QUALITATIVE STUDY

The communication and emotional support needs to improve women’s experience of childbirth care in health facilities in Southwest Nigeria: A qualitative study

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Synopsis: Nigerian women value communication and support during childbirth, and practical and sustainable actions should be taken to ensure positive childbirth experiences.

Abstract
Objective: To improve women’s childbirth experiences in health facilities, their psychosocial and communication needs have to be met. However, what constitutes these specific needs is poorly understood, particularly in Sub-Saharan Africa. This paper explores women’s needs for communication and emotional support during facility-based childbirth.

Methods: Qualitative research was conducted in a large referral maternity hospital and its catchment communities in Akure, Nigeria. In-depth interviews (IDIs) and focus group discussions (FGDs) were conducted among women of reproductive age, midwives, doctors, and facility administrators. Thematic analysis was used to synthesize findings, and then interpreted within the context of this study and existing quality of care framework.

Results: Forty-two IDIs and 10 FGDs are included in this analysis. Participants reported such needs as communication in simple words in local language by healthcare staff, having their husbands as birth companions, spiritual support, and prayers from family members and healthcare providers.

Conclusion: To increase, improve, and sustain facility-based childbirth in Nigeria, health systems should appreciate the uniqueness and importance of each woman’s needs during childbirth. Practical and sustainable actions should be taken to meet these needs, within the confines of the acceptable sociocultural norms.

1. Introduction
Globally, approximately 830 women die every day from preventable causes related to pregnancy and childbirth, with over 99% occurring in low-resource countries [1]. More than 60% of these deaths occur in Sub-Saharan Africa. The maternal mortality ratio (MMR) in low-resource countries in 2015 was 239 per 100,000 live births, compared
with 12 per 100,000 live births in high-resource countries [1]. Nigeria alone accounts for 19% of the global burden of maternal mortality with an MMR of 814 per 100,000 live births in 2015; almost five times that of the average in high-resource countries [1]. Most maternal deaths are due to preventable causes including hemorrhage, sepsis, pre-eclampsia/eclampsia, obstructed labor and unsafe abortion, and the healthcare solutions to prevent or manage these complications are well known.

Millennium Development Goal (MDG) 5 targeted a 75% decrease in maternal mortality, but the number of maternal deaths worldwide only dropped by 43% between 1990 and 2015 [1]. To accelerate this decline, the international community set another target under the Sustainable Development Goals (SDGs) to reduce the global maternal mortality ratio to less than 70 per 100,000 births, with no country having an MMR of more than twice the global average. One of the key interventions to improve maternal health is increasing the proportion of births attended by skilled health professionals, as timely and effective management and treatment of complications can make the difference between life and death for both the mother and the baby [2–5]. However, despite a global increase in coverage of skilled birth attendance, associated declines in maternal mortality have been modest, and declines in stillbirths virtually nonexistent [6]. The lack of significant improvement highlights the need for continued focus on quality of care, including provider competencies and environments that enable provision of essential clinical interventions with dignity. To improve on the services currently available in health facilities, barriers limiting access to quality maternal health services must be identified and addressed at all levels of the health system, and systems must be strengthened to be responsive to the needs of women and girls [6,7]. Two of the strategic objectives of the ending preventable maternal mortality framework are addressing inequities in access to and quality of sexual, reproductive, maternal, and newborn health care; and strengthening health systems to respond to the needs and priorities of women and girls [7].

1.1. Experience dimension of quality of care
According to the WHO, quality of care during childbirth in health facilities reflects both how care is provided and how care is experienced, within the available physical infrastructure, supplies, management, and human resources with the knowledge, skills, and capacity to deal with pregnancy and childbirth [8]. Research demonstrates that it is necessary to go beyond maximizing coverage of essential interventions to accelerate reductions in maternal and perinatal mortality and severe morbidity [9]. Moreover, there is a complex interplay of experiences of mistreatment and lack of support that impact women’s childbirth experiences and outcomes [10,11]. Good experiences in the health facilities may encourage the further use of health facilities and bad experiences may discourage the use of health facilities.

The needs and priorities of women differ during childbirth. A woman’s perception of how her needs are prioritized and met determines her childbirth experience. Studies of childbirth experiences have revealed that they are multidimensional and difficult to describe, explain, and measure [12]. Furthermore, efforts to measure and describe childbirth experiences are often confused with satisfaction over care provided [12]. Dimensions of the childbirth process that may influence how women experience it include labor pain management [13–15], control in decision-making in relation to childbirth procedures [16,17], treatment during labor and birth [18], and waiting time at the facility [18,19]. In comparison, satisfaction is a composite measure and it is strongly influenced by the outcome of care, i.e. a live baby and mother, which supersedes the negative experiences of women in the process of reaching that outcome [20,21]. Research has shown that women in labor have a profound need for companionship, empathy, and support [22], as well as emotional support in the form of encouragement, praise, reassurance, listening, and a continuous physical presence. This type of continuous support during labor and childbirth has been identified as a crucial component of sensitive and responsive woman-centered care, and has demonstrated effectiveness at improving women’s and newborn’s health outcomes [23].

