuring privacy in the public health facilities.</p> | <p>training of CLS persons and public awareness campaigns, as facilitators to the possible implementation of CLS in public health facilities.</p>  | <p>orientation and re-training of all healthcare providers, inclusion of CLS in educational curricula, modelling and trialling of CLS concept in public health facilities, and carrying out of awareness campaigns are possible facilitators to the implementation of CLS in public health facilities.</p> | <p>-.There is a need for public awareness campaigns for CLS..</p> <p>-Content deficiency regarding CLS in healthcare providers' educational curricula.</p> <p>-Need for orientation and training of all stakeholders on roles and expectations regarding CLS.</p> <p>-There is a need for a harmonious relationship between the healthcare providers, women and support people for CLS to</p> |
| 3.Nurturers' | <p>•Women desire their support person to be a close relative, a husband, sister-in-law, mother or mother-in-law or anybody</p>  | <p>•Midwives observed that the women's fear and mistrust of their relatives'</p>   |  |   |



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|--|---|--|--|--|
| <p>Preference indicators and practice</p>  | <p>who is trusted, reliable, and available and will be willing to assist without conflict with healthcare providers.</p> <ul style="list-style-type: none"> <li>• Women's choice of support persons is influenced by personal conviction, interrelatedness, gender, childbirth experience and the number of support persons allowed in the public health facilities.</li> </ul> | <p>presence during labour, cultural/ religious exclusion of men in women's care during childbirth, issues of polygamy, and level of education of clients and support persons may interfere with the practice of CLS in public health facilities.</p> |  | <p>succeed in public health facilities.</p> <p>- Preference for support person influenced by individual conviction, interrelatedness, gender, experience, willingness to support, trust and reliance, and also the number of support person(s) allowed in health facilities.</p> |
| <p><b>Cultural empowerment</b></p> <ul style="list-style-type: none"> <li>• Positive attitude influenced by</li> </ul> | <ul style="list-style-type: none"> <li>• Women stated that CLS from a familiar person as beneficial to them given that it provides companionship, emotional and spiritual support, comfort,</li> </ul>  | <ul style="list-style-type: none"> <li>• Midwives had positive attitude towards the CLS concept and felt it can be introduced, tested and implemented in public health facilities, based on perceived benefits to the</li> </ul>                     | <ul style="list-style-type: none"> <li>• Policy-makers' positive attitude was defined by their perceived benefits of CLS, such as contribution to successful delivery process in the community, psychological and</li> </ul> | <ul style="list-style-type: none"> <li>- Women's positive attitude is related to positive benefits of the family support. Culturally defined role, emotional support, protection, sense of belonging, benefits of</li> </ul>   |

|                                  |   |  |   |   |
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| <p>perceived benefits of CLS</p> | <p>advocacy support, and has the potential to contribute to the reduction of medicolegal hazards.</p> <p>-Women saw family support system as means to promote male involvement in women's care because involvement of husbands during labour promotes a sense of belonging, increased value, appreciation and care for women, promotes attitudinal change; and enhances insight and utilisation of family</p> | <p>woman, such as promotion of family planning, emotional care during labour, love and bonding within the family, reduction in the use of medical intervention due to conditions making the women feel at home, building women's confidence and diversional therapy for labour pain.</p> | <p>emotional support, enhancement of cooperation of women with healthcare providers during childbirth, promotion of positive labour experience and boosting of women's confidence in care at public health facilities which may improve positive hospital image and increase utilisation of services.</p> | <p>husband involvement, supportive to healthcare providers.</p> <p>- Positive attitude of midwives and policy-makers is related to possible benefits to the woman and healthcare facilities: increased cooperation, emotional support, confidence in care, assistance to staff addresses under-staffing problems in hospitals, and increased utilisation of public healthcare facilities.</p> |
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|  | <p>planning and child spacing.</p> <p>-Women believe inclusion of their family member is supportive to the healthcare providers as it enhances the birthing woman's cooperation with nurses' procedures and renders personal assistance; because the number of doctors and nurses are not usually adequate to care for the high number of patients in the hospital.</p> |  <p>UNIVERSITY of the<br/>WESTERN CAPE</p> |  | <ul style="list-style-type: none"> <li>- Husband involvement is key factor to improving quality of women's labour experience regarding CLS and utilisation of healthcare services.</li> <li>- Implementation of CLS is influenced by availability of resources, i.e. structure, personnel, equipment, finance.</li> <li>- Women's fear and mistrust is related to perceived evil intentions towards them, of support persons.</li> <li>- Threat to safety as stated by nursing staff, related to use of unorthodox medication and</li> </ul> |
|--|---|--|--|--|

|   |  |   |  |   |
|---|--|---|--|---|
|   |  |   |  | spread of nosocomial infection.   |
| Negative attitudes influenced by perceived challenges | <ul style="list-style-type: none"> <li>• Women felt the attendance of family for CLS might not be convenient in public health facilities, due to inadequate infrastructure, resistance from healthcare providers, personal fear and mistrust of some people as support persons during labour, and perceived conflict of interest between the support person and healthcare providers.</li> </ul> | <ul style="list-style-type: none"> <li>• Midwives' negative attitudes were influenced by a sense of uncertainty due to the perceived challenges associated with the introduction of CLS in public health facilities, such as lack of privacy, inadequate health facility infrastructure, shortage of health personnel and risk of nosocomial infection.</li> </ul> <p>Midwives believe that the support persons might misuse the opportunity to</p> | <ul style="list-style-type: none"> <li>• Policy-makers believed that absence of CLS policy and legal framework, poor infrastructure resources, possible resistance by healthcare providers, fear and mistrust of people's intentions, belief systems and cultural misgivings might serve as impediments to the implementation of CLS in public hospitals.</li> </ul> | <ul style="list-style-type: none"> <li>- Resistance to CLS introduction by healthcare providers.</li> <li>- Misgivings due to cultural/religious beliefs concerning male inclusion during childbirth.</li> <li>- Perceptions about support persons' interference with nurses' routines and procedures, conflict of support person with healthcare providers.</li> </ul> |

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|  |  | stay with women during labour by using unorthodox medicine, and interfering with midwives' procedures which may result in delay in the delivery process. |  |  |
|--|--|--|--|--|



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## **6.2 Concluding statements from quantitative result**

Based on the findings from participants' responses on perceptions, attitudes and preferences regarding CLS in public health facilities in Ondo state, the researcher concludes that:

1. Women perceived labour support from midwives in all the hospitals as inadequate.
2. Women perceived CLS from members of their social networks in public health facilities as more beneficial.
3. Women had a positive perception of the implementation of CLS in public health facilities in Ondo state.
4. Women had a positive attitude to CLS from members of their social network in public health facilities, and perceive this as beneficial.
5. Women had positive attitude regarding the implementation of CLS in public health facilities in Ondo state.
6. Women had high preference for CLS from persons in their social network in public health facilities and perceived this as beneficial.
7. Women had preference for their husbands and mothers as labour support persons.

## **6.3 Concluding statements from the qualitative result of the pregnant women**

1. Women acknowledged family as the traditional support system which should be involved in their care during childbirth in public health facilities as support during labour as it is also acceptable and expected cultural practice across Nigeria especially among the Yoruba.

2. Women declared CLS from a familiar person as beneficial to them, given that it provides companionship, emotional and spiritual support, comfort, and advocacy support, and has the potential to contribute to the reduction of medico legal hazards.
3. Women believe the family support system as a means to promote male involvement in women's care because involvement of husbands during labour promotes a sense of belonging, increased value, appreciation and care for women, promotes attitudinal change, and enhances insight into and utilisation of family planning and child spacing.
4. Women believed that the presence of a family member as labour support person would prevent the women from midwives' abuse and neglect due to the advocacy role they can play.
5. Women believed the inclusion of a family member is supportive to the healthcare providers as it enhances the birthing woman's cooperation with nurses' procedures and renders personal assistance. This is because the number of doctors and nurses are not usually sufficient to care for the number of patients in the hospitals.
6. Women desired their support person to be a close relative: a husband, sister-in-law, mother or mother-in-law or anybody who is trusted, reliable, and available and will be willing to assist, without coming into conflict with healthcare providers.
7. Women's choice of support persons is influenced by factors such as personal conviction, interrelatedness, gender, childbirth experience and the number of support persons allowed in the public health facility.
8. Women felt family CLS might not be convenient in public health facilities due to inadequate infrastructure, resistance from healthcare providers, personal fear and

mistrust of some people as support person during labour, and perceived conflict of interest between the support person and healthcare providers. Women suggested a renewal of physical structures to provide an environment conducive to the practice of CLS. They were also in support of the inclusion of CLS in hospital policy, rules and regulations regarding CLS, training of health workers, clients and support persons on CLS expectations, responsibilities and collaborations, and public awareness programmes in order to facilitate the practice of the CLS system while ensuring privacy in public health facilities.

### **6.3 Concluding statements from the qualitative result of the nurse- midwives**

1. CLS is not part of current hospital policies in public health facilities in Ondo state and not routinely practiced, the nurse -midwives acknowledged occasional practice based on discretion and the situation in the ward.
2. Midwives had a positive attitude towards CLS and felt it can be introduced, tested and implemented in public health facilities due to the perceived benefits to the woman, such as promotion of family planning, emotional care during labour, love and bonding within the family, and reduction in the use of medical intervention.
3. Midwives' negative attitude was influenced by a sense of uncertainty due to the perceived challenges associated with the introduction of CLS in public health facilities, such as lack of privacy, inadequate health facility infrastructure, a shortage of health personnel and the risk of nosocomial infection.
4. Midwives observed that the women's fear and mistrust of their relatives' presence during labour, cultural/ religious exclusion of men in women's care during



childbirth, the issue of polygamy, and the level of education of the clients and support persons may interfere with the practice of CLS in public health facilities.

5. Midwives believed that the support persons might misuse the opportunity to stay with women during labour by using unorthodox medicine, and interfering with midwives' procedures, which may result in delays in the delivery process.
6. Midwives believed that government's involvement through the issuing of policy statements about CLS, reorganization and rehabilitation of existing structure, orientation and training of CLS persons, and public awareness campaigns could be driving factors in the possible implementation of CLS in public health facilities.

#### **6.4 Concluding statements from the qualitative result of the policy-makers**

1. Policy-makers perceived family support during child birth as an accepted traditional and cultural practice throughout Nigeria, but noted that it was a concept alien to healthcare providers in public health facilities as it was never practiced in that manner before.
2. The policy-makers believed CLS is an evidence-based practice that should be incorporated into public health facilities based on the beneficial outcomes reported in developed countries.
3. Policy-makers' positive attitude was defined by the benefits of CLS as understood by them that included the contribution to a successful delivery process in the community, psychological and emotional support, enhancement of cooperation of women with healthcare providers during childbirth, promotion of a positive labour experience and boosting of women's confidence in care at public health facilities,

which may improve the image of the hospital as well, and increase the utilisation of services.

4. Policy-makers believed that the absence of a CLS policy and legal framework, poor infrastructure and resources, possible resistance by healthcare providers, fear and mistrust of people's intentions, belief systems and cultural misgivings might serve as impediments to the implementation of CLS in public hospitals.
5. The policy-makers agreed that enabling legal and political support, facilitating structural change/ rehabilitation, collaboration with all stakeholders, resources, orientation and re-training of all healthcare providers, inclusion of CLS in educational curricula, modeling and trialing the CLS concept in public health facilities, and conducting awareness campaigns are possible facilitators to the implementation of CLS in public health facilities.

**a. Final concluding statements based on mixed data**

Both the quantitative and qualitative data showed similarities and some differences in the perceptions of all stakeholders as depicted above however the researcher made the overall conclusions for this study as follows:

1. Family support during childbirth is an accepted traditional practice in south-west Nigeria thus it forms an important basis for the implementation of CLS in health care settings.
2. CLS is not routinely practiced in public health facilities in south-west Nigeria but acknowledged as a beneficial model by all the stakeholders.

3. There is lack of policy and legal framework for CLS practice in south-west Nigeria which create a barrier for the implementation of CLS thus the correction of this gap can be a facilitator that can benefit women and the health system itself by reducing infant mortality and increasing safe birthing outcomes.
4. Pregnant women desires involvement of trusted and close person(s) from the social network during labour in public health facilities in south-west Nigeria as they are seen as great support system not only for the women but for the midwives too.
5. All stakeholders in the study has positive perceptions and attitudes towards introduction of CLS in public health facilities in south-west Nigeria based on the perceived benefits for all.
6. All stakeholders agrees that inadequate infrastructure and resources are barriers to CLS practice in public health facilities in south-west Nigeria therefore governments have to improve these to facilitate implementation of CLS thus increase utilization of labour services by women who believes in CLS.
7. Stakeholders' acceptance, collaboration and community involvement are facilitators to CLS implementation hence the need for CLS orientation, education and training for all stakeholder.
8. CLS is key to the achievement of male involvement in women's care as they are seen as close kins who will also learn about the labour process the women go through and the importance of family planning practices.

## **6.6. Relationship of study findings with PEN model**

The Pen 3 Model explore how cultural and social context affects the perception of health praxis to guide culturally focused health initiatives. The model comprises of three interconnected and interdependent domains: cultural empowerment (CE), relationships and expectations (RE), and cultural identity (CI). The cultural identity dimension of the PEN-3 model in this study identified the cultural practices regarding labour support from the study participant context. CLS practice is affirmed a beneficial cultural childbirth practices from the findings from all stakeholders in this study. The relationships and expectations domain of PEN 3 explore the perception, attitude, barriers and nurturers (facilitators) for the introduction and implementation of CLS in public health facilities. The findings not only indicated positives perceptions of all stakeholders in this study to CLS practice, it also show the various challenges and factors that can promote CLS practice. The application of PEN 3 model has assisted the researcher to uncover salient facts that will contribute richly to the development of the culturally congruent CLS framework.

## **6.7Summary**

This chapter discussed concluding statements from the findings from both the quantitative and qualitative results of all stakeholders' perceptions: pregnant women's attitudes and preferences for CLS from persons of their own choice in public hospitals in Ondo state, Nigeria. All stakeholders in this study agreed on the need for family support in public health facilities in that CLS is based on traditional / cultural beliefs about childbirth practices and is currently lacking in most public health facilities. Their

positive attitude was related to the perceived benefits of family support as an expected cultural role. They concluded that support will be beneficial to all stakeholders and may also fulfil the goal of enhancing male involvement in women's care. All stakeholders highlighted the factors that could hinder and also raised possible enablers/ facilitator the implementation of CLS using women's family members in public hospitals.



**CHAPTER 7**  
**DEVELOPMENT AND DESCRIPTION OF THE CULTURALLY**  
**CONGRUENT CLS FRAMEWORK FOR WOMEN**

**7.1 introduction**

Chapter 5 focused on the vertical results and concluding statements of the focus group discussions of pregnant women, and semi-structured interviews with policy-makers in the qualitative aspect of the study. An integrative discussion of findings from both quantitative and qualitative aspects of all groups of participants was done in Chapter 6. The findings were discussed according to the themes and categories which emerged from the data, in relation to literature review, and horizontal concluding statements were formulated, based on the summary of the vertical themes, which cut across the group participants' responses.

The focus of this chapter is to describe the process for the development of the culturally congruent CLS framework for women in South-West Nigeria. The process of framework development in this study followed the model development approach by Walker & Avant (1988, 2005, and 2011) and Dickoff et al (1968) as described in Chapter 3, which is based on synthesis of concepts to achieve the set goal. Concept synthesis is a strategy for developing concepts based on observation or other forms of empirical evidence (Walker & Avant, 1988, 2005). It is used in generating novel ideas that add to theoretical development, and also in bringing together or ordering different concepts from a body of data or a set of observations, when the key dimensions are not clear or altogether unknown (Walker & Avant, 2011). According to Walker & Avant

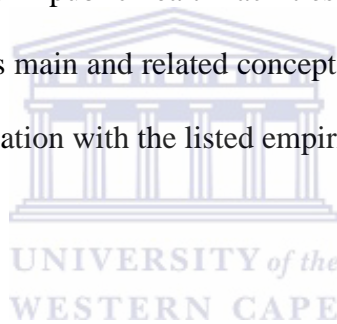
(2011), the approach involved in concept synthesis can be quantitative, qualitative or literary. Each approach can be used alone or mixed to study issues in which no concept has been developed or areas where a concept is present but has no real impact on practice, as well in areas where observations of phenomena are available but not yet classified or named (Walker & Avant, 2005). The procedure for concept synthesis is usually iterative, which means that the researcher does not always progress sequentially from step to step but rather, the researcher can go through the steps many times or back and forth between steps. The steps involved in framework development at this stage of the study are as follows:

1. Concept identification (Phase 1, step 1)
2. Concept classification (step 2)
3. Framework development and description (step 3)
4. Validation of the framework (step 4)

## **7.2 Step 1: Concept Identification**

Concepts are mental images that represent an idea, phenomenon, or a construct about something or an action. It brings about the mental representation of an idea, phenomenon, or a construct which helps in categorizing or organizing in relation to environmental stimuli (Walker and Avant, 2011). It also assists in identifying people's experiences that are similar or dissimilar by equating them against a mental image of related aspects of the stimuli (Bodrick, 2011). The process of concept identification according to Chinn and Kramer (2008) refers to 'searching out words or groups of

words' that represent the phenomena and their related actions. Concept identification process in this study commenced by reviewing the concluding statements that were generated from the themes and responses which emerged from the quantitative results relating to the pregnant women, and the qualitative findings of the focus group discussions and interviews with pregnant women, nurse-midwives and the policy-makers as presented in Chapters 4 and 5 respectively. The researcher also made use of the main element of the PEN-3 cultural model to facilitate the process of concept identification so that concepts that were connected to perceptions, attitudes, and preferences regarding CLS in public health facilities, as well as barriers and enablers, were linked accordingly as main and related concepts. Table 31 that follows gives the details of concept identification with the listed empirical concepts.






**Table 31 : Concept identification from empirical data**

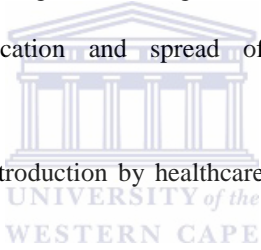
| PEN-3 CULTURAL MODEL   | CONCLUDING STATEMENTS BASED ON HORIZONTAL THEMES  | MAIN CONCEPTS   | KEY CONCEPTS  |
|--|---|---|---|
| <p><b>Relationship/ expectation</b></p> <ul style="list-style-type: none"> <li>• Perception</li> </ul> | <ul style="list-style-type: none"> <li>• Family support during childbirth is an accepted traditional practice across Nigeria</li> <li>• Family support during labour is not a routine practice in public health settings</li> <li>• Absence of policy and legal framework for CLS practice in public health facilities</li> <li>• Negative attitude of midwives to women during labour influences desire of women for CLS</li> <li>• All stakeholders agreed to the introduction of CLS in public health</li> <li>• Poor orientation/ training of healthcare providers regarding CLS</li> </ul> | <ul style="list-style-type: none"> <li>- Family traditional support system</li> <li>- Lack of CLS in public health facilities</li> <li>- Absence of CLS policy and legal framework</li> <li>- Negative attitude of midwives during labour</li> <li>- Stakeholders' involvement and participation</li> </ul> | <p><b>Cultural expectation</b></p> <ul style="list-style-type: none"> <li>- Family support system</li> <li>- Childbirth routines</li> <li>- Organisational culture and policy</li> </ul> <p><b>Challenges</b></p> <ul style="list-style-type: none"> <li>- Infrastructure</li> <li>- Trust</li> <li>- Privacy and confidentiality</li> <li>- Cultural/ religious conflicts</li> <li>- Professional gate keeping</li> <li>- Role conflicts</li> <li>- Security/ safety issues</li> </ul> |

|  |   |  |   |
|--|---|--|---|
|  |   | <ul style="list-style-type: none"> <li>- Poor CLS orientation and training among healthcare providers</li> </ul>   | <p><b>Enablers</b></p> <ul style="list-style-type: none"> <li>- Government involvement and policy change</li> <li>- -Resources: infrastructure, finances, recruitment of staff</li> <li>- Designing programme structure</li> <li>- Flexibility of choice</li> <li>- CLS inclusion in educational curricula</li> <li>- Education/ training</li> <li>- Positive attitude of all stakeholders (women, healthcare providers and policy-makers)</li> </ul> |
| <p><b>Enablers</b></p> <ul style="list-style-type: none"> <li>• <b>Facilitators</b></li> </ul> | <ul style="list-style-type: none"> <li>• Inadequate infrastructure and resources for practice of CLS in public health facilities</li> <li>• Need for government support and involvement regarding CLS</li> <li>• Need for public awareness campaigns for CLS.</li> <li>• Content deficiency regarding CLS in healthcare providers' educational curricula</li> <li>• Need for orientation and training of all stakeholders on role and expectations regarding CLS</li> </ul> | <ul style="list-style-type: none"> <li>- Physical infrastructure</li> <li>- Government involvement and support</li> <li>- Awareness programme</li> <li>- CLS inclusion in educational curricula</li> <li>- Orientation and training</li> </ul> | <p><b>Collaboration</b></p> <ul style="list-style-type: none"> <li>- Multi-faceted approach</li> <li>- Accommodation and negotiation</li> </ul>   |

