Women and Continuous Labour Support in Public Health Facilities in Nigeria

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Abstract

Childbirth is a multifaceted process that is influenced by several factors resulting in an unsatisfactory or satisfactory childbirth experience. Continuous labour support (CLS) has been identified as a positive contributor to a satisfactory birthing experience, and consequently positive maternal health outcomes. The World Health Organization recommended the right of a pregnant woman to have a companion of her choice during labour, but CLS practice remains a mirage in Nigerian hospitals. This descriptive cross-sectional study explores the perceptions, attitudes and preferences of 368 randomly selected women regarding CLS in public hospitals in South West Nigeria. Data were collected using a pretested questionnaire developed from the literature review and analysed with descriptive and inferential statistics using SPSS Version 20. The findings revealed that the participants perceived support from midwives during labour as inadequate but that they were satisfied with professional care at birth. The participants perceived the inclusion of a familiar person for support as beneficial and expressed positive disposition to the introduction of persons from their social network for labour support in public health facilities. The preference for husbands and mothers as labour support persons was higher among the study participants.

Keywords: continuous labour support; perception; attitude; preference

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Introduction and Background Information

Worldwide, women share a common need and desire for continuous therapeutic support in labour (Mahdi and Habib 2010, 874). Historically and transculturally, childbirth usually took place at homes 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 and is associated with a positive childbirth experience. However, with the shift of childbirth from the home to the hospital, the valued traditional childbirth practice has been subsumed by technological interventions (Hodnett et al. 2013, 7). 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, 2). With the depersonalisation of women's birth experiences in hospitals, women have rediscovered the value of additional support during childbirth (Hodnett et al. 2012, 2).

According to Lundgren and Berg (2007, 220), 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 et al. 2011, 4). CLS refers to the provision of non-medical continuous support such as physical comfort, emotional support, instructional information and advocacy to a woman in labour from shortly after admission to the hospital to the birth of the child without interruption, except for toileting (Hodnett et al. 2011, 3). 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 healthcare providers (Ngai, Chan, and Holroyd 2011, 1482).

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. 2012, 3, Rosen 2004, 24). Based on the overwhelming benefits of CLS and the endorsement of the World Health Organization, a parturient woman should be allowed to have a birth companion she trusts and with whom she feels at ease (WHO 2009 cited in Sapkota et al. 2012, 2). 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. CLS has been the exception rather than routine for women attending medical facilities to give birth in developing countries especially in Nigeria with the worst maternal and child health indices, and limited health resources (Banda et al. 2010, 937; Bruggemann et al. 2007, 2; Hodnett 2013, 7; Morhason-Bello et al. 2008, 554).

Research Problem

Nigeria constitutes just 1 per cent of the world population but ranks second after India on the maternal mortality scale with the rate of 800 deaths per 100 000 live births, and thus accounts for 10 per cent of the world's maternal mortality (Olusegun, Ibe, and Micheal 2012, 34). The Nigeria Demographic and Health Survey 2008 (DHS) (Nigeria 2009) reported that about 62 per cent of deliveries take place at home, 15 per cent at private health facilities while less than 20 per cent of women deliver their babies in public health facilities. In addition to the direct causes of maternal mortality such as puerperal sepsis, abortion complications, pre-eclampsia or 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 have been linked to maternal mortality. Implementation of CLS from a woman's social network has been argued to be significant to the improvement of the utilisation of maternal and child healthcare services 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 several women familiar to her, who could be involved in the delivery (Hodnett 2011, 3).

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 et al. 2011, 472; Morhason–Bello et al. 2008, 554). Despite documented benefits of CLS to women's experience of labour and outcomes, its practice has remained an exception rather than the rule in Nigeria especially at public health facilities (Hodnett 2013, 7; Sapkota et al. 2012, 2).

Purpose of the Study

The purpose of the study was to assess Nigerian women's perceptions, attitudes and preferences regarding CLS from their social network in a public health facility.

Methodology

Design

A descriptive cross-sectional study design was adopted to assess the women's perceptions, attitudes and preferences regarding CLS from their social network in selected public health facilities.