1.2. WHO “Better Outcomes in Labour Difficulty” (BOLD) project
The “Better Outcomes in Labour Difficulty” (BOLD) project was initiated by the WHO to address the quality of facility-based childbirth care in low-resource settings [24]. The goal of this project is to accelerate the reduction of childbirth-related maternal, fetal, and newborn mortality and morbidity by addressing the critical impediments in the process of care of women and fetus during labor, and taking advantage of the interactions between the health system and the community to learn what kind of care women want and value. The project seeks to achieve this goal through a two-pronged approach: the development of a Simplified, Effective, Labour Monitoring-to-Action tool (SELMA) [25] and the Passport to Safer Birth [26]. SELMA is a digital tool developed to enhance the expertise of health professionals assisting labor in health facilities. Aimed at optimizing the outcomes of labor and childbirth, SELMA was developed by combining up-to-date scientific evidence and care pathways derived from detailed labor progression data of approximately 10,000 women giving birth in Nigeria and Uganda. The Passport to Safer Birth is a set of innovative service prototypes and tools, co-designed with women, community members, and providers to promote access to quality care for women and their companions during childbirth, and are described in detail in the paper by Salgado et al. [27] in this Supplement. The Passport to Safer Birth was developed through a combination of qualitative research and service design methods, with the goal of identifying and prioritizing the needs of the end-users and integrating their voices into the proposed solutions.

As part of the BOLD project activities, formative research was conducted with women and healthcare providers to support the development of innovative tools to improve the ability of healthcare providers to manage labor and to increase demand for respectful quality care at the time of birth. In particular, the formative research was used to explore the needs and expectations of women and healthcare providers related to improving quality of care during childbirth. This includes improving women’s birth experiences and both clinical and sociobehavioral outcomes; for example, satisfaction with care provided and adequate provision of emotional support. As part of this larger project, this analysis is focused on the communication and emotional needs of women during facility-based childbirth in Southwest Nigeria, from the perspectives of women, healthcare providers,
and administrators. While women themselves are the “gold standard” for information on their own needs and preferences, healthcare providers and administrators can provide interesting input to explore convergent and divergent perspectives on women’s needs. This paper is part of a series on the BOLD project formative research; other aspects of the project are described in detail elsewhere in this Supplement [27–31].

2. Materials and methods
This study was conducted in four health facilities and corresponding facility catchment areas in Akure and Abuja, Nigeria. However, this analysis focuses on the data from Akure to provide a deep exploration into communication and emotional needs of women at one of the study sites, which will feed back directly to the local and hospital authorities. Focus group discussions (FGDs) and in-depth interviews (IDIs) were conducted among different cadres of healthcare providers and health facility administrators to explore their expectations and needs from women in labor relating to provision of quality care during childbirth, as well as barriers and enablers to the provision of high-quality care throughout the labor and childbirth period. Furthermore, FGDs and IDIs were conducted among women of reproductive age (15–49 years) who had given birth in any health facility in the previous 12 months, to explore their expectations and needs.

Scientific and technical approval was obtained from the WHO Human Reproduction Programme (HRP) Review Panel on Research Projects. Ethical approval was obtained from the WHO Ethical Review Committee (protocol ID, A65878), the University of Ibadan/University College Hospital Ethical Review Committee (protocol ID, AD 4693/168; approved October 16, 2014), and the Research and Ethics Committee of Ondo State Ministry of Health (approved September 1, 2014). All participants gave written informed consent to participate and were free to withdraw their participation at any time. This manuscript is reported according to the Consolidated Criteria for Reporting Qualitative research (COREQ) checklist [32].

2.1. Study setting
The study was conducted in the Mother and Child Hospital (MCH) in Akure, the capital of Ondo State, and in its urban catchment area and two peri-urban/rural catchment areas of Akure—all in the Southwest of Nigeria. MCH is the referral hospital established in 2010 for the “Abiye” (safe birth) program—a Safe Motherhood project organized by the Ondo State Government that was sponsored by the World Bank. It is a 100-bed hospital that caters for pregnant women and children under 5 years, and services are provided free of charge. The hospital has three obstetricians/gynecologists, two pediatricians, and seven Medical Officers in the obstetrics department. There were 2616 births during the study period (January to May 2015), and seven maternal deaths were reported. The MMR for Ondo State is lower than the national MMR, the contraceptive prevalence for the state is 31.1%, delivery by skilled provider is 67.2%, and the rate of facility-based childbirth is 56.2% [33].