|  |  |  |   |
|--|--|--|---|
|  | <ul style="list-style-type: none"> <li>• Need for harmonious relationship between healthcare provider, women and support people for CLS to succeed in public health facilities.</li> </ul>   | <ul style="list-style-type: none"> <li>- Good relationship</li> </ul>  | <ul style="list-style-type: none"> <li>- Advocacy</li> <li>- Community involvement</li> <li>- Public health education and awareness programmes</li> </ul>   |
| <p><b>Nurturers</b></p> <ul style="list-style-type: none"> <li>• Preference</li> </ul> | <ul style="list-style-type: none"> <li>• Preference for support person influenced by individual conviction, interrelatedness, gender, experience, willingness to support, trust and reliance and number of support person(s) allowed in health facilities.</li> </ul>  | <ul style="list-style-type: none"> <li>- Number of support persons allowed</li> <li>- Issues with male involvement in women's care</li> <li>- CLS in polygamous family</li> <li>- Flexibility on choice of support person</li> <li>• Gender preference</li> <li>• Childbirth experience</li> <li>• Trust</li> <li>• Reliability</li> <li>• Availability</li> <li>• Level of education</li> </ul> | <p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>- Fulfilment of cultural expectations</li> <li>- Family involvement in care</li> <li>- Positive childbirth outcomes and experience</li> <li>- Sense of belonging and control</li> <li>- Confidence and trust in organisation care</li> <li>- Increased utilisation of care</li> <li>- Male involvement in women's care</li> </ul> |

|  |  |  |  |
|--|--|--|--|
|  |  |  | - Cooperation and confidence building between women, family and healthcare workers |
| <p><b>Cultural empowerment</b></p> <ul style="list-style-type: none"> <li>• Attitude (positive and negative )</li> </ul> | <ul style="list-style-type: none"> <li>• Women's positive attitude is related to positive benefits of family support. Culturally expected role, emotional support, protection, sense of belonging, husband's involvement benefits, supportive to healthcare providers</li> <li>• Positive attitude of midwives and policy-makers is related to possible benefits to the woman and healthcare facilities: increased cooperation, emotional support, confidence in care, assistance addresses shortage of staff, and increased utilisation of public healthcare facilities</li> <li>• Husband's involvement as key factor to women's emotional needs in positive labour experience regarding CLS and utilisation of healthcare services</li> </ul> | <ul style="list-style-type: none"> <li>• Positive birth outcome</li> <li>- Companionship</li> <li>- Emotional support</li> <li>- Advocacy</li> <li>- Supportive role to healthcare providers</li> <li>- Positive labour experiences</li> <li>- Positive image of healthcare providers and facilities</li> <li>• Trust dynamics</li> <li>• Patient safety</li> <li>• Attitude of healthcare providers to CLS</li> </ul> |  |

|  |   |   |  |
|--|---|---|--|
|  | <ul style="list-style-type: none"> <li>• Implementation of CLS is influenced by availability of resources i.e. structure, personnel, equipment, finance</li> <li>• Women's fear and mistrust relating to fear of evil intention of support person</li> <li>• Risks perceived by nursing staff relating to use of unorthodox medication and spread of nosocomial infection</li> <li>• Resistance to CLS introduction by healthcare providers</li> <li>• Misgivings arising from cultural/ religious beliefs, relating to male involvement during childbirth</li> <li>• Perceptions about support persons' interference with nurses' routines and procedures, conflict of support person with healthcare providers</li> </ul> | <ul style="list-style-type: none"> <li>• Conflict of interest</li> <li>• Privacy and confidentiality</li> <li>• Professional gate keeping</li> <li>• Cultural/ religious conflicts</li> </ul> |  |
|--|---|---|--|



### **7.3. Step 2: Concept Classification**

The process of concept classification in this study adopted the survey list developed by Dickoff et al (1968). This classification was done by the researcher and a group of experts in maternal and child healthcare.

### **7.4 Expert Review**

An expert refers to “ a professional who has acquired knowledge and skills through study and practice over the years in a particular field or subject to the extent that his or her opinion may be helpful in fact finding, problem solving or understanding of a situation” (Business dictionary.com). The expert group in this study comprised highly skilled professionals who are purposefully selected from the clinical area, ministry of health, nursing and midwifery education units in Ondo and Osun states, South-West Nigeria. Twelve letters of invitation were dispatched with purpose, venue and time of the meeting after telephone contact and verbal expression of interest to participate. The expert group membership invited consists of 12 representatives including two obstetricians, one Director of Nursing Services, three Heads of Nursing Services, two principals of Schools of Nursing and Midwifery, one Chief Midwife Educator and one Principal Midwife Educator, and one sociologist. Only nine experts were able to make the review.

The expert review was conducted at the Nurses’ house Igbatoro Road, Akure, Ondo state on 27<sup>th</sup> August 2015 from 10:30 am to 3:45 pm. The researcher obtained written and verbal permission and biodata and an expert review agreement form was filled by all participants. However, more than 50% of the participants objected to an audio

recording, but gave assent to group photography after the discussion. The activity for the discussion includes overview of the background and objectives of the study, presentation of quantitative results and themes, and categories of the qualitative, with a summary of the literature review in powerpoint presentation. Concepts were identified and classified by the researcher and the group of experts using the Dickoff, James and Wiedenbach survey list.

#### **7.4.1: Demographic characteristics of the expert review participants**

A total number of nine participants were involved in the expert review comprising two obstetricians, one Director of Nursing services, two Heads of Nursing Services from the clinical area, principals of Midwifery, one Chief Midwife Educator, one sociologist and a lecturer from the Department of Nursing. Three of the participants were male while the remaining six were female, with an age range of between 42 and 55. Work experience ranges from 15-27 years. Eight of the participants were Christians and only one was Muslim.

#### **7.5 Classification of the main concepts for framework structure**

The survey list of Dickoff et al. (1968) was used in this study as the reasoning map for describing a framework for culturally congruent CLS for women in South-West Nigeria. This survey list intends to provide answers to six key questions for prescriptive theory (Meleis, 2012). These questions are:

1. Who or what performs the activity (agent)?
2. Who or what is the recipient of the activity (recipient)?

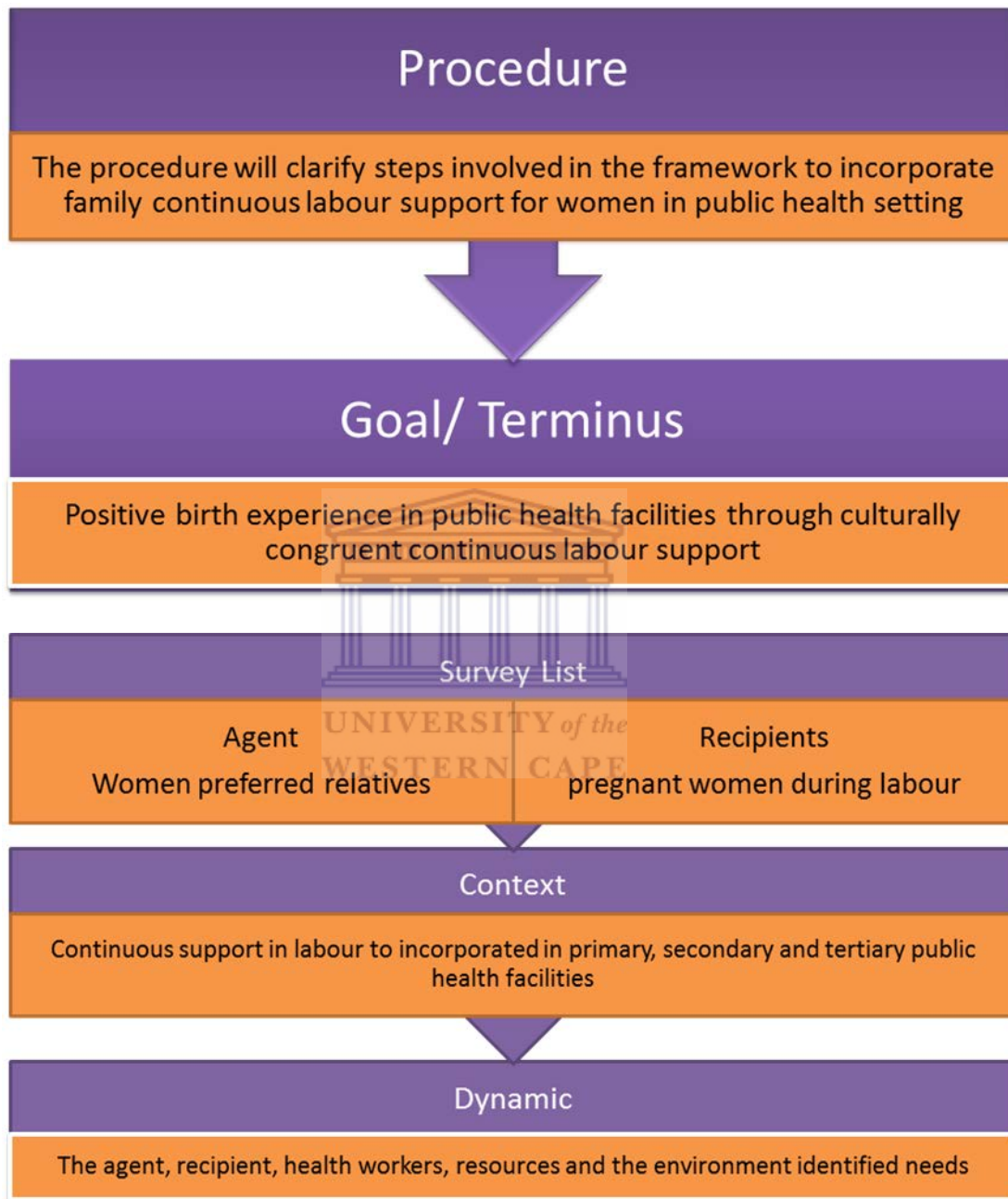
3. In what context is the activity performed (framework)?
4. What is the energy source for the activity (dynamics)?
5. What is the guiding procedure, technique, or protocol of the activity (procedure)?
6. What is the endpoint of the activity (terminus)? (Dickoff et al., 1968)

Figure 8 that follows illustrates the coherent generation by use of deductive logic from concept identification to concept classification, using the survey list of Dickoff, James and Wiedenbach (1968).



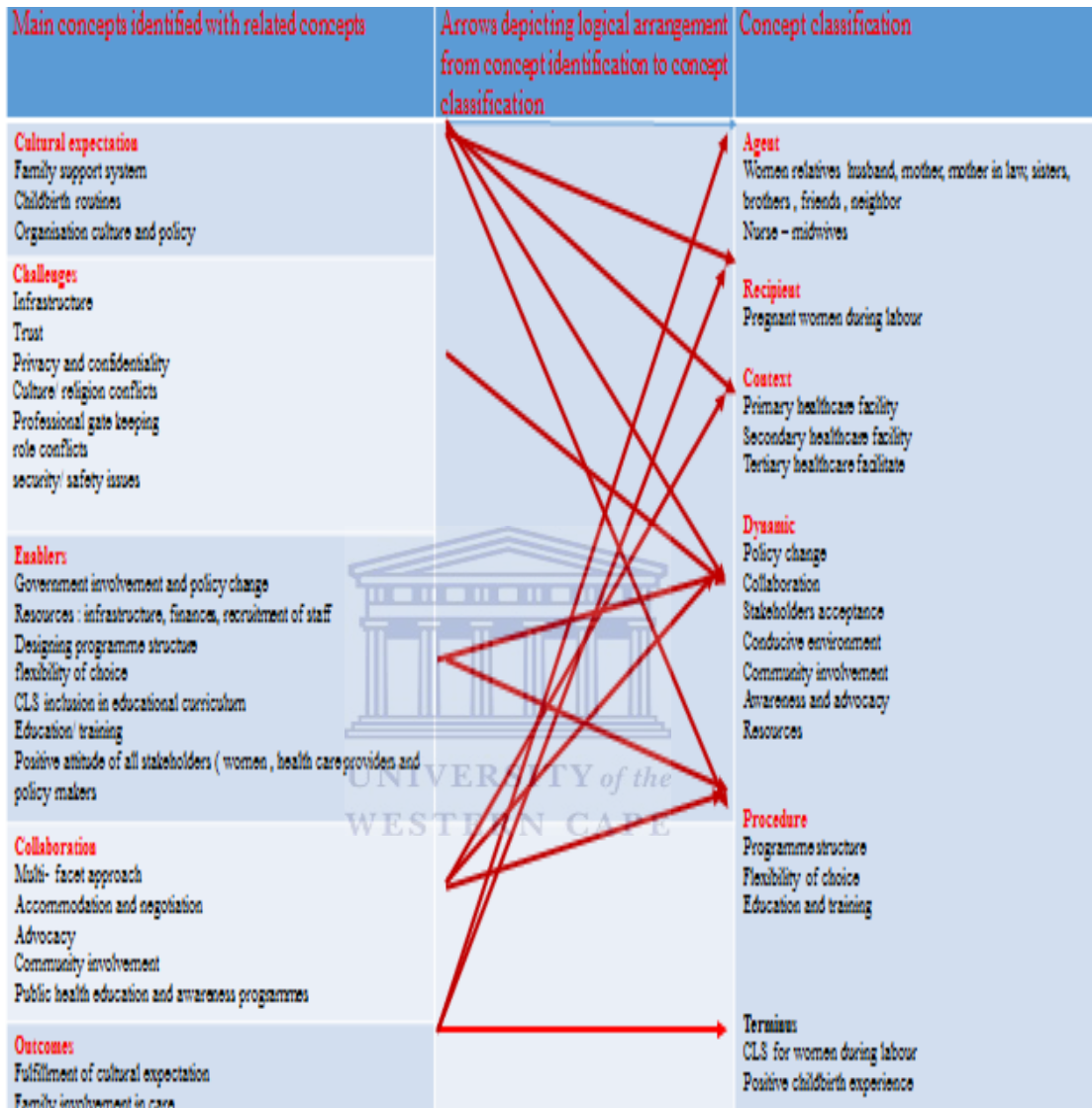


**Figure 8 : The researcher’s reasoning map for classification of concepts**



The systematic ordering of the concepts is depicted in figure 9 and is followed by an exposition of the concepts according to the six elements of the survey list.

**Figure 9 : Elements of the survey list**



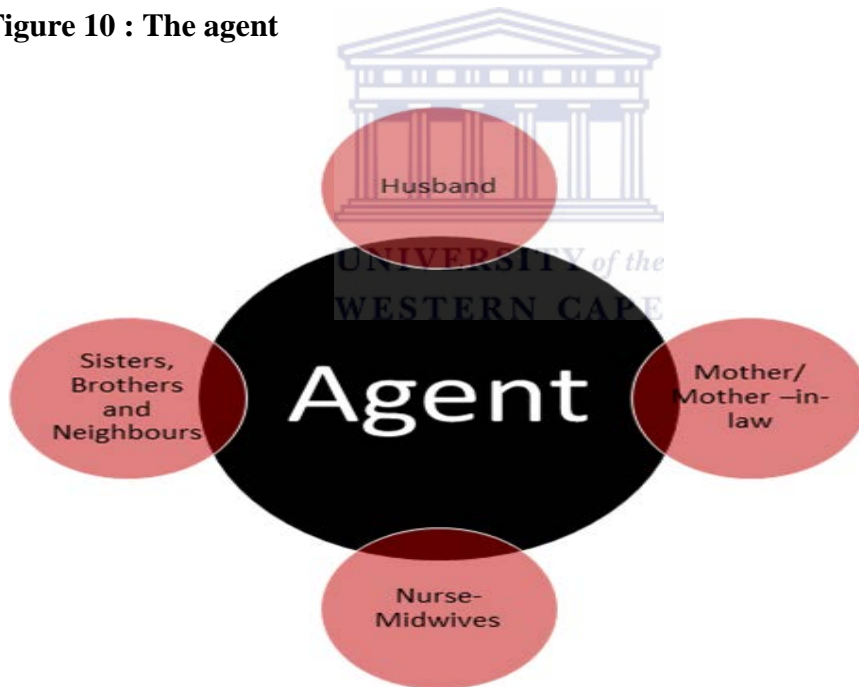
**7.6 Description of the implementation of the survey**

Brief explanations of how the concepts and the main concepts were used to answer the question in the survey list are given below:

### 7.6.1 Agent

The “Agent” according to Dickoff et al (1968) is a person who performs an activity towards realisation of a goal. The “Agent” in this study are in two categories: the woman’s preferred relative (husband or spouse, mother/mother-in-law, sisters, and brothers, neighbours), and the nurse-midwives. The agent will be responsible for offering CLS activities for women during labour. The nurse-midwives are considered agents in the framework because they are responsible for the coordination of activities in the labour room, for the woman in labour and her family

**Figure 10 : The agent**



### 7.6.2 Recipient

The “Recipient” is the person who is the receiver of the activity by the agent. The recipients in the CLS framework are pregnant women in labour. The pregnant women

will be the beneficiary of the family support system and involvement in their care from the onset of labour till post-delivery in public health facilities.

**Figure 11 : The recipient**



### **7.6.3 Context**

The “Context” refers to the setting, location, space, or structure in which the activity occurs (Dickoff, James and Wiedenbach, 1968). The context in this framework includes the incorporation of family support system as CLS in primary, secondary and tertiary public health facilities in South-West Nigeria.

**Figure 12 : The context**



#### **7.6.4 Dynamics**

Dickoff, James and Wiedenbach (1968:431) described “*dynamics*” as chemical, physical, biological or psychological power sources that can drive the activity towards the attainment of a goal.

The main concepts identified during the classification process pertaining to the *dynamics* are displayed in figure 13

**Figure 13 : Dynamics**

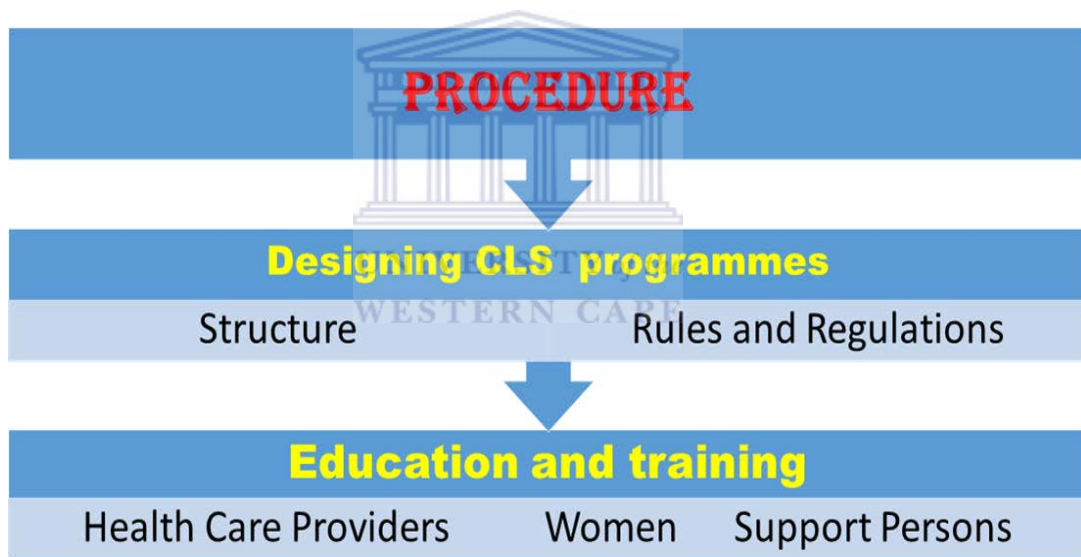


### **7.6.5 Procedure**

Dickoffet al (1968) state that procedure refers to the path, steps or general patterns on the way to the accomplishment of the goal or how the activity is to be performed. The procedure described the principles, sets of rules, routines or particular features that contribute a series of actions aimed at achieving the goal that will benefit the recipient. The procedure in this study involves every step to implement pregnant women's preferred relative as a source of CLS in public health facilities in South-West Nigeria. A plan will be drafted for the adoption and implementation of the framework

in the public healthcare setting and beyond. The draft will include: the designed structure for the CLS concept, rules and regulations, training and education programmes for the stakeholder as well as the practice guidelines. Figure 14 displays the main concept identified during the classification process relating to the procedure:

**Figure 14 : Procedure to be followed in the incorporation and implementation of women’s preferred family members as source of CLS in public health facilities in South-West Nigeria**

