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INFLUENCE OF COMMUNICATION BETWEEN HEALTHCARE PROVIDERS AND NULLIPAROUS WOMEN IN COPING WITH CHILDBIRTH EXPERIENCES IN ANYIGBA METROPOLIS

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Abstract
Childbirth is a significant life event, especially for nulliparous women who often experience fear, anxiety, and uncertainty due to lack of prior experience. Effective communication between healthcare providers and mothers is crucial in shaping coping strategies and overall childbirth experiences. This study examined the influence of healthcare provider communication on the coping experiences of nulliparous women in selected hospitals in Anyigba Metropolis. A mixed-method design was employed, involving 192 nulliparous women selected from a population of 383 using Krejcie and Morgan's formula. Data were collected via structured questionnaires and in-depth interviews with four healthcare providers (two doctors and two nurses). Quantitative data were analysed using descriptive statistics, while qualitative data underwent thematic analysis. The study was guided by the Patient-Centered Care (PCC) Model. Findings indicated that communication strategies such as clear explanations, emotional reassurance, active listening, and supportive non-verbal cues helped reduce fear, enhance dignity, and improve coping during labour. Women reported that effective communication enabled them to remain calm, manage pain, and build confidence. However, challenges like staff shortages, overcrowding, heavy workloads, medical jargon, cultural barriers, and lack of privacy hindered communication. The study recommends regular training for healthcare providers on patient-centered communication to enhance maternal experiences and outcomes.
Keywords: Communication, Nulliparous Women, Coping Strategies, Childbirth, Patient-Centered Care Model.

Introduction

Childbirth is a profound physiological, emotional, and social event in a woman's life, marking a critical transition to motherhood. While it represents joy and new beginnings, it is also associated with uncertainty, fear, anxiety, and heightened vulnerability, especially for

nulliparous women, those giving birth for the first time (Bohren et al., 2015). Unlike multiparous women who may draw from prior experience, nulliparous women typically lack practical knowledge about the process of labour and delivery, making them heavily dependent on the guidance, reassurance, and support of healthcare providers (Fenwick et al., 2009; Størksen et al., 2013).

Communication between healthcare providers and expectant mothers emerges as a cornerstone of effective maternity care. Communication goes beyond the transmission of medical information. It encompasses verbal and non-verbal interactions such as clarity of instructions, empathetic listening, tone of voice, body language, and emotional reassurance (Sacks, 2017). Effective communication not only reduces anxiety and fear but also fosters trust, strengthens coping mechanisms, and empowers women to participate in decision-making about their own care (Renfrew et al., 2014; Afulani et al., 2020). For nulliparous women, this interaction is particularly critical in shaping perceptions of childbirth, influencing emotional resilience, and determining overall satisfaction with the birthing process.

The World Health Organization (WHO, 2018) emphasizes communication as a core element of respectful maternity care, advocating for practices that uphold dignity, autonomy, and meaningful patient engagement. However, in many healthcare settings, especially in low- and middle-income countries like Nigeria, gaps persist due to systemic constraints such as staff shortages, overcrowded facilities, inadequate training in interpersonal skills, and hierarchical provider-patient dynamics (Filby et al., 2016; Okafor et al., 2021). These shortcomings often result in depersonalized interactions where communication is limited to commands or medical jargon, leaving nulliparous women unsupported and emotionally distressed.

The consequences of poor communication during childbirth are significant. Studies have shown that dismissive, unclear, or absent communication can lead to heightened anxiety, a sense of powerlessness, dissatisfaction with care, and even long-term psychological trauma such as postpartum depression or post-traumatic stress disorder (Hodnett et al., 2013; Slade et al., 2019). Conversely, clear, compassionate communication enhances women's sense of control, promotes adaptive coping strategies, and contributes to positive birth outcomes (Green & Baston, 2003; Hodnett, 2002). This dynamic is especially relevant for first-time mothers whose ability to cope is strongly influenced by the emotional and informational support they receive from their care providers.

In Nigeria, maternal health challenges remain pressing, with high maternal mortality rates and limited resources in many health facilities (Ogbonna & Akinyemi, 2022). In such

contexts, communication is often deprioritized in favor of clinical efficiency. Yet, research underscores that improving communication is not just a matter of emotional well-being but a strategic imperative for improving health outcomes and encouraging future utilization of health facilities for childbirth (Bohren et al., 2017). For nulliparous women in particular, the first childbirth experience can shape long-term maternal confidence, healthcare-seeking behavior, and trust in medical institutions.

Coping strategies adopted during labour, such as breathing techniques, relaxation, and positive thinking, are heavily influenced by the communicative relationship with healthcare providers. When providers offer continuous emotional reassurance and clear explanations, nulliparous women are better able to manage pain, reduce anxiety, and maintain psychological stability (Lunda et al., 2018). On the other hand, neglectful or dismissive communication may foster maladaptive coping responses such as fear, withdrawal, or hyper-vigilance.

Given the emotional, psychological, and cultural complexities surrounding childbirth, understanding the influence of healthcare providers' communication on nulliparous women's coping strategies is crucial. While extensive research exists on maternal mortality, antenatal care, and skilled birth attendance in Nigeria, limited studies focus specifically on the lived experiences of first-time mothers and how provider-patient communication shapes these experiences (Downe et al., 2018; Ogbonna & Akinyemi, 2022). Addressing this gap is especially important in semi-urban contexts such as Anyigba Metropolis, where cultural expectations, healthcare infrastructure, and communication practices intersect to influence maternal experiences.