Population and Sample

The total calculated sample was 382 antenatal women. Antenatal care (ANC) registers were used as a proportional sampling frame to select eligible participants in the hospitals for the study. An eligibility criterion was that a woman should have at least one delivery experience; first-time pregnant women and those unwilling to participate in the study

were excluded. One out of every three eligible women was randomly selected to fill the questionnaire with an average of 15 women of the sample per clinic day (Tuesdays and Thursdays).

Data Collection

Data were collected through an adapted questionnaire from the Bryanton Adaptation of the Nursing Support in Labor Questionnaire (BANSILQ) and other instruments used in previous studies. The instrument was pretested with 30 pregnant women at an ANC clinic in another state. Grammatical errors were corrected, some items were broken into simpler sentences and additional options were added to some items. The validity of the instrument was ensured through a comprehensive related literature review and expert opinion. Back-to-back translation from English to Yoruba was done for illiterate participants. The Cronbach's alpha coefficient of the instrument yielded $r = 0.85$ indicating a high internal consistency according to Burns and Grove (2010). Data were collected by the principal investigator and two research assistants between January and April 2015.

Data Analysis

The completed questionnaires were entered into the Statistical Package for Social Sciences (SPSS) version 20 software daily with a saved copy on an external hard drive. About 14 incomplete questionnaires were discarded leaving only 368 for analysis. Descriptive and inferential statistics were done using SPSS version 20. The chi-square and a binary logistic regression were used to test for associations and predictors of preference for continuous support, with the level of significance set at $p < 0.05$.

Ethical Considerations

Ethical approval was granted by the Research Ethical Review Committees of the University of the Western Cape and the facilities used. Written and verbal consent was obtained from the participants after detailed explanation of the purpose of the study in English and local dialects. Basic ethical principles of respect for autonomy, justice, beneficence and non-maleficence were valued, and the anonymity, privacy and confidentiality of the participants were also maintained.

Research Results

Socio-demographic Characteristics of Respondents

The respondents' mean age was 31 years with the oldest respondent older than 46 years and the youngest respondent younger than 26 years. Most of the respondents were married; 96.7 per cent (n = 356). A total of 46.2 per cent (n = 170) of the respondents had a tertiary level of education, followed by 40.2 per cent (n = 148) with a secondary level of education.

Table 1 gives details of the demographic characteristics of the respondents in relation to their CLS preference.

Table 1: Socio-demographic characteristics of respondents

	Preference for CLS		*Total N = 368*	X^2	*P-value*
	Yes n (%)	*No n (%)*			
Age in years					
≤ 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		
Level of education					
No formal education	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		
Ethnicity					
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		
Religion					
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		
Number of children					
1	97 (76.5)	35 (26.5)	132	0.5	0.783
2	94 (77.0)	28 (23.0)	122		
> 2	87 (76.3)	27 (23.7)	114		

* The Hausa in Edo State who speak Egbira.

Perceived Support Received from Midwives during the Last Delivery

The perceived support from midwives was measured by the physical comfort measure, emotional support, instruction information and advocacy. Physical comfort measures were rated slightly above average while emotional, instructional and advocacy support were rated below average. The mean score for the physical comfort measure was 19.37 ± 10.20 followed by emotional support (7.47 ± 6.31), while instruction and information support was 6.68 ± 7.57, and advocacy support was 2.56 ± 3.26. Therefore, the mothers perceived the highest level of supportive care only on physical support while emotional, instructional information and advocacy support was low. Association

between satisfaction with support provided by midwives and the preference for CLS revealed that a higher proportion of respondents who were satisfied had a preference for CLS, compared with those who were not satisfied. However, the association was not statistically significant (p = 0.669). See Table 2.

Table 2: Perceived support and preference for CLS

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

Perceptions of Respondents of CLS from Social Network

Most of the respondents, n = 274, felt that a family member can serve as CLS person and wanted public health facilities to allow such practice. See Table 3.