2.2. Study participants, recruitment, and sampling
There were three groups of study participants:
1. Facility administrators working at the study hospital, including a Medical Director and head of obstetric department, were invited to participate in key informant interviews. The research team sought to recruit 1–2 administrators.
2. Healthcare providers: midwives and doctors working in the obstetric department in the study facility were invited to participate in FGDs and IDIs. The participants were allocated to either IDI or FGD; no participant participated in both. The minimum number of participants for each FGD session was five while the maximum was seven. The research team sought to recruit midwives for 3–5 IDIs and to hold 1–2 FGDs, and to recruit doctors for 3–5 IDIs and to hold 1–2 FGDs.
3. Women: women of reproductive age who had given birth in any facility in the previous 12 months were invited to participate in IDIs, and women of reproductive age who had given birth in any facility in the previous five years were invited to participate in FGDs. The research team sought to recruit 10–15 women per catchment area (one urban and one peri-urban) for IDIs and to hold 2–3 FGDs.
Prior to data collection, the teams received two days of training on the study protocol, interview guides, and research ethics. The head of facility who attended the study training workshop acted as an entry point to connect the trained research assistants to the healthcare providers. The research assistants visited households within the catchment areas and identified women who met the inclusion criteria. Individuals who met the inclusion criteria in each group were interviewed.

Quota sampling was used to achieve a stratified purposive sample without random selection using specified parameters to stratify the sample, including setting (urban or rural), religion, and age for all participants. Using these stratification parameters, the research team recruited participants to achieve a diverse and varied sample. Facility administrators and healthcare providers were sampled from the study facilities and stratified by years of experience and cadre (doctor, nurse, midwives). Women who met the eligibility criteria and who were willing to participate in the study irrespective of religion and ethnicity were sampled from the urban and rural/peri-urban communities in the selected facility catchment area.

2.3. Data collection and management

The interviews were moderated by female Master’s degree holders in public health with experience in maternal health research and qualitative data collection who had been previously trained on the study protocol. The IDI and FGD sessions were conducted at the homes of the women and private areas in MCH. An interview lasted an average of 1 hour with the range of 45 minutes to 2 hours. Participants received an incentive of 2500 Naira (approximately USD $10) as compensation for their transportation costs and light refreshment. The interviews were conducted in English and Yoruba languages, and were digitally recorded and transcribed verbatim by the data collectors immediately thereafter. Observations and assessments during interviews were digitally recorded and field notes were taken and added to the end of the interview transcripts. Interviews conducted in Yoruba were translated into English by the data collectors, which helped to retain the originality of the contextual meaning of statements made in Yoruba language. The transcription and translation processes, which took place in parallel to the data
collection, were overseen by the lead social scientist. Completed and translated transcripts were shared and reviewed by the study team on an on-going basis and prior to the conclusion of data collection to ensure data quality and consistency. De-identified transcripts were kept in password protected computers.

2.4. Study instruments
Semistructured discussion guides were used to guide the IDIs and FGDs, which helped to ensure comparability across participants and groups (full study instruments are available as Supplementary Material S1). The instruments were pilot tested prior to the commencement of data collection to ensure applicability in the study context. The instruments used to guide the discussions with women explored five major domains: (1) perceptions of care provided at the facility and decision-making to seek care at the facility; (2) the meaning of good quality of care during childbirth in health facilities; (3) perceived expectations and needs of women during facility-based childbirth care; (4) potential changes that could be made to enhance the provision of quality childbirth care; and (5) perceived expectations and needs of providers during facility-based childbirth. The instruments used to guide the discussions with providers were similar, and explored five major domains: (1) the meaning of good quality of care during childbirth in their work environment; (2) expectations and needs to provide good quality care; (3) barriers and facilitators to the provision of quality care during childbirth; (4) potential changes that could be made to enhance the provision of quality childbirth care; and (5) perceived expectations and needs of women during facility-based childbirth.

2.5. Data analysis
Data from the study were analyzed using the thematic analysis approach. This method is useful for identifying key themes; it describes large bodies of qualitative data richly and highlights similarities and differences in experiences [34]. After transcription, line-by-line coding was conducted on a sample of transcripts by two independent researchers. Initial themes that emerged naturally from the data were used to develop the codes and thematic framework. Initial codes were then synthesized with questions from the discussion guides and the WHO quality of care framework for maternal and
newborn health [8] into a coding hierarchy transferable to the other transcripts. This process yielded a hierarchical codebook to organize codes into meaningful code families and to explore higher level concepts and themes related to quality of care. To improve inter-rater reliability, two researchers jointly coded three transcripts, then two researchers independently coded two transcripts and discussed coding decisions until consensus. Based on this process, a final codebook was developed, including the code families, code names, definitions, and examples of correct use. All transcripts were coded using Atlas.ti, version 7.5.6 (ATLAS.ti Scientific Software Development, Berlin, Germany), and a subset of the transcripts was reviewed by an independent researcher for reliability. Findings were organized into meaningful subthemes, narrative text, and illustrative quotations to explore and explain patterns in the data.