Therefore, this study seeks to investigate the influence of communication relationships between healthcare providers and nulliparous women in coping with childbirth experiences in selected hospitals in Anyigba. Despite global recognition of communication as a cornerstone of respectful maternity care (WHO, 2018), evidence indicates that many women continue to encounter poor communication in healthcare settings. These gaps manifest in various ways, such as the use of medical jargon that patients cannot understand, lack of timely explanations, brusque interactions, or dismissive attitudes (Filby et al., 2016). For nulliparous women, such lapses may intensify feelings of fear, helplessness, and disempowerment, leading to negative coping responses and even traumatic childbirth experiences (Slade et al., 2019). Inadequate communication during labour has further been linked to long-term psychological consequences, including postpartum depression and post-traumatic stress disorder (Hodnett et al., 2013).

In Nigeria, systemic challenges, such as overburdened health facilities, staff shortages, and inadequate training in interpersonal skills, further exacerbate communication barriers in maternal care (Okafor et al., 2021). In semi-urban contexts like Anyigba metropolis, cultural dynamics and resource constraints compound the problem, leaving nulliparous women particularly vulnerable to depersonalized and command-based care. Although previous studies have examined maternal health broadly, there is limited empirical research that specifically explores how communication between healthcare providers and first-time mothers influences coping mechanisms during childbirth in this setting (Ogbonna & Akinyemi, 2022).

This gap in knowledge is concerning, given that the first birth experience is pivotal in shaping women's trust in healthcare systems, their future health-seeking behaviors, and their long-term psychological well-being. If communication during this critical stage is poor, nulliparous women may not only struggle to cope with childbirth but may also develop negative perceptions of institutional delivery, discouraging them from seeking skilled care in subsequent pregnancies. Addressing this problem is essential for improving maternal satisfaction, promoting positive coping strategies, and ultimately enhancing maternal and neonatal outcomes.

To examine the influence of communication relationships between healthcare providers and nulliparous women in coping with childbirth experiences in selected hospitals in Anyigba Metropolis. The specific objectives are:

1. To identify the communication strategies healthcare providers use to support nulliparous women in the childbirth process.
2. To find out the perceptions and experiences of nulliparous women regarding the communication and support they received during childbirth.
3. To determine the extent to which these communication influences the coping mechanisms of nulliparous women during childbirth.
4. To examine the challenges affecting effective communication between healthcare providers and nulliparous women in selected hospitals in Anyigba metropolis.

Review of Related Literature

Communication Strategies in Maternity Care

Communication refers to the dynamic and ongoing process of exchanging information, emotions, and meanings between healthcare providers and patients. It is not merely a technical

act but a relational tool that builds trust, fosters cooperation, and enhances therapeutic engagement (Fleischer et al., 2009). In healthcare broadly, effective communication has been shown to influence diagnostic accuracy, patient adherence to treatment, safety outcomes, and overall satisfaction. It is equally central to promoting shared decision-making, reducing medical errors, and ensuring that patients feel respected and supported throughout their care journey (O'Hagan et al., 2014).

Communication assumes an even more critical role. Childbirth, particularly for nulliparous women, is accompanied by a unique set of physical, emotional, and psychological uncertainties. Effective communication in this setting transcends the delivery of medical instructions to encompass holistic strategies such as verbal clarity, empathetic reassurance, active listening, and the use of supportive non-verbal cues like eye contact, touch, and attentive posture (McCabe, 2004). These strategies help normalize the childbirth process and provide psychological anchoring for women experiencing labour for the first time.

Research underscores that communication strategies such as continuous support, empathetic listening, and plain language explanations can significantly reduce anxiety and foster positive coping during labour. For example, continuous one-to-one support during childbirth has been associated with shorter labour, reduced use of pain relief interventions, and higher maternal satisfaction, largely due to the emotional and informational communication it entails (Bohren et al., 2017). Similarly, empathic communication from healthcare providers has been linked to better psychological outcomes and greater maternal confidence, highlighting the importance of relational sensitivity during childbirth (Jin et al., 2022).

Furthermore, frameworks such as the Person-Centred Maternity Care model emphasise that communication should empower women by providing clear information, respecting autonomy, and involving them in decision-making (Afulani et al., 2021). This approach is especially vital for nulliparous women, who rely heavily on provider communication to construct coping mechanisms and gain confidence in their ability to manage the birthing process. However, challenges such as staff shortages, cultural hierarchies, and inadequate interpersonal training often constrain providers from fully implementing these strategies, particularly in resource-limited settings (Filby et al., 2016).

The literature reveals that communication in maternity care is not a singular act but a collection of strategies which include verbal, non-verbal, and relational, which directly shape the childbirth experiences of nulliparous women. The degree to which these strategies are

effectively employed can determine whether childbirth is perceived as empowering and manageable, or as traumatic and overwhelming.

Bohren et al. (2017) conducted a comprehensive Cochrane systematic review of randomised and quasi-randomised trials comparing continuous support during labour (from a midwife, doula or trained companion) with routine care. Across many settings, the review found that continuous support was associated with shorter labours, higher rates of spontaneous vaginal birth, less need for analgesia, and greater maternal satisfaction. The authors conclude that the benefits derive largely from continuous emotional reassurance, coaching, and clear information, including communicative behaviours that directly support coping during childbirth.

Similarly, Lunda, Downe, & Mwenechanya (2018) conducted qualitative interviews with women who received continuous support during labour to identify the specific supportive strategies that mattered to them. Participants emphasised practical guidance (breathing, positioning), calm verbal reassurance, non-verbal presence (attentive posture, touch), and prompt explanations of procedures. The study highlights that a combination of informational, emotional and physical support (all communicated by providers/companions) shaped women's ability to manage pain and remain emotionally stable.

