RELATIONAL COMMUNICATION BEHAVIOUR IN GROUP PRENATAL CARE CLINICS IN IBADAN, NIGERIA

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CERTIFICATION

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DEDICATION

This project is dedicated to the Almighty God without whom I am nothing. It is also dedicated to my loving husband and children.

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ABSTRACT

Relational communication behaviour in group prenatal care explores the relational interaction between caregivers and pregnant women. Existing studies on group prenatal care in Nigeria have focused on evolving antenatal practices, with little attention paid to the implication of systemic issues for relational communication in the Nigeria group care programme. Therefore, this study was designed to investigate the dynamics of systemic issues in the prenatal care clinics in Ibadan, Nigeria. This was with a view to determining the influence of systemic issues on how pregnant women, nursing mothers and care providers perceived the care quality.

Attribution, Systems and Communication Accommodation theories were used as the framework, while the mixed methods design was employed. Eight group prenatal clinics were purposively selected (Jericho Nursing Home, Jericho Specialist, Ring Road Specialist, Maternal and Child Health Apata, Our Lady of Apostles Oluyoro, St. Peters Aremo, Moniya General and Adeoyo Teaching Hospitals). Group prenatal care questionnaire was administered to 355 available pregnant women from June to October, 2018 across the selected hospitals. In-depth interviews were conducted with eight group care nurses, while four sessions of focus group discussion with eight respondents per group, were held across four randomly selected hospitals. Through a 20-item observational checklist, pregnant women and nurses' verbal and non-verbal behaviours were observed for five months across the sampled hospitals. Quantitative data were analysed using ANOVA at 0.05 level of significance, while qualitative data were content-analysed.

Pregnant women at Adeoyo Hospital reported a statistically significant difference [$F_{(3;256)}$ =7.48] in nurses' rapport, listening [$F_{(3;256)}$=8.84], informing [$F_{(3;256)}$=10.38] and feedback skills $F_{(3;254)}$=2.87]. Conversely, there was no significant difference in nurses' confirming/disconfirming behaviours at Adeoyo. The Chief Medical Director (CMD) of St. Peters Hospital Aremo noted the hospital's location within a cemetery made pregnant women avoid it. Nursing mothers at St. Peters Aremo disagreed with the CMD's claims, stressing that their manageable group size contributed to the good relational care. The absence of a feedback checking mechanism in seven of the eight hospitals explains why interviewed caregivers could not determine how feedback modified the conduct of prenatal care. Differences in the administration of prenatal care across the hospitals were based on group size, care provider and situational factors. Rapport building, listening, confirming (acknowledgement and supportive responses), disconfirming (side-talk, conversational dominance and one-sided laughter) and feedback skills were the index of relational communication behaviours. The unmanageable sizes of groups of pregnant women at three hospitals accounted for their inattentiveness and side talk. Providers' conversational dominance was, however, common across the hospitals. Nursing mothers at two of the hospitals attested to the disconfirming behaviours of nurses.

Prevalent systemic issues weakened existing relational communication between care receivers and the nurses in prenatal care clinics in Ibadan, Nigeria.

Keywords: Relational communication, Group prenatal care in Ibadan, Pregnant women, Nursing mothers

Word count: 446

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LIST OF ABBREVIATIONS

JNH	–	Jericho Nursing Home
JSH	–	Jericho Specialist Hospital
RRSH	–	Ring Road Specialist Hospital
OLA	–	Our Lady of Apostles Catholic Hospital Oluyoro
MNCH	–	Maternal and Child Health Apata
GPC	-	Group Prenatal Care
UK	-	United Kingdom
CP	-	Centring Pregnancy
PP	-	Parenting Partners
EC	-	Expecting and Connecting
TBA	-	Traditional Birth Attendants
SOP	-	Standard Operating Procedure
IEC	-	Information education and communication
WHO	-	World Health Organisation
IPA	-	Interaction Process Analysis

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CHAPTER ONE
INTRODUCTION

1.1 Background to the study

The group prenatal care programme is a health care model that not only allows pregnant women to receive systematic care and counselling within the context of a group but also affords such women better psychosocial adjustment throughout the period of pregnancy. The form and practice of the care model differs across different countries and this has implication on care receivers' health outcome. In the United States of America, for example, the introduction of the group prenatal model helped to reduce power relations between patients and health care providers (Ickovics, Kershaw, Westdahl, Magriples, Massey, Reynolds & Rising, 2007; Heberlein, 2014). Though prenatal care is also dispensed to pregnant women within a group context in Nigeria, there are still existing power differentials between patients and care providers. It is speculated that the formality of the group process accounts for the prevalent power play particularly between nurses and pregnant women. On the one hand, the differences in patients ' culture, education, experience and personality account for the relational divide between them and nurses, while, on the other hand, nurses' experience and training in the biomedical approach to care explains the power struggle between them and patients. The praxis of the nursing profession in contemporary times, however, calls for a change in the approach to care.