The findings of this research were discussed and analyzed by the Nigeria qualitative research team members.

3. Results
3.1. Overview
We conducted 42 IDIs and 10 FGDs between January and May 2015. Among women of reproductive age, six FGDs and 30 IDIs were conducted. Among providers, two FGDs and five IDIs were conducted with midwives, and two FGDs and five IDIs were conducted with doctors working in the maternity wards. Two IDIs were also conducted with facility administrators. Table 1 reports the number of IDIs and FGDs by participant type. Sociodemographic characteristics of participants are shown in Tables 2 and 3.

3.2. Communication needs of women in labor
3.2.1. Use of simple words and local language
Both the women and healthcare providers highlighted the importance of effective communication to improve women’s childbirth experiences. As stated by one woman: “Communication is very, very important…it is everything” (IDI, 30–45 years). A key aspect of communication was continuously checking on the woman and asking her questions to understand how she feels:
“They [healthcare providers] should continuously ask questions... ‘how do you feel,’ ‘how are you feeling now.’ It’s not supposed to just be the woman that will be telling them ‘please come check on me’...they [healthcare providers] should be continuously telling the woman ‘this is your condition,’ and educate them.” (Woman, IDI, 30–45 years).

To effectively communicate, providers need to improve their use of simple words that are easily understood by women. Healthcare providers acknowledged that they may not always convey convincing messages to the women, because the women may not understand the “medical jargon” that is used to convey information. However, doctors agreed that most of them “have that kind of communication problem,” and that as a solution to the problem they “as health providers need to learn and train” themselves “more on how to communicate effectively, learn to break information [down] to patients and relatives in very simple terms and clear terms they can understand.” A doctor further explained it this way:

“The thing is that you explain, but you don’t explain using medical terms now, you explain using words that the patient can understand... Instead of telling a patient that the cervical dilation is not adequate...So I do the practical thing... I tell patient see you need 10 over 10 to pass this exam, to give birth, and now you just have 2 over 10 so that means you need 8 over 10 more. So you explain to them in terms they can understand and I think they do that here, we do here. Explain to patient in a language... in a way they can understand what is happening so that they understand the essence of the intervention you want to render and how promptly you need to do it.” (Doctor, FGD, 30-45 years).

It is also believed that communication using simple words is an important way to make the work of healthcare providers easier and ultimately improve the experience of women and their relative during childbirth. It is noted that when a woman is properly counselled in a way that she understands, it will be easier to convince her to follow medical advice if a complication should arise. A nurse elaborated on this:
“...when something negative is happening, you just tell the woman, ‘madam, can you see now that we have been trying for some time to make sure that you are alive and the baby is alive?’...you guide the patient, any procedure you are doing with the patient, you’d relate with the patient and let the patient know.” (Nurse, FGD, 30–45 years).

Women interviewed also highlighted the importance of addressing language barriers and providing translation services when the provider does not speak their language. A woman explained her challenge communicating with the provider:

“You know I don’t understand Yoruba that much, so I just have to tell them, see I don’t understand what you are saying, you understand, thank God the person attending to me just start breaking it down, break everything down for my own understanding, you get it?” (Woman, IDI, 30–45 years).

Despite women’s professed need for clear communication and being well received in their interactions with providers, women lamented that healthcare providers often “didn’t hear me out” (Woman, IDI, 30–45 years) as they were rushing off to see another patient. One woman expressed that she felt that the communication channels between women and providers was in dire need of improvements:

“Communication is very vital…I think that’s just what we are lacking in this government facility…the communication channel there is broken already. We need to try and bring it back to normal the way it is supposed to be. Let’s teach them how to communicate with people as if they are the owner of this health facility, because if you are the owner of something you want to make it good.” (Woman, IDI, 30–45 years).

3.2.2. Use of other information, education, and communication (IEC) tools
Pictorial and graphical materials to visualize and communicate information for patients with low literacy could also be helpful in communicating difficult medical processes or procedures, such as what to expect while progressing through labor, cesarean delivery, and childbirth position. Doctors suggested that:
“Guidelines and additional tools that will be pointing towards a patient that will need a particular intervention earlier, could make it easier for healthcare providers to decide and to communicate early and more effectively with the relatives and the patient herself.” (Doctor, FGD, 30–45 years).

While women did not specifically mention that visual communication and educational tools would help them to understand complex procedures, both the healthcare providers and the women suggested the need to improve on what is currently available for communication between the healthcare providers and the woman.