Fenwick et al. (2009) conducted a longitudinal cohort study measuring pre- and post-partum childbirth fear among primiparous women and examined relationships with birth outcomes and experiences. The study found that higher antenatal fear correlated with more negative birth perceptions and that positive, clear communication from staff during labour helped reduce fear and improve post-partum appraisal of the birth. The authors emphasize that first-time mothers' perceptions of staff communication are a key determinant of whether the experience is judged traumatic or manageable.

Slade et al. (2019) used qualitative interviews to conceptualize what women identify as traumatic about childbirth. Poor communication such as lack of explanation, feeling ignored, and feeling powerless when decisions were made without consent was repeatedly named as central to traumatic appraisals. The study shows that women's subjective experiences of communication shape not only immediate satisfaction but also longer-term psychological interpretations of the birth. (Slade, Balling, Sheen, & Houghton, 2019).

Green and Baston (2003) conducted observational and survey research linking perceived control in labour with coping and satisfaction. Their findings indicate that clear explanations, timely information about progress and options, and encouragement from staff

increase women's sense of control which in turn supports active coping (use of breathing/relaxation, decision participation) and better emotional outcomes. For nulliparous women, who often start labour with low procedural knowledge, this communicative support was particularly influential. Hodnett (2002) reviewed literature concerning pain in labour and women's satisfaction with childbirth. The review found that women's satisfaction is not predicted solely by pain intensity but strongly influenced by the quality of interpersonal care and communication they receive. Supportive communication that frames pain, offers coping techniques, and validates women's feelings was associated with better coping and higher satisfaction even when pain was present.

Filby, McConville, and Portela (2016) produced a systematic mapping of qualitative and quantitative studies from low- and middle-income countries examining what prevents quality midwifery care. Key challenges included excessive workloads, inadequate staffing, limited training in interpersonal skills, and hierarchical medical cultures that prioritise clinical tasks over communication. These systemic constraints were reported to reduce providers' time and emotional capacity to communicate effectively with labouring women.

Okafor et al. (2021) used a mixed-methods design to assess respectful maternity care in Nigerian public hospitals. The study documented frequent instances of brusque or authoritarian communication, limited explanations, and poor consent processes. Structural pressures (crowding, low staff morale) and entrenched provider attitudes were identified as drivers of suboptimal communication, suggesting that both organisational reforms and interpersonal training are necessary to improve provider-woman interactions.

Literature Gap

Existing literature has extensively documented the importance of effective communication in maternity care, highlighting its role in shaping maternal satisfaction, coping strategies, and childbirth outcomes (Bohren et al., 2017; Green & Baston, 2003; Hodnett, 2002). However, most of these studies have been conducted in high-income or urban healthcare contexts, with limited empirical evidence focusing specifically on nulliparous women who are uniquely vulnerable due to their lack of prior childbirth experience. In Nigeria, while research has explored maternal health challenges and respectful maternity care broadly (Okafor et al., 2021; Ogbonna & Akinyemi, 2022), few studies have examined how the communication relationship between healthcare providers and first-time mothers directly influences their coping mechanisms during labour. This leaves a significant gap in understanding how

contextual realities such as cultural expectations, limited resources, and interpersonal dynamics in semi-urban settings like Anyigba shape nulliparous women's childbirth experiences. The present study seeks to fill this gap by investigating the influence of healthcare provider communication on the coping experiences of nulliparous women in selected hospitals in Anyigba Metropolis.

Theoretical Framework: Patient-Centered Care Model

The Patient-Centered Care (PCC) Model was popularised by the Institute of Medicine (IOM) in its landmark report "*Crossing the Quality Chasm: A New Health System for the 21st Century"*, published in 2001. While the *idea* of patient-centeredness had been discussed earlier in medical sociology and nursing (notably by Balint in 1969, who spoke about "patient-centered medicine"), it was the IOM (2001) that formally defined patient-centered care as one of the six aims for improving healthcare quality in the United States. Since then, it has been widely adopted as a guiding framework in healthcare, emphasising respect for patients' preferences, values, and needs, and encouraging shared decision-making.

The Patient-Centred Care (PCC) model provides a useful theoretical lens for examining how healthcare provider communication influences nulliparous women's coping experiences during childbirth. The PCC approach emphasises care that is respectful of, and responsive to, individual patient preferences, needs, and values, ensuring that patients are active participants in their healthcare journey (Institute of Medicine [IOM], 2001). At its core, the model highlights effective communication as the foundation of quality care, arguing that healthcare interactions must extend beyond the delivery of clinical interventions to include empathy, trust-building, shared decision-making, and emotional support (Stewart et al., 2014).

In maternity care, PCC is reflected in communication strategies such as listening attentively to women's concerns, providing clear and accessible information, acknowledging emotional needs, and involving women in decisions about their labour and delivery (Sidani & Fox, 2014). For nulliparous women, these communicative practices are particularly vital as they reduce fear and uncertainty, foster a sense of control, and enable adaptive coping mechanisms during childbirth. Studies have shown that when healthcare providers adopt patient-centered communication, women report greater satisfaction, lower anxiety, and a stronger ability to cope with pain and stress (Frampton et al., 2017).

