Women Choice of Social Support During Childbirth, Nurses/Midwives Opinion to Practice

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Abstract
Birth is a life changing and emotional event for women and their family. The childbirth experience is influenced by several factors that could result to either an unsatisfactory or a satisfactory childbirth experience. These factors include a sense of security, perceived control, experiences of prior deliveries and most important the quality of support during labour. Studies have documented the contribution of Continuous Labour Support (CLS) to women satisfactory childbirth experience, however, CLS practice is still not a routine in most maternity settings in Nigeria. The study explored the Nurse/Midwives perceptions and attitudes to CLS of a woman choice in public health facilities in the South-West region of Nigeria. A qualitative, exploratory and descriptive design was adopted for the study. The study population were Nurse/Midwives (n= 45) selected purposefully in seven public health facilities in Ondo state, Nigeria. Data was collected through Focus Group Discussion and analyzed through Tesch's method of thematic analysis yielding themes and categories. The study reveals that women family are not usually involved in supportive care during childbirth in all of the study settings. CLS is not routine but only occasional/discretional practice largely due to lack of policy, protocols and guideline for its implementation. The study revealed a positive disposition to CLS introduction and use women preferred choice from their social networks based on beneficial effect to all stakeholders. However, implementation of CLS depend largely on complete overhauling existing infrastructure with adequate measures to other challenges identified in the study.

Keywords: Social support; Childbirth; Midwives; Perception; Practice.

Introduction

Every woman giving birth has expectations. Identifying and attending to women's expectations, wishes and needs during childbirth will fulfill the goal of promoting a positive birth experience. Historically and transculturally, women usually go through the process of childbirth with the support of trusted family members, friends and neighbors within their community (Hodnett *et al.*, 2013; Mbekenga, Pembe, Christensson, Darj and Olsson, 2011). This family ritual and traditional support is valued by women and has been associated with a positive childbirth experience. However, with the shift of childbirth from home to the hospital, this valued traditional childbirth practice has been overruled 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, Gate, Hofmeyr, Sakala and Weston, 2011). Although the modern technological maternity interventions achieved some success in the reduction of maternal mortality and morbidity mostly in the developed countries, the increased medicalisation of the labour and birth process also resulted in deprivation of women from the valued domestic support networks (Hodnett, Gates, Hofmeyr and Salaka, 2013; Buasi, 2011). The depersonalization of women's birth experiences in hospitals led to the clarion call for resurgence need for additional support during childbirth even at the hospital in the developed countries in the 21st century (Hodnett, Gate, Hofmeyr, Sakala and Weston 2012).

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 and 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 and 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.*, 2012). 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 feels 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 particularly Nigeria despites the worst maternal and child health indices, as well as limited health resources including shortage of health care providers especially midwives (Hodnett,et al, 2013; Banda et al. 2010; Morhason-Bello *et al.* 2008; Bruggeman *et al.* 2007;Maimbolwa *et al.* 2003). The study explores 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.

Methods

This qualitative, descriptive and exploratory study was carried in seven (7) purposively selected secondary public health facilities in Ondo State, South- Western Region of Nigeria. Total number of forty –five nurse/ midwives (n= 45) working at the obstetrics and gynecology units of the selected hospitals. The inclusion criterion was at least five years' experience working in the obstetrics and gynecology units Data was collected through Focus Group Discussion (FGD). A total of eight FGDs were conducted with each lasting about 60- 90 minutes and the proceedings were recorded with the permission of participants. A consent form and FGD Confidential Binding Form was filled in by each participant before the commencement of each FGD session. Data collected was analyzed through Tesch's method of qualitative analysis, themes and categories were generated. Permission to access the selected hospitals were obtained from the Research Ethical Review Committees of the Hospital Management Board, and the Mother-and-child Hospital in Akure. Ethical approval was also gained Ethical Review Committees of the University of Western Cape (Ethical Clearance Number: 2014/04). Informed written consent was also sought from all the participants of the study. Confidentiality and anonymity were ensured by allocation of code number to each participant.