Table 3: Perceptions of women of CLS from social network

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

Attitude of Respondents to CLS

The attitude of the respondents to CLS showed a positive attitude to CLS from a family member, 92.9 per cent (n = 342) 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. This implies that their attitude to CLS was largely dependent on how they viewed the supportive role of the familiar person in the public hospital during the birthing period. The preference for a husband, mother and mother-in-law was higher in this study. See Table 4.

Table 4: Preference of CLS person among respondents

	Frequency n = 368	*Percentage (%)*
Preferred CLS from familiar person		
Yes	278	75.5
No	90	24.5
Preferred person for CLS		
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
Neighbours	4	1.1

Discussion of Research Findings

The mean age for the study population, n = 638, was 30.1 ± 5.1 years with the majority younger than 35 years of age. None of the socio-demographic data showed a statistical significance. A higher proportion (80.0%) of the respondents in the age group ≤ 25 years preferred 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 preferred CLS compared to 64.1 per cent of those who had primary, secondary (73.6%) and tertiary (78.2%) education, p = 0.06. A slightly higher proportion (76.9%) of the respondents from other ethnic groups such as the Hausa and Edo preferred CLS compared to the Yoruba (76.6%) and Igbo (65.7%), p = 0.364. A higher proportion (76.4%) of the 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 preferred CLS compared to those with one child (73.5%) and more than two children (76.3%).

This study report signposted a higher preference for CLS among the younger group of the respondents and those with no formal education which might be connected with a fear of the hospital environment fuelled by rampant reports of the negative attitudes of health workers. They might feel that their youthfulness and lack of formal education predispose them to ill treatment when they are on their own. However, previous studies on the influence of characteristics of respondents on social support revealed a significant preference for labour support among unmarried women of an older age with a higher level of education and lower income (Morhason-Bello et al. 2008, 554; Teshome, Abdella, and Kumbi 2007, 38).

Perceptions of CLS among the Respondents

Women's perceptions of CLS and their opinion regarding the need to introduce it in public health facilities were based on their perceived support and satisfaction derived from midwives' care during previous deliveries.

The perceptions of a woman regarding support during labour can enhance her coping efforts and positive feelings about her labour experience (McCourt 2009, 193; Tarkka and Paunonen 1996, 72). Individual needs of support during labour differ depending on factors guiding cultural and societal norms, as well as personal circumstances and preferences (McCourt 2009, 193). This is similar to what was reported in previous studies (Banda et al. 2010, 938; Maimbolwa et al. 2001, 230; Maimbolwa et al. 2003, 273) on the significance of social network support during childbirth. 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 and the majority felt that the hospital should allow a woman to have a familiar person for support during labour.

Likewise, previous descriptive studies of women's experiences during childbirth suggested four major areas in which women can receive support during labour. These are the emotional, informational, physical, and advocacy areas (Alexander et al. 2003, 215). The findings of this study showed that more than half of the respondents received physical support such as assistance in bathing (60.3%), changing of clothes or gowns (60.3%), holding hands (60.3%), assisting with walking to the bath or toilet (60.3%), back massaging (59.5%), and therapeutic touching (57.9%) compared to a lower proportion (19.8%) of women in a Jos study who received physical support such as massage from midwives during labour (Daniel, Oyetunde, and Eleri 2015, 6). These techniques are meant to reduce painful stimuli and to help the women manage pain during labour. The low proportion of the 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 and midwives may not be available to offer such services for all women in labour.

Morhason-Bello et al. (2008, 553) 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 for their verbalisation 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 this study and a similar study in Malawi described emotional support from family birth companions as useful and beneficial to their birth experience (Kungwimba et al. 2013, 46). The inability of the midwives to provide emotional support may be attributed

to the busy schedule and shortage of staff as reported in a study conducted in Papua New Guinea, north of Australia (Buasi 2011, 94).

Pregnant women and their families require basic, accurate, science-based instructions or 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 (Iravani et al. 2015, 31). 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 the respondents were not given instructions or information on breathing exercises and bearing down, hospital routines, 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 the level of pain experienced by women during childbirth (Kungwimba et al. 2013, 46).