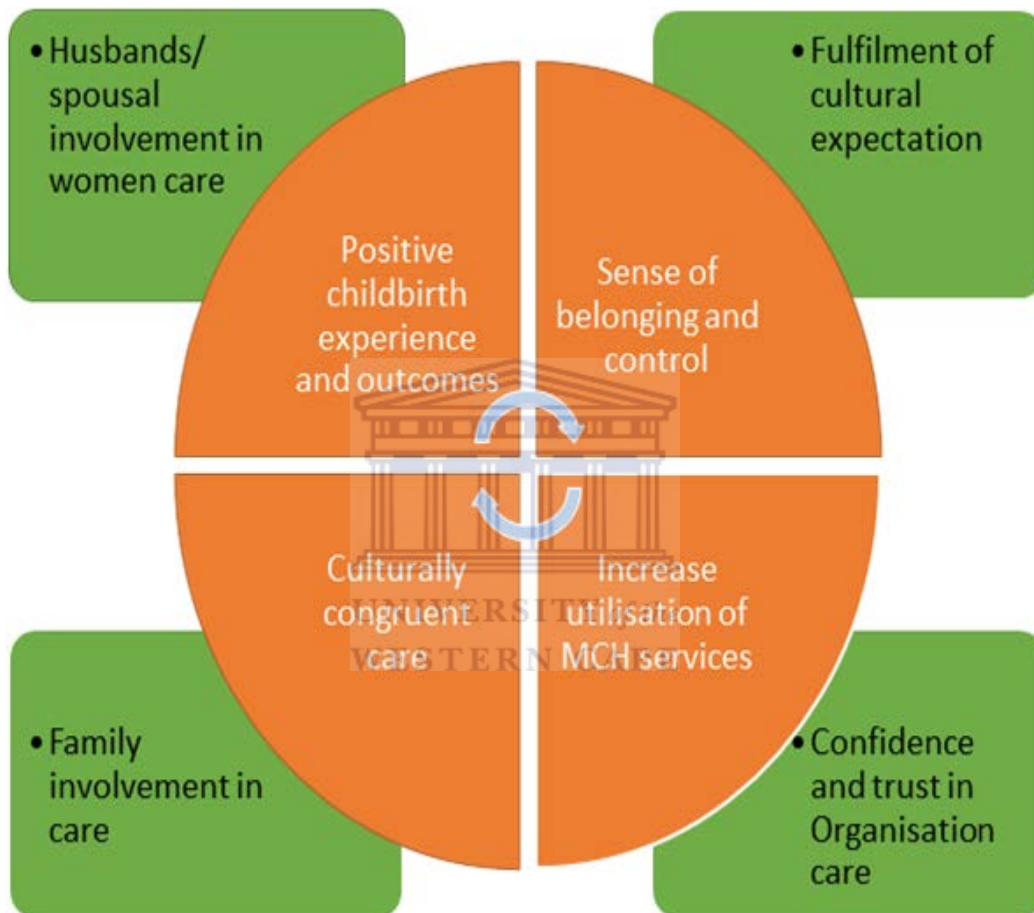


**7.6.6 Goal or Terminus**

The “ terminus” or “goal” is the end point or purpose of the activity (Dickoff et al, 1968). It describes the aim or the purpose for which the framework is developed. The aim and purpose in this study was to develop and implement the women’s preferred relative as source of CLS in public health facilities so that women can enjoy an expected cultural

family support and have a positive birth experience. The main derived concepts during the classification process pertaining to the terminus are presented in figure 15:

**Figure 15 : Terminus for CLS framework**

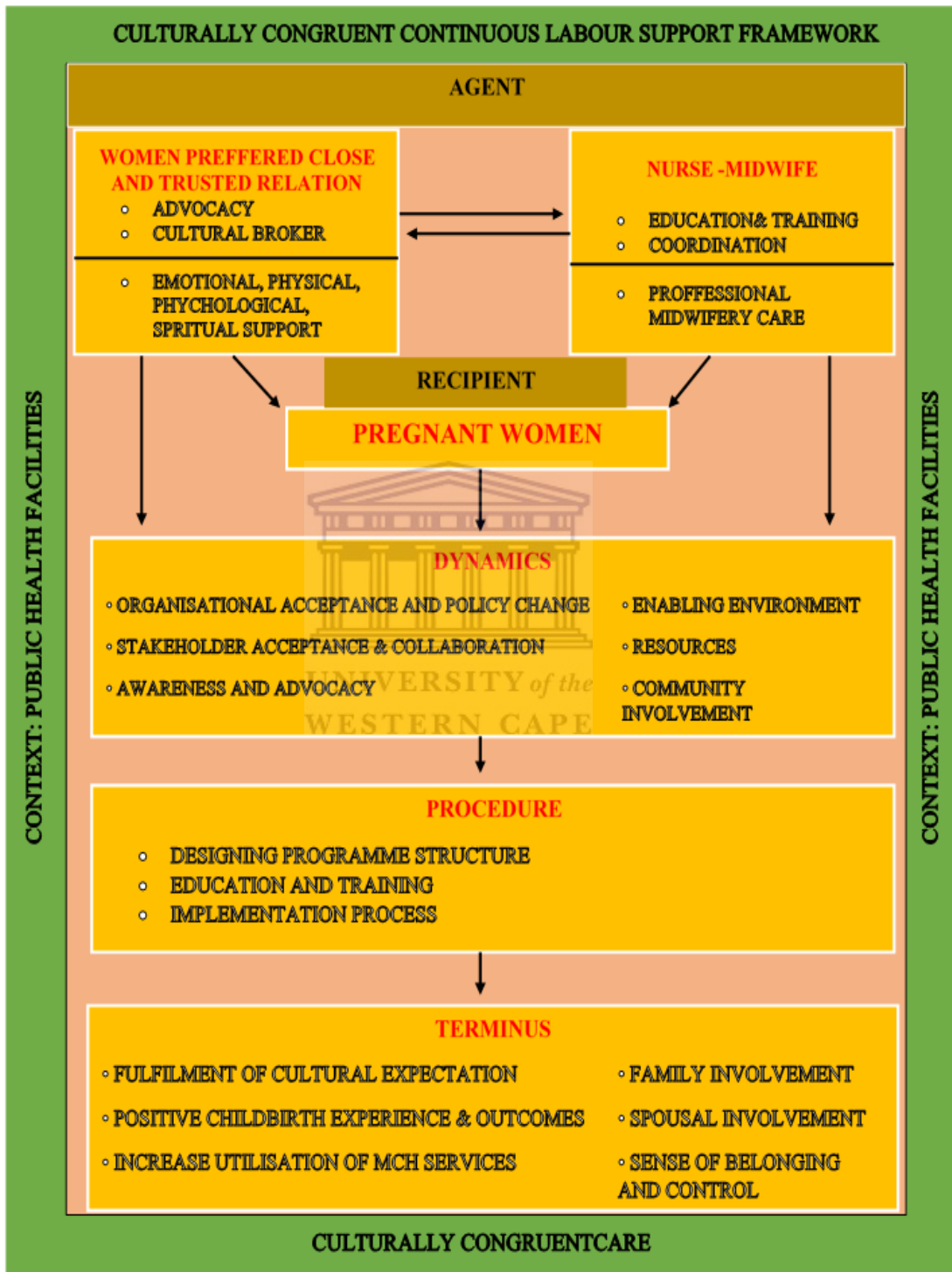


**7.6.7 Schematic representation of the framework**

A conceptual framework is a group of concepts that are broadly defined and systematically organized to provide a focus, a rationale, and a tool for the integration and interpretation of information on CLS during childbirth for women in Nigeria. The figure 16 presents a graphic representation of the framework.



Figure 16 : Schematic representation of the culturally congruent CLS framework



## 7.7 Framework Description

The description of the framework is based on the schematic representation in figure 7.9. It was evident from the findings of the study that pregnant women cherished, and perceived their family and relatives as the traditional support system which should be involved in their care during labour in public health facilities. However, despite the nurse-midwives' acknowledgment of this cultural childbirth practice at home and the community setting, CLS is not commonplace practice in the public health sector, due to absence of policy, poor infrastructure, inadequate resources and a host of other impediments highlighted by the study. This creates a gap between cultural expectation and social support during labour which the developed framework when put to practice intends to fill. The components of the framework includes the "Agent" who offers the CLS role, the "Recipient", i.e. the pregnant woman who benefits from CLS during labour, the prerequisites or enablers for the CLS, the CLS procedure or protocol as the goals at the terminus of the CLS experience, in public health facilities.

The Basic Concepts Underlying Supportive Care in this framework are based on the artistic and cultural representations of birth throughout the world, all of which were affirmed by the participants in this study. Labour usually involves at least two other women, surrounding and supporting the birthing woman. One of these women is the midwife, who is responsible for the safe passage of the mother and the baby. The other woman/ women are behind or beside the mother, holding and comforting her. The framework also fulfils the basic assumptions of culturally congruent care and objectives of the study as discussed in Chapter 1 of this paper.

### **7.7.1 The agent**

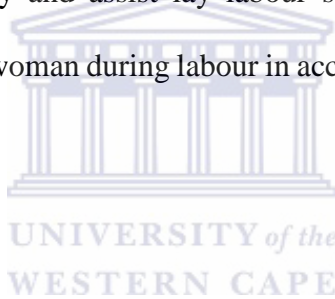
The agent in this framework is a non-member of the health team from the woman's social network who is close, trusted, reliable, and willing. This could be the husband, mother/ mother-in-law, sister, friend or neighbour, someone the woman wants present with her from the beginning to the end of labour in addition to the midwives/nurses. These agents give either supportive care or are coordinators of care and activities in the hospital. The women's choice of support person in the study has been adjudged the most beneficial to the women during labour. According to the Cochrane review of different providers of support during labour, support from a chosen family member or friend appears to increase women's satisfaction with their childbearing experience (Hodnett et al, 2011).

Supportive care refers to non-medical care that is intended to ease a woman's anxiety, discomfort, loneliness, or exhaustion, to help her draw on her own strengths, and to ensure that her needs and wishes are known and respected. It includes physical comforting measures, emotional support, information and instruction, advocacy, and liaison with healthcare providers. The role of the support person in labour in the framework includes:

- i. Continuous presence from the first stage of labour, and continued through the second stage of labour and post-partum period in the public health facilities
- ii. Nurturing and protection of the women's memory of birth
- iii. Provision of comfort techniques and encouragement of positions that promote progress during labour

- iv. Provision of physical care that does not interfere with healthcare providers' responsibilities
- v. Provision of information regarding women's choices during labour and delivery
- vi. Advocating for the birthing mother's needs
- vii. Acting as cultural brokers during labour and delivery
- viii. Promotion of early breastfeeding and bonding

Nurse-midwives are identified as co-agents in this study, as the coordinators of care and activities in the hospital. The nurse-midwives' responsibility is to mobilize resources from the facility and assist lay labour supporters to provide continuous emotional support for the woman during labour in accordance with organisational rules and regulations.



### **7.7.2 The recipient**

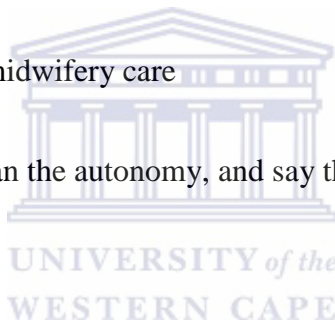
Pregnancy and childbirth are important moments in the lives of the family and the community. Honouring and respecting these times is seen as part of growing healthy individuals, healthy communities, and a healthy nation. In this study, the word "recipients" refers to the pregnant women who benefit from the continuous presence, physical care, emotional support, information and advocacy of her chosen labour support persons from her social network. Labour support for pregnant women is a right that all women should have, regardless of where they come from or who they are. This right is based on the World Health Organization recommendation that the parturient should be accompanied by people she trusts and with whom she feels at ease, possibly her partner, a friend, a *doula*, a nurse or midwife ( WHO, 2009,2010). Similarly, the

first of the 10 steps of the Mother-Friendly Childbirth Initiative, published by the Coalition for Improving Maternity Services (CIMS), incorporates the need for a support person during labour. The Initiative states that the mother-friendly hospital, birth centre, or home birth service should offer to all birthing mothers:

- Unrestricted access to the birth companions of their choice, including father, partner, children, family members, and friends
- Unrestricted access to continuous emotional and physical support from a skilled woman—for example, a doula or labour-support professional
- Access to professional midwifery care

They also afford the woman the autonomy, and say that every woman should have the opportunity to:

- Have a healthy and joyous birth experience for herself and her family, regardless of her age or circumstances
- Give birth as she wishes in an environment in which she feels nurtured and secure, and her emotional well-being, privacy and personal preferences are respected
- Have access to the full range of options for pregnancy, birth, and nurturing her baby, and to accurate information on all available birthing sites, caregivers and practices



- Receive accurate and up-to-date information about the benefits and risks of all procedures, drugs and tests suggested for use during pregnancy, birth and the postpartum period, with the right to informed consent and informed refusal
- Receive support for making informed choices about what is best for her and her baby based on her individual values and beliefs.( Coalition for Improving Maternity Services, 2016)

The responsibility of the pregnant woman in this framework is to:

- Identify her preferred labour support person during antenatal care in the public health facility based on her personal conviction, cultural/ religious inclination, relationship, and trust.
- Come with the chosen support person for orientation and training at the appointed time during antenatal care
- Come with the chosen support person for labour and childbirth in a public health facility.

### **7.7.3 The context**

The context in this study is the adoption and implementation of the culturally congruent CLS framework at all levels of care in public health facilities in Ondo state and other states in the south-western region of Nigeria. All hospitals should implement programmes that offer continuous support to women during labour, and the presence of a companion of the woman's own choice should be permitted and encouraged. However, the contextual reality of the framework is tied to finding solutions to the

implementation barriers identified in the study. The most common barriers highlighted by the group of participants are listed below:

- Infrastructure
- Trust
- Privacy and confidentiality
- Cultural/ religious conflicts
- Professional gate keeping
- Role conflicts
- Security/ safety issues

The proffered solutions to the barriers are fully discussed under dynamics for CLS model.



#### **7.7.4 The dynamics**

The dynamics are the enablers and facilitators to the effective adoption and implementation of the culturally congruent CLS framework in public health facilities.

These factors are:

##### **7.5.4.1 Organisational acceptance and policy change**

Based on the empirical benefits of CLS worldwide and the need to cater for the cultural expectations of women at in childbirth, especially in public health facilities, the CLS concept has gained momentum in many countries. In 2001, Uruguay became the first country in the world to pass legislation mandating the right of every birthing woman to have continuous support. Law No 17.386 states that “every woman, during the time

her labour lasts, including the moment of birth, has the right to be accompanied by a person she trusts, or if not, at her own will, by somebody specially trained to provide her emotional support” (Legislative General Assembly of the Oriental Republic of Uruguay, 2001). In the same vein, several low- and middle-income countries (including China, South Africa, Tanzania and Zimbabwe) have added CLS as part of birth policy in line with the Better Births Initiative’s recommendation of labour companionship as a core element of care for improving maternal and infant health (WHO 2010, Hodnett et al, 2012).

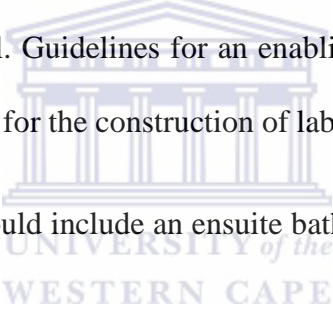
There is the need for the governmental and public health parastatals in South-West Nigeria to incorporate CLS into an appropriate women’s rights law, and also institute a committee to formulate hospital policy statements on companions in childbirth. The committee will comprise staff from all disciplines relating to maternal and children’s healthcare services and representatives of pregnant women and the community. The committee will be responsible for:

- i. Formulating objectives for CLS in the hospital
- ii. Develop practicability of the policy and the rationale
- iii. Develop CLS circumstances regarding preferences, accepted role of the support people, number of support persons allowed and duration of CLS in the facility.
- iv. Appoint and designate an officer in charge of midwifery services who will be responsible for the management of the community participants and support persons in the hospital.



#### **7.5.4.2: Enabling environment**

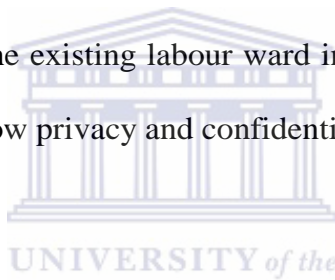
All women need to feel safe during labour and birth and feelings of safety and satisfaction are influenced by the birth environment. Current labour room practice and policy in Nigeria which negates women's privacy and confidentiality was identified as a barrier in the study. The focus of the framework is to prescribe an enabling birth environment for the implementation of CLS in public health facilities. This involves creation of space or rehabilitation of the existing labour practice to a standard which will enable women to feel safe and relaxed during labour and birth. Such an environment is characterised by privacy and homeliness, and provides the woman with a sense of personal control. Guidelines for an enabling birthing environment can be adopted as a long term strategy for the construction of labour room

- 
- All birth rooms should include an ensuite bathroom with a shower and private toilet.
  - Doors and windows should be positioned and covered or screened so as to protect the privacy of the birthing woman.
  - Furniture should encourage and support women to adopt non-supine positions for labour and birth.
  - Deep, non-reflective colour schemes should be used.
  - Lighting design should contribute to a calming ambience.
  - Birth rooms should be spacious and support and encourage women to maintain mobility.

- Spaces should be provided in the birth room to encourage women to personalise their environment.
- Birth rooms should accommodate and support people comfortably.
- Local communities should be consulted regarding the design of culturally safe birth spaces.
- Birth rooms should allow access to outdoor spaces and support locally relevant traditional ceremonies. (<http://www.qcmb.org.au/birthspace>).

**Short-term strategies include:**

- Modification of the existing labour ward into cubicles by erecting mobile partitioning to allow privacy and confidentiality and also accommodate the support persons.



**7.5.4.3. Stakeholders' acceptance and collaboration**

Despite all stakeholders' affirmation of family as traditional support system at home and the importance of community involvement, healthcare providers' resistance to incorporation and implementation of CLS in public health facilities was identified as a hindrance. This gave credence to the need for orientation and education of all stakeholders to foster understanding of the need to negotiate agreeable terms regarding CLS practice. This will be achieved through Information, Education and Communication (IEC) strategy. (IEC) combines strategies, approaches and methods that enable individuals, families, groups, organisations and communities to play an active role in achieving, protecting and sustaining their own health. IEC aims to

increase awareness, change attitudes and bring about a change in specific behaviour. It means sharing information and ideas in a way that is culturally sensitive and acceptable using appropriate channels, messages and methods that involve active participation of all stakeholders. Stakeholders' acceptance and collaboration will be achieved through:

- i. In-service training programme for healthcare providers, particularly the midwives on support skills of women in labour and their labour companions, the implementation of labour companionship in a hospital setting and guidelines on how to implement labour companionship.
- ii. Incorporation of the CLS concept into educational curricula of healthcare providers.
- iii. Orientation and awareness of health education for all pregnant women at antenatal clinics.
- iv. Use of printed material, mass media and other innovative ideas for public awareness about CLS in the hospital.

#### **7.5.4.4 Awareness and advocacy**

Awareness campaigns and advocacy are needed to orientate the following:

- Different stakeholders regarding the need and benefits of incorporating CLS into women's care during labour in public health settings
- Educate on the guidelines and protocols for CLS
- Create public awareness and support for the programme
- Guide against instances of malpractice, and complications that could arise

- Information and orientation of relatives regarding the ward and which items to bring to the hospital to facilitate optimal use of available resources

#### **7.5.4.5 Community involvement**

Social support during childbirth is an accepted practice in socio-cultural/ religious practice among the participants in this study. There was significant desire for husbands'/ spousal involvement in women's care, which may be against the cultural/ religious belief that childbirth and support is solely for women. There may be a need to liaise with community leaders and religious organisations as a means to mobilize and create awareness for male involvement in women's care and utilisation of healthcare services.



## **7.5.5 The procedure**

### **7.5.5.1 Programme structure**

This involves organisation of a step-by-step process in adopting CLS in public health facility settings:

- i. Agreement on commencement in the hospital
- ii. Determining eligibility of women who may benefit from CLS
- iii. Flexibility for women to choose labour companion(s)
- iv. Freedom to opt in or out of the CLS concept
- v. Time and selection criteria for support person(s)
- vi. Rules and regulations for practice

### **7.5.5.2 Education and training**

Recommended, is the development of an in-service training programme to promote implementation of labour companionship at all levels of public health facilities by improving midwives' management skills, with regard to women and their labour companions during labour and delivery. The programme objectives will be:

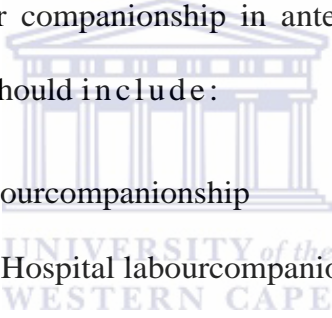
- i. To provide standardized information about labour companionship
- ii. To train midwives on how to modify traditional labour companionship to fit into the public health facility setting
- iii. To provide guidelines on how to implement labour companionship

The training module will include:

- Support skills of women in labour and their labour companions

- Implementation of labour companionship in a hospital setting
- Interpersonal and communication skills
- Counselling
- Programme Implementation

The aim is to develop a training programme for women and labour support persons to develop their knowledge on the concept of labour companionship and the implementation process in public health facilities. The trained nurse-midwives will provide information to the women and support persons on the skills and implementation of labour companionship in antenatal clinic. A comprehensive information programme should include:

- 
- The concept of labour companionship
  - Traditional versus Hospital labour companionship
  - Rationale for, and modification of traditional labour companionship for the hospital setting
  - Implementation of modified labour companionship in the hospital
  - Coping strategies during labour
  - Comfort measures as well as praise and reassurance
  - Skills in communicating with people in stressful situations
  - Skills on listening, guiding for assistance and supporting during first and second stage of labour

## **Training strategies**

- Standard semi-structured teaching plan for uniformity
- Commencement of awareness on CLS and training from first prenatal contact
- Duration of training should range between 2 and 4 hours, around 28-32 weeks' gestation
- Use of audio-visual materials, print, posters and pamphlets
- Reinforced information on CLS with every ANC visit

### **7.5.6 The terminus**

The target goal of the CLS programme in the public health facilities will be followed by proper monitoring and evaluation. Monitoring and evaluation involve the procedures to ensure that the intended results of a programme are being achieved. Follow up and periodic evaluation of outcome of CLS in public healthcare facilities should be conducted through:

- Checklists/ nursing audits
- Questionnaires
- Medical records
- Other research methods

### **7.8 Validation of the framework**

The developed culturally congruent CLS framework was validated through consensus expert review, which consisted of four people selected from the larger group of previous expert review group participants used for the development of the framework.