Although medical malpractice legal suits are rarely instituted in Nigeria, recent developments in the promotion of health insurance schemes tend to put many hospitals out of business especially where the paternalistic approach to care is favoured. Thus, in recent times, there has been a gradual paradigm shift from the paternalistic approach to patient-centred medicine, which has led to the formation of different career groups (Sears, 2010). The growing awareness of health workers on

the importance of partnership between patients and caregivers especially in maternity care also accounts for the emergence of the centring pregnancy model of prenatal care which is otherwise referred to as group prenatal care. The group prenatal care model was invented and popularised by Sharon Schindler Rising in 1998. In this model of care, between 8 and 12 women of similar gestational ages of pregnancy are put into a group under the supervision of a facilitator (midwife, obstetrician or nurse) and an attendant who may be a dietician, a health educator or a social worker. The facilitators bear the responsibility of the physical and emotional wellbeing of participants as they closely monitor the women throughout the period of their pregnancy. Thus, expectant mothers' concerns when expressed are addressed within the peer space so that mutual trust exists between members and their providers. The facilitator earns respect through partnership and a more inclusive relationship with participants. Meanwhile, these women are offered the opportunity of dictating the topic, as well as the pace of each meeting' s discussion. At the beginning of every group session, pregnant women are to fill a self– assessment questionnaire which forms the content of the day' s discussion (Test, 2008). During the group sessions, the group leader (midwife) initiates the discussion but allows the women to share their thoughts on the issue. The group leader allows members of the group to participate, listens to them and corrects them when there is a need to do so. The group' s session is a forum for the women to share their concerns, anxieties and myths surrounding vaginal delivery, breastfeeding, family planning and sundry other issues.

A number of scholarly efforts devoted to group prenatal care in the United States deal with the impact of prenatal care on neonatal and maternal outcomes of African-American women with low-risk pregnancies. The centring pregnancy model was said to have reduced incidence of preterm delivery and low birth weight among premature infants. It has also reduced the call for caesarean section among a population where vaginal delivery is increasingly becoming unpopular (Ickovics, *et al*, 2007). Results from other studies show that there is a correlation between the use of the centring pregnancy model of prenatal care and an improvement in patient-provider interaction. The use of the model in some other places has been reported to have led to a reduction in the stress level experienced by pregnant women and better psychosocial adjustment during prenatal and postnatal care (Ickovics, *et al*. 2007; Heberlein, 2014). In contrast,

recent scholarly efforts on the centring pregnancy model of care present conflicting reports that may undermine the efficacy of the model and its wider acceptance in varied settings (Carter & Mazzoni, 2017). The practice of the centring pregnancy model of group prenatal care is gaining acceptance in some parts of Africa. For example, the model has been tested in Ghana, Egypt and Tsibiri in Kaduna State Nigeria. There is however, danger in replicating the model in this part of the world without due cognizance of the dynamics of the indigenous African culture and environment. Nevertheless, the act of dispensing prenatal care within a group forum is not totally alien to the African continent, as its development in Nigeria, for instance, predates the evolvement of the centring pregnancy model of care. Interestingly, African scholars have paid little or no attention to that area of research; for which reason, the nuances and limitations of the existing model of prenatal care in Nigeria remain unknown. Akinware (2015) for example, has also argued that, to date, most studies on group prenatal care have been conducted in developed countries; thus, there is sparse literature to describe the quality of group prenatal care in the developing areas of the world, as well as indicating if the procedure of delivery satisfies women' s preferences and needs.

The above observation informs the need to investigate the content and the relational aspect of communication that occurs in such group prenatal care. It should be noted here that in Nigeria, group prenatal care is otherwise referred to as the health-talk programme. Though the health- talk programme also occurs within a group context it is not the same as the centering pregnancy model of care. The health- talk programme to Akinware (2015) is characterised by facilitated sessions during the course of which the women are supposed to receive both informational and emotional support from midwives/nurses. Informational support comes in the form of relevant health education on various topics such as nutrition, exercise, breast-feeding, personal hygiene, family planning among other topics. On the other hand, emotional support is provided to the pregnant women by way of allaying their anxieties over varying issues, such as, for example, the fear of many pregnant women that sexual intimacy with their partners during pregnancy may lead to a miscarriage (Al-Ateeq & Al-Rusaress, 2015: 239; Akinware, 2015: 64). The health-talk is usually conducted very early in the morning by midwives/nurses in government hospitals before the

women' s private consultations with the doctors. The nurses/midwives who educate the women do so with the aid of IEC (informational, educational and communication) materials. Also, during the health-talk programme, the women undergo relevant screening exercises such as urine test, blood pressure test and body weight index (Akinware, 2015:64).