3.2.3. Attention and respectful communication
When interacting with providers, women desired to be treated in a dignified and respectful manner. Most women agreed that healthcare providers and “especially nurses are rude,” they “shout,” and “talk badly” to the women. They reported that providers made unreasonable requests of women, such as asking them to perform tasks that are inappropriate to ask of a woman in labor. Instances were cited where providers would tell a woman who is in labor or who has just given birth to a baby that “if you stain the bed you will wash it yourself before leaving.” Women believed that the rude attitudes of nurses discouraged some women from presenting for childbirth in the health facility. One woman said:

“We need them [healthcare providers] to be patient with us, they should know how to pamper us whenever we are in labor, they should not shout at us. Some people decided not give birth in the hospital because she did not like the way they treat her.” (Woman, FGD, 30–45 years).

Women emphasized that rather than being rude and dismissive, healthcare providers should listen and respond to the needs of the women:

“…to have listening ears, they have to listen to complaint of their patients and they should not be too harsh, because during that labor we [women] were something else, but they don’t have to pamper us and they don’t have to be too harsh and they should stop cursing, they should stop cursing. Nurses. Doctors
Women also desired personalized attention from the health providers, where each woman is treated as a unique person with a unique need. Women do not want healthcare providers to “think of what they handle every time” a woman is in labor during their shift. Rather, women said they would prefer that the providers treat every woman in labor with extreme care and attention, regardless of her parity, recognizing “that this person is new, they should not use such statements as ‘after all this is not your first baby, not your second baby, you know the way’”. When healthcare providers used phrases such as “don’t shout, don’t disturb me” for the women in labor, women felt discouraged.

3.2.4. Opportunity to ask questions

Many women interviewed perceive that many healthcare providers in this facility, “especially nurses,” are offended when asked questions and that asking questions may result in abuse of the women. Women would like to be given opportunities to ask questions and would like their questions to be answered properly; they felt that denial of this opportunity left them in the dark with regard to their own safety and that of their baby during labor and birth. Women emphasized that they need detailed information about the health procedures to be carried out on them and the opportunity to consent to or refuse treatments.

Another woman had this to say when asked for her communication needs from her healthcare provider:

“There was a time that my baby did not go past 6 centimeters [i.e. the woman’s cervix was not dilating], so I heard them discussing some kind of things… so I called the nurse that was attending to me… that does that mean they have to tear me and all that, so they said no, no, no, so she told me one thing that see,
what we are doing here, what we are saying here does not concern you, we might just be talking, that is our own, but for, for me here, say before they do anything they should seek my consent, they cannot just come and do whatever they want, before they do anything they should seek my consent and that of my family that came with me.” (Woman, IDI, 30–45 years)

3.3. Emotional support needs of women during childbirth

3.3.1. Empathy

Women desired emotional support during labor and delivery, which includes demonstrations of respect and empathy from the providers. Rather than shouting at women, women wanted nurses to show empathy to the pain of labor, demonstrating that they “at least they know what labor entails” (Woman, FGD, <30 years).

“She needs…to be shown love at that time [during labor], she needs to be shown care at that time…you start shouting on the person, no, it should not be like that.” (Woman, IDI, 30–45 years).

“This is what makes me love this set of nurses…I got to the hospital in the morning and delivered at night. The nurses that came to greet and stay with me, one has [gone] home and returned later to stay with me until I gave birth…they stayed and played with me, they also took care of me, they were not hostile…I like them because they are trying their best and I cannot forget them for this.” (Woman, FGD, <30 years)

“She need empathy, she needs to be shown love at that time, she needs to be shown care at that time, ok, it’s not ah! you start shouting on the person, no, it should not be like that.” (Woman, IDI, 30–45 years).

The women desired healthcare providers that “will take care of” them as if they “are their biological children and that they [the healthcare provider] have the experience of childbirth.” However, they reported that “some [healthcare providers] will shout at you as if they have never given birth before.” One woman said:
“They should attend to us well any time we come, as if they are the one that is pregnant, because this is why they are employed and being paid, they should not be cranky, they should do their work with love. Nobody is perfect and we are not all the same but once we come, they should care for people appropriately, because then... it seems to be better now; before they cast dirty looks at you, people say they don’t value life, as if one comes begging, this is why they are being paid, they too should be committed to the work so that they will reduce mortality, they should reduce all sorts [of problems] in the community, those are my observations, and they should give us attention.” (Woman, IDI, 30–45 years).

The women recommended that the healthcare providers should be “instructed to treat women well and handle them like eggs” and that “they should not be edgy with pregnant women” knowing “that pregnancy period is a delicate period and they [healthcare providers] should show empathy, the healthcare providers should treat the women fine, be patient with them and attend to them promptly.” (Woman, IDI, 30–45 years). A woman who senses empathy from her healthcare provider would receive care with more open mindedness, understand the constraints of the facility where she gives birth, and take the instructions of the healthcare provider with less criticism thus improving her perception and experience of care in the facility.