The experts assessed the suitability and applicability of the framework for its intended purpose in public health facilities in Ondo state. The evaluation of the framework was based on its content, component structure and the list of prescriptive recommendations in each context and category. A consensus agreement form was sent to each expert to decide on each of the statements in the first draft of the framework. The consensus agreement consists of the following options for the expert to pick from: (Annexure Q)

A =Agree with the Statement

B= Modify the statement

C= Abstain (No comment)

D= Delete the statement



\* The experts were also asked to write other suggestions not included in the agreement in the space provided.

### **7.8.1 Result of the expert validation**

All the expert participants fully agreed with the structure and content of the framework but made suggestions for the modification of some of the prescriptive statements in some contexts. Two of the experts also suggested some statements be added to the prescriptive statements under the Procedure section of the framework. The suggested modification of the prescriptive statements was looked into and three statements were modified with minimal change to the context of the framework. Two additional



statements were also added from the new suggested list. All the relevant changes were discussed with the supervisor before the final draft was submitted.

### **7.7: Summary**

This chapter discussed in detail the process of a framework development for culturally congruent CLS in public health facilities: i.e. the concepts development and classification, framework components, description and validation. The next chapter presents the conclusions, limitations and recommendations of the study.



## **CHAPTER 8**

### **SUMMARY CONCLUSIONS LIMITATIONS AND RECOMMENDATIONS**

#### **8.1 Introduction**

The previous chapter gave the description of the process for concept identification and classification, the framework development, description and validation. In this chapter the overview of the research, conclusion, mode of disseminating the framework, limitations and recommendations are discussed.

#### **8.2 Overview of the research process**

The purpose of this study was to develop a culturally congruent CLS framework in South-West Nigeria. Four objectives were set for the study, namely: to assess the perceptions, attitudes and preferences of women to CLS; to explore the perceptions and attitudes of nurse- midwives to CLS by person/s from the women's social network in public hospitals; to determine the position of hospital policy-makers to CLS by person/s from the women's social network in public hospitals (Phase 1) and to develop a culturally congruent CLS framework for women in the south-west region of Nigeria (Phase 2).

The first objective was achieved through collection of both qualitative and quantitative data simultaneously in two strands. The first strand involved administration of questionnaires to three hundred and sixty-eight antenatal women in seven secondary hospitals in Ondo state with a mean age of 30 years. The second

strand involved ten (10) focus group discussions with eighty- eight antenatal women in seven selected secondary health facilities in Ondo state. After quantitative and qualitative analysis of the findings the study shows that the antenatal women had positive perceptions and attitudes for CLS from a familiar, close and trusted person, in public health facilities. The women affirmed that extended family, intimate partners and friends constitute a culturally accepted traditional support system during labour, and expressed a strong desire for their involvement in women's care during labour in public health facilities.

The second objective was also attained through focus group discussions conducted with a total of forty-five (45) nurse-midwives in seven selected hospitals in Ondo state. Findings from this part of the study revealed that pregnant women's family members are not usually involved in women's care during labour in public health facilities. Also, CLS is not part of current hospital policy in hospitals involved in the study. However, nurse-midwives expressed satisfaction with the few occasional/ discretionary occasions on which the practice had been implemented, and the majority showed positive perceptions and attitudes to the introduction of CLS from a person of the woman's choice, in public health facilities. They also highlighted the risks/ challenges and suggested enablers for the effective implementation of CLS.

Equally, the third objective was realized through semi-structured interview with a total number of fourteen (14) hospital policy-makers comprising two (2) Directors of Nursing Services (DNS), five (5) Chief Medical Directors (CMD) and Medical

Director (MD) and Seven (7) Heads of Nursing Services (HNS) at Ondo State Ministry of Health, Hospital Management Board and selected hospitals. Findings from interviews with the policy-makers affirmed family support system during labour as a cultural expectation and a traditional practice at home. The findings also showed, however, that the CLS concept is alien to many healthcare providers and public health facilities, and that this was why there was no policy for its practice in most hospitals. The policy-makers also expressed a positive standpoint on the introduction of CLS by persons of the woman's choice from her social network, in the public hospital. They stated that CLS is an evidence-based practice in developed countries and that, being an accepted tradition in Nigeria it can be tested, trialed and implemented in public health facilities in Nigeria. They also elucidated the challenges that might face attempts to incorporate CLS as standard practice in public health settings, and suggested facilitators for its implementation.

The findings from objectives 1-3 (Phase 1) were synthesized for the achievement of objective 4 (Phase2), which was the development of a culturally congruent CLS framework in South-West Nigeria, using the Walker and Avant (2011) model development approach. The survey list Dickoff et al. (1968) was utilised as the reasoning map for describing the developed framework by using six key elements: agent, recipient, context, dynamics, procedure and terminus. The agents identified were the women's preferred close and trusted person (husband, mother/ mother-in-law, sisters, friends and neighbours) as primary agent, while the nurse-midwife was also identified as co-agent in the framework. The role encompassed provision of

emotional, physical, psychological and spiritual support for the woman during labour, as well as women's advocacy and culture broker with nurse-midwives. The nurse-midwives as co-agents, perform the role of coordinator and trainer of the primary agent and is responsible for professional midwifery care for the woman in labour. The contextual realities of the framework are the adoption and implementation of CLS at all levels of public healthcare in South-West Nigeria. The dynamics and procedure for the CLS framework include: organisational acceptance and policy change, enabling environment, resources, stakeholders' acceptance and collaboration, awareness and advocacy, and community involvement. The procedure includes designing CLS programme structure, rules and regulations, and education and training.

The researcher believed the framework when adopted and implemented in Nigeria's public health facilities will fulfill the yearning of the women for a culturally congruent maternity care which will minimise the socio-cultural hindrances to utilisation of maternal and child health services in Nigeria, as an effort to increase skilled birth attendance and reduce the menace of maternal mortality and morbidity in Nigeria.

### **8.3 Unique contribution of the CLS framework**

The development of a culturally congruent CLS framework for women during childbirth in public health facilities in South-West Nigeria is the key contribution of this investigation. None of the earlier studies on labour support in Nigeria has ever considered development of a culture-sensitive or culturally relevant framework

on labour support for Nigerian women care. Most studies conducted on CLS in Nigeria only involved pregnant women as participants, and none have been conducted among healthcare providers and policy-makers. This framework is unique because it has integrated the opinions and interests of all stakeholders (expectant mothers, nurse-midwives and policy-makers) in women's care during childbirth. It has also linked cultural childbirth practice at home with expectations within public health facilities, to ensure a cultural congruent approach to the problems of poor utilisation of maternal and healthcare services, and maternal mortality in Nigeria, and in particular to positive birthing experience even with healthy deliveries. The developed framework can be adopted for implementation at all levels of care in any state within South-West Nigeria and can also be extended for use in other states in Nigeria.

#### **8.4 Limitations of the study**

The study was conducted in only one state of the six in South-West Nigeria although the pilot test for all the instruments for data collection was done in another state within the south-west region. The study's pregnant women sample size was only 362, which might not represent the opinion of all women within the region, but the researcher attempted to compensate for this by following up the quantitative data with qualitative data from pregnant women. The study also involved only nurse-midwives n= 45 as healthcare providers, although some other professionals were part of the study at policy-makers level.

## 8.5 Dissemination plan

The researcher plans to disseminate the developed framework in the following ways:

- It will be communicated to Ondo state government through the Ministry of Health to inform political support and policy endorsement.
- A copy will be forwarded to the Nursing and Midwifery Council of Nigeria for possible consideration into the Midwifery curriculum.
- The framework will be presented at seminars and workshops organised by healthcare professionals.
- It will be shared with other scholars and academic peers through scientific research conferences organised both nationally and internationally.
- The findings of the study will be published in peer review journals for awareness and accessibility.
- Finally, the researcher plans to test and evaluate the framework post-doctorally.

## 8.6 Recommendations

The following recommendations are suggested from the findings of this study.

- **Public health practice**

The researcher recommends adoption and implementation of this framework at all levels of public healthcare for women during childbirth, to ensure culture-based care that will boost women's confidence in organisational care as a means to

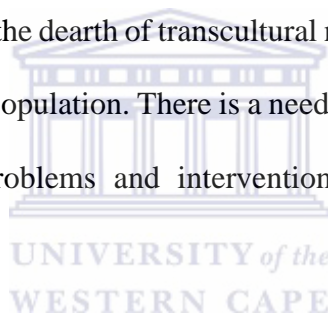
improve service utilisation, skilled birth attendance, and reduce maternal mortality related to socio-cultural causes.

- **Midwifery education**

There is a need for nurse-midwives to embrace evidence-based family-centred care through orientation and implementation of care. It is therefore recommended that the Nursing and Midwifery Council of Nigeria considers inclusion of CLS into curricular content and practical skills for midwifery training.

- **Nursing research**

The researcher observed the dearth of transcultural nursing research in the divergent cultures of the Nigerian population. There is a need for nurse researchers to explore some of the nursing problems and intervention programmes from a cultural perspective.



### **8.7. Conclusion**

Maternal mortality remains relatively high in Nigeria despite several interventions in the country. This study developed a culture-based framework that may assist in reducing the rate of maternal mortality related to socio-cultural causes, a framework that can be implemented at any level of healthcare in the country.



## References

- Abimbola, S., Okoli, U., Olubajo, O., Abdullahi, M. J., & Pate, M. A. (2012). The midwives service scheme in Nigeria. *PLoS Med*, 9(5), e1001211.
- Abushaikha, L., & Massah, R. (2012). The roles of the father during childbirth: The lived experiences of Arab Syrian parents. *Health Care for Women International*, 33(2), 168-181.
- Adams, E. D., & Bianchi, A. L. (2008). A practical approach to labor support. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37(1), 106-115.
- Adeniran, A. S., Aboyeji, A. P., Fawole, A. A., Balogun, O. R., Adesina, K. T., & Adeniran, P. I. (2015). Male Partner's role during pregnancy, labour and delivery: Expectations of pregnant women in Nigeria. *International Journal of Health Sciences*, 9(3), 305.
- Adeyemo, D. (2005). Local government and health care delivery in Nigeria: A case study. *J.Hum.Ecol*, 18(2), 149-160.
- Airhihenbuwa, C. O. (1995). *Health and culture: Beyond the western paradigm* Sage.
- Airhihenbuwa, C. O. (1999). Of culture and multiverse: Renouncing "the universal truth" in health. *Journal of Health Education*, 30(5), 267-273.

- Airhihenbuwa, C. O. (2007). *Healing our differences: The crisis of global health and the politics of identity* Rowman & Littlefield.
- Airhihenbuwa, C. O. (2010). Culture matters in global health. *European Health Psychologist, 12*(4), 52-55.
- Airhihenbuwa O., Bunmi M., Rafael Obregon, Collins. (2000). Toward a new communications framework for HIV/AIDS. *Journal of Health Communication, 5*(sup1), 101-111.
- Airhihenbuwa, C. O., & Webster, J. D. (2004). Culture and African contexts of HIV/AIDS prevention, care and support. *SAHARA-J: Journal of Social Aspects of HIV/AIDS, 1*(1), 4-13.
- Airhihenbuwa, C., Okoror, T., Shefer, T., Brown, D., Iwelunmor, J., Smith, E., Dlakulu, R. (2009). Stigma, culture, and HIV and AIDS in the western cape, South Africa: An application of the PEN-3 cultural model for community-based research. *Journal of Black Psychology, 35*(4), 407-432.
- Airhihenbuwa, C. O. (1990). A conceptual model for culturally appropriate health education programs in developing countries. *International Quarterly of Community Health Education, 11*(1), 53-62. Doi: 10.2190/LPKH-PMPJ-DBW9-FP6X [doi]

Airhihenbuwa, C. O. (2007). On being comfortable with being uncomfortable: Centering an Africanist vision in our gateway to global health. *Health Education & Behavior: The Official Publication of the Society for Public Health Education*, 34(1), 31-42. Doi: 1090198106291377 [pii]

Airhihenbuwa, C. O., Ford, C. L., & Iwelunmor, J. I. (2014). Why culture matters in health interventions: Lessons from HIV/AIDS stigma and NCDs. *Health Education & Behavior: The Official Publication of the Society for Public Health Education*, 41(1), 78-84. Doi: 10.1177/1090198113487199 [doi]

Airhihenbuwa, C. O., Kumanyika, S. K., TenHave, T. R., & Morssink, C. B. (2000). Cultural identity and health lifestyles among African Americans: A new direction for health intervention research? *Ethnicity & Disease*, 10(2), 148-164.

Alebiosu, E. (2014). National Health System, Maternal Health and the Millennium Development Goals: A Review of Abiye Programme in Ondo State, Nigeria. *International Journal of Humanities and Social Science*, 4(12).

Akodu, S. (2014). Awareness and knowledge of HIV counselling and testing among undergraduate university students in Lagos, Nigeria. *International Journal of TROPICAL DISEASE & Health*, 4(9), 896-904.

Alexander, A., Mustafa, A., Emil, S. A., Amekah, E., Engmann, C., Adanu, R., & Moyer, C. A. (2014). Social support during delivery in rural central Ghana: A

mixed methods study of women's preferences for and against inclusion of a lay companion in the delivery room. *Journal of Biosocial Science*, 46(05), 669-685.

Allen, K., Blascovich, J., & Mendes, W. B. (2002). Cardiovascular reactivity and the presence of pets, friends, and spouses: The truth about cats and dogs. *Psychosomatic Medicine*, 64(5), 727-739.

Al-Mandeel, H. M., Almufleh, A. S., Al-Damri, A. J., Al-Bassam, D. A., Hajr, E. A., Bedaiwi, N. A., & Alshehri, S. M. (2013). Saudi women's acceptance and attitudes towards companion support during labor: Should we implement an antenatal awareness program? *Annals of Saudi Medicine*, 33(1), 28-33. doi:10.5144/0256-4947.2013.28 [doi]

Almushait, M., & Ghani, R. A. (2014). Perception toward non-pharmacological strategies in relieving labor pain: An analytical descriptive study. *Perception*, 4(2)

Altranais, A. B. (2007). Decision making framework for nurses and midwives with prescriptive authority. *An Bord Altranais, Dublin*,

Amorim, M., & Katz, (2012). Continuous support for women during childbirth: RHL commentary. The WHO reproductive health library; Geneva: World health organization. Available: [Http. Apps.Who.int/rhl/pregnancy childbirth/childbirth/2nd stage/jlcom/es/index.Html](http://apps.who.int/rhl/pregnancy_childbirth/childbirth/2nd%20stage/jlcom/es/index.html),

- Antonucci, T. C., & Israel, B. A. (1986). Veridicality of social support: A comparison of principal and network members' responses. *Journal of Consulting and Clinical Psychology*, 54(4), 432.
- Asher, C. C. (1984). The impact of social support networks on adult health. *Medical Care*, 349-359.
- Atuyambe, L. M. (2008). *Adolescent motherhood in Uganda: Dilemmas, health seeking behaviour and coping responses*. PhD Thesis, Makerere University, Kampala. <http://diss.kib.ki.se/2008/978-91-7409-212-7/thesis.pdf>
- Aune, I., Amundsen, H. H., & Aas, L. C. S. (2014). Is a midwife's continuous presence during childbirth a matter of course? Midwives' experiences and thoughts about factors that may influence their continuous support of women during labour. *Midwifery*, 30(1), 89-95.
- Awolalu J.O and Adelumo D. P. (2005). *West African Tradition Religion*, (Ibadan: MacmillanNigeria Publishers Ltd., pp178ff.
- Bäckström, C., & Wahn, E. H. (2011). Support during labour: First-time fathers' descriptions of requested and received support during the birth of their child. *Midwifery*, 27(1), 67-73.

- Bakhta, Y., & Lee, R. H. (2010). A survey of Russian women regarding the presence of a companion during labor. *International Journal of Gynecology & Obstetrics*, *109*(3), 201-203.
- Baldwin, M. W. (1992). Relational schemas and the processing of social information. *Psychological Bulletin*, *112*(3), 461.
- Banda, G., Kafulafula, G., Nyirenda, E., Taulo, F., & Kalilani, L. (2010). Acceptability and experience of supportive companionship during childbirth in Malawi. *BJOG: An International Journal of Obstetrics & Gynaecology*, *117*(8), 937-945.
- Bankole, A., Sedgh, G., Okonofua, F., Imarhiagbe, C., Hussain, R., & Wulf, D. (2009). *Barriers to safe motherhood in Nigeria*. Guttmacher Institute Washington DC.
- Barnes, M. L., & Sternberg, R. J. (1997). A hierarchical model of love and its prediction of satisfaction in close relationships. In R. J. Sternberg & M. Hojjat (Eds.), *Satisfaction in close relationships* (pp. 79-101). New York: Guilford.
- Barrera Jr, M. (1986). Distinctions between social support concepts, measures, and models. *American Journal of Community Psychology*, *14*(4), 413-445.
- Bartlett, E. E. (2004). The effects of fatherhood on the health of men: A review of the literature. *The Journal of Men's Health & Gender*, *1*(2), 159-169.



- Basavanthappa, B. (2007). *Textbook of nursing research*. Review of Literature, Jaypee Brothers. New Delhi,
- Bazzano, A. N., Kirkwood, B., Tawiah-Agyemang, C., Owusu-Agyei, S., & Adongo, P. (2008). Social costs of skilled attendance at birth in rural Ghana. *International Journal of Gynecology & Obstetrics*, 102(1), 91-94.
- Behruzi, R., Hatem, M., Fraser, W., Goulet, L., Ii, M., & Misago, C. (2010). Facilitators and barriers in the humanization of childbirth practice in Japan. *BMC Pregnancy and Childbirth*, 10(1), 1.
- Behruzi, R., Hatem, M., Goulet, L., Fraser, W., & Misago, C. (2013). Understanding childbirth practices as an organizational cultural phenomenon: A conceptual framework. *BMC Pregnancy and Childbirth*, 13, 205-2393-13-205. Doi: 10.1186/1471-2393-13-205 [doi]
- Berg, M., & Terstad, A. (2006). Swedish women's experiences of doula support during childbirth. *Midwifery*, 22(4), 330-338.
- Berkowitz, B. (2008). Cultural aspects in the care of the orthodox Jewish woman. *Journal of Midwifery & Women's Health*, 53(1), 62-67.
- Bertsch, T., Nagashima-Whalcn, L., Dykcman, S., Kennell, J. H., & McGrath, S. (1990). Labor support by first-time fathers: Direct observations with a

comparison to experienced doulas. *Journal of Psychosomatic Obstetrics & Gynecology*, 11(4), 251-260.

Bewley, S., & Cockburn, J. (2002). Responding to fear of childbirth. *The Lancet*, 359(9324), 2128-2129.

Bina, R. (2008). The impact of cultural factors upon postpartum depression: A literature review. *Health Care for Women International*, 29(6), 568-592.

Bluff, R., & Holloway, I. (2008). The efficacy of midwifery role models. *Midwifery*, 24(3), 301-309.

Bodrick, M. M., Klopper, H. C., BA, C., & Bruce, J. C.A (2011). Practice model in ambulatory care services for patient liaison nursing in Saudi Arabia. A conference paper. Sigma Theta Tau International Nursing Research Congress. Virginia Henderson e-Repository,

Boender, C., Santana, D., Santillán, D., Hardee, K., Greene, M. E., & Schuler, S. (2004). *The "so what?" report: A look at whether integrating a gender focus into programs makes a difference to outcomes* Interagency Gender Working Group Task Force, Population Reference Bureau.

Bondas-Salonen, T. (1998). How women experience the presence of their partners at the births of their babies. *Qualitative Health Research*, 8(6), 784-800.



- Bonds, D. E., Zaccaro, D. J., Karter, A. J., Selby, J. V., Saad, M., & Goff, D. C., Jr. (2003). Ethnic and racial differences in diabetes care: The insulin resistance atherosclerosis study. *Diabetes Care*, 26(4), 1040-1046.
- Bowen, S., & Zwi, A. B. (2005). Pathways to “evidence-informed” policy and practice: A framework for action. *PLoS Med*, 2(7), e166.
- Bowers, B. B. (2001). Development of an instrument to measure mothers' perceptions of professional labor support. Dissertation Abstracts International: Section B: The Sciences and Engineering, 62 (2001), p. 1802
- Bowser, D., & Hill, K. (2010). Exploring evidence for disrespect and abuse in facility-based childbirth. *Boston: USAID-Traction Project, Harvard School of Public Health*,
- Bradley, P., Cooper, S., & Duncan, F. (2009). A mixed-methods study of interprofessional learning of resuscitation skills. *Medical Education*, 43(9), 912-922.
- Brink, H., Van der Walt, C., & Van Rensburg, G. (2006). *Fundamentals of research methodology for health care professionals*. Juta and Company Ltd.
- Brodsky, P. L. (2006). Childbirth: A journey through time. *International Journal of Childbirth Education*, 21(3)

- Bromell, L., & Cagney, K. A. (2014). Companionship in the neighborhood context: Older adults' living arrangements and perceptions of social cohesion. *Research on Aging, 36*(2), 228-243. doi:10.1177/0164027512475096
- Brown, C. (2001). Focal point on labor support: Pregnancy and labor support for the high-risk woman. *International Journal of Childbirth Education, 16*(2), 24-30.
- Bruggemann, O. M., Parpinelli, M. A., Osis, M. J., Cecatti, J. G., & Neto, A. S. C. (2007). Support to woman by a companion of her choice during childbirth: A randomized controlled trial. *Reprod Health, 4*(5), 1-7.
- Brunson, J. (2010). Confronting maternal mortality, controlling birth in Nepal: The gendered politics of receiving biomedical care at birth. *Social Science & Medicine, 71*(10), 1719-1727.
- Bryanton, J., FRASER-DAVEY, H., & Sullivan, P. (1994). Women's perceptions of nursing support during labor. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 23*(8), 638-644.
- Bryanton, J., Gagnon, A. J., Johnston, C., & Hatem, M. (2008). Predictors of women's perceptions of the childbirth experience. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 37*(1), 24-34.

