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ATTITUDE AND PREFERENCES OF NIGERIAN ANTENATAL WOMEN TO SOCIAL SUPPORT DURING LABOUR

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Summary. This was a hospital-based cross-sectional study of 224 randomly selected antenatal women receiving care at the University College Hospital, Ibadan, Nigeria. The study aimed to seek the attitude and preferences of respondents about social support during childbirth and also identify variables that may influence their decisions. Seventy-five per cent of respondents desired companionship in labour. Approximately 86% preferred their husband as companion while 7% and 5% wanted their mother and siblings as support person respectively. Reasons for their desire for social support were emotional (80·2%), spiritual (17·9%), errands (8·6%) and physical activity (6·8%). Socio-demographic variables found to be statistically significant on logistic regression analysis for the desire of a companion in labour were nulliparity (OR 3·57, 95% CI 1·49–8·52), professionals (OR 3·11, 95% CI 1·22–7·94) and women of other ethnic groups besides Yoruba (OR 2·90, 95% CI 1·02–8·26), which is the predominant ethnic group in the study area. Only those with post-secondary education were found to want their husbands as doula (OR 2·96, 95% CI 1·08–8·11). More than half of the respondents wanted information about labour prior to their experience. It is important that Nigerian women are allowed the benefit of social support during childbirth, particularly as there is a lack of one-to-one nursing care and other critical services, including epidural analgesia in labour, at many of the health care facilities in Nigeria. Men could play a pivotal role in the process of introducing support in labour so as to improve the outcome for both the mother and her newborn.

Introduction

Labour forms the transitory phase between pregnancy and parenting, and is characterized by fears and anxiety by both the woman (Rofe *et al*., 1993; Hofberg &

Ward, 2003; Bastani *et al.*, 2006) and her family members (Chapman, 2000). This observation cuts across culture and race (Karauda *et al.*, 2006; Todman, 2007). Previous studies have shown that fears and a state of anxiety increase operative intervention in labour (Sjogren, 1998) and adverse delivery outcomes (Sjogren, 1997; Sieber *et al.*, 2006).

Nigeria, with its population of about 140 million (NPC, 2006), currently lacks the necessary resources for an efficient and effective maternal health care service (Galadanci *et al.*, 2007). The last National Demographic Health Survey showed that about two-thirds of Nigerian women registered for antenatal care with about a third delivering with skilled birth attendants (NDHS 2003). Of these, one-third – about 85% – patronized public hospitals, with the remainder using private health facilities (NDHS 2003). The magnitude of this problem within Nigeria varies with region, with the south having better care/facilities and the northern region having the worst. One of the major reasons identified why women do not deliver in Nigerian health care facilities is the poor attitude of health workers to their clients and poverty (Okafor, 2003). This issue is further compounded by the usual maternity policy of no patients' relations being allowed at the bedside in labour rooms. Women therefore patronize traditional birth attendants and mission homes, which offer all forms of reassurances to pregnant women but with minimal or no obstetric care during labour (Okafor & Rizzuto, 1994; Etuk *et al.*, 1999).

Social/emotional support by companions has been shown to be beneficial to women in labour irrespective of where it is practised (Hodnett & Osborn, 1989; Saisto *et al.*, 2001; Waldenstrom, 2004). The degree of the benefit varies with the type of companion (Malestic, 1990; Ip, 2000a). Reduced perception of labour pain and fear/anxiety, shorter duration of labour, and an overall feeling of a satisfying childbirth experience are some of the identified benefits for women who had companions during labour (Hofmeyr *et al.*, 1991; Sjogren & Thomassen, 1997; Waldenstrom, 2004).

In Nigeria, situated in sub-Saharan western Africa, many studies have reported that women perceive pain in the same way as their colleagues in other parts of the world (Olayemi, 2005; Kuti, 2006). It is therefore probable that levels of distress during labour may be reduced if social support during labour is practised. Presently in Nigeria, current public or government-owned hospital policies lack the incorporation of social support for a patient during the course of her labour, hence the basis of this work. This study aims to document the attitude and preferences of pregnant women about social/emotional support while in labour and also to seek factors that may influence such attitudes.

Methods

This was a hospital-based cross-sectional study. Women attending antenatal clinic at the University College Hospital, Ibadan (a government-owned tertiary institution in south-western Nigeria) were recruited for the survey using systematic random sampling. On each clinic day, a starting number between 1 and 10 was randomly selected using a ballot and then every 10th woman was interviewed. This was continued until the sample size was achieved. The instrument used for the study was

an open- and close-ended structured questionnaire. An initial pilot study was conducted to validate the questionnaire at a separate health facility. The pilot revealed the need to define specifically the types of support desired by respondents to the research assistants so as to have a uniform interpretation of the result. The identified types of support from the pilot were spiritual, errand, physical and emotional.