The PCC model also draws attention to barriers that hinder effective communication, such as hierarchical provider-patient dynamics, staff shortages, and cultural insensitivity, all of which are prevalent in low- and middle-income settings like Nigeria (Okafor et al., 2021). Since this study seeks to evaluate how communication strategies employed by healthcare providers can either empower or disempower nulliparous women in coping with their first childbirth experiences, the PCC model is considered relevant. The PCC model not only frames communication as a technical skill but as a relational process that fundamentally shapes maternal outcomes.

Materials and Method

This study employed a mixed-methods design comprising a quantitative survey of nulliparous women and qualitative in-depth interviews with healthcare providers to obtain complementary perspectives on communication practices and coping during childbirth in the Anyigba Metropolis. The survey population comprised 383 registered nulliparous women from PAAU Teaching Hospital (301) and Grimmard Hospital (82), from which a sample size of 192 was determined using Krejcie and Morgan's table. The researcher proportionately allocated 152 to PAAU Teaching Hospital and 41 to Grimmard Hospital through proportionate stratified sampling, while convenience sampling was used to administer questionnaires to postnatal attendees.

The self-developed questionnaire, informed by the Patient-Centered Care Model and prior studies on provider–patient communication, underwent expert validation and achieved a Cronbach's Alpha reliability coefficient of 0.81 following a pilot test with 20 nulliparous women from another facility. For the qualitative component, purposive sampling was employed to select four healthcare providers (two doctors and two nurses) with at least three years' maternity-care experience. Interviews were conducted face-to-face in private office settings which lasted 25–35 minutes each, and were audio-recorded with consent while field notes were also taken. Ethical approval was obtained from the PAAU Teaching Hospital Ethics Committee, administrative approval was secured from Grimmard Hospital, and informed consent obtained from all participants, who were assured of confidentiality, voluntariness, and anonymity. Of the 192 questionnaires distributed, 188 were returned valid (98% response rate). Quantitative data were analysed using descriptive statistics (mean and standard deviation) in SPSS version 20 to assess perceived communication influence, while interview transcripts

were subjected to thematic analysis following Braun and Clarke's six-step approach, and emerging themes were integrated into the discussion to enrich interpretation of survey findings.

Data Presentation and Analysis

Analysis of Survey Data

A total of 192 copies of the questionnaire were distributed across the two selected hospitals, out of which 188 were correctly completed and returned, representing a 98% response rate. The survey analysis presents only the aspects that nulliparous women are qualified to evaluate, namely their perceptions of communication during childbirth, the perceived influence of communication on their coping mechanisms, and the challenges affecting effective provider–patient communication. The analysis of the 188 valid responses is presented in the tables below.

Table 1: Perceptions and Experiences of Nulliparous Women Regarding Communication during Childbirth

Perceptions and Experiences	VHE	HE	LE	VLE	N	$\bar{x}$	SD	Decision
I felt respected and valued through the way healthcare providers communicated with me.	74	61	32	21	188	3.00	1.12	Accepted
Communication from providers reduced my fear and anxiety during labour.	79	58	31	20	188	3.04	1.10	Accepted
I was actively involved in decisions about my childbirth due to effective communication.	62	57	44	25	188	2.82	1.15	Accepted
Providers showed empathy and emotional support during the childbirth process.	67	64	35	22	188	2.91	1.12	Accepted
I was dissatisfied with the level of attention and explanation given to me during childbirth.	28	39	70	51	188	2.20	1.13	Rejected

Cluster Mean = 2.79; SD = 0.197

The findings show that nulliparous women generally held positive perceptions of provider communication during childbirth. They reported that communication reduced fear ($\bar{x}$ = 3.04), created a sense of respect ($\bar{x}$ = 3.00), and facilitated emotional support ($\bar{x}$ = 2.91). However, some dissatisfaction existed, especially regarding insufficient explanations and attention,

although this perception did not dominate ($\bar{x}$ = 2.20). Overall, women perceived communication as supportive and reassuring.

Table 2: Perceived Influence of Communication on Coping Mechanisms of Nulliparous Women

Perceived Influence on Coping	VHE	HE	LE	VLE	N	$\bar{x}$	SD	Decision
Clear communication helped me remain calm and composed during labour.	83	61	29	15	188	3.13	1.04	Accepted
Emotional reassurance from providers improved my ability to manage pain.	72	65	31	20	188	3.01	1.07	Accepted
Encouragement and explanations increased my confidence to cope with childbirth stress.	69	60	36	23	188	2.91	1.13	Accepted
Communication about breathing/relaxation techniques supported my coping strategies.	64	57	40	27	188	2.80	1.16	Accepted
Lack of communication made me feel powerless and less able to cope.	27	34	71	56	188	2.18	1.13	Rejected

Cluster Mean = 2.81; SD = 0.204

The findings indicate that communication had a positive perceived influence on women's coping during childbirth. Clear explanations ($\bar{x}$ = 3.13) and emotional reassurance ($\bar{x}$ = 3.01) were especially helpful, enabling women to remain calm and manage pain. Breathing guidance and procedural explanations further strengthened coping. Few respondents felt communication weakened their coping ability ($\bar{x}$ = 2.18), suggesting that communication generally enhanced psychological stability.