Buasi, N. O. (2011). *The Implementation of Providing Support in Labour by a Person of the Birthing Woman's Choice at the Port Moresby General Hospital (PMGH) in Papua New Guinea (PNG)* (Doctoral dissertation, University of Technology, Sydney).

Burns, N., & Grove, S. (2009). *The practice of nursing research: Appraisal, Synthesis and Generation of Evidence*. 6th Edition St Louis: Saunders Elsevier,

Burns, N., & Grove, S. (2010). *Understanding nursing research: Building an evidence-based practice*. Elsevier Health Sciences.

Callaghan, P., & Morrissey, J. (1993). Social support and health: A review. *Journal of Advanced Nursing*, 18(2), 203-210.

Callister, L. C. (2004). Making meaning: Women's birth narratives. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 33(4), 508-518.

Callister, L. C., Getmanenko, N., Garvrish, N., Eugenevna, M. O., Vladimirova, Z. N., Lassetter, J., & Turkina, N. (2007). Giving birth: The voices of Russian women. *MCN: The American Journal of Maternal/Child Nursing*, 32(1), 18-24.

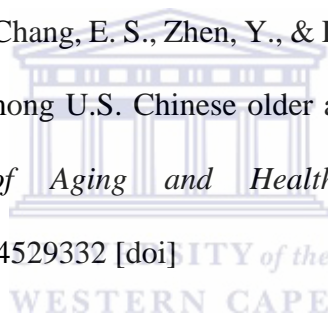
- Campbell, D. A., Lake, M. F., Falk, M., & Backstrand, J. R. (2006). A randomized control trial of continuous support in labor by a lay doula. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35(4), 456-464.
- Campero, L., García, C., Díaz, C., Ortiz, O., Reynoso, S., & Langer, A. (1998). "Alone, I wouldn't have known what to do": A qualitative study on social support during labor and delivery in Mexico. *Social Science & Medicine*, 47(3), 395-403.
- Caplan, G. (1974). *Support systems and community mental health: Lectures on concept development*. Behavioral Publications.
- Caplan, G., Killilea, M., & Abrahams, R. B. (1976). *Support systems and mutual help: Multidisciplinary explorations* Grune & Stratton.
- Caplan, R. D. (1979). Social support, person-environment fit, and coping. *Mental Health and the Economy*, 89-137.
- Carlton, T., Callister, L. C., & Stoneman, E. (2005). Decision making in laboring women: Ethical issues for perinatal nurses. *The Journal of Perinatal & Neonatal Nursing*, 19(2), 145-154.
- Cassel, J. (1976). The contribution of the social environment to host resistance. *American Journal of Epidemiology*, 104(2), 107-123.

Center for Reproductive Rights, Federation of Women Lawyers—Kenya (FIDA), (2008). At risk. Rights violations of HIV-positive women in Kenyan health facilities./http://www.tractionproject.org/sites/default/files/upload/Events/Do-No-Harm/at%20Risk%20hiv%20stigma%20women%20kenya.pdfS.

Center for the Advancement of Health (2012)

Chan, K. K., & Paterson-Brown, S. (2002). How do fathers feel after accompanying their partners in labour and delivery? *Journal of Obstetrics and Gynaecology*, 22(1), 11-15.

Chen, R., Simon, M. A., Chang, E. S., Zhen, Y., & Dong, X. (2014). The perception of social support among U.S. Chinese older adults: Findings from the PINE study. *Journal of Aging and Health*, 26(7), 1137-1154. Doi: 10.1177/0898264314529332 [doi]



Cheung, W., Ip, W., & Chan, D. (2007). Maternal anxiety and feelings of control during labour: A study of Chinese first-time pregnant women. *Midwifery*, 23(2), 123-130.

Chinn, P. L., Kramer, M. K., & Chin, P. L. (2004). *Integrated knowledge development in nursing*. Mosby, St Louis, MO.

Chinn, P., & Kramer, M. (2008). *Integrated theory and knowledge development in nursing*. Mosby Elsevier.

Chou, D., Inoue, M., Mathers, C., Oestergaard, M., Say, L., Mills, S., Wilmoth, J. (2010). Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO UNICEF UNFPA and the World Bank.

Chukuezi, C. (2010). Socio-cultural factors associated with maternal mortality in Nigeria. *Research Journal of Social Sciences*, 1(5), 22-26.

Chunuan, S., Somsap, Y., Pinjaroen, S., Thitimapong, S., Nangham, S., & Ongpalanupat, F. (2010). Effect of the presence of family members, during the first stage of labor, on childbirth outcomes in a provincial hospital in sangha province, Thailand. *Thai Journal of Nursing Research*, 13(1), 16-27.

Cindoglu, D., & Sayan-Cengiz, F. (2010). Medicalization discourse and modernity: Contested meanings over childbirth in contemporary turkey. *Health Care for Women International*, 31(3), 221-243.

Clinical Guideline (2007). Intrapartum Care: Care of Healthy Women and their babies during Childbirth *National Institute for health and Clinical Excellence, London*. <http://guidance.nice.org.uk/CG55/>

Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine*, 38(5), 300-314.

- Cohen, S., & Hoberman, H. M. (1983). Positive events and social supports as buffers of life change stress<sup>1</sup>. *Journal of Applied Social Psychology, 13*(2), 99-125.
- Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98*(2), 310.
- Confidential Enquiries into Maternal Deaths in the United Kingdom. 2001. Why mothers die. Fifth report 1997– 1999. London: RCOG Press.
- Cooker J. and Tahir, F. (2013) Maternal Health in Nigeria: Centre for Strategic and International Studies. Washington D.C.
- Cooper, S. (2005). A rite of involvement: Men's transition to fatherhood. *Durham Anthropology Journal, 13*(2), 1742-2930.
- Corbett, C. A., & Callister, L. C. (2000). Nursing support during labor. *Clinical Nursing Research, 9*(1), 70-83.
- Creswell, J. W. (2009). Research design: Qualitative and mixed methods approaches. *London and Thousand Oaks: Sage Publications,*
- Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches* Sage.

- Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches* Sage publications.
- Creswell, J. W. (2014). *A concise introduction to mixed methods research*. Sage Publications.
- Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.
- Cutrona, C.E., & Russell, D.W. (1990). Type of social support and specific stress: Toward a theory of optimal matching. In B.R. Sarason, I.G. Sarason & G.R. Pierce (Eds.), *Social Support: An interactional view* (pp.319-366). New York: J. Wiley & Sons
- D'Ambruso L (2005). *Midwives Attitudes to Women in Labour in Ghana Accra*, Mikono Publisher
- Daniel, G., Oyetunde, M., & Eleri, G. (2015). Mothers' validation of midwives care in the management of labour pain in Plateau State, Nigeria. *International Journal of Nursing and Midwifery*. Vol. 7;Iss. 1; Pp 1-8
- Davies, B. L., & Hodnett, E. (2002). Labor support: Nurses' Self-Efficacy and views about factors influencing implementation. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 31(1), 48-56.
- Davis-Floyd, R. (2009). *Birth models that work*. University of California Press.



Davis-Floyd, R. E. (2004). *Birth as an American rite of passage: With a new preface* University of California Press.

Davis-Floyd, R., Pigg, S. L., & Cosminsky, S. (2001). Introduction. Daughters of time: The shifting identities of contemporary midwives. *Medical Anthropology*, 20(2–3 and 4), 105–39.

Demographic Health Survey (2008). Countdown on 2015. Maternal, Newborn and Child Survival.

De Oliveira Rodrigues, Ana Áurea Alécio, dos Santos, A. M., & Assis, M. M. A. (2010). Agente comunitário de saúde: Sujeito da prática em saúde bucal em alagoinhas, bahia. *Revista Ciência & Saúde Coletiva*, 15(3)

De Vos, A. S. (2002). *Research at grass roots: For the social sciences and human services professions* Van Schaik.

Devries R, Wiede S, van Teijlingen E & Benoit C.(2001).*Birth by design. Pregnancy, maternity care and midwifery in North America and Europe*.Routledge,London.

eclercq, E. R., Sakala, C., Corry, M. P., & Applebaum, S. (2007). Listening to mothers II: Report of the second national US survey of women's childbearing experiences. *The Journal of Perinatal Education*, 16(4), 9-14.

- Declercq, E., Menacker, F., & MacDorman, M. (2006). Maternal risk profiles and the primary cesarean rate in the United States, 1991-2002. *American Journal of Public Health, 96*(5), 867-872.
- Dellmann, T. (2004). "The best moment of my life": A literature review of fathers' experience of childbirth. *Australian Midwifery, 17*(3), 20-26.
- Dencker, A., Taft, C., Bergqvist, L., Lilja, H., & Berg, M. (2010). Childbirth experience questionnaire (CEQ): Development and evaluation of a multidimensional instrument. *BMC Pregnancy and Childbirth, 10*(1), 1.
- Dewey, J. (1997). *How we think* Courier Corporation.
- Dhakal, S., Van Teijlingen, E., Raja, E. A., & Dhakal, K. B. (2011). Skilled care at birth among rural women in nepal: Practice and challenges. *Journal of Health, Population and Nutrition, 371-378*.
- Dickenson, D. (2002). *Ethical issues in maternal-fetal medicine*. Cambridge University Press.
- Dickoff, J., James, P., & Wiedenbach, E. (1968). Theory in a practice discipline: Part i. practice oriented theory. *Nursing Research, 17*(5), 415-434.
- Dick-Read, G. (2004). *Childbirth without fear: The principles and practice of natural childbirth* Pinter & Martin Publishers.

- Dick-Read, G. (2013). *Childbirth without fear: The principles and practice of natural childbirth* Pinter & Martin Ltd.
- Digest, 2008. Nigerian Women Would Like to Receive Social Support During Childbirth. *International Family Planning Perspectives*, 34 (4).
- Dike, P. (2013). Birth practices of Nigerian women in the UK. *British Journal of Midwifery*, 21(1)
- Dim, C. C., Ikeme, A. C., Ezegwui, H. U., & Nwagha, U. I. (2011). Labor support: An overlooked maternal health need in Enugu, south-eastern Nigeria. *The Journal of Maternal-Fetal & Neonatal Medicine*, 24(3), 471-474.
- Diniz, C. S. G., d'Orsi, E., Domingues, Rosa Maria Soares Madeira, Torres, J. A., Dias, M. A. B., Schneck, C. A., Sandall, Implementation of the presence of companions during hospital admission for childbirth: Data from the birth in brazil national survey . *Cad. Saúde Pública*, 30 (Suppl 1) (2014), pp. S140–S153
- Dodou, H. D., Rodrigues, D. P., Guerreiro, E. M., Guedes, M. V. C., Lago, P. N., & Mesquita, N. S. (2014). The contribution of the companion to the humanization of delivery and birth: Perceptions of puerperal women. *Escola Anna Nery*, 18(2), 262-269.

- Dolan, A., & Coe, C. (2011). Men, masculine identities and childbirth. *Sociology of Health & Illness*, 33(7), 1019-1034.
- d'Oliveira, Ana Flávia Pires Lucas, Diniz, S. G., & Schraiber, L. B. (2002). Violence against women in health-care institutions: An emerging problem. *The Lancet*, 359(9318), 1681-1685.
- Downe, S. (2007). Campaign for normal birth. Trust and expertise. *RCM Midwives: The Official Journal of the Royal College of Midwives*, 10(2), 66.
- Dragonas, T. G. (1992). Greek fathers' participation in labour and care of the infant. *Scandinavian Journal of Caring Sciences*, 6(3), 151-159.
- Draper, H., & Ives, J. (2013). Men's involvement in antenatal care and labour: Rethinking a medical model. *Midwifery*, 29(7), 723-729.
- Draper, J. (1997). Whose welfare in the labour room? A discussion of the increasing trend of fathers' birth attendance. *Midwifery*, 13(3), 132-138.
- 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 support questionnaire. *Midwifery*, 30(7), 847-852.
- Dutta, M. J. (2007). Communicating about culture and health: Theorizing culture-centered and cultural sensitivity approaches. *Communication Theory*, 17(3), 304-328.

- Edewor, P. (2006). Changing perceptions of the value of daughters and girls' education among the isoko of Nigeria. *Union for African Population Studies*, 21(1), 55-70.
- Ehiemere Ijeoma, O., Ada, N., Peace, I., & Akpati, V. (2011). Helpless patients' satisfaction with quality of nursing care in federal tertiary hospitals, Enugu, southeast, Nigeria. *International Journal of Nursing and Midwifery*, 3(1), 6-13.
- Elfeshawy, N. I. M., Elmashad, H. A. M., & El-Nemer, A. M. (2015).R. Feasibility and acceptability of labor companionship at Mansoura university Hospital/Egypt. *Journal of Nursing and Health Science* Volume 4, Issue 5 Ver. III (Sep. - Oct. 2015), PP 39-45
- Eneji, M. A., Juliana, D. V., & Onabe, B. J. (2013). Health care expenditure, health status and national productivity in Nigeria (1999-2012). *Journal of Economics and International Finance*, 5(7), 258.
- Enkin, M., Keirse, M. J., Chalmers, I., & Enkin, E. (2000). *A guide to effective care in pregnancy and childbirth*. Oxford University press Oxford.
- Eriksson, C., Salander, P., & Hamberg, K. (2007). Men's experiences of intense fear related to childbirth investigated in a Swedish qualitative study. *The Journal of Men's Health & Gender*, 4(4), 409-418.

- Erol, R. Y., & Orth, U. (2014). Development of self-esteem and relationship satisfaction in couples: Two longitudinal studies. *Developmental Psychology*, 50(9), 2291.
- Esposito, N. W. (1999). Marginalized women's comparisons of their hospital and freestanding birth center experiences: A contrast of inner-city birthing systems. *Health Care for Women International*, 20(2), 111-126.
- Essex, H. N., & Pickett, K. E. (2008). Mothers without companionship during childbirth: An analysis within the millennium cohort study. *Birth*, 35(4), 266-276.
- Etowa, J. B. (2012). Black women's perceptions of supportive care during childbirth. *International Journal of Childbirth Education*, 27(1)
- Ezeama, M.C., and Ezeamah, I. 2014. Attitude and socio-cultural practice during pregnancy among women in Akinyele LGA.of Oyo State, Nigeria. *Journal of Research in Nursing and Midwifery*. 3 (1): 14-20.
- Ezeama, M., and Ezeamah, F. (2013).Geneva Health Forum. Online. [Accessed October 28, 2014]. Available from: <http://ghf.g2hp.net/2013/07/19/the-use-of-insecticide-treated-nets-among-pregnant-women-in-nigeria/#.VE-j7NhOUIY>

Ezire, O., Adebayo, S. B., Idogho, O., Bamgboye, E. A., & Nwokolo, E. (2015). Determinants of use of insecticide-treated nets among pregnant women in Nigeria. *International Journal of Women's Health*, 7, 655.

Fahy, K. (2007). An Australian history of the subordination of midwifery. *Women and Birth*, 20(1), 25-29.

Fajimbola, T. (2011) 'Abiye Safe Motherhood: A Case of Leadership in Turning the Tide of Maternal Mortality in Nigeria'. *Nigerian Health Journal*, 19.

Federal Ministry of Health and National Primary Health Care Development Agency (2009). Midwives Service Scheme (MSS) MDG-DRGS Funded [www.nphcda.gov.ng](http://www.nphcda.gov.ng)

Federal Ministry of Information (2011). *Cultural Policy in Nigeria*, [www.wgcd.org/policy/clink/Nigeria.html](http://www.wgcd.org/policy/clink/Nigeria.html)

Federal Ministry of Health, Department of Planning and Statistics. Draft: National Child Health Policy.

Feeney, B. C., & Collins, N. L. (2015). A new look at social support: A theoretical perspective on thriving through relationships. *Personality and Social Psychology Review: An Official Journal of the Society for Personality and Social Psychology, Inc*, 19(2), 113-147. Doi: 10.1177/1088868314544222 [doi]

- Fenwick, J., Bayes, S., & Johansson, M. (2012). A qualitative investigation into the pregnancy experiences and childbirth expectations of Australian fathers-to-be. *Sexual & Reproductive Healthcare, 3*(1), 3-9.
- Fenwick, J., Hauck, Y., Downie, J., & Butt, J. (2005). The childbirth expectations of a self-selected cohort of western Australian women. *Midwifery, 21*(1), 23-35.
- Folkman, S., & Moskowitz, J. T. (2004). Coping: Pitfalls and promise. *Annu.Rev.Psychol., 55*, 745-774.
- Frels, R. K., & Onwuegbuzie, A. J. (2013). Administering quantitative instruments with qualitative interviews: A mixed research approach. *Journal of Counseling & Development, 91*(2), 184-194.
- Fujita, N., Perrin, X. R., Vodounon, J. A., Gozo, M. K., Matsumoto, Y., Uchida, S., & Sugiura, Y. (2012). Humanised care and a change in practice in a hospital in Benin. *Midwifery, 28*(4), 481-488.
- Gagnon, A. J., & Waghorn, K. (1996). Supportive care by maternity nurses: A work sampling study in an intrapartum unit. *Birth, 23*(1), 1-6.
- Gale, J., Fothergill-Bourbonnais, F., & Chamberlain, M. (2001). Measuring nursing support during childbirth. *MCN: The American Journal of Maternal/Child Nursing, 26*(5), 264-271.



- Ganster, D. C., & Victor, B. (1988). The impact of social support on mental and physical health. *British Journal of Medical Psychology*, 61(1), 17-36.
- Geissbuehler, V., & Eberhard, J. (2002). Fear of childbirth during pregnancy: A study of more than 8000 pregnant women. *Journal of Psychosomatic Obstetrics & Gynecology*, 23(4), 229-235.
- Gerein, N., Green, A., & Pearson, S. (2006). The implications of shortages of health professionals for maternal health in sub-saharan africa. *Reproductive Health Matters*, 14(27), 40-50.
- Gill, Z., Bailey, P., Waxman, R., & Smith, J. (2005). A tool for assessing 'readiness' in emergency obstetric care: The room-by-room 'walk-through'. *International Journal of Gynecology & Obstetrics*, 89(2), 191-199.
- Gilliland, A. L. (2011). After praise and encouragement: Emotional support strategies used by birth doulas in the USA and Canada. *Midwifery*, 27(4), 525-531.
- Glanz, K., Rimer, B. K., & Viswanath, K. (2008). *Health behavior and health education: Theory, research, and practice*. John Wiley & Sons.
- Glanz, K., Rimer, B. K., & Viswanath, K. (2015). *Health behavior: Theory, research, and practice*. John Wiley & Sons.

- Gottlieb, B. H. (2000). Selecting and planning support interventions. *Social Support Measurement and Intervention: A Guide for Health and Social Scientists*, 195-220.
- Gottlieb, B. H., & Bergen, A. E. (2010). Social support concepts and measures. *Journal of Psychosomatic Research*, 69(5), 511-520.
- Granovetter, M. (1985). Economic action and social structure: The problem of embeddedness. *American Journal of Sociology*, 481-510.
- Green, J., & Thorogood, N. (2004). *Qualitative methods for health research*. SageNew, York,
- Green, J. M., Coupland, V. A., & Kitzinger, J. V. (1990). Expectations, experiences, and psychological outcomes of childbirth: A prospective study of 825 women. *Birth*, 17(1), 15-24.
- Green, J., & Thorogood, N. (2013). *Qualitative methods for health research*. Sage.
- Gribble, J. N. (2003). The standard day's method of family planning: A response to Cairo. *International Family Planning Perspectives*, 29(4), 188-191.
- Grove, S. K., Burns, N., & Gray, J. (2012). *The practice of nursing research: Appraisal, synthesis, and generation of evidence*. Elsevier Health Sciences.

- Grove, S. K., Gray, J. R., & Burns, N. (2014). *Understanding nursing research: Building an evidence-based practice*. Elsevier Health Sciences.
- Guba & Lincoln (1994). The postmodern paradigms that we discussed (postmodernist critical theory and constructivism). *The Landscape of Qualitative Research*, 1, 255.
- Gungor, I., & Beji, N. K. (2007). Effects of fathers' attendance to labor and delivery on the experience of childbirth in turkey. *Western Journal of Nursing Research*, 29(2), 213-231. Doi: 29/2/213 [pii]
- Halldorsdottir, S., & Karlsdottir, S. I. (2011). The primacy of the good midwife in midwifery services: An evolving theory of professionalism in midwifery. *Scandinavian Journal of Caring Sciences*, 25(4), 806-817.
- Halldorsdottir, S., & Karlsdottir, S. I. (2011). The primacy of the good midwife in midwifery services: An evolving theory of professionalism in midwifery. *Scandinavian Journal of Caring Sciences*, 25(4), 806-817.
- Hanna-Leena Melender, R. (2002). Experiences of fears associated with pregnancy and childbirth: A study of 329 pregnant women. *Birth*, 29(2), 101-111.
- Harrison, K. A. (2009). The struggle to reduce high maternal mortality in Nigeria. *African Journal of Reproductive Health*, 13(3)

- Heale, R., & Twycross, A. (2015). Validity and reliability in quantitative studies. *Evidence-Based Nursing, 18*(3), 66-67. Doi: 10.1136/eb-2015-102129 [doi]
- Hill, K., Thomas, K., AbouZahr, C., Walker, N., Say, L., Inoue, M., Maternal Mortality Working Group. (2007). Estimates of maternal mortality worldwide between 1990 and 2005: An assessment of available data. *The Lancet, 370*(9595), 1311-1319.
- Hoberman, Sheldon Cohen<sup>2</sup> Harry. (1983). Positive events and social supports as buffers of life change Stress<sup>1</sup>. *Journal of Applied Social Psychology, 13*(2), 99-125.
- Hodnett, E. (1996). Nursing support of the laboring woman. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 25*(3), 257-264.
- Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2007). Continuous support for women during childbirth (review). *The Cochrane Database of Systematic Reviews, 3*
- Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2013). Continuous support for women during childbirth. *The Cochrane Library,*
- Hodnett, E. D., Gates, S., Hofmeyr, G. J., Sakala, C., & Weston, J. (2013). Continuous support for women during childbirth. *Cochrane Database Syst Rev, 7*(7)

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2003). Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews*, (3), CD003766.