Spiritual support included reassurance through faith in God's protection and promises of safe delivery, repeated traditional verses such as 'the goat delivers effortlessly without a midwife and the sheep never requires the intervention of a health worker, you too [i.e. the patient by her name] will deliver with ease', constant reiteration of intercessionary prayers that use Biblical or Quranic memory verses etc.

'Errand' refers to support in the form of attending to payment of bills in tranches and purchase of needed materials as may be prescribed by health workers. It may also include calling the attention of the on-duty health workers, making contact with other family members and the denominational clergy or Imam (Muslim clergy) or even familiar personnel (especially senior physicians or midwives) within the facility. Physical reasons include massage of the woman's back, assisting in changing position and holding hands during childbirth.

Emotional support includes the use of constant words of encouragement and comfort, assurances that the childbirth process will be trouble-free and just the sense of security that someone familiar is around them.

The questionnaire was then administered to the consenting antenatal patients. The information obtained included their socio-demographic characteristics, past obstetric history and views on social support in labour. The data were collated from August to November 2006.

Statistical analysis was performed using SPSS 11 software. Bivariate analysis was done using χ^2 test while multivariate analysis was performed using logistic regression and the level of statistical significance was set at $p<0{\cdot}05$ (or 95% confidence level).

Results

Two hundred and twenty-four women were studied between the ages of 18 and 44 years with a mean age of 31 years (SD=4·27 years). Approximately half of the women were between 30 and 34 years. Pertaining to occupation, professionals constituted about 28%, followed by teachers (17%), traders (15·2%) and artisans (11·2%) (Table 1). Three-quarters had tertiary education while 21% had secondary school education as the highest level of education. The predominant religion was Christianity (76·8%). Primigravid women constituted about 37% of the respondents. Additionally, there were equal proportions of those who had two and three pregnancies while about 21% have four or more pregnancies. They were largely nulliparous (45·4%). Most of the respondents had no history of abortion or miscarriage (Table 1).

Concerning preferences for social support, about 75% of these antenatal patients wanted someone to be present to offer social support during their labour. Nearly 86% of these women preferred their husband, while 7% and 5% respectively wanted their mothers and siblings (Fig. 1).

Table 1. Univariate distribution of patient's socio-demographic characteristics

Variable	Frequency	Percentage
Age (years)		
15–24	13	5·9
25–29	59	26·7
30–34	108	48·9
>34	41	18·6
Occupation		
Housewife	21	9·4
Artisan	25	11·2
Civil servant	23	10·3
Teaching	38	17·0
Professional	63	28·1
Trading	34	15·2
Student	20	8·9
Educational level		
Primary	10	4·5
Secondary	47	21·2
Tertiary	165	74·3
Religion		
Christianity	172	76·8
Islam	51	22·8
Gravidity		
1	83	37·1
2	42	18·8
3	43	19·2
≥4	48	21·5
Parity		
None	98	45·4
1	56	25·9
2	38	17·6
>3	24	11·1
Abortion/miscarriages		
None	160	75·1
1	29	13·6
2	24	11·3

The main rationale for desiring social support during labour was discovered to be emotional support (80·2%). Others included: spiritual (17·9%), errands (8·6%) and physical activity (6·8%) (Fig. 2). About 67% would be happy if their relations were allowed to be by their side during labour, while around 58% indicated their desire to visit the labour ward before delivery. Three-quarters of the women felt information materials/leaflets describing labour would be helpful prior to the actual experience and about 69% expressed their willingness to pay additional charges for social care in labour (data not shown).

Education ($p=0·049$), religion ($p=0·025$) and occupation ($p=0·005$) were significantly associated with desire for a doula. Also significant were gravidity ($p=0·004$)

