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Midwives' perceptions of partner presence in childbirth pain alleviation in Nigeria hospitals

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ABSTRACT

Objective: partner presence in the labour room can influence childbirth pain outcomes and maternal well-being. We examined midwives' perception of the use of partner presence in the management of childbirth pain in Nigerian hospitals.
Design: a descriptive cross-sectional quantitative study.
Setting: maternity units of four hospitals in Abuja, Nigeria, Jun.-Dec., 2014.
Participants: 100 midwives selected through convenience sampling.
Measurements: data collected using the Abuja Instrument for Midwives (AIM) questionnaire underwent frequency, correlation, and content analysis.
Findings: most midwives felt partner presence contributed to pain relief and were willing to allow partner presence as an intervention for childbirth pain. However, only every fourth midwife reported using partner presence as a pain management intervention. Key Conclusion: partner presence is perceived as contributing to pain relief and is a non-pharmacological technique reported to be utilised by midwives for pain management during childbirth. However, Nigeria suffers from poor utilisation of partner presence as a pain management intervention during childbirth.
Implication for practice: information from this study can improve midwifery practice and aid further research regarding midwives' attitudes, knowledge and usage of partner presence in pain management during childbirth.

Introduction

Midwives play a vital role of care during pregnancy, labour, delivery, and the post-natal periods (Adeyemo, 2013) and in alleviating pain. Adequate pain alleviation during childbirth reduces suffering, promoting satisfactory maternal birth experiences (Baker et al., 2001). For optimal childbirth pain management, midwives' knowledge, proper assessment, and pain management intervention, are crucial. Their training, health institutions' guidelines on midwifery practices, the perception of the midwives, and societal norms, all influence their choices.

The majority of women giving birth desire relief from pain (Kuti and Faponle, 2006; Obuna and Umeora, 2014; Lally et al. 2014, Lindholm and Hildingsson, 2015). Women undergoing childbirth without effective pain relief often experience excruciating pain (Abushaikha and Oweis, 2005). Pain relief contributes to a satisfactory experience and healthy outcome during childbirth. The use of pain relief measures by midwives to prevent harm to the mother and fetus is also important (Brown et al., 2001).

Pain relief techniques utilized during childbirth can be pharmacological or non-pharmacological and they can also complement each other (Cambic and Wong, 2012; Jones, 2012, 2015). In Nigeria, while pharmacological interventions are rarely adopted or non-existent, non-pharmacological interventions such as breathing exercises and relaxation are what midwives mostly utilize as pain management methods (Daniel et al., 2015). The adoption of non-pharmacological methods for pain relief during childbirth in low-resource areas, such as Nigeria, is due to barriers such as limited resources, inadequate health infrastructure, and poor knowledge among health professionals on pharmacological pain management methods (IASP, 2010). With emphases on the psychological, emotional, spiritual, and cultural aspects of the woman, non-pharmacological techniques aim to reduce anxiety, fear

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and tension, factors associated with childbirth pain. Vis-à-vis pharmacological methods, non-pharmacological methods are nonintrusive, non-invasive, low-cost, simple, effective and, most importantly, without adverse effects (Almushait and Ghani, 2014; Jones, 2015).

Partner presence as an intervention provides physical support and comfort for women during childbirth; it enhances pain relief, childbirth progress, and satisfaction with the birth experience (Adams and Bianchi, 2008). Continuous partner presence during childbirth provides emotional support as well as physical comfort and is an important natural pain relief measure. According to Bradley (1965 p. 16), *"how much more calm and cooperative the patient [mother] was when her husband was present. If he left the room, even temporarily, the mother became anxious and tense and relaxed poorly with contractions"*. Partners can be labour coaches providing support for women during childbirth by encouraging them to use techniques for pain relief learnt during antenatal classes and by creating a relaxed environment (Bradley, 2008).

In the past few decades, partners' attendance in labour and at delivery has increased in developed countries. The UK and Denmark have a high percentage (95%) (Somers-Smith 1999; WHO, 2007) and the US, Finland, and Sweden have witnessed an increase since the 1960s (Vehvilainen-Julkunen and Liukkonen, 1998; Green et al., 2007). In lower income countries, the issue is still debated. In Nigeria, partners are absent in the labour room during labour and at birth; they delegate their roles to female relatives and midwives (Iliyasu et al., 2010).

Partner absence at delivery can be due to health facility policies, health workers' attitudes and social-cultural and religious beliefs (Vehvilainen-Julkunen and Emelonye, 2014). In Malawi, maternity staff forbade most men, who had accompanied their wives, from entering the delivery room (Kululanga et al., 2012). Kaye et al. (2014) report that fathers found the system unwelcoming, intimidating and unsupportive. In contrast, reports of midwives' practices as regards childbirth pain and attitudes towards partners during childbirth have been positive. Thelin et al. (2014) demonstrated that midwives were comfortable with partner presence, had positive feelings towards the woman and her partner, and thus created a comfortable atmosphere. Midwife support and their ongoing presence in the delivery room made the birth experience for fathers positive (Hildingsson et al., 2011).