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2007). Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews*, (3), CD003766.

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2005). Continuous support for women during childbirth. *Birth: Issues in Perinatal Care*, 32(1), 72-72. doi:10.1111/j.0730-7659.2005.00336.x

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2012). Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews*, 10, CD003766. doi:10.1002/14651858.CD003766.pub4

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

Hodnett, E. D., Gates, S., Hofmeyr, G. J., Sakala, C., & Weston, J. (2011). Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews*, (2), CD003766. doi:10.1002/14651858.CD003766.pub3

- Hogg, M., & Vaughan, G. (2005). *Social psychology*. Essex: Pearson education limited.
- Holroyd, E., Yin-Icing, L., Pui-yuk, L. W., Kwok-Hong, F. Y., & Shuk-lin, B. L. (1997). Hong Kong Chinese women's perception of support from midwives during labour. *Midwifery*, *13*(2), 66-72.
- Hong, J. S., & Espelage, D. L. (2012). A review of mixed methods research on bullying and peer victimization in school. *Educational Review*, *64*(1), 115-126.
- Hotelling, B. A. (2007). The coalition for improving maternity services: Evidence basis for the ten steps of mother-friendly care. *The Journal of Perinatal Education*, *16*(2), 38-43. Doi: 10.1624/105812407X197744 [doi]
- House, J. S., Umberson, D., & Landis, K. R. (1988). Structures and processes of social support. *Annual Review of Sociology*, 293-318.
- House, J. (1981). Addison-Wesley series on occupational stress: Work stress and social support.
- House, J. S., Landis, K. R., & Umberson, D. (1988). Social relationships and health. *Science (New York, N.Y.)*, *241*(4865), 540-545.
- Howarth, A., Swain, N., & Treharne, G. J. (2011). First-time new Zealand mothers' experience of birth: Importance of relationship and support. *New Zealand College of Midwives Journal*, (45).

Hunter, B., & Segrott, J. (2008). Re-mapping client journeys and professional identities: A review of the literature on clinical pathways. *International Journal of Nursing Studies*, 45(4), 608-625.

Hunter, L. P. (2002). Being with woman: A guiding concept for the care of laboring women. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 31(6), 650-657.

Ige, O. K., Adesanmi, A. A., & Asuzu, M. C. (2011). Hospital-acquired infections in a Nigerian tertiary health facility: An audit of surveillance reports. *Nigerian Medical Journal: Journal of the Nigeria Medical Association*, 52(4), 239-243.  
doi:10.4103/0300-1652.93796

Iliyasu, Z., Abubakar, I. S., Galadanci, H. S., & Aliyu, M. H. (2010). Birth preparedness, complication readiness and fathers' participation in maternity care in a northern Nigerian community. *African Journal of Reproductive Health*, 14(1)

International Confederation of Midwives (ICM), 2008. *Keeping Birth Normal. Positionstatement 6.1d*. The Hague,ICM.

International Confederation of Midwives (ICM) (2011). *Essential competencies for basic midwifery practice*,ICM.

- Ip, W. Y. (2000a). Chinese husbands' presence during labour: A preliminary study in Hong Kong. *International Journal of Nursing Practice*, 6(2), 89-96.
- Ip, W. Y. (2000b). Relationships between partner's support during labour and maternal outcomes. *Journal of Clinical Nursing*, 9(2), 265-272.
- Isola, O. (2013). The Use of Mobile Telephone in Reducing Pre-Natal Maternal Mortality: Case Study of Abiye (Safe Motherhood) Project in Ondo State, Southwest Nigeria. A Paper Presented at the International Conference on Habitele in University Sciences Po, Paris, France; May 28- June 2.
- Jamas, M. T., Hoga, L. A., & Tanaka, A. C. (2011). Mothers' birth care experiences in a Brazilian birth centre. *Midwifery*, 27(5), 693-699.
- Joffe, S., Manocchia, M., Weeks, J. C., & Cleary, P. D. (2003). What do patients value in their hospital care? An empirical perspective on autonomy centred bioethics. *Journal of Medical Ethics*, 29(2), 103-108.
- Johnson, R., & Slade, P. (2002). Does fear of childbirth during pregnancy predict emergency caesarean section? *BJOG: An International Journal of Obstetrics & Gynaecology*, 109(11), 1213-1221.
- 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 & Obstetrics*, 129(3), 223-226.



- Kainz, G., Eliasson, M., & von Post, I. (2010). The child's father, an important person for the mother's well-being during the childbirth: A hermeneutic study. *Health Care for Women International, 31*(7), 621-635.
- Kambala, C., Morse, T., Masangwi, S., & Mitunda, P. (2011). Barriers to maternal health service use in Chikhwawa, southern Malawi. *Malawi Medical Journal, 23*(1)
- Kashanian, M., Javadi, F., & Haghghi, M. M. (2010). Effect of continuous support during labor on duration of labor and rate of cesarean delivery. *International Journal of Gynecology & Obstetrics, 109*(3), 198-200.
- Keirse, M., Enkin, M., Renfrew, M., & Nelson, J. (1995). Pregnancy and childbirth module of the Cochrane database of systematic reviews. London. *BMJ Publishing Group*, UNIVERSITY of the WESTERN CAPE
- Kennell, J., Klaus, M., McGrath, S., Robertson, S., & Hinkley, C. (1991). Continuous emotional support during labor in a US hospital: A randomized controlled trial. *Jama, 265*(17), 2197-2201.
- Kettlei, C., & Perkins, E. (2006). There should be no limit on numbers attending at birth. *Br.J.Midwifery, 12*, 223.
- Kish, L. (1965). Sampling organizations and groups of unequal sizes. *American Sociological Review, 564-572*.

- Klaus, M. (1998). Mother and infant: Early emotional ties. *Pediatrics*, 102(Supplement E1), 1244-1246.
- Klaus, M. H., Kennell, J. H., Robertson, S. S., & Sosa, R. (1986). Effects of social support during parturition on maternal and infant morbidity. *British Medical Journal (Clinical Research Ed.)*, 293(6547), 585-587.
- KNBS, I. (2010). Macro: Kenya demographic and health survey 2008-09. *Calverton, MD: Kenya National Bureau of Statistics and ICF Macro*, 430
- Koblinsky, M., Matthews, Z., Hussein, J., Mavalankar, D., Mridha, M. K., Anwar, I., van Lerberghe, W. (2006). Going to scale with professional skilled care. *The Lancet*, 368(9544), 1377-1386.
- Koniak-Griffin, D. (1993). Maternal role attainment. *Image: The Journal of Nursing Scholarship*, 25(3), 257-262.
- Krause, N. (1986). Social support, stress, and well-being among older adults. *Journal of Gerontology*, 41(4), 512-519.
- Kruk, M. E., Paczkowski, M., Mbaruku, G., de Pinho, H., & Galea, S. (2009). Women's preferences for place of delivery in rural Tanzania: A population-based discrete choice experiment. *American Journal of Public Health*, 99(9), 1666-1672.

Kungwimba, E., Maluwa, A., & Chirwa, E. (2013). Experiences of women with the support they received from their birth companions during labour and delivery in Malawi.

Kwambai, T. K., Dellicour, S., Desai, M., Ameh, C. A., Person, B., Achieng, F., Ter Kuile, F. O. (2013). Perspectives of men on antenatal and delivery care service utilisation in rural western Kenya: A qualitative study. *BMC Pregnancy and Childbirth*, 13(1), 1.

Kyomuhendo, G. B. (2003). Low use of rural maternity services in Uganda: Impact of women's status, traditional beliefs and limited resources. *Reproductive Health Matters*, 11(21), 16-26.

Lakey, B., & Cohen, S. (2000). Social support theory and measurement. *Social Support Measurement and Intervention: A Guide for Health and Social Scientists*, 29-52.

Lakey, B., & Orehek, E. (2011). Relational regulation theory: A new approach to explain the link between perceived social support and mental health. *Psychological Review*, 118(3), 482.

Langer, A., Campero, L., Garcia, C., & Reynoso, S. (1998). Effects of psychosocial support during labour and childbirth on breastfeeding, medical interventions, and mothers' wellbeing in a Mexican public hospital: A randomised clinical

trial. *BJOG: An International Journal of Obstetrics & Gynaecology*, 105(10), 1056-1063.

Langford, C. P. H., Bowsher, J., Maloney, J. P., & Lillis, P. P. (1997). Social support: A conceptual analysis. *Journal of Advanced Nursing*, 25(1), 95-100.

Larkin, P., Begley, C. M., & Devane, D. (2012). 'Not enough people to look after you': An exploration of women's experiences of childbirth in the republic of Ireland. *Midwifery*, 28(1), 98-105.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer publishing company.

Leahy-Warren, P. (2014). Social support theory. *Theories Guiding Nursing Research and Practice: Making Nursing Knowledge Development Explicit*, 85.

Lee, A. C., Lawn, J. E., Cousens, S., Kumar, V., Osrin, D., Bhutta, Z. A., Darmstadt, G. L. (2009). Linking families and facilities for care at birth: What works to avert intrapartum-related deaths? *International Journal of Gynecology & Obstetrics*, 107, S65-S88.

Lee, J., Seong, H. S., Kim, B. J., Jun, J. K., Romero, R., & Yoon, B. H. (2009). Evidence to support that spontaneous preterm labor is adaptive in nature: Neonatal RDS is more common in "indicated" than in "spontaneous" preterm birth. *Journal of Perinatal Medicine*, 37(1), 53-58.

Lee, S. S., Lee, K. A., Rankin, S. H., Alkon, A., & Weiss, S. J. (2005). Acculturation and stress in Chinese-American parents of infants cared for in the intensive care unit. *Advances in Neonatal Care*, 5(6), 315-328.

Lee, M. D., Friedenber, A. S., Mukpo, D. H., Conray, K., Palmisciano, A., & Levy, M. M. (2007). Visiting hours policies in New England intensive care units: Strategies for improvement. *Critical Care Medicine*, 35(2), 497-501. doi:10.1097/01.CCM.0000254338.87182.AC [doi]

Leedy, P., & Ormrod, J. (2001). Practical research: Planning and design (7th edit). Upper saddle river, NJ: Merrill prentice hall.

Leininger, M. (2002). Transcultural nursing and globalization of health care: Importance, focus and historical aspects. *MM Leininger & MR McFarland, Transcultural Nursing: Concepts, Theories, Research, and Practice*, 3-43.

WESTERN CAPE

Leininger, M., & McFarland, M. R. (2002). Transcultural nursing: Concepts, theories, research and practice. *Journal of Transcultural Nursing*, 13(3), 261.

Leininger, M., & McFarland, M. R. (2002). Transcultural nursing: Concepts, theories, research and practice. *Journal of Transcultural Nursing*, 13(3), 261.

Leininger, M. (2002). Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. *Journal of Transcultural*

*Nursing: Official Journal of the Transcultural Nursing Society / Transcultural Nursing Society*, 13(3), 189-92; discussion 200-1.

Lewis, J. A. (2007). A randomized control trial of continuous support in labor by a lay doula. *MCN: The American Journal of Maternal/Child Nursing*, 32(1), 62.

Lichtenstein, S., & Slovic, P. (2006). *The construction of preference* Cambridge University Press.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. (Sage publications: California).

Longman, W., Vaughan, G., & Hogg, M. (1995). *Introduction to social psychology*.

Love O.O. (2013). Experiences of women participating in a safe motherhood (Abiye) project in Ondo state of Nigeria. *Int J Curr Microbiol App Sci*, 2 (12): 148-61

Lund, T. (2012). Combining qualitative and quantitative approaches: Some arguments for mixed methods research. *Scandinavian Journal of Educational Research*, 56(2), 155-165.

Lundgren, I. (2010). Swedish women's experiences of doula support during childbirth. *Midwifery*, 26(2), 173-180.

- Lundgren, I. (2010). Swedish women's experiences of doula support during childbirth. *Midwifery*, 26(2), 173-180.
- Lundgren, I., & Berg, M. (2007). Central concepts in the midwife–woman relationship. *Scandinavian Journal of Caring Sciences*, 21(2), 220-228.
- MacCormack, C. (1996). Birth in four cultures: A Cross-Cultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States. Brigitte Jordan (revised and expanded by Robbie Davis-Floyd). *Medical Anthropology Quarterly*, 10(1), 96-98.
- Madi, B. C., Sandall, J., Bennett, R., & MacLeod, C. (1999). Effects of female relative support in labor: A randomized controlled trial. *Birth*, 26(1), 4-8.
- Mahdi, S. S., & Habib, O. (2010). A study on preference and practices of women regarding place of delivery/Étude portant sur les préférences et les pratiques des femmes quant au lieu d'accouchement. *Eastern Mediterranean Health Journal*, 16(8), 874.
- Maher, J. (2004). Midwife interactions with birth support people in Melbourne, Australia. *Midwifery*, 20(3), 273-280.
- Maimbolwa, M. C., Sikazwe, N., Yamba, B., Diwan, V., & Ransjö-Arvidson, A. (2001). Views on involving a social support person during labor in Zambian maternities. *Journal of Midwifery & Women's Health*, 46(4), 226-234.

- Maimbolwa, M. C., Yamba, B., Diwan, V., & Ransjö-Arvidson, A. (2003). Cultural childbirth practices and beliefs in Zambia. *Journal of Advanced Nursing*, 43(3), 263-274.
- Majiyagbe, J. (2010). Healthy Mothers and Sustainable Development in Africa'. *The Guardian*. September 24
- Manogin, T. W., Bechtel, G. A., & Rami, J. S. (2000). Caring behaviors by nurses: Women's perceptions during childbirth. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 29(2), 153-157.
- Maternal Health in Nigeria Statistical Overview, Global One 2015. Version 30 June 2011. Revised, 17 Aug. 2011. Revised again 26 June 2012.
- Mathole, T., Lindmark, G., Majoko, F., & Ahlberg, B. M. (2004). A qualitative study of women's perspectives of antenatal care in a rural area of Zimbabwe. *Midwifery*, 20(2), 122-132.
- McCourt, C. (2006). Supporting choice and control? Communication and interaction between midwives and women at the antenatal booking visit. *Social Science & Medicine*, 62(6), 1307-1318.
- McCourt, C. (2009). Social support and childbirth. *The Social Context of Birth*, 191-214.



- McCourt, C., & Beake, S. (2001). Using midwifery monitor to assess quality in two maternity care systems. *The Practising Midwife*, 4(2), 23-29.
- 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.
- McNiven, P., Hodnett, E., & O'Brien-Pallas, L. L. (1992). Supporting women in labor: A work sampling study of the activities of labor and delivery nurses. *Birth*, 19(1), 3-8.
- Meleis, A. I. (1985). Theoretical nursing: Development and progress. *AJN the American Journal of Nursing*, 85(12), 1350.
- Meleis, A. I. (2011). *Theoretical nursing: Development and progress*. Lippincott Williams & Wilkins.
- Melender, H. (2002). Fears and coping strategies associated with pregnancy and childbirth in Finland. *Journal of Midwifery & Women's Health*, 47(4), 256-263.
- Melender, H. (2006). What constitutes a good childbirth? A qualitative study of pregnant Finnish women. *Journal of Midwifery & Women's Health*, 51(5), 331-339.

- Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. John Wiley & Sons.
- Meyer, B. A., Arnold, J. A., & Pascali-Bonaro, D. (2001). Social support by doulas during labor and the early postpartum period. *Hospital Physician*, 37(9), 57-63.
- Miller, A. C., & Shriver, T. E. (2012). Women's childbirth preferences and practices in the United States. *Social Science & Medicine*, 75(4), 709-716.
- Mills, S., & Bertrand, J. T. (2005). Use of health professionals for obstetric care in northern Ghana. *Studies in Family Planning*, 36(1), 45-56.
- Misago, C., Kendall, C., Freitas, P., Haneda, K., Silveira, D., Onuki, D., Umenai, T. (2001). From 'culture of dehumanization of childbirth' to 'childbirth as a transformative experience': Changes in five municipalities in north-east Brazil. *International Journal of Gynecology & Obstetrics*, 75, S67-S72.
- Mitchell, I., Evans, L., Rees, T., & Hardy, L. (2014). Stressors, social support, and tests of the buffering hypothesis: Effects on psychological responses of injured athletes. *British Journal of Health Psychology*, 19(3), 486-508.
- Mojekwu, J. N., & Ibekwe, U. (2012). Maternal mortality in Nigeria: Examination of intervention methods. *International Journal of Humanities and Social Science*, 2(20), 135-149.

- Mondiale, B. (2007). Healthy development: The World Bank strategy for health, nutrition, and population results.
- Morhason-Bello, I. O., Adedokun, B. O., Ojengbede, O. A., Olayemi, O., Oladokun, A., & Fabamwo, A. O. (2009). Assessment of the effect of psychosocial support during childbirth in Ibadan, south-west Nigeria: A randomised controlled trial. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 49(2), 145-150.
- Morhason-Bello, I., Olayemi, O., Ojengbede, O., Adedokun, B., Okuyemi, O., & Orji, B. (2008). Attitude and preferences of Nigerian antenatal women to social support during labour. *Journal of Biosocial Science*, 40(4), 553.
- Mosallam, M., Rizk, D. E., Thomas, L., & Ezimokhai, M. (2004). Women's attitudes towards psychosocial support in labour in United Arab Emirates. *Archives of Gynecology and Obstetrics*, 269(3), 181-187.
- Moyer, C. A., Aborigo, R. A., Logonia, G., Affah, G., Rominski, S., Adongo, P. B., Engmann, C. (2012). Clean delivery practices in rural northern Ghana: A qualitative study of community and provider knowledge, attitudes, and beliefs. *BMC Pregnancy and Childbirth*, 12(1), 1.
- Moyer, C. A., Adongo, P. B., Aborigo, R. A., Hodgson, A., & Engmann, C. M. (2014). 'They treat you like you are not a human being': Maltreatment during labour and delivery in rural northern Ghana. *Midwifery*, 30(2), 262-268.

- Moyer, C. A., Adongo, P. B., Aborigo, R. A., Hodgson, A., Engmann, C. M., & DeVries, R. (2014). "It's up to the woman's people": How social factors influence facility-based delivery in rural northern Ghana. *Maternal and Child Health Journal*, 18(1), 109-119.
- Mrisho, M., Obrist, B., Schellenberg, J. A., Haws, R. A., Mushi, A. K., Mshinda, H., Schellenberg, D. (2009). The use of antenatal and postnatal care: Perspectives and experiences of women and health care providers in rural southern Tanzania. *BMC Pregnancy and Childbirth*, 9(1), 1.
- Mullany, B. C. (2006). Barriers to and attitudes towards promoting husbands' involvement in maternal health in Katmandu, Nepal. *Social Science & Medicine*, 62(11), 2798-2809.
- Mullick, S., Kunene, B., & Wanjiru, M. (2005). Involving men in maternity care: Health service delivery issues. *Agenda Special Focus*, 6, 124-135.
- Mumtaz, Z., & Salway, S. (2009). Understanding gendered influences on women's reproductive health in Pakistan: Moving beyond the autonomy paradigm. *Social Science & Medicine*, 68(7), 1349-1356.
- National Bureau of statistics, Nigeria (2010). GeoHive – Nigeria Population Statistics, [www.xist.org](http://www.xist.org) retrieved on 18/09/2010

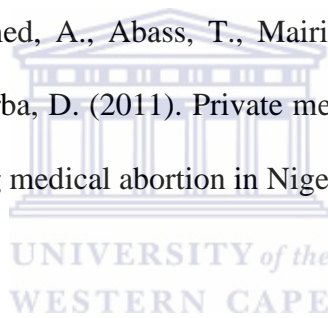
- Natukunda, C. (2007). *Midwifery behaviour and practice. Accra: Mikono Publishers,*
- Nejad, V. (2012). Couples' attitudes to the husband's presence in the delivery room during childbirth. *International Journal of Gynecology & Obstetrics, 119,* S796-S797.
- Newman, B.M. and Newman, P.R. (2009). *Development through life: A psychosocial approach.* Wadsworth Cengage Learning, New York.
- Ngai, F., Chan, S. W., & Holroyd, E. (2011). Chinese primiparous women's experiences of early motherhood: Factors affecting maternal role competence. *Journal of Clinical Nursing, 20(9-10),* 1481-1489.
- Nigeria National Health Conference (2009) Communiqué. Abuja, Nigeria. Available at: <http://www.ngnhc.org>
- Norris, F. H., & Kaniasty, K. (1996). Received and perceived social support in times of stress: A test of the social support deterioration deterrence model. *Journal of Personality and Social Psychology, 71(3),* 498.
- Nwokocha, E. E. (2008). Maternal crises and the role of African men: The case of a Nigerian community. *Afr Popul Stud. 2008, 22 (1):* 31-48.
- Oboro, V. O., Oyeniran, A. O., Akinola, S. E., & Isawumi, A. I. (2011). Attitudes of Nigerian women toward the presence of their husband or partner as a support

person during labor. *International Journal of Gynecology & Obstetrics*, 112(1), 56-58.