Table 3: Challenges Affecting Effective Communication between Healthcare Providers and Nulliparous Women

Communication Challenges	VHE	HE	LE	VLE	N	$\bar{x}$	SD	Decision
Overcrowding and staff shortages limit effective communication.	81	67	25	15	188	3.13	1.03	Accepted
Use of medical jargon makes it difficult for mothers to understand.	73	62	31	22	188	2.99	1.08	Accepted
Workload stress reduces time for emotional support.	78	59	30	21	188	3.03	1.07	Accepted
Cultural and hierarchical barriers weaken open dialogue.	64	58	42	24	188	2.84	1.14	Accepted
Lack of privacy during labour hinders communication.	59	55	48	26	188	2.73	1.14	Accepted

Cluster Mean = 2.94; SD = 0.193

The findings reveal that several systemic and contextual challenges hinder effective communication during labour. Overcrowding and inadequate staffing ($\bar{x} = 3.13$) were the most critical barriers, followed by high workload and time constraints ($\bar{x} = 3.03$). Use of medical jargon ($\bar{x} = 2.99$) also complicated understanding. Cultural and hierarchical barriers, alongside limited privacy, further inhibited meaningful provider–patient interaction.

Presentation of Interview Data

To complement the survey findings and address aspects of the study that require professional insight, in-depth interviews were conducted with four healthcare providers across the two selected hospitals in Anyigba Metropolis. The interview participants included two medical doctors and two nurses with at least three years of experience in maternity care. The interviews explored the communication strategies they employ during labour, their observations on how nulliparous women respond to communication, the perceived influence of communication on women's coping abilities, and the challenges that hinder effective communication. Four major themes emerged from the data, presented below in line with the study objectives.

Theme 1: Communication Strategies Used by Healthcare Providers during Childbirth

Healthcare providers consistently emphasized the central role of communication in supporting women during labour. They described using a combination of verbal and non-verbal strategies to promote calmness, understanding, and cooperation. A nurse explained: "The first thing we do is to reassure them. Most first-time mothers are already scared, so we try to speak softly and use simple language to explain what is happening." Another provider highlighted the importance of clear explanations thus: "We avoid medical terms because they get confused. I explain each procedure such as why we need to check their cervix, why they feel pain, and what stage they are in." Providers also mentioned non-verbal strategies, including touch, body posture, and facial expressions, to reinforce reassurance: "Sometimes just holding their hand or maintaining eye contact helps them relax. They feel someone is there with them."

These insights confirm that communication strategies in the study setting are multifaceted and grounded in empathy, clarity, and supportive presence which are elements central to patient-centered maternity care.

Theme 2: Healthcare Providers' Observations of Nulliparous Women's Responses to Communication

Providers were asked only to share what they observe in women's behavioural responses during labour. Providers noted that effective communication tends to produce more cooperative, calmer mothers, while poor communication results in fear and tension. A midwife reported: "You can visibly see their fear drop when you explain what is happening. Their breathing becomes more stable, and they stop asking panicky questions." A doctor added: "Some of them come in very anxious, especially the younger women. But once we reassure them and guide them through the process, they seem to trust us more and follow instructions better." Providers also observed that when communication breaks down, often due to workload pressures, women appear distressed: "When we are overwhelmed and cannot give enough attention, they start to worry. Some keep asking for updates because they don't know what is going on." These observations align with survey responses showing that communication reduced anxiety for many women but left others dissatisfied during moments of limited staff availability.

Theme 3: Influence of Provider Communication on Women's Ability to Cope with Labour

Healthcare providers emphasized that communication plays a crucial role in enabling nulliparous women to cope with the physical and emotional demands of labour. Providers described how giving instructions, offering reassurance, and guiding women through breathing techniques improved their ability to manage pain and anxiety. One nurse stated: "If you teach them how to breathe and relax the muscles, the pain becomes more bearable for them. Without communication, they panic and tense up, making labour harder." Similarly, a doctor noted: "We see a clear difference between women who receive continuous reassurance and those left unattended. The former are calmer and more in control. Communication really shapes their coping behaviour." Providers also highlighted the role of tone: "Sometimes it's not about what you say but how you say it. A calm voice reduces their stress, while a harsh tone makes them more restless." These insights strongly support survey data showing that communication enhances women's coping through calmness, confidence, and pain management techniques.

Theme 4: Challenges Hindering Effective Communication

All interviewees identified multiple systemic and contextual challenges that impede effective communication. The most frequent challenge was staff shortages, which reduce providers' ability to offer individualized attention. A provider stated: "There are too many patients and too few staff. We want to spend more time with each woman, but we simply can't." Workload pressure and time constraints were also major barriers: "We may be attending to emergencies or multiple deliveries at once, so communication suffers. It's not intentional, it's the system." Providers also acknowledged cultural and linguistic barriers: "Some women hold strong traditional beliefs or speak local dialects that we don't speak well. It slows communication down because we need to find interpreters." Environmental factors such as lack of privacy also hindered communication: "Labour wards are crowded. Women may feel shy to ask questions or express pain when others are present." Finally, the use of medical jargon was identified as an inadvertent obstacle: "Sometimes we forget and use clinical terms. They nod as if they understand, but later we realize they did not." These provider perspectives mirror the survey findings, confirming that structural, cultural, and environmental barriers significantly reduce the quality of communication during childbirth.

Discussion of Findings

This study examined the communication practices used by healthcare providers during childbirth and explored how these practices shape the perceptions and coping experiences of nulliparous women in selected hospitals in Anyigba Metropolis. The discussion below integrates the survey data and the interview findings.