Besides the medical assessment, nurses educate pregnant women on relevant subject areas during the course of scheduled appointments. Communication is thus employed by both nurses and expectant mothers in negotiating meaning. Every communication encounter has both content and relationship dimensions (Hargie & Dickson, 2004). One of the earliest researches on relational communication by Bales (1950) distinguished between the content aspect of communication and its relationship aspects. The content dimension, according to Bales, has to do with information that is exchanged by interlocutors in the communication encounter. Some other authors describe the content dimension of communication as being synonymous with task-oriented communication (Keyton, 1999; Keyton, 2009; Kehoe, 2011). For example, the content dimension of communication in a group prenatal care may refer to information that is supplied to the pregnant women on how to maintain a healthy pregnancy. On the other hand, the relationship aspect of communication is otherwise referred to as relational communication. According to Keyton (1999:92),

> Relational communication in groups refers to the verbal and non-verbal messages that create the social fabric of a group by promoting relationships between and among group members. It is the affective or expressive dimension of group communication as opposed to the instrumental or task-oriented dimension.

In other words, while the content dimension of communication depicts what is exchanged during the communication encounter, the relational dimension has to do with how information is exchanged and interpreted within the group. The content and relational dimensions to communication are however, not independent of each other, but are inextricably intertwined (Kehoe, 2011). Therefore, there is an interdependent relationship between content and relational dimensions of communication. However, in the opinion of Barbosa, Piccolo and Barbosa (2019), relational communication applied to nursing should empower clients in the decision making process, create

mutual provider-client satisfaction and ultimately lead to an improved health outcome. Finally, the core principles of the Nightingale nursing tradition espouse the essentiality and interconnectedness between the content and relational communication in hospitals, as nurses are encouraged to work in the spirit " which asks not what do you want? But what can I do for you? How can I help you" ?

1.2 Statements of the problem

In the developed parts of the world the existence of medical malpractice legal suits and the promotion of patient-centred medicine in recent times have encouraged clients to demand more relational care. Consequently, this has led to the evolvement of improved prenatal care practices such as the Centring Pregnancy (CP), Parenting Partners (PP) and Expecting and Connecting (EC) models. A system of prenatal care that is gaining global acceptance is the centring pregnancy model also referred to as group prenatal care (GPC). Interestingly, health care providers in Nigeria also dispense prenatal care to clients within a group forum. While there are numerous studies emanating from the West on group prenatal care and its influence on health outcome (Heberlein, 2014; Carter & Mazzoni, 2017), there is a dearth of literature on the nature of the group prenatal care that is practised in low resource economies such as Nigeria. There is a report from scholars that previous studies on group prenatal care lacked rigour and a Standard Operating Procedure (SOP) (Sheeder, Weber, Yorga & Kabir-Greher, 2012). In view of the absence of a Standard Operating Procedure (SOP) in the reviewed studies, one could justifiably assume that previous works on group prenatal care has failed to examine the dynamics of group processes involved in group prenatal care (Sheeder, *et al.,* 2012).

In addition, the fundamental differences in the size and features of group prenatal care have implication on both providers and clients, as there is evidence to suggest that GPC in high resource economies has a significant effect not only on maternal and neonatal health outcomes but also on providers' relational skills. In contrast, the strength and weaknesses of the existing system of prenatal care in Nigeria remains unknown due to the paucity of research in that area. Again, the approach of caregivers to relational care in public hospitals is said to affect clients' health-care seeking decision (Nnebue, Ebenebe, Adinma, Iyoke, Obionu & Ilika, 2014; Nwaeze, Enabor,

Oluwasola & Aimakhu, 2013). Other scholars, however, contend that when a receiver' s relational assessment of a sender is consistent with the sender' s messages, the receiver will attribute validity and credibility to the sender' s messages (Keyton & Beck, 2009). With particular reference to the current study, a pregnant woman' s relational assessment of nurses/midwives is likely to influence the extent to which such a woman accepts or rejects the messages that come from the nurses. Moreover, a large group size may pose difficulties for the health-care provider in developing a one- on- one relationship with members of the group. As a result, pregnant women may unwittingly develop inaccurate perceptions about the attitude of health-care providers to dispensing care. Previous studies on the perceived quality of prenatal care services in Nigeria indicate a lacklustre performance on the part of care providers (Envuladu, Agbo, Lassa, Kigbu & Joakah, 2013; Nnebue, *et al.,* 2013). These studies examined the issue from a monolithic perspective, without recourse to associated factors that may account for individual behaviour. In addition, studies suggest that contemporary group researchers have devoted much scholarly attention to the study of task groups with little attention paid to relational communication and relational groups (Keyton & Beck, 2009; Dorbosh, 2015). The preference of small group researchers to study task groups and task dimension of communication probably stemmed from the goal-oriented nature of the society. Thus, groups that are organised solely for social support purposes are likely to be perceived as atypical in nature. In order to address the identified gaps, this study sought to investigate the underlying causes of perceived relational and group problems. It examined how factors such as hospital' s administrative structure, physical infrastructure and other variables contribute to nurses' performance in the prenatal care hospitals. It also investigated the relational dimension of communication in prenatal care groups in selected Nigerian hospitals, more specifically, in Ibadan, Oyo State Nigeria.