3.3.2. Privacy
Women would like to have auditory and visual privacy when communicating with their healthcare providers because they may want to say certain things that may be particular to the woman’s need. On occasion, embarrassing things happen during labor that women do not want others to see: “each woman has a different way of giving birth, some vomit while in labor, some defecate, while some urinate incessantly” (Woman, FGD, <30 years). At such times, the women would like “the nurse to be close” to them so that they can communicate privately. However, most of the public hospitals in Nigeria do not have sufficient physical space to provide this type of privacy. One woman had this to say about the privacy provided in the facility where she delivered:
“Where we give birth in this general hospital is not good because up to four people can go through labor in a single room…. nurses and visitors will also be in the same room… sleeping on the floor, this is not adequate.” (Woman, FGD, <30 years).

Furthermore, most women would appreciate to be in a private room when in labor. Most women believe that it is not “right for you to be having like 3, 4, 5 people at the labor room at the same time.” (Woman, FGD, 30–45 years).

3.3.3. Prayers and spiritual support
Nigeria is a very religious country and many of the women in this study desired the prayers of their family members and healthcare providers during childbirth. Women in this study stated that they would like the prayers of their healthcare providers and family members irrespective of their religious affiliation as long as the prayers are being offered to “God.” The women further stated that this act of prayer, especially from a healthcare provider, in itself is reassuring to a woman in labor and her family members, and makes the woman connect better with her healthcare provider and also encourages her cooperation with the healthcare provider. In this study, many women referred to these prayers as one of the best experiences they have ever had during childbirth. In particular, women wanted their family member to stay with them and pray with them especially if their labor becomes difficult. Below is the memorable experience a woman shared about the facility where she delivered:

“They [healthcare providers] also have faith in God, they place their trust in God, they know they are not perfect, but they just say do this, do that, use your faith, they encourage us with God’s words, that we should have faith in God, that they are only trying their best but we should put our trust in God, so such things and prayers, they pray for us.” (Woman, IDI, 30–45 years).

The statements above exemplify the spiritual needs of a Nigerian woman during childbirth, as most women agreed that they would like health facilities where spiritual support could be provided.
3.3.4. Labor companionship

Most of the women agreed that they would like to have a labor companion, with only a few objecting to this idea. Several reasons for the value of companions were given including: (1) decision-making and consent for hospital procedures; (2) a sense of appreciation; (3) hospital companion and assistant; and (4) provision of food. Most women agreed that having their husbands beside them during childbirth was desirable, and would like this to be made policy in Nigeria. However, a key barrier identified by women was that “the doctors won’t agree that men should stay with you when giving birth” (Woman, FGD, <30 years). Having their husband with them during labor would better engage him in the childbirth experience; one woman suggested that “let him stay by the window then so that he can know what it entails” (Woman, FGD, <30 years); while another suggested that “even if he does not stay by the window let him come in so that he can see the pain involved” (Woman, FGD, <30 years).

Lack of respect for women is still an issue in Nigeria. Both women and the healthcare providers agreed that women deserve a deep sense of appreciation for going through the rigors of labor and childbirth. Most of the women believed that having their husband present during labor and childbirth would help him to respect the process she has gone through and understand the pain she has felt. One woman said: “At least he would respect me at home that what this woman passed through is not easy” (Woman, IDI, 30–45 years).

“Because some men you will even see that is like they don’t appreciate the women. Sometimes they will say what has she done based on my relationship with the husband or sometimes they will come if it is not the sex they prefer, some will leave their wife in the hospital premises, they will abandon them and go, not even minding what they are going to eat...But when they [the men] are there...I think it will have impact on them and they will appreciate their wife more and they will know it is not easy. Because we call it labor pain you know, labor plus pain, it is a severe pain, oh, I think that will help those kind of men, it will change their orientation.” (Nurse, IDI, 30–45 years).
However, women also stated that in cases where it may not be feasible to have their husbands as their labor companion, a female labor companion would be appreciated; for example their mother, sister, or friend. Some women preferred their mother (especially) or mother-in-law (occasionally), sister, or friend as labor companion, rather than their husbands or partners.

A minority of women objected to the idea of having a labor companion at all. These minority respondents gave reasons such as “a woman will be lazy during labor if somebody she loves is around her especially her husband.” They believed such women would want their husband to “pet” them (treat them with love or coddle them) during labor, which might demotivate or distract her from following a provider’s instructions. Some women also believed that men would not be able to stand the labor pains their wives go through and may be “crying” while accompanying their wife or partner, which they considered unhelpful for the woman in labor. One woman mentioned that she would prefer to have no-one including her husband as a labor companion because childbirth is a delicate period and should be kept a secret until the woman successfully gives birth. She feared that a companion may reveal her pregnant state to those who could “charm” (hex) her during the process.