The first objective sought to identify the communication strategies healthcare providers use to support nulliparous women in the childbirth process. Healthcare providers reported using several key communication strategies, including the use of simple, non-technical language, continuous reassurance, active listening, and supportive non-verbal cues such as eye contact, appropriate touch, and calm tone. These strategies were described as essential for helping first-time mothers understand the childbirth process and remain emotionally stable. Providers emphasized that clear explanations of procedures and progress reduce panic, while non-verbal expressions of empathy help mothers feel supported. These findings align with the Patient-Centered Care (PCC) Model, which underscores communication as a foundation for respectful and supportive maternity care. The strategies reported also reflect earlier evidence by Bohren et al. (2017), who noted that continuous informational and emotional support improves

women's labour experiences, and by McCabe (2004), who highlighted the importance of relational communication in reducing patient anxiety. Overall, the data show that healthcare providers in the study setting employ a combination of verbal and relational communication practices that align with patient-centered maternity care guidelines.

The second objective sought to explore the perceptions and experiences of nulliparous women regarding the communication and support they received during childbirth. Findings revealed that most nulliparous women held positive perceptions of the communication they received during childbirth. Many respondents indicated that communication from providers reduced their fear and anxiety, made them feel respected, and offered emotional support. These findings correspond with providers' observations that women tend to relax, cooperate more, and express fewer fears when communication is clear and reassuring. However, the survey also revealed pockets of dissatisfaction, particularly regarding instances where providers did not give adequate explanations or attention, often during busy periods. This reflects interview findings that workload, staffing shortages, and multiple simultaneous emergencies sometimes limit providers' ability to engage in consistent, high-quality communication. These outcomes reinforce previous studies, such as Fenwick et al. (2009), which found that clear staff communication reduces childbirth fear, and Slade et al. (2019), which showed that poor communication increases stress and negative emotional responses. The findings therefore show that while communication is generally perceived positively, structural constraints sometimes undermine women's experiences.

The third objective sought to determine the extent to which communication influences the coping mechanisms of nulliparous women during childbirth. Findings showed that communication was perceived by women as playing a strong role in enabling them to cope during labour. Respondents noted that clear instructions helped them remain calm, reassurance improved their ability to manage pain, and explanations increased their confidence to endure labour stress. Interview data support these findings, as providers reported that women who received continuous guidance and reassurance tended to breathe better, relax their muscles, follow instructions, and display more emotional stability during labour. The findings correspond with the PCC model, which posits that communication strengthens patient autonomy, emotional security, and psychological readiness to cope with stress. They also align with Green and Baston (2003), who found that communication enhances women's sense of control, and with Hodnett (2002), who reported that satisfaction and coping are shaped more by interpersonal communication than by the level of pain experienced. Because the study

assessed perceived influence, rather than statistically tested influence, the findings appropriately indicate that communication was viewed by women as a key support mechanism during childbirth.

The fourth objective sought to examine the challenges affecting effective communication between healthcare providers and nulliparous women in selected hospitals in Anyigba. Both survey and interview data revealed several structural and contextual challenges that hinder effective communication in the study setting. The most prominent challenges identified were staff shortages, overcrowded labour wards, and high workload which are factors that limit the time available for meaningful provider–patient interactions. Providers also acknowledged that medical jargon, cultural differences, and linguistic barriers impeded clear communication. Additionally, lack of privacy in labour wards prevented open dialogue, especially for young or anxious women. These findings are consistent with those of Filby et al. (2016), who identified systemic constraints as major barriers to midwifery communication in resource-limited settings, and with Okafor et al. (2021), who documented authoritarian communication patterns in Nigerian public hospitals arising from workload pressure and facility limitations. The findings point to the need for institutional improvements such as increased staffing, privacy-enhancing infrastructure, and communication-focused training to support sustainable enhancement of maternity communication practices.

Across all objectives, the study shows that communication is a critical component of maternity care for nulliparous women. Provider interviews confirm that communication is intentional and multifaceted, while survey data show that women perceive communication as valuable for reducing fear, enhancing understanding, and improving coping capacity. However, the communication process is constrained by persistent systemic challenges. The findings validate the relevance of the PCC model, demonstrating that communication is not an optional supplement to clinical care, but a core determinant of women's childbirth experiences in the study area.

Conclusion and Recommendations

This study investigated the influence of communication between healthcare providers and nulliparous women in coping with childbirth experiences in selected hospitals in Anyigba Metropolis, using both quantitative and qualitative approaches. The findings demonstrated that effective communication through clear verbal explanations, emotional reassurance, active listening, and supportive non-verbal cues as they played pivotal role in reducing fear,

enhancing trust, and strengthening coping mechanisms among first-time mothers. The study further revealed that nulliparous women generally perceived communication from healthcare providers positively, noting its role in reducing anxiety and promoting dignity. However, instances of dissatisfaction were also reported, particularly when workload pressures limited explanations and emotional support. Communication was found to be central in shaping coping strategies, especially in helping women remain calm, manage pain, and develop confidence during labour. Despite these positive outcomes, significant challenges hindered effective communication. These included overcrowding, staff shortages, excessive workload, the use of medical jargon, cultural barriers, hierarchical provider-patient dynamics, and lack of privacy in labour wards. These findings affirm the relevance of the Patient-Centered Care (PCC) Model, which emphasizes empathy, respect, and shared decision-making but also highlights systemic constraints that limit its full realization in Nigerian maternity care. The study affirms that communication is not just an adjunct to clinical care but a core determinant of maternal coping and satisfaction during childbirth. Addressing structural and cultural barriers is essential to achieving consistent, patient-centered maternity care in Anyigba and similar areas.