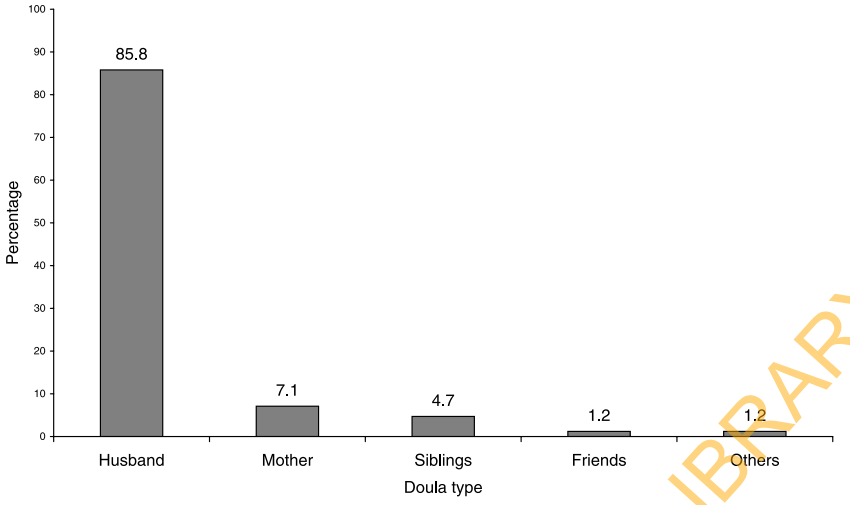

Fig. 1. Preference for social support during labour.

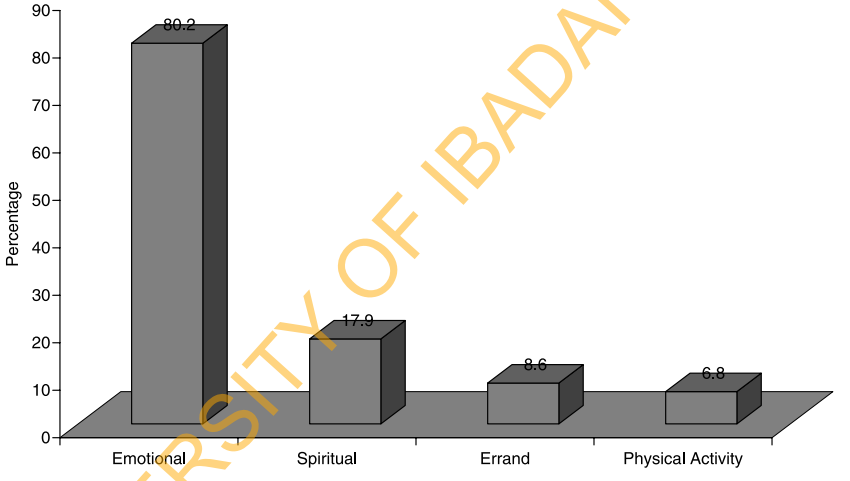

Fig. 2. Reasons for requesting social support (a doula) during labour.

and parity (0·003) (Table 2). Age and previous abortion or miscarriage were, however, not significant (not shown).

The variables significant at the 10% level of significance were further subjected to logistic regression analysis to adjust for possible confounding. Nulliparous women were significantly more likely to desire social support in labour compared with other parity groups (OR 3·57, 95% CI 1·49–8·52). Also, professionals were more likely to desire social support compared with other occupational groups (OR 3·11, 95% CI 1·22–7·94) (Table 2). Women of other ethnic groups were also more likely to desire social support compared with the predominant Yoruba ethnic group (OR 2·90, 95% CI 1·02–8·26). Education, gravidity and religion were not significant.

Table 2. Bivariate and logistic regression analysis of desire for social support by patients' characteristics

Characteristic	Bivariate		Multivariate	
	% desiring support (*n*)	*p*	OR	95% CI OR
Education				
Tertiary	78·7 (164)	0·049*	1·21	0·56–2·59
vs ≤secondary	65·5 (55)			
Religion				
Christianity	78·9 (171)	0·025*	1·64	0·77–3·45
vs Islam	63·3 (49)			
Occupation				
Professional	88·7 (62)	0·005*	3·11	1·22–7·94*
vs Other	70·4 (159)			
Tribe				
Other	87·5 (40)	0·052	2·90	1·02–8·26*
vs Yoruba	72·9 (181)			
Gravidity				
1	85·4 (82)	0·004*	1·86	0·82–4·24
vs 2+	67·9 (131)			
Parity				
Nulliparous	84·4 (96)	0·003*	3·57	1·49–8·52*
vs parous	66·7 (117)			

*Significant at 5% level.

Choice of individual to act as support was significantly related to education ($p=0·003$), age ($p=0·040$) and occupation ($p=0·028$) on bivariate analysis. Women of higher ages, higher education and professionals preferred husbands as doula (Table 3). Religion, gravidity and previous abortion were not significantly related (not shown). Higher education was significantly associated with preference for husbands as doula (OR=2·96, 95% CI 1·08–8·11) on logistic regression (Table 3).

Concerning willingness to pay for social support, demographic characteristics, gravidity or previous abortion were not significantly associated (data not shown).