Women reflected that a companion would also help to support with the logistics of their stay. In this setting, women are required by the health facilities to bring several items with them (baby cloths, mackintosh, cotton wool, pads), and women believed that a labor companion could assist in making these items available. Women stated that such a companion could equally serve as a bridge to any communication gaps between the healthcare provider and the woman. Women noted that some parents are to be blamed for “not have anything to use for the baby or themselves” during childbirth. They noted that husbands must provide everything needed during labor and they should stay with the women in hospital. Women observed that some women may be neglected in the facilities if certain provisions are not made by the woman and her family members,
and therefore the presence of a labor companion would help to advocate on behalf of the woman. This is captured in the statement of one woman:

“When I wanted to give birth, my mother, husband and mother-in-law was around, whenever the nurses want something I cannot leave the bed to buy it they are the ones who get everything the nurses wanted. If there were no family members with me they won’t attend to us, we need our family members to accompany us so that they can assist us.” (Woman, FGD, 30–45 years).

The hospital does not provide food for their patients and women reflected that they would like to have a labor companion who could bring them “tea, milk, food, hot water and other things that can give her strength” (Woman, FGD, 30–45 years).

In this context, many women are not permitted to make decisions independently, including for issues related to their own health, and decisions may be made by others such as their husbands or mother-in-laws. In such situations, women and the healthcare providers in this study agreed that having a companion present would help facilitate the consent and approvals needed for interventions or healthcare decision-making, as women may be incapacitated by the demands of labor.

“I told you that my blood pressure was low, so at that time when they even checked me, they asked my husband to go for a blood transfer, you understand, so at that moment I wasn’t told, maybe they don’t want to give me the pressure, I wasn’t told, so he had to do it, so when he finished doing it, he came then and then everything was normal, everything was fine. But at that moment, I know that if the decision of ‘let’s give her blood’ should come up, I know he would decide it on my behalf, yes, he should decide it on my behalf.” (Woman, IDI, 30–45 years).

Participants believed that having a companion present and available to agree if interventions are needed would reduce delays in providing care, as often it is a time-consuming process to track down this person via telephone or outside the hospital.

“If our family members stay with us there won’t be the need to start looking for them in order to get their consent if delivery is going to be by cesarean; the
husband can also sign if he is the one around so that the operation can be done on time.” (Woman, FGD, 30–45 years).

Based on these perspectives, it is apparent that women may have different needs and opinions regarding labor companionship, and it is important to ensure that the decision to have a companion or not, and who the companion is (husband/sister/mother) should be the woman’s.

4. Discussion
This study suggests women place a high value on information and effective communication, emotional support, and labor companionship when giving birth in a health facility. These needs may not be met through the care currently provided in the particular health facility where women give birth. Concerns about privacy were identified by both women and healthcare providers. However, the women said they would appreciate having a female labor companion on such occasions. Most believed that a labor companion could facilitate communication between health provider and the woman by explaining things in simple language, be trained in use of simple communication tools, how to identify danger signs, and when to call for help. The labor companion could have the responsibility for ensuring that all the materials needed for the childbirth (e.g. mama kit) are purchased and available prior to the onset of labor.

Studies from other settings have similarly revealed that issues relating to women’s experiences during childbirth are multidimensional and extend beyond medical needs [35]. Therefore, there is a need to have a holistic approach toward childbirth for women, including in low-resource countries like Nigeria. In other studies, women preferred not to be treated only as medical patients during childbirth, but also as human beings with feelings, and as active agents, in charge of the process of childbirth [36–39]. In our study setting, we found that women have limited control over their childbirth process, as decisions about their care and consent processes may happen around the woman, but without her direct involvement or final say. Cultural practices in Nigeria may call for the approval of a husband, mother-in-law, other family member, or clergy member to
provide consent or approval for interventions to take place (e.g. cesarean delivery, blood transfusion). Despite this, women in our study noted that care should be taken to ensure that the woman’s autonomy and self-determination are preserved.

Women in this study described their need for effective communication with their health providers. Healthcare providers should strive to “carry women along” (ensure that they understand what is happening to their bodies and what to expect) throughout childbirth, as this has been documented to improve health outcomes [40]. Women expressed that they would like healthcare providers to avoid the use of medical jargon when communicating with them and make their explanations as simple as possible with the use of the local language or the language that the woman prefers when this is feasible. When it is not feasible to communicate with the woman in a local language, the use of professional translators can be explored as lay translators at times may distort the original message that is being passed across to the woman and may further have a negative effect on the health outcome [41]. The women would like to express their concerns freely without fear of any reprimand. The importance of communication in any physician–patient relationship cannot be over emphasized [42]. Even when the needs and expectations of women cannot be met for systemic reasons that cannot be addressed by the provider, simple communication may help to ease the problem.