Previous studies have demonstrated the beneficial effects during childbirth of non-pharmacological pain relief measures such as relaxation (Smith et al., 2011), acupressure (Sedigheh et al., 2007), massages (Taghinejad et al., 2010; Gallo et al. 2013) and music (Liu et al., 2010). Despite the importance and the role of partners in pain relief during childbirth, particularly in Nigeria, few studies have examined partner presence as a method in childbirth pain relief or midwives' perception of the use of partner presence as a pain management method. Daniel et al. (2015) examined non-pharmacological methods utilized by midwives in Nigeria and showed that partner presence was excluded from midwives' lists of interventions for pain relief; breathing exercises were the most common intervention. However, Gayeski et al. (2014) report that primiparous women indicated that emotional support provided by their companion was the most used method.

We examined midwives' perception of the use of partner presence in the management of childbirth pain in Nigerian hospitals.

Methods

Study setting

This descriptive quantitative multisite study involved the maternity units of four hospitals in Abuja, Nigeria - Kubwa General, Garki General, Wuse General and Maitama District. The data were collected Jun.–Dec., 2014. We chose Abuja because of its cosmopolitan nature as the Federal Capital Territory, with an estimated population of over three million people (NBS, 2012). Abuja is also culturally diverse, with its population drawn from 371 ethnicities in Nigeria (DHS, 2013). Abuja, unlike other Nigerian cities, is dominated by no particular ethnicity. In Nigeria, the Igbos dominate the east, the Yorubas the west, and the Hausas the north.

Three of the research sites for this study are fully government-operated hospitals: Kubwa General with 110 beds, of which 24 are maternity beds; Wuse General with 130 beds, of which 20 are maternity beds; and Maitama District with 60 beds, of which 26 are maternity beds. The fourth, Garki, with 70 beds, of which 20 are maternity beds, has been privatized and has been running on a public-private partnership since 2007 (Garki Hospital, 2015). Two hospitals in this study had both private and multiple occupant wards, while the other two had only the latter. The annual delivery rate at Kubwa General is 2500; at Wuse General, 2000; at Garki, 1500; and at Maitama District, 1800.

Around 88,796 midwives (including nurse-midwives) work in Nigeria (UNFPA, 2011), and the ratio of midwives and nurses together is 1.6 per 1000 people (World Bank, 2010). Multiple paths exist to become a midwife, a professional skilled midwife, or a university-educated midwife. Professional skilled midwives do either the three-year basic midwifery diploma programme to qualify as midwives or complete the general nursing three-year diploma programme with an additional 18 months of midwifery education to qualify as nurses/midwives (Oyetunde and Nkwonta, 2014). University-educated midwives study a four-year degree programme in a recognized university, completing the Registered Midwifery and Registered Nurse certification examination administered by the Nursing and Midwifery Council of Nigeria (NMCN) to qualify for licensing as midwives (LASU, 2010).

Professional and university-educated midwives work mostly in health facilities in urban or rural areas. They are certified by the NMCN after the completion of their programme from an approved school (NMCN, 2014). The NMCN is the only legal, administrative, corporate, and statutory body charged with ensuring the delivery of safe and effective nursing and midwifery care to the public. This is achieved through quality education, adherence to best practices, and the setting of regulatory guidelines for midwifery care practices in Nigeria. The NMCN regulates policy and practices relating to childbirth pain management. In Nigeria, most midwives are also registered nurses, and some civil service establishments require this dual qualification for employment.

Ethical issues

The Ethics Committee of the University of Eastern Finland (28/2012) and the Federal Capital Territory Health Research Ethics Committee of Nigeria (FHREC/2014/01/17/06-05-14) approved the study. We obtained permission from the four hospitals concerned.

Data collection

Participants

Of the 120 midwives approached, 100 participated in the study; those who declined blamed it on the pressure of work. Midwife distribution (n) per health facility was as follows: Kubwa General (n=32), Wuse General (n=22), Garki (n=18), and Maitama District (n=28). We used the convenience sampling technique for participant selection across the four hospitals. Inclusion criteria were the following: practising clinical midwives, licensed and registered by the NMCN. The chiefs of the respective maternity units informed all these midwives about the study. The principal investigator approached potential participants and verbally invited them. We made available fact sheets of the study and explanatory notes to all the midwives approached. All participants provided informed consent on a short and simple form. Participating midwives were free to withdraw from the study at any time, and confidentiality was maintained.