Discussion

A positive childbirth experience is usually seen as the end-point of a successful parturition (Crowe & von Baeyer, 1989). Studies have shown that knowledge of parturients and their suggestions on ways of achieving an uncomplicated childbearing process are associated with positive outcomes in labour (Crowe & von Baeyer, 1989, Elcioglu *et al.*, 2006). Social/emotional support during labour is one of the interventions that has been employed to achieve positive childbirth experiences in many settings (Hodnett & Osborn, 1989; Hofmeyr *et al.*, 1991).

Preference for support in labour among the majority of Nigerian parturients in this study is in tandem with their peers from other countries. This desire for social

Table 3. Bivariate and logistic regression analysis of preferred doula type (husband vs other) by socio-demographic characteristics

Characteristic	Bivariate		Multivariate	
	% preferring husband (*n*)	*p*	OR	95% CI OR
Education				
Tertiary	90·0 (130)	0·003*	2·96	1·08–8·11*
vs ≤secondary	70·3 (37)			
Age group (years)				
≥30	89·4 (113)	0·040*	2·19	0·88–5·44
vs<30	77·4 (53)			
Occupation				
Professional	94·5 (55)	0·028*	1·74	0·50–6·02
vs Other	82·3 (113)			

*Significant at 5% level.

support was found to be more among professionals and primigravid women. Christianity appeared to be a significant factor influencing desire for social support; however, on the logistic regression analysis model it was no longer significant, probably due to the confounding factor that more professionals were Christians. All these findings were at variance with many Nigerian hospital policies where women in labour are barred from having relations by their side. Although there is no study from Nigeria yet on the labour outcome among women that have had support, the findings of this study need to be subjected to large multicentred research with the intention of determining its relevance during parturition in the Nigerian environment.

It is probable that the liberal disposition of private health care services in Nigeria forms a major attraction for women who – though they receive antenatal care at public health centres – tend to deliver in private and faith-based maternity homes (NDHS 2003).

Most respondents preferred their husband to be their doula. This preference was found to be significant among women with the following characteristics: professionals, tertiary education and above the age of 25 years. Higher educational status (at least above secondary level) was found to be more statistically significant than others on further analysis. Generally, women in the higher social class (higher educational level) tend to practise monogamy and hence the likelihood of their preference for their husband. Although the presence of the woman's partner as a companion is associated with a better labour outcome in some settings (Ip, 2000b), the overall available evidence suggests that – in general – female doula are associated with a better labour outcome, when compared to others such as husbands, midwives and monitrice. This is a challenge to the men folk, especially in a country where men do not normally participate fully in the health care of their spouse. Therefore, the question of whether Nigerian husbands are ready to be their spouse's doula/companion in labour remains unresolved.

The reasons given by those who desired support were similar to those mentioned in earlier studies, except 'errand'. This may be a reflection of the level of education among the study population, and more so, that none of the respondents had ever experienced social support in labour. The identified predictors of those desiring support were at least secondary education, professionals and nulliparity. These were the same categories of Nigerian parturients identified by Olayemi *et al.* (2005) with higher pain score in labour. It is advisable to allow such women the benefit of support because many health care delivery facilities in Nigeria cannot afford enough midwives to provide social support to parturients. It is not unusual to find a midwife on duty in the labour ward suite with more than two women in labour at a time.

Another interesting finding of this study was that parturients from other ethnic groups are more likely to demand social support in labour. This observation reflects the views of earlier studies that showed that women who deliver in an environment where the care-giver shares the same cultural background with her generally have a more pleasant childbirthing experience (Olayemi, 2005). It is therefore understandable why women from other ethnic groups would wish to have someone known to them by their side during labour.

Although more than half of women interviewed were willing to pay for social support, none of the factors considered were found to influence this decision. This decision may encourage the hospital management to introduce the social support programme especially for women who have no relations around.

Another important finding from this study was that more than half of the respondents were willing to seek information about labour events, such as a prior visit to the labour ward, a guided tour of the available medical facilities and as well as information leaflets. Receiving qualitative information about childbirth during the prenatal period has been found to reduce the anxiety level of parturients, reduce labour pain perception and is associated with a more pleasant labour experience (Heaman *et al.*, 1992; Lang *et al.*, 2006). Therefore, there is a need to make available information leaflets for antenatal patients, as this will enable them to gain more knowledge about labour events and also serve as educational materials for their spouses and other family members.

In conclusion, this study revealed that Nigerian parturients desire social support during childbirth. It is therefore imperative for health care-givers to pursue this issue and determine whether the presence of companions will positively influence labour outcomes in Nigeria through further operations research. The challenges that religious values in a large heterogeneous population may throw up in the process should be critically resolved, and these include diverse interpretation and myths as regards specific meaning of issues surrounding childbirth in Nigeria (Etuk *et al.*, 1999; Okafor, 2000). In addition, men should be included in the process of investigating the relevance of this topical issue.

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