Findings from this study have directly informed the development of the “Passport to Safer Birth,” as the needs, expectations, and gaps in how care is provided to pregnant women have been identified and prioritized in Nigeria [26,27]. The Passport to Safer Birth is a set of tools designed to help increase demand for quality of care during childbirth in health facilities, and aims to facilitate better communication between women and their providers during pregnancy and childbirth, and provides information to women in a clear, simple, and culturally-appropriate way. We envision that the Passport to Safer Birth will better prepare women with what to expect during childbirth, and prompt them to ask questions and seek clarifications from their providers at key points throughout pregnancy and childbirth. A full description of the Passport to Safer Birth tools is available in papers by Salgado et al. [27,31] in this Supplement.
The provision of continuous support to women during labor has also been documented to increase the likelihood of spontaneous vaginal birth, reduce the duration of labor and use of analgesia, and lower the incidence of cesarean and instrumental deliveries [23]. Despite the clear benefit of labor companionship and women’s acceptability of labor companionship described in this study, it is not the norm in Nigeria. Our findings revealed that most women would prefer their husbands as their labor companions. The study conducted in Nigeria by Adeniran et al. [35] also emphasized this: most women (80.8%) preferred their husbands as their labor companion, while only 10.8% would prefer their mother, 4.7% their sister, 2.8% their mother-in-law, and 0.9% their friends. Facility structure is a major barrier to this as most facilities in Nigeria are not structured to accommodate male companions during childbirth. Most facilities are built in a way that more than one woman will be in a labor room at a time. This implies that there is a need to make structural provisions for husbands accompanying their wives/partners for childbirth; for example with curtains or partitions to provide privacy. Studies have equally shown that women whose husbands were involved in their pregnancy-related matters had a higher level of psychological well-being and lower levels of depressive symptoms compared with women who reported no father involvement during pregnancy [43]. A major reason stated by women in this study for preferring their husbands as their labor companion is because they want to be deeply appreciated for what they go through during childbirth.

4.1. Limitations and strengths of the study
This study has both limitations and strengths. First, some of the IDIs and FGDs conducted with women were conducted in local languages and translated into English, therefore it is possible that some culturally relevant phrases or words were lost in translation. The research team mitigated this by having the same moderator who conducted the IDI or FGD transcribe the data. Second, this analysis focused on a sample of women and providers from one region of southwestern Nigeria and may not be transferable to other settings. The strengths of this study include that the research team was warmly accepted by participants who expressed their views on the subject
freely with openness and readiness. Furthermore, women were recruited from urban, peri-urban, and rural settings to improve the diversity of the sample and transferability of the results.

5. Conclusions
The health sector should think beyond the provision of minimal medical care for women during childbirth and consider the emotional needs of women who are planning for childbirth in health facilities. Women’s experiences could affect the utilization of facilities in the future, and may, therefore, directly or indirectly influence neonatal and maternal mortality and morbidity. Because women and their family members tend to value emotional support and positive experiences of care as important components of health care, it is important for healthcare providers and systems administrators to understand and respond to women’s needs and preferences, and to ensure that their own perceptions regarding how women define quality care align with what women say that they value.

Author contributions
This analysis was planned by MAB and BF, with input from MT and AOO. Data analysis was conducted by OAO, MT, and MAB, with support from AAO. OAO and MT wrote the first draft of the paper. All authors commented on and approved the final manuscript.

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Conflicts of interest
The authors have no conflicts of interest to declare.

References


Table 1

**In-depth interviews and focus group discussions by categories.**

<table>
<thead>
<tr>
<th>Participant type</th>
<th>IDI</th>
<th>FGD</th>
<th>Total participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of FGDs</td>
<td>No of participants (Total)</td>
<td></td>
</tr>
</tbody>
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### Table 2
Sociodemographic characteristics of participants: healthcare providers and administrators

<table>
<thead>
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<th>Characteristics</th>
<th>Nurse/midwives (n=17)</th>
<th>Doctors (n=16)</th>
<th>Administrators (n=2)</th>
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<tr>
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<td>7</td>
<td></td>
</tr>
<tr>
<td>30–45</td>
<td>8</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>&gt;45</td>
<td>8</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cadre and position</td>
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<td>Facility head</td>
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<td>1</td>
</tr>
<tr>
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</tr>
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<td>Years of experience</td>
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<tr>
<td>&gt;5</td>
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<td>6</td>
<td>2</td>
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</tbody>
</table>

Abbreviations: IDI, in-depth interview; FGD, focus group discussion.

### Table 3
Sociodemographic characteristics of participants: women of reproductive age
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>IDIs (n=30)</th>
<th>FGDs (n=6 FGDs&lt;sup&gt;a&lt;/sup&gt;)</th>
</tr>
</thead>
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<tr>
<td>Age, y</td>
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<tr>
<td>Education</td>
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</tr>
<tr>
<td>4–5</td>
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<td>3</td>
</tr>
</tbody>
</table>

Abbreviations: IDI, in-depth interview; FGD, focus group discussion.

<sup>a</sup> Six FGDs conducted with 47 women.
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