Advocacy for 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, 412). When advocating for the woman in labour, the nurses or midwives must convey respect, acknowledge her expectations, and resolve conflict (Adams and Bianchi 2008, 106). In corroboration with a previous study in Nigeria (Daniel, Oyetunde, and Eleri 2015, 4), 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 deal with the main causes of maternal mortality (WHO 2009). 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 owing to their attitude to the pregnant women, which previous studies have reported as unfriendly (Bazzano et al. 2008, 92; Mathole et al. 2004, 123; Mrisho et al. 2009, 9).

Satisfaction of Respondents with Midwives' Support during Last Labour

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 (Howarth, Swain, and Treharne 2011, 7; Van 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, 258; Waldenström et al. 2004, 18). One factor contributing towards birth satisfaction is experiencing personal and caring support (Van Teijlingen et al. 2003, 76). Although the respondents reported a lack of the core component of labour from the midwives in this study, the majority of them still expressed a high level of satisfaction

with the care received from midwives in almost all the facilities used for the study. This indicates that the women in this study value the midwives' professional duties during labour but still desire CLS from their social network. Similar to this study's findings, a previous study in Benin, Nigeria, also discovered that the midwives are highly appreciated by women and their families (Fujita et al. 2012, 486). Thus, a heightened sense of satisfaction may improve communication between a woman during labour and the health workers, thus contributing to a positive birth experience (Aune, Amundsen, and Aas 2014, 90).

However, the high level of satisfaction with labour support received from midwives expressed by the respondents in this study may also denote the hesitation of women to criticise despite the extremely negative treatment they receive from health providers. According to Van Teijlingen et al. (2003, 76) reluctance to criticise professionals by women may be related to their joy of having a live, healthy baby which was their ultimate goal regardless of any negative experience or abusive treatment from care providers. 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, 80).

Attitude to CLS among the Respondents

Women's attitudes to health-related factors exert an important influence on maternal healthcare and practices (Ezeama and Ezeamah 2013, 15). 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. Oboro et al. (2011, 58) found that most women in Osogbo, Nigeria, were willing to have a companion during their subsequent labour, while more than half of them decided to recommend it to other women. Another hospital-based cross-sectional study in Ibadan also found that 75 per cent of the respondents desired companionship during labour (Morhason-Bello et al. 2008, 553). Furthermore, other studies found the need for emotional support to be the main rationale for women desiring support during labour (Morhason-Bello et al. 2008, 553; Teshome, Abdella, and Kumbi 2007, 38). 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, namely CLS from a familiar person.

Preference for CLS among Respondents

More than two-thirds (75.5%) of the respondents 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 the support from midwives. As reflected in the study findings, the respondents' high level of satisfaction with care from midwives may not imply a low preference for CLS from familiar persons. The women in this study showed a high preference for their husbands, mothers or mother- in-laws,

sisters and neighbours as preferred CLS providers in public health facilities. 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 et al. 2008, 553).

Likewise, Bakhta and Lee (2010, 202), found the husband to be the main source of companionship during labour, while other studies in Africa found that women preferred female relatives as companions or supporters during labour (Madi et al. 1999, 8; Oboro et al. 2011, 57). The small proportion of women who preferred not to have their husbands as companions during labour in the Oboro et al. (2011, 58) study was attributed to various reasons such as the feeling of being embarrassed or depersonalised or de-individualised during delivery, the fear of losing their sexual attractiveness and the lack of privacy resulting in the loss of the perceived sacrosanct character of the childbirth process, as well as a fear of loss of the seriousness with which their medical condition was regarded by healthcare personnel. The respondents who declined CLS in this study believed that CLS might not be necessary and ascribed to the belief that the outcome of labour is only in God's hand.

Limitations

The results may not be generalised to all women in Nigeria because the study was conducted only in secondary healthcare facilities in South West Nigeria.

Conclusion and Recommendation

This study revealed that the emotional support from the midwives to women in labour was inadequate compared to the professional care at birth; women perceived the inclusion of a familiar person for support as beneficial and expressed positive disposition to the introduction of persons from their social network for labour support in public health facilities, with a higher preference for their husbands and mothers as labour support persons. Hence CLS from the preferred person from the woman's social network needs to be incorporated into hospital policy in Nigeria.

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