Based on the findings, the following recommendations were made:

1. Healthcare providers should receive regular training in patient-centered communication, focusing on empathy, active listening, use of simple language, and non-verbal support to enhance the childbirth experience of nulliparous women.
2. The government and hospital management should recruit more healthcare personnel and reduce overcrowding in maternity wards to allow providers adequate time for personalized communication and emotional support.
3. Healthcare providers should avoid excessive medical jargon and instead use plain, culturally sensitive language that first-time mothers can easily understand, ensuring informed participation in decision-making.
4. Hospitals should improve the physical setup of labour wards to ensure privacy and confidentiality, thereby encouraging open dialogue between providers and patients.
5. Training modules should incorporate awareness of cultural and traditional beliefs surrounding childbirth to help providers communicate effectively within the socio-cultural context of Anyigba.
6. Policies should be developed to encourage continuous emotional reassurance, guidance on breathing and relaxation, and shared decision-making as standard practices in maternal care.

7. Hospital administrators should establish feedback mechanisms where women can report on their communication experiences, providing data to improve maternity care quality and align with PCC principles.

References

Afulani, P. A., Diamond-Smith, N., Phillips, B., Singhal, S., & Sudhinaraset, M. (2020). Validation of the person-centered maternity care scale in India. *Reproductive Health, 17*(1), 1–15. https://doi.org/10.1186/s12978-020-01015-2

Afulani, P. A., Diamond-Smith, N., Phillips, B., Singhal, S., & Sudhinaraset, M. (2021). Validation of the person-centered maternity care scale in India. *Reproductive Health, 18*(1), 1–15. https://doi.org/10.1186/s12978-020-01015-2

Bohren, M. A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R. K., & Cuthbert, A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews, 7*(CD003766). https://doi.org/10.1002/14651858.CD003766.pub6

Bohren, M. A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R. K., & Cuthbert, A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews, 7*(CD003766). https://doi.org/10.1002/14651858.CD003766.pub6

Bohren, M. A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R. K., & Cuthbert, A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, 2017(7), CD003766. https://doi.org/10.1002/14651858.CD003766.pub6

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., & Gülmezoglu, A. M. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS Medicine, 12*(6), e1001847. https://doi.org/10.1371/journal.pmed.1001847

Downe, S., Lawrie, T. A., Finlayson, K., & Oladapo, O. T. (2018). Effectiveness of respectful care policies for women using routine intrapartum services: A systematic review. *Reproductive Health, 15*(23). https://doi.org/10.1186/s12978-018-0466-y

Fenwick, J., Gamble, J., Nathan, E., Bayes, S., & Hauck, Y. (2009). Pre- and post-partum levels of childbirth fear and the relationship to birth outcomes in a cohort of Australian women. *Journal of Clinical Nursing, 18*(5), 667–677.

Fenwick, J., Gamble, J., Nathan, E., Bayes, S., & Hauck, Y. (2009). Pre- and postpartum levels of childbirth fear and the relationship to birth outcomes in a cohort of Australian women. *Journal of Clinical Nursing, 18*(5), 667–677. https://doi.org/10.1111/j.1365-2702.2008.02568.x

Fenwick, J., Gamble, J., Nathan, E., Bayes, S., & Hauck, Y. (2009). Pre- and postpartum levels of childbirth fear and the relationship to birth outcomes in a cohort of Australian

women. *Journal of Clinical Nursing, 18*(5), 667–677. https://doi.org/10.1111/j.1365-2702.2008.02568.x

Filby, A., McConville, F., & Portela, A. (2016). What prevents quality midwifery care? A systematic mapping of barriers in low- and middle-income countries from the provider perspective. *PLoS ONE, 11*(5), e0153391. https://doi.org/10.1371/journal.pone.0153391

Filby, A., McConville, F., & Portela, A. (2016). What prevents quality midwifery care? A systematic mapping of barriers in low- and middle-income countries from the provider perspective. *PLoS ONE, 11*(5), e0153391. https://doi.org/10.1371/journal.pone.0153391

Filby, A., McConville, F., & Portela, A. (2016). What prevents quality midwifery care? A systematic mapping of barriers in low- and middle-income countries from the provider perspective. *PLoS ONE, 11*(5), e0153391. https://doi.org/10.1371/journal.pone.0153391

Filby, A., McConville, F., & Portela, A. (2016). What prevents quality midwifery care? A systematic mapping of barriers in low- and middle-income countries from the provider perspective. *PLoS ONE, 11*(5), e0153391. https://doi.org/10.1371/journal.pone.0153391

Fleischer, S., Berg, A., Zimmermann, M., Wüste, K., & Behrens, J. (2009). Nurse-patient interaction and communication: A systematic literature review. *Journal of Public Health, 17*(5), 339–353. https://doi.org/10.1007/s10389-008-0238-1

Frampton, S. B., Guastello, S., Hoy, L., Naylor, M., Sheridan, S., & Johnston-Fleece, M. (2017). Harnessing evidence and experience to change culture: A guiding framework for patient and family engaged care. *National Academy of Medicine, Discussion Paper.* https://doi.org/10.31478/201701f

Green, J. M., & Baston, H. A. (2003). Feeling in control during labour: Concepts, correlates, and consequences. *Birth, 30*(4), 235–247. https://doi.org/10.1046/j.1523-536X.2003.00253.x

Green, J. M., & Baston, H. A. (2003). Feeling in control during labour: Concepts, correlates, and consequences. *Birth, 30*(4), 235–247. https://doi.org/10.1046/j.1523-536X.2003.00253.x

Hodnett, E. D. (2002). Pain and women's satisfaction with the experience of childbirth: A systematic review. *American Journal of Obstetrics and Gynecology, 186*(5), S160–S172.