Results

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 lgbo. 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. The results on perception and attitude of nurse/ midwives to CLS in public health facilities yielded two (2) major themes, six subthemes and several categories.

Theme 1: Perceptions about CLS

The nurse/ midwife's perceptions on CLS and introduction of the women' s preferred choice of CLS person from social network in public health facilities was based on personal belief and experience within the public service.

Sub-theme 1: Non- existence/intermittent practice

The nurse/ midwives in this study affirmed that CLS was not part of the current hospital policy and therefore not routinely practiced except for few occasionally based individual nurse/ midwife's discretion based on particular need of the clients.

*'It's not been in practice in this hospital since its inception.' (**FGDMA1)***

'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.' (FGDME 3)

Sub-theme 2: Perceptions about introduction of family CLS in public health facilities

Majority of the nurse/ 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. Few of the study participants 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)*

*'…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)***

Theme B2: Attitude toward CLS

The nurse/ midwives' attitude to involvement family members as part of the CLS system in public health facilities were influenced either positively or negatively by their perceived benefit or risks/ challenges that could come with CLS in a public health setting. These factors were articulated in the sub- themes below: -

Sub-Theme 1: Positive attitude

The nurse/ midwives who expressed a positive attitude to CLS and see the concept as beneficial to the woman, health care providers and the facility as a whole. The 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 promotes bonding, it makes the woman feels emotional support with the family members, and maybe the husband is there, some women say they want their husband to be there to feel the measure of pain they feel.' (**FGDMB** 1)*

Family support to the woman during labour may also reduce the midwives stress through enhancement of women cooperation with care and other forms of assistance during labour.

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

The involvement of the husbands in labour support is seen by the midwives as an opportunity to reach out to the man as the decision-maker in the traditional family in Nigeria to promote utilization 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)*

Sub-Theme 2: Negative Attitude

Negative attitude to CLS and implementation of family members as CLS provider in public health facilities was influenced by the midwives perceived risks/ barriers to the concept. The identified challenges were discoursed in relation to women-related and facility-related challenges.

Women-Related Challenges

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.

*' '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)***

The presence of family members in the labour room also recognized as a factor that may lead to obstruction or delay the delivery process due to "pampering" of the women by the relatives.

'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**)*

Another important factor discussed was the potential tendency for "misuse the opportunity" given to the women relatives to assist in childbirth. The labour support person may use her presence to introduce or administer unorthodox treatment to the woman, 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)*

Facility-Related Challenges

Inadequate state of the structure of the health facilities was branded an impediment to the CLS concept. The structure of 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. Aside poor infrastructure, shortage of staff and confidentiality are other challenges to the CLS concept.

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

The presence of the birth companions may hinder disclosure of 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.

*'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**)*

Culture and religion may pose as hindrance to the implementation of CLS as asserted by the study participants. The midwives in this study admitted that it will not be easy dealing with some categories of birth companions during childbirth especially women who had cultural and religious beliefs that prohibits the presence of men at childbirth.

*'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**)*

Sub-Theme 3: Enablers for CLS practice

To encourage the practice of labour support in the hospitals, the nurse/midwives shared their views on factors that may enhance CLS practices. In Nigeria, the provision of health care and policies and budgeting lies within the function and capacity of government at all three tiers of government. The midwives opined the need to solicit for inclusion of CLS concept in the policy and protocol related to childbirth care in in public health facilities.

*'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**)*

An upgrade and reconstruction of existing physical infrastructure including employment of more health care providers may be necessary for effective implantation of the concept.

> *'If there are more buildings and we have antenatal wards, postnatal wards and labour room separate it can help, and more staff.' (**FGDME 4**)*

Other enablers for CLS in public health facilities include standardized CLS clinical guidelines for practice and training programme for health care providers, clients and preferred support persons, need for public awareness was also recommended.