Odent, M. (2005). *Birth Reborn: What Childbirth Should Be*. London: Cambridge University Press.

Ogrodniczuk, J. S. (2004). Increasing a partner's understanding of motherhood significantly reduces postnatal distress and depression in first time mothers with low self-esteem. *Evidence-Based Mental Health*, 7(4), 116. Doi: 7/4/116 [pii]

Okonofua, F. E., Hammed, A., Abass, T., Mairiga, A. G., Mohammed, A. B., Adewale, A., & Garba, D. (2011). Private medical providers' knowledge and practices concerning medical abortion in Nigeria. *Studies in Family Planning*, 42(1), 41-50.



Olayemi, O., Bello, F., Aimakhu, C., Obajimi, G., & Adekunle, A. (2009). Male participation in pregnancy and delivery in Nigeria: A survey of antenatal attendees. *Journal of Biosocial Science*, 41(04), 493-503.

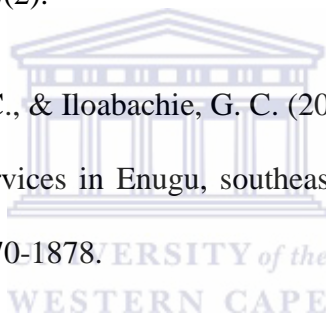
Olde, E., van der Hart, O., Kleber, R. J., van Son, M. J., Wijnen, H. A., & Pop, V. J. (2005). Peritraumatic dissociation and emotions as predictors of PTSD symptoms following childbirth. *Journal of Trauma & Dissociation*, 6(3), 125-142.

Olde, E., van der Hart, O., Kleber, R., & Van Son, M. (2006). Posttraumatic stress following childbirth: A review. *Clinical Psychology Review*, 26(1), 1-16.

Olusegun, O. L., Ibe, R. T., & Micheal, I. M. (2012). Curbing maternal and child mortality: The Nigerian experience. *International Journal of Nursing and Midwifery*, 4(3), 33-39.

Omolase, C., Mahmoud, A., Fadamiro, C., Omolase, B., & Omolade, E. (2009). Millennium development goals: An assessment of awareness and perceptions of attainability by health workers in Owo, Nigeria. *Nigerian Journal of Clinical Practice*, 12(2).

Onah, H. E., Ikeako, L. C., & Iloabachie, G. C. (2006). Factors associated with the use of maternity services in Enugu, southeastern Nigeria. *Social Science & Medicine*, 63(7), 1870-1878.



Onayade, A. A., Akanbi, O. O., Okunola, H. A., Oyeniya, C. F., Togun, O. O., & Sule, S. S. (2010). Birth preparedness and emergency readiness plans of antenatal clinic attendees in Ile-Ife, Nigeria. *The Nigerian Postgraduate Medical Journal*, 17(1), 30-39.

Ondo State Primary Health Care Development Board. OSPHCDB. (2015). AGBEBIYE Initiative in Ondo state. <http://www.osphcdb.org>.

- Ono, M., Matsuyama, A., Karama, M., & Honda, S. (2013). Association between social support and place of delivery: A cross-sectional study in Kericho, western Kenya. *BMC Pregnancy and Childbirth*, 13(1), 1.
- Onumere, O. (2010). Averting maternal mortality in Nigeria. The willnigeria.com.
- Otley, H. (2011). Fear of childbirth: Understanding the causes, impact and treatment. *British Journal of Midwifery*, 19(4).
- Pagel, M. D., Erdly, W. W., & Becker, J. (1987). Social networks: We get by with (and in spite of) a little help from our friends. *Journal of Personality and Social Psychology*, 53(4), 793.
- 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(S1), 19-27.
- Payant, L., Davies, B., Graham, I. D., Peterson, W. E., & Clinch, J. (2008). Nurses' intentions to provide continuous labor support to women. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37(4), 405-414.
- Polit, D., & Beck, C. (2012). Essentials of nursing research. *Ethics*, 23(2).
- Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods* Lippincott Williams & Wilkins.



- Polit, D. F., & Beck, C. T. (2012). *Resource manual for nursing research: Generating and assessing evidence for nursing practice* Wolters Kluwer Health/Lippincott Williams & Wilkins.
- Popoola, O. E., Irinoye, O. O., & Oginni, M. O. (2015). Financing health systems in Nigeria; current trends and prospects. *International Journal of Health Sciences and Research (IJHSR)*, 5(2), 343-353.
- Price, S., Noseworthy, J., & Thornton, J. (2007). Women's experience with social presence during childbirth. *MCN. The American Journal of Maternal Child Nursing*, 32(3), 184-191. doi:10.1097/01.NMC.0000269569.94561.7c [doi]
- Ramashwar, S. (2008). Nigerian women would like to receive social support during childbirth. *International Family Planning Perspectives*, 34(4), 202-203.
- Ratsma, Y. E., & Malongo, J. (2009). Maternal health and human rights. *Malawi Medical Journal*, 21(2).
- Rijnders, M., Baston, H., Schönbeck, Y., Van Der Pal, K., Prins, M., Green, J., & Buitendijk, S. (2008). Perinatal factors related to negative or positive recall of birth experience in women 3 years postpartum in the Netherlands. *Birth*, 35(2), 107-116.

- Rini, C., Schetter, C. D., Hobel, C. J., Glynn, L. M., & Sandman, C. A. (2006). Effective social support: Antecedents and consequences of partner support during pregnancy. *Personal Relationships, 13*(2), 207-229.
- Romano, A. M., & Lothian, J. A. (2008). Promoting, protecting, and supporting normal birth: A look at the evidence. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 37*(1), 94-105.
- Rook, K. S. (1987). Social support versus companionship: Effects on life stress, loneliness, and evaluations by others. *Journal of Personality and Social Psychology, 52*(6), 1132.
- Rook, K. S., & Dooley, D. (1985). Applying social support research: Theoretical problems and future directions. *Journal of Social Issues, 41*(1), 5-28.
- Rosen, P. (2004). Supporting women in labor: Analysis of different types of caregivers. *Journal of Midwifery & Women's Health, 49*(1), 24-31.
- Ross-Davie, M. C. (2012). Measuring the quantity and quality of midwifery support of women during labour and childbirth: the development and testing of the 'Supportive Midwifery in Labour Instrument'. Stirling, Scotland, UK: University of Stirling.

- Rowe, A. K., de Savigny, D., Lanata, C. F., & Victora, C. G. (2005). How can we achieve and maintain high-quality performance of health workers in low-resource settings? *The Lancet*, 366(9490), 1026-1035.
- Royal College of Obstetrics and Gynaecology (RCOG), (2001). *The National Sentinel Caesarean Section Audit Report*, RCOG Press, London.
- Royal College of Obstetricians and Gynecologists (RCOG), (2007). *Safer Childbirth*, RCOG press, London.
- Russell, K. E. (2007). Mad, bad or different? Midwives and normal birth in obstetric led units. *British Journal of Midwifery*, 15(3).
- Ryding, E. L., Persson, A., Onell, C., & Kvist, L. (2003). An evaluation of midwives' counseling of pregnant women in fear of childbirth. *Acta Obstetrica Et Gynecologica Scandinavica*, 82(1), 10-17.
- Sainola-Rodriguez, K. (2009). Transnationaalinen osaaminen. *Uusi Terveystenhooltohenkilöstön Osaamisvaatimus. Kuopion Yliopisto. Yhteiskuntatieteellinen Tiedekunta. Akateeminen Väitöskirja*.
- Saisto, T., & Halmesmäki, E. (2003). Fear of childbirth: A neglected dilemma. *Acta Obstetrica Et Gynecologica Scandinavica*, 82(3), 201-208.

- Saisto, T., Salmela-Aro, K., Nurmi, J., & Halmesmäki, E. (2001). Psychosocial characteristics of women and their partners fearing vaginal childbirth. *BJOG: An International Journal of Obstetrics & Gynaecology*, *108*(5), 492-498.
- Sapkota, S., Kobayashi, T., Kakehashi, M., Baral, G., & Yoshida, I. (2012). In the nepalese context, can a husband's attendance during childbirth help his wife feel more in control of labour? *BMC Pregnancy and Childbirth*, *12*(1), 1.
- Sarason, S. B. (1974). *The psychological sense of community: Prospects for a community psychology*. Jossey-Bass.
- Sauls, D. J. (2002). Effects of labor support on mothers, babies, and birth outcomes. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *31*(6), 733-741.
- Sauls, D. J. (2004a). Adolescents' perception of support during labor. *The Journal of Perinatal Education*, *13*(4), 36-42.
- Sauls, D. J. (2004b). The labor support questionnaire: Development and psychometric analysis. *Journal of Nursing Measurement*, *12*(2), 123-132.
- Sauls, D. J. (2006). Dimensions of professional labor support for intrapartum practice. *Journal of Nursing Scholarship*, *38*(1), 36-41.
- Say, L., & Raine, R. (2007). A systematic review of inequalities in the use of maternal health care in developing countries: Examining the scale of the

problem and the importance of context. *Bulletin of the World Health Organization*, 85(10), 812-819.

Schaefer, C., Coyne, J. C., & Lazarus, R. S. (1981). The health-related functions of social support. *Journal of Behavioral Medicine*, 4(4), 381-406.

Schaffer, M. A., & Lia-Hoagberg, B. (1997). Effects of social support on prenatal care and health behaviors of low-income women. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 26(4), 433-440.

Scherer, K. R. (2005). What are emotions and how can they be measured? *Social Science Information*, 44(4), 695-729.

Schuiling, K. D., & Sampsel, C. M. (1999). Comfort in labor and midwifery art. *Image: The Journal of Nursing Scholarship*, 31(1), 77-81.

Schurink, W., Fouché, C., De Vos, A., De Vos, A., Strydom, H., Fouché, C., & Delpont, C. (2011). Research at grass roots: For the social sciences and human service professions.

Schwandt, T. A. (2015). *The sage dictionary of qualitative inquiry*. Sage Publications.

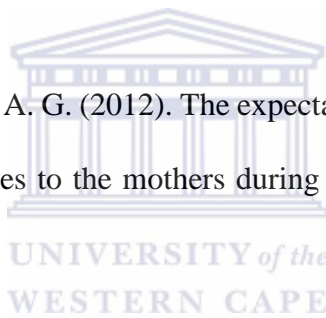
Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the

scientific, interpretive, and critical research paradigms. *English Language Teaching*, 5(9), 9.

Scott, K. D., Berkowitz, G., & Klaus, M. (1999). A comparison of intermittent and continuous support during labor: A meta-analysis. *American Journal of Obstetrics and Gynecology*, 180(5), 1054-1059.

Senanayake, H., Somawardana, U., & Samarasinghe, M. (2014). Effect of a female labour companion and of educating her regarding support during labour on perinatal and labour outcomes. *Sri Lanka Journal of Obstetrics and Gynaecology*, 35(4)

Sengane, M. L., & Nolte, A. G. (2012). The expectations of fathers concerning care provided by midwives to the mothers during labour. *Health SA Gesondheid*, 17(1).



Shaw, S. J., Huebner, C., Armin, J., Orzech, K., & Vivian, J. (2009). The role of culture in health literacy and chronic disease screening and management. *Journal of Immigrant and Minority Health*, 11(6), 460-467.

Shelton, D. (2002). Human rights and environment issues in multilateral treaties adopted between 1991 and 2001. *Joint UNEP-OHCHR Expert Seminar on Human Rights and the Environment*, 14-16.

- Shumaker, S. A., & Brownell, A. (1984). Toward a theory of social support: Closing conceptual gaps. *Journal of Social Issues, 40*(4), 11-36.
- Siedlecki, K. L., Salthouse, T. A., Oishi, S., & Jeswani, S. (2014). The relationship between social support and subjective well-being across age. *Social Indicators Research, 117*(2), 561-576.
- Simbar, M., Nahidi, F., Tehran, F. R., & Ramezankhani, A. (2010). Fathers 'educational needs for perinatal care in urban Iran: A qualitative approach. *Journal of Biosocial Science, 42*(05), 633-641.
- Simkin, P. (2002). Supportive care during labor: A guide for busy nurses. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 31*(6), 721-732.
- Simpson, K. R. (2003). Labor and birth today: Things have changed. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 32*(6), 765-766.
- Simpson, K. R., & James, D. C. (2005). Effects of immediate versus delayed pushing during second-stage labor on fetal well-being: A randomized clinical trial. *Nursing Research, 54*(3), 149-157.
- Singh, A. S., & Masuku, M. B. (2014). Sampling techniques & determination of sample size in applied statistics research: An overview. *International Journal of Economics, Commerce and Management, 2*(11), 1-22.

- Singh, K. K., Bloom, S. S., & Tsui, A. O. (1998). Husbands' reproductive health knowledge, attitudes, and behavior in Uttar Pradesh, India. *Studies in Family Planning*, 388-399.
- Singhal, A. (2015). Focusing on the forest not just the tree: Cultural strategies for combating AIDS. *MICA Communications Review*, 1(1), 21-28.
- Sleutel, M., Schultz, S., & Wyble, K. (2007). Nurses' views of factors that help and hinder their intrapartum care. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 36(3), 203-211.
- Sluzki, C. E. (2010). Personal social networks and health: Conceptual and clinical implications of their reciprocal impact. *Families, Systems, & Health*, 28(1), 1.
- Smith, J. (2011). The 'natural caesarean' technique as inspiration for normalising practice for all types of birth. *Promoting Normal Birth: Research, Reflections & Guidelines (British Edition)*, 210.
- Sofolahan, Y. A., & Airhihenbuwa, C. O. (2013). Cultural expectations and reproductive desires: Experiences of South African women living with HIV/AIDS (WLHA). *Health Care for Women International*, 34(3-4), 263-280.
- Somers-Smith, M. J. (1999). A place for the partner. Expectations and experiences of support during childbirth. *Midwifery*, 15(2), 101-108.



- Sosa, R., Kennell, J., Klaus, M., Robertson, S., & Urrutia, J. (1980). The effect of a supportive companion on perinatal problems, length of labor, and mother-infant interaction. *New England Journal of Medicine*, 303(11), 597-600.
- Spangler, S. A., & Bloom, S. S. (2010). Use of biomedical obstetric care in rural Tanzania: The role of social and material inequalities. *Social Science & Medicine*, 71(4), 760-768.
- Spear, H. J. (2006). Policies and practices for maternal support options during childbirth and breastfeeding initiation after cesarean in southeastern hospitals. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35(5), 634-643.
- Squire, C. (2009). *The social context of birth*. Radcliffe Publishing.
- Stommel, M., & Wills, C. (2004). *Clinical research: Concepts and principles for advanced practice nurses* Lippincott Williams & Wilkins.
- Strydom, H., In de vos, AS, strydom, H., fouché, C.B., & Delport, C.S.L. (2005). *Research at Grass Roots for the Social Sciences and Human Service Professions*,
- Sweidan, M., Mahfoud, Z., & DeJong, J. (2008). Hospital policies and practices concerning normal childbirth in Jordan. *Studies in Family Planning*, 39(1), 59-68.

- Swiatkowska-Freund, M., Kawiak, D., & Preis, K. (2007). Advantages of father's assistance at the delivery. [Pozytywne aspekty obecności ojca przy porodzie] *Ginekologia Polska*, 78(6), 476-478.
- Szeverenyi, P., Poka, R., Hetey, M., & Török, Z. (1998). Contents of childbirth-related fear among couples wishing the partner's presence at delivery. *Journal of Psychosomatic Obstetrics & Gynecology*, 19(1), 38-43.
- Tarkka, M., & Paunonen, M. (1996). Social support and its impact on mothers' experiences of childbirth. *Journal of Advanced Nursing*, 23(1), 70-75.
- Taylor, C., & Gibbs, G. (2010). What is qualitative data analysis (QDA)? *Online QDA Web Site*,
- Taylor, S. E. (2011). Social support: A review. *The Handbook of Health Psychology*, 189-214.
- Teijlingen, E. R., Hundley, V., Rennie, A., Graham, W., & Fitzmaurice, A. (2003). Maternity satisfaction studies and their limitations: "What is, must still be best". *Birth*, 30(2), 75-82.
- Tesch, R. (1990). *Qualitative analysis: Analysis types and software tools* Falmer Press, London.

Teshome, M., Abdella, A., & Kumbi, S. (2007). Parturients' need of continuous labor support in labor wards. *Ethiopian Journal of Health Development*, 21(1), 35-39.

The Center for Health Design (2003). The cost of nosocomial infection. The Center for Health Design: News brief. Retrieved from <http://www.healthdesign.org/news.briefs.html>

The Royal College of Midwives (RCM), (2004). Normal Childbirth position statement, London, RCM. Ref Type: Pamphlet

Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior*, 52(2), 145-161. Doi: 10.1177/0022146510395592 [doi]

Thorpe, K. J., Dragonas, T., & Golding, J. (1992). The effects of psychosocial factors on the emotional well-being of women during pregnancy: A cross-cultural study of Britain and Greece. *Journal of Reproductive and Infant Psychology*, 10(4), 191-204.

Thwala, S. B., Jones, L. K., & Holroyd, E. (2011). Swaziland rural maternal care: Ethnography of the interface of custom and biomedicine. *International Journal of Nursing Practice*, 17(1), 93-101.

- Tilden, V. P., & Galyen, R. D. (1987). Cost and conflict. The darker side of social support. *Western Journal of Nursing Research*, 9(1), 9-18.
- TO, W. Companionship during labour. (2015). Attitudes and expectations of Hong Kong Chinese. *Hong Kong J Gynaecol Obstet Midwifery* 2015; 15(2):124-30
- Trochim, W. M. (2006). The research methods knowledge base, internet WWW page, at URL :<[http://www. socialresearchmethods. Net/kb/](http://www.socialresearchmethods.net/kb/)>
- Tumblin, A., & Simkin, P. (2001). Pregnant women's perceptions of their nurse's role during labor and delivery. *Birth*, 28(1), 52-56.
- Turner, R. J., & Brown, R. L. (2010). Social support and mental health. *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems*, 200-212.
- Uchino, B. N. (2009). Understanding the links between social support and physical health: A life-span perspective with emphasis on the separability of perceived and received support. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science*, 4(3), 236-255. doi:10.1111/j.1745-6924.2009.01122.x [doi]
- Ulrich, R. (2003). Creating a healing environment with evidence-based design. *American Institute of Architects Academy of Architecture for Health Virtual Seminar-Healing Environments*,

- Umeora, J., Ugochukwu, O., Ukkaegbe, C. I., Eze, J. N., & Masekoameng, A. K. (2011). Spousal companionship in labor in an urban facility in south east Nigeria. *Anatolian Journal of Obstetrics & Gynecology*, (2)
- United Nations Fund for Population Activities. (2003). Making safe motherhood a reality in West Africa: Using indicators to programme for results.
- UNFPA, (2011). *The State of World's Midwifery Report: Delivering health, saving life*. United Nations Population Fund, Geneva.
- UNICEF, (2012). The State of the World's Children 2012: Children in an Urban World. United Nations Children's Fund (UNICEF), New York, USA
- UNICEF, (2008). Progress for children: a report card on maternal mortality. Retrieved from [http://www.childinfo.org/files/progress for children maternal mortality. pdf](http://www.childinfo.org/files/progress_for_children_maternal_mortality.pdf)
- United Nations University, (2015). The Yoruba Family. Retrieved from <http://archive.unu.edu/unupress/unupbooks/uu13se/uu13se0e.htm>.
- University of Johannesburg. (2009). *Theory of health promotion in nursing: department of nursing science paradigm*. Auckland Park: University of Johannesburg.
- Vandervoort, D. (1999). Quality of social support in mental and physical health. *Current Psychology*, 18(2), 205-221.

- Venkatesh, V., Brown, S. A., & Bala, H. (2013). Bridging the qualitative-quantitative divide: Guidelines for conducting mixed methods research in information systems. *MIS Quarterly*, 37(1), 21-54.
- Vinokur, A. D., & Van Ryn, M. (1993). Social support and undermining in close relationships: Their independent effects on the mental health of unemployed persons. *Journal of Personality and Social Psychology*, 65(2), 350.
- Wahyuni, D. (2012). The research design maze: Understanding paradigms, cases, methods and methodologies. *Journal of Applied Management Accounting Research*, 10(1), 69-80.
- Waldenström, U. (2004). Why do some women change their opinion about childbirth over time? *Birth*, 31(2), 102-107.
- Waldenström, U., Hildingsson, I., Rubertsson, C., & Rådestad, I. (2004). A negative birth experience: Prevalence and risk factors in a national sample. *Birth*, 31(1), 17-27.
- Walker, L. O., & Avant, K. C. (1988). *Strategies for theory construction in nursing*. Appleton & Lange Norwalk, CT.
- Walker, L. O., & Avant, K. C. (2005). *Strategies for theory construction in nursing*. Appleton & Lange Norwalk, CT

- Weaver, K., & Olson, J. K. (2006). Understanding paradigms used for nursing research. *Journal of Advanced Nursing*, 53(4), 459-469.
- Welch, L, Miller, L.(2008). Emotional and Educational Components of Pregnancy. *Glob. libr.Women's med.*,(ISSN: 1756-2228) 2008; DOI 10.3843/GLOWM.10415
- Welcome, M. O. (2011). The Nigerian health care system: Need for integrating adequate medical intelligence and surveillance systems. *Journal of Pharmacy and Bio allied Sciences*, 3(4), 470.
- Wijma, K., Alehagen, S., & Wijma, B. (2002). Development of the delivery fear scale. *Journal of Psychosomatic Obstetrics & Gynecology*, 23(2), 97-107.
- Williamson, M., & Harrison, L. (2010). Providing culturally appropriate care: A literature review. *International Journal of Nursing Studies*, 47(6), 761-769.
- Wills, T. A., & Ainette, M. G. (2012). 20 social networks and social support. *Handbook of Health Psychology*, 465.
- World Health Organization. (2000). *The world health report 2000: Health systems: Improving performance*. World Health Organization.
- World Health Organization. (2010). Caesarean section without medical indication increases risk of short-term adverse outcomes for mothers: Policy brief.