Hodnett, E. D. (2002). Pain and women's satisfaction with the experience of childbirth: A systematic review. *American Journal of Obstetrics and Gynecology, 186*(5), S160–S172. https://doi.org/10.1067/mob.2002.123704

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2013). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews, 7*, CD003766.

Hodnett, E. D., Gates, S., Hofmeyr, G. J., Sakala, C., & Weston, J. (2013). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews, 7*(CD003766). https://doi.org/10.1002/14651858.CD003766.pub5

Institute of Medicine (IOM). (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: National Academies Press.

Jin, Y., Xu, J., & Yuan, J. (2022). The relationship between midwives' empathy and women's childbirth experience: A cross-sectional study. *BMC Pregnancy and Childbirth, 22*(1), 1–9. https://doi.org/10.1186/s12884-022-04825-0

Lunda, P., Downe, S., & Mwenechanya, M. (2018). Women's experiences of continuous support during childbirth: A qualitative study. *BMC Pregnancy and Childbirth, 18*, Article. https://doi.org/10.1186/s12884-018-1784-1

McCabe, C. (2004). Nurse-patient communication: An exploration of patients' experiences. *Journal of Clinical Nursing, 13*(1), 41–49. https://doi.org/10.1046/j.1365-2702.2003.00831.x

O'Hagan, S., Manias, E., Elder, C., Pill, J., Woodward-Kron, R., McNamara, T., & Webb, G. (2014). What counts as effective communication in nursing? Evidence from nurse educators and clinicians' feedback on nurse interactions with simulated patients. *Journal of Advanced Nursing, 70*(6), 1344–1355. https://doi.org/10.1111/jan.12296

Ogbonna, C., & Akinyemi, O. (2022). Barriers to maternal health services utilization in Nigeria: A review. *African Journal of Reproductive Health, 26*(3), 15–27.

Ogbonna, C., & Akinyemi, O. (2022). Barriers to maternal health services utilization in Nigeria: A review. *African Journal of Reproductive Health, 26*(3), 15–27. https://doi.org/10.29063/ajrh2022/v26i3.2

Okafor, I. I., Arinze-Onyia, S. U., Ohayi, S. R., Onodugo, V. A., & Ugwu, E. O. (2021). Respectful maternity care in Nigerian public hospitals: A mixed-methods study. *International Journal of Gynecology & Obstetrics, 153*(2), 365–372. https://doi.org/10.1002/ijgo.13432

Okafor, I. I., Arinze-Onyia, S. U., Ohayi, S. R., Onodugo, V. A., & Ugwu, E. O. (2021). Respectful maternity care in Nigerian public hospitals: A mixed-methods study. *International Journal of Gynecology & Obstetrics, 153*(2), 365–372. https://doi.org/10.1002/ijgo.13432

Okafor, I. I., Arinze-Onyia, S. U., Ohayi, S. R., Onodugo, V. A., & Ugwu, E. O. (2021). Respectful maternity care in Nigerian public hospitals: A mixed-methods study. *International Journal of Gynecology & Obstetrics, 153*(2), 365–372. https://doi.org/10.1002/ijgo.13432

Okafor, I. I., Arinze-Onyia, S. U., Ohayi, S. R., Onodugo, V. A., & Ugwu, E. O. (2021). Respectful maternity care in Nigerian public hospitals: A mixed-methods study. *International Journal of Gynecology & Obstetrics, 153*(2), 365–372. https://doi.org/10.1002/ijgo.13432

Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., … Declercq, E. (2014). Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. *Lancet, 384*(9948), 1129–1145.

Sacks, E. (2017). Defining disrespect and abuse of newborns: A review of the evidence and an expanded typology of respectful maternity care. *Reproductive Health, 14*(66), 1–9.

Sidani, S., & Fox, M. (2014). Patient-centered care: Clarification of its specific elements to facilitate interprofessional care. *Journal of Interprofessional Care, 28*(2), 134–141. https://doi.org/10.3109/13561820.2013.862519

Slade, P., Balling, K., Sheen, K., & Houghton, G. (2019). Establishing a valid construct of traumatic childbirth experiences: A qualitative study. *BMJ Open, 9*(3), e024296.

Slade, P., Balling, K., Sheen, K., & Houghton, G. (2019). Establishing a valid construct of traumatic childbirth experiences: A qualitative study. *BMJ Open, 9*(3), e024296. https://doi.org/10.1136/bmjopen-2018-024296

Slade, P., Balling, K., Sheen, K., & Houghton, G. (2019). Establishing a valid construct of traumatic childbirth experiences: A qualitative study. *BMJ Open, 9*(3), e024296. https://doi.org/10.1136/bmjopen-2018-024296

Stewart, M., Brown, J. B., Donner, A., McWhinney, I. R., Oates, J., Weston, W. W., & Jordan, J. (2014). The impact of patient-centered care on outcomes. *The Journal of Family Practice, 49*(9), 796–804.

Størksen, H. T., Garthus-Niegel, S., Vangen, S., & Eberhard-Gran, M. (2013). Fear of childbirth; The relation to anxiety and depression. *Acta Obstetricia et Gynecologica Scandinavica, 92*(1), 130–136.

Størksen, H. T., Garthus-Niegel, S., Vangen, S., & Eberhard-Gran, M. (2013). Fear of childbirth; The relation to anxiety and depression. *Acta Obstetricia et Gynecologica Scandinavica, 92*(1), 130–136. https://doi.org/10.1111/aogs.12072

World Health Organization (WHO). (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience.* Geneva: World Health Organization.

World Health Organization (WHO). (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience.* Geneva: World Health Organization. Retrieved from https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/