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

Discussion of Findings

The study affirmed that CLS was not part of current hospital policy, hence not part of the hospital routine to allow family members in women's care or to offer support during labour. This result confirmed the submission that CLS is only practiced mostly in developed countries while its practice remained the exception rather than the rule in most developing countries, particularly Nigeria (Sapkota, 2012; Hodnett *et al.*, 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, Almufleh, Al-Damri, Al-Bassam *et al.* 2013). There were positive perceptions regarding the introduction CLS by persons of the woman's choice from her social network in this study participants based on the beneficial effects of CLS from the few occasional practice. 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 emphasized the importance of a woman in labour to have a supportive companion (Banda, Kafulafula, Nyirenda, Taulo and Kalilani, 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, Adedokun, Ojengbede, Olayemi, Oladokun and Fabamwo, 2009).

In support of the midwives' assertion of the benefits of supportive care to women during childbirth. 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 and Sakala, 2007; Melender, 2006; Romano and Lothian, 2008; Sauls, 2002).

The 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. Positive attitude was aligned with the benefits that could be derived from CLS practice, and negative attitudes expressed the risks/ challenges of the practice. The benefit accrued from the participant's experiences includes promotion of love, sense of belonging and bonding. Psychological support, improvement patient cooperation with care, assistance and reduction nurses' stress and well as ability to promote family planning update and utilization with family involvement in care. In line with the positive disposition in this study, the Malawian midwives also highlighted the benefits of women companions as the reason for their positive support for CLS in health facilities in Malawi (Banda et al, 2010). Likewise, 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 , Similarly, companions can provide emotional and spiritual reassurance to parturient women during labour and most importantly 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; Banda *et al.*, 2010; Morhason-Bello *et al.*, 2009).

The negative attitudes to CLS was hanged on the inadequate and inappropriate physical infrastructure, lack of privacy and confidentiality in the labour room setting. These inadequacies if not corrected may make CLS practice in public health services a tall dream. Likewise, Healthcare providers, in the Elfeshawy, Elmashad and El-Nemer (2015) study, also expressed concern on overcrowding in the labour and other related issues that may affect CLS implementation. Sociocultural phenomena and religious beliefs were also as a key factor militating in CLS practice most 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. Men are mainly viewed as providers while pregnancy support is regarded as a female role in some cultures in Africa (Kungwimba, Maluwa and Chirwa, 2013; Chongo and Ngoma, 2014). 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. Malawian midwives argued cultural hindrances to male involvement in women's care, the presence of males during the intimate period of labour and delivery, when the mother's body is continuously exposed are sociocultural and religiously prohibited in Eastern societies (Al-Mandeel *et al.*, 2013; Oboro, Oyeniran, Akinola and Isawumi, 2011; Banda *et al.*, 2010).

The midwives in this study also believe labour companions may misuse the opportunity given to them by some health facilities to assist in childbirth and give the woman some unorthodox method of treatment, or infect the newborn child. 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.

To encourage the practice of labour support in the hospitals, the midwives expressed the need for overhauling and rehabilitation of public health facilities to enhance implementation of CLS. Physical restructuring of labour room into separate compartments for women in labour and their families to enable privacy and confidentiality is uppermost, the need for incorporation of CLS in hospital policies and protocols remain evident. Corresponding to this report, Sweidan Mahfoud and DeJong (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).

Conclusions

This study acknowledged that CLS is not part of current hospital policies in public health facilities in Nigeria and not routinely practiced. However, there was positive attitude by the nurse –midwives towards the introduction of CLS based of the benefit derived from the few discretional practice. Conclusively Implementation of CLS in public health facilities depends largely on all stakeholders' acceptance and government's involvement through the issuing of enabling policy statements about CLS, reorganization and rehabilitation of existing hospital structure, orientation and training of CLS persons, and public awareness campaigns

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