World Health Organization. (2013). Health systems strengthening glossary. *Geneva: World Health Organization,*

World Health Organization, UNICEF, & United Nations Fund for Population Activities. (2012). *Trends in maternal mortality: 1990 to 2010: WHO, UNICEF, UNFPA, and the World Bank estimates* World Health Organization.

WHO, UNICEF, UNFPA, World Bank, 2012. Trends in Maternal Mortality, 1990–2010. World Health Organization, Geneva

World Health Organization, World Health Report (2005). *Make every mother and childcount.* Geneva, Switzerland: World Health Organization; 2005

WHO (2007). Making Pregnancy Safer: Annual Report 2007 Geneva: World Health Organization.

WHO (2007). Maternal mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and the World bank. Geneva, World Health Organization.

Yuenyong, S., O'Brien, B., & Jirapeet, V. (2012). Effects of labor support from close female relative on labor and maternal satisfaction in a Thai setting. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 41*(1), 45-56.

Zar, M., Wijma, K., & Wijma, B. (2001). Pre-and postpartum fear of childbirth in nulliparous and parous women. *Scandinavian Journal of Behaviour Therapy, 30*(2), 75-84.



Zhang, J., Bernasko, J. W., Leybovich, E., Fahs, M., & Hatch, M. C. (1996). Continuous labor support from labor attendant for primiparous women: A meta-analysis. *Obstetrics & Gynecology*, 88(4, Part 2), 739-744.

Zwelling, E. (2008). The emergence of high-tech birthing. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37(1), 85-93.

Zwelling, E. (2008). The emergence of high-tech birthing. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37(1), 85-93.



ANNEXURE A



UNIVERSITY of the  
WESTERN CAPE

OFFICE OF THE DEAN  
DEPARTMENT OF RESEARCH DEVELOPMENT

05 May 2014

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:  
Mrs OF Ibitoye (School of Nursing)

Research Project: Developing a culturally congruent continuous labour support framework for women in South West, Nigeria.

Registration no: 14/3/15

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink, appearing to read 'Josias'.

*Ms Patricia Josias  
Research Ethics Committee Officer  
University of the Western Cape*

TELEGRAMS.....

TELEPHONE.....



**MINISTRY OF HEALTH**  
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION  
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. ....

All communications should be addressed to

the Honorable Commissioner quoting

Our Ref. No. AD 13/ 479/ 442

7<sup>th</sup> July, 2014

The Principal Investigator,  
University of the Western Cape,  
Faculty of Community and Health Sciences,  
School of Nursing,  
South Africa.

**Attention: Ibitove Olabisi,**  
**Ethical Approval for the Implementation of your Research Proposal in Oyo State**

This acknowledges the receipt of the corrected version of your Research Proposal titled:  
"Developing a Culturally Congruent Continuous Labour Support Framework for Women  
in South West, Nigeria."

2. The committee has noted your compliance with all the ethical concerns raised in the initial review of the proposal. In the light of this, I am pleased to convey to you the approval of committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of the findings as this will help in policy making in the health sector.

4. Wishing you all the best.

Secretary (Dr)  
Director, Planning, Research & Statistics  
Secretary, Oyo State, Research Ethics Review Committee

**ANNEXURE C**

TELEGRAMS.....  
PRIVATE MAIL BAG No. 781



TELEPHONE.....

**HOSPITALS' MANAGEMENT BOARD**  
**AKURE, ONDO STATE, NIGERIA.**

Your Ref. No.....  
All Communications should be addressed  
to the Permanent Secretary quoting

Our Ref No.....G.8061/93.....

Date: 8<sup>th</sup> September, 2014

The Principal Investigator,

“Developing a Culturally Congruent Continuous Labour Support Framework for Women in South West, Nigeria.”

Attention: Mrs. Ibitoye Olabisi

Ethical Approval

The Ethical Review Committee of the Hospitals' Management Board, Akure had critically evaluated your request to conduct a research at some of our secondary health facilities in Ondo State.

I am pleased to inform you that the Committee is satisfied with your study proposal and its instrument. In view of this, you have been granted permission to carry out the study at the health facilities of your choice.

However, you are to adhere strictly to the instrument presented to this Committee without breaching any of the ethical issues discussed with you during the last ethical approval interview held with you on 29<sup>th</sup> August, 2014.

The committee will also monitor the progress and conduct of this research. In addition, you are to forward to this office the important findings and recommendations of this study.

Best regards.

*[Handwritten Signature]*  
Permanent Secretary  
Hospitals Management Board  
P.M.B. 781 Akure

Dr. F.A. Akanbiemu, MBBS (Benin), MPH (Ib.), FWACP (Comm. II)  
(Consultant Community Physician) DPR&S, HMB.  
**For: Permanent Secretary & Chairman HMB Ethical Review Committee**

**CC: All Chief Medical Directors/Medical Directors**

ANNEXURE D



## Mother and Child Hospital, Akure

Fadaka Street, Oke Aro, Akure  
www.ondnstate.gov.ng/mcha2

Your Ref:.....

Our Ref: 20149/1

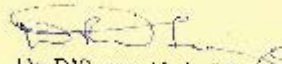
September  
3<sup>rd</sup> 2014

Ms Olabisi Fatima Ibitayo  
School of Nursing  
Faculty of Community & Health Sciences  
University of Western Cape  
South Africa

### Re: Research & Ethical Clearance

At the meeting of the Research & Ethic committee, your application to carry out research on the "Developing on culturally congruent continuous labour support frame work for women in south west Nigeria was deliberated on.

I am pleased to inform you that the committee has approved your application. Please submit a copy of your completed project to this committee.

  
Dr. D'Souza-Akeju DP

Chairman  
Research & Ethics Committee

## ANNEXURE E



### UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa  
Tel: +27 21-9593303 Fax: 27 21-9592679  
E-mail: bisitoye04@yahoo.co.uk

#### INFORMATION SHEET

**Project Title: Developing a Culturally Congruent Continuous Labour Support Framework for women in South West, Nigeria**

##### **What is this study about?**

This is a research project being conducted by Ibitoye Olabisi Fatimo, a postgraduate student of University of the Western Cape to develop a culturally congruent continuous labour support framework for women during childbirth in Nigeria. We are inviting you to participate in this research project because you are a user/ provider/ policymaker of maternal health care services in Ondo state. The purpose of this research project is to explore the perception of stakeholders (antenatal women, midwives and policy maker) to Continuous Labour Support by person from woman social network in public maternity health facilities in Ondo state. The information that would be gathered will be used to develop culturally congruent continuous labour support framework for women during childbirth. The broad aim is to provide cultural competent maternal health care that will enhance skilled birth attendance in order to reduce maternal mortality in Nigeria.

##### **What will I be asked to do if I agree to participate?**

You will be asked to respond to question items in the questionnaire and/or participate in an interactive group discussion, which will involve 10 midwives in a group. The filling of the questionnaire will last about 10 minutes, while discussion session will last 20 to 30 minutes. The questionnaire is to assess attitude and preference of women to continuous labour support while the focus group discussion is to assess midwives perception and attitude to continuous labour support by person from woman social network in public hospitals.

##### **Would my participation in this study be kept confidential?**

We will do our best to keep your personal information confidential. To help protect your confidentiality, your name and name of the facility you are going to talk about will not be required.

This research project involves making *audiotapes/videotapes/photographs* of you, if you are participating in FGDs. The purpose of these recording media is to help the researcher to remember all useful information that may be lost, if only writing which may be very slow sometimes is used for documentation. Only the researcher and research Supervisor will have access to them. They will be stored in a folder and kept under lock and key in a cabinet. All will be destroyed after using them for transcription and report writing.

Audiotapes and videotapes will not be play for any other person apart from the researcher who will use it for transcription and reporting.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

**ANNEXURE F**



**UNIVERSITY OF THE WESTERN CAPE**

Private Bag X 17, Bellville 7535, South Africa  
Tel: +27 21-9593303 Fax: 27 21-9592679  
E-mail: bisitoye04@yahoo.co.uk

**CONSENT FORM**

**Title of Research Project: Developing a Culturally Congruent Continuous Labour Support Framework  
for women during childbirth in Nigeria**

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name: .....

Participant's signature: .....

Witness' name: .....

Witness' signature: .....

Date: .....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

**Study Coordinator's Name: Professor Rene Phetlhu**

**University of the Western Cape**

**Private bag X17, Belleville 7535**

**Telephone : (021)9593303**

**Email: dphetlhu@uwc.ac.za**

ANNEXURE G



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa  
Tel: +27 21-9593303 Fax: 27 21-9592679  
E-mail: bisitoye04@yahoo.co.uk

FOCUS GROUP CONFIDENTIALITY BINDING FORM

**Title of Research Project:** Developing a Culturally Congruent Continuous Labour Support Framework for women in South West, Nigeria

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I also agree to be audio-taped during my participation in the study. I agree not to disclose any information that was discussed during the group discussion.

**Audio taping/Videotaping/Digital Recordings**

This research project involves making *audiotapes/videotapes* of you. The purpose of these recording media is to help the researcher to remember all useful information necessary for the study for data analysis. Audiotapes and videotapes will only be accessible to the research and the supervisor for transcription and report writing. Articles written from the report will never reveal personal identity of the participants. Data collected will be protected under lock and key in a cabinet and will be discarded after five years.

I agree to be [videotape/audiotape] during my participation in this study.

I do not agree to be [videotape/audiotape] during my participation in this study.

Participant's name: .....

Participant's signature: .....

Witness's name: .....

Witness's signature: .....

Date: .....



ANNEXURE H



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa  
Tel: +27 21-9593303 Fax: 27 21-9592679  
E-mail: bisitoye04@yahoo.co.uk

EXPERT REVIEW AGREEMENT FORM

Title of Research Project: Developing a Culturally Congruent Continuous Labour Support Framework for women in South West, Nigeria

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I also agree to be audio-taped during my participation in the study. I agree not to disclose any information that was discussed during the group discussion.

Audio taping/Videotaping/Digital Recordings

This research project involves making *audiotapes/videotapes* of you. The purpose of these recording media is to help the researcher to remember all useful information necessary for the study for data analysis. Audiotapes and videotapes will only be accessible to the research and the supervisor for transcription and report writing. Articles written from the report will never reveal personal identity of the participants. Data collected will be protected under lock and key in a cabinet and will be discarded after five years.

I agree to be [videotape/audiotape] during my participation in this study.

I do not agree to be [videotape/audiotape] during my participation in this study.

Participant's name: .....

Participant's signature: .....

Witness's name: .....

Witness's signature: .....

Date: .....

ANNEXURE I



QUESTIONNAIRE

Number \_\_\_\_\_

**PERCEPTION, ATTITUDE AND PREFERENCE OF WOMEN TO CONTINUOUS LABOUR SUPPORT DURING CHILDBIRTH**

Dear Participants,

I am a PhD student of the University of the Western Cape, South Africa and I humbly invite you to partake in this exercise. I am conducting a study on the topic: Developing a Culturally Congruent Continuous Labour Support Framework for women in South West, Nigeria.

The purpose of this questionnaire is to evaluate the perception, attitude and preference of women to Continuous Labour Support during childbirth for the framework development. I will be grateful if you take 10- 15 minutes of your time to answer the questions in this survey instrument. While your co – operation in completing this questionnaire is valued, your participation is voluntary and can therefore withdraw from it anytime you feel like doing so.

The result will only be used in an aggregate form and therefore your anonymity and confidentiality of your responses are assured. The completed questionnaires will be stored and will be available only to the researcher.

Your participation is appreciated.

For further inquiry, contact me on +2347061683769 Or +2348058023991 or email: bisitoye04@yahoo.co.uk

Thank you in anticipation of your co-operation

Yours Faithfully

Ibitoye Olabisi Fatimo

**SECTION A: BIOGRAPHICAL & DEMOGRAPHICAL INFORMATION**

1. Age at last birthday .....
2. How many children do you have.....
3. Marital Status
 

|                                      |                                       |
|--------------------------------------|---------------------------------------|
| 1. Married <input type="checkbox"/>  | 2. Single <input type="checkbox"/>    |
| 3. Divorced <input type="checkbox"/> | 4. Separated <input type="checkbox"/> |
4. Educational status
 

|   |                                      |
|---|--------------------------------------|
| 1. Never attended school <input type="checkbox"/> | 2. Primary <input type="checkbox"/>  |
| 3. Secondary <input type="checkbox"/>             | 4. Tertiary <input type="checkbox"/> |
5. Other (specify) .....
5. Ethnicity
 

|                                    |                                   |
|------------------------------------|-----------------------------------|
| 1. Yoruba <input type="checkbox"/> | 2. Hausa <input type="checkbox"/> |
| 3. Igbo <input type="checkbox"/>   | 4. Others specify .....           |
6. Religion
 

|                |                         |
|----------------|-------------------------|
| 1. Christian   | 2. Islam                |
| 3. Traditional | 4. Other (specify)..... |

## ANNEXURE J



### IWE ASEBERE

#### IWOYE, IHUWASI ATI IFE TI AWON OBIRIN NI SI KI ELOMIRAN WA PELU WON LATI S'ATILEHIN NI GBOGBO AKOKO IROBI NI IGBA IBIMO

**Olukopa Owon,**

Mo je akeko ti o fe gba oye keta ni ile eko giga Yunifasiti Western Cape, ni orile-ede Gusu (South) Afrika. Nitori naa, mo fi irele ro yin lati kopa ninu ise iwadii yi. Mo nse iwadii ti o da lori akori yii "Sise Agbende ilana fun oluranlowo, aladuroti ati alatihin obirin ni gbogbo akoko irobi ati ibimo l'ona ti o ba asa mu ni Iwo-oorun-Gusu Naijiria". Ete ibeere yi ni lati se agbeyewo iwoye, ihuwasi ati ife ti awon obirin ni si atilehin igbadeegba ni akoko irobi ki a baa le se amulo re lati gbe ilana kale.

Inu mi yoo dun ti e ba le lo iseju meedogun si ogun iseju ninu akoko yin lati dahun awon ibeere wonyi. Bi a se gbe ifowosowopo yin laruge ni didadhun awon ibeere wonyi, ikopa yin gbudo wa lati inu kan yin wa,, e ni anfaani lati y'owo kuro ni igbakugba ti o ba wu yin.

Amulo esi iwadii yi yoo je akojopo idahun gbogbo awon akopa, nitori naa, gbogbo idahun yin ni a o se ni oro asiri ti enikeniki ko ni ni anfaani lati mo idahun olonjori. Awon ibeere ti e ba ti dahun ni kikun ni yoo wa ni ipamo ti yoo si wa fun imulo oluwadi nikan.

A mo riri ikopa yin ninu iwadii yi.

Ti e ba ni ibeere ti o da lori iwadii yi, e temi laago lori noomba yii: +2347061683769 tabi +2348058023991 tabi ki e fiwe sowo simi lori atejise: [bisitoye04@yahoo.co.uk](mailto:bisitoye04@yahoo.co.uk)

E se, a o maa fojusona fun ifowosowopo yin.

Emi ni tiyin ni tooto,

**Ibitoye Olabisi Fatimo**

#### ISORI A: APEJUWE ATI IGBESI AYE ARA ENI L'AWUJO

1. Omo odun melo ni o je ni ojo ibi re ti o koja .....
2. Omo melo ni Olorun fit a o lore?: .....
3. Ipo ti igbeyawo re wa:
  1. Abileko [ ]
  2. Omidan [ ]
  3. Opo [ ]
  4. Dalemosu [ ]

## ANNEXURE K

### Focused Group Discussion Guide

#### Major Questions

1. Can you please give a short profile of yourself (Professional status, place of work, current position etc)?
2. Do your Facility/Institution allow Continuous Labour Support person to stay with women in the labour room/suite from the beginning of labour to the end?
3. if No ,why has your institution never introduced Continuous Labour Support Concept into the labour ward/suit?
4. There have been strong empirical evidences that allowing a woman in labour to have preferred person to offer non medical Continuous Labour Support care in the labour room from the beginning of labour till the end promote better birth outcomes and experience. What do you think about this concept?
5. What do you think about introducing Continuous Labour Support person of a woman's choice to stay with a woman and provide support from the beginning of labour to the end
6. What do you think should be put in place in the hospital for the concept to work
7. In your own view what are the possible challenges that we might face if we are to introduce Continuous Labour Support concept in government hospital.
8. If we are to introduce Continuous Labour Support person for women in labour in our facilities, what are your suggestion in terms of modalities to use.

**Thank you for participating in this research**

ANNEXURE L



**UNIVERSITY OF THE WESTERN CAPE**

Private Bag X 17, Bellville 7535, South Africa  
Tel: +27 21-9593303 Fax: 27 21-9592679  
E-mail: [bisitoye04@yahoo.co.uk](mailto:bisitoye04@yahoo.co.uk)

17<sup>th</sup> August 2015

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STAKEHOLDER/ EXPERT REVIEW MEETING**

I humbly invite you as a stakeholder in maternal and child health care in Ondo State to be part of expert review for the data collected toward the development of a culturally congruent continuous labour support framework for women during childbirth in South West Nigeria.

**Date:** 27<sup>th</sup> August 2015  
**Venue:** Nurses' house, Igbatoro road Akure, Ondo State  
**Time:** 10am prompt

Your participation is highly essential, please notify on or before 21<sup>st</sup> August, 2015 your acknowledgment of participation

Thank you for usual cooperation.

**Ibitoye Olabisi Fatimo**  
[bisitoye04@yahoo.co.uk](mailto:bisitoye04@yahoo.co.uk)  
08058023991 / 07061683769

## ANNEXURE M

**STAKEHOLDER/EXPERT REVIEW ON DEVELOPMENT OF A CULTURALLY  
CONGRUENT CONTINUOUS LABOUR SUPPORT FRAMEWORK FOR WOMEN  
DURING CHILDBIRTH IN SOUTH WEST NIGERIA AT NURSES HOUSE  
IGBATORO ROAD, AKURE**

**PARTICIPANT'S BIODATA**

1. Age at last birthday \_\_\_\_\_
2. Gender: Male [  ] Female [  ]
3. Ethnicity: \_\_\_\_\_
4. Religion: \_\_\_\_\_
5. Profession : \_\_\_\_\_
6. Highest Academic Qualification \_\_\_\_\_
7. Present Rank: \_\_\_\_\_
8. Area of Practice: \_\_\_\_\_
9. Position: \_\_\_\_\_



## ANNEXURE N

**STAKEHOLDER/ EXPERT REVIEW ON DEVELOPMENT OF A CULTURALLY  
CONGRUENT CONTINUOUS LABOUR SUPPORT FRAMEWORK FOR WOMEN  
DURING CHILDBIRTH IN SOUTH WEST NIGERIA AT NURSES HOUSE  
IGBATORO ROAD ON 27<sup>TH</sup> AUGUST 2015**

**Agenda**

1. Opening prayer
2. Introduction
3. Review of the study
4. Agreement
5. Concept identification and classification
6. Discussion
7. Refreshment
8. Vote of thanks
9. Closing prayer



**STAKEHOLDER/ EXPERT REVIEW ON DEVELOPMENT OF A CULTURALLY  
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9. Closing prayer

**ANNEXURE O**



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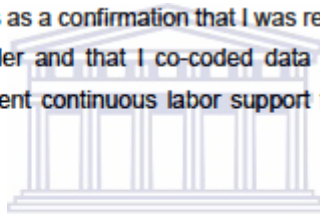
Fax: +2786 621-4308

Web: <http://www.nwu.ac.za>

11 July 2015

To whom it may concern:

This letter serves as a confirmation that I was requested by Mrs Ibitoye Olabisi Fatimo to act as co-coder and that I co-coded data collected in the study "Developing a culturally congruent continuous labor support framework for women in South West Nigeria"



Yours sincerely

UNIVERSITY of the  
WESTERN CAPE

Mr. Leepile Alfred Sehularo (PhD Candidate)

Lecturer: Psychiatry/Mental Health Nursing Science

Tel: 0183892642 Cell: 0603470183

A handwritten signature in black ink, appearing to read 'L. Sehularo'.



## ANNEXURE P

(MA Applied Linguistics, University of Durban)

Academic Editing

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✉ llesley.watsoncushman@yahoo.com

26 May 2016

TO WHOM IT MAY CONCERN

This statement serves to confirm that I edited the doctoral thesis of Ms Olabisi Fatimo Ibitoye (Student number: 3315132), submitted for the degree of Doctor Philosophiae in the School of Nursing, University of the Western Cape.

Title of Thesis

DEVELOPING A CULTURALLY CONGRUENT CONTINUOUS LABOUR SUPPORT FRAMEWORK FOR WOMEN IN SOUTH-WEST NIGERIA

Editing and further comment were completed between 13 and 29 May 2016.

Yours faithfully  
Mrs L Cushman