1.3 Research questions

This study seeks to provide answers to the following research questions:

1. What are the characteristics of the group prenatal care model as practised in selected hospitals in Ibadan?
2. What are the relational dynamics between caregivers and pregnant women during interaction within group spaces in selected hospitals?

3. How do pregnant women in selected Ibadan hospitals perceive the relational communication behaviour in their group?
4. What structural organisational characteristics influence the relational communication behaviours in the group spaces?
5. In what ways did prenatal care clinics in Ibadan modify operations in response to patient' s feedback

1.4 Objectives of the study

The central concern of this study is to ascertain the relational communication behaviour of those involved in group prenatal care sessions, as a means of determining the effectiveness of such groups in promoting prenatal care adoption among pregnant women. The study also seeks to investigate the following:

- To identify the attributes of prenatal care groups in Ibadan;
- To establish the relational dynamics in the various group prenatal care clinics in Ibadan;
- To examine the perception of pregnant women on the pattern of relational communication in prenatal care clinics in selected hospitals in Ibadan;
- To identify the structural organisational characteristics that are likely to affect the relational communication in a group prenatal care in selected hospitals in Ibadan; and
- To identify the extent to which prenatal care groups in Ibadan modify their operations to reflect the feedback from clients.

1.5 Significance of the study

This work is significant as it hopes to refocus the attention of health policymakers, government, researchers and health care providers on the importance of relational communication in maternity care delivery. If the relational skill of health-care providers is in doubt, their client may resort to patronising alternative health-care centres such as faith-based or traditional-medical maternity homes. The higher the number of deliveries in such alternative health-care homes, the more difficult it will be to curtail infant and maternal mortality in the country. Similarly, understanding

how women perceive nurses' relational skills can help to design or improve interventions and policies aimed at care givers. Consequently, this study will assist health policy makers to develop relevant policies on the retraining of health care providers especially in the area of interpersonal communication skills. Furthermore, it will also offer useful insights into the inherent strengths and weaknesses of the existing model of prenatal care in Nigeria, as a means of assisting policymakers to develop a standard prenatal care guide that will ensure uniformity in the administration of prenatal care in the country.

Similarly, one of the objectives of this study is to ensure that health care providers who are usually at the forefront of prenatal care delivery in the country are given appropriate feedback on the quality of their services. Hence when the report of this study is appropriately disseminated, care givers will receive feedback on the conduct of prenatal care. If the latter does not receive feedback from their clients there may be no improved delivery of maternity care in the country.

This study is also significant in that it has mitigated one of the limitations of previous health communication studies which is an overt focus on interpersonal than intergroup dynamics. This study has also re-established the role of Nigerian researchers in furthering research in this line of enquiry, in order to underline, the importance of redesigning the content of group prenatal care in the country.

1.6 Scope of the study

The focus of this study is to examine the relational communication behaviour of nurses/midwives who facilitate group prenatal care sessions in selected government hospitals in Ibadan as well as those of the pregnant women who access care. The relational communication skills of nurses/midwives cannot be separated from the behaviours/attitude of pregnant women in the group prenatal care. Thus, this study will examine perceptions of relational communication behaviour, not only from the perspective of pregnant women but also from that of the nurses/midwives.

In addition, this study investigated structural organisational characteristics that determine the relational communication during group prenatal care. It also examined the nature of group prenatal care in Nigeria and if each of the sampled hospitals in this

study adjusted their mode of operations to reflect the feedback from their clients. The sampled hospitals in this study are as follows: Adeoyo Maternity Hospital, Yemetu; General Hospital, Moniya; Jericho General Hospital; Jericho Nursing Home; Maternal and Child Health Hospital, Apata, Ibadan; Ring Road State Hospital, Ibadan; St Peters Hospital, Aremo and Our Lady of Apostles Catholic Hospital, Oluyoro.

1.7 Operational definition of key terms

Affection: It refers to the level of social support a pregnant woman receives from other pregnant women in a group prenatal care as well as the support from her caregivers.

Complementarity: Refers to the similarity in the communication pattern of both the pregnant woman and her caregiver.

Context: This may refer to either the peculiarity of the hospital environment or the situation surrounding a communication encounter.

Control: This refers to the precautions taken by pregnant women during pregnancy to forestall any negative birth outcome.

Culture: It may refer to the differences in the allocation of meaning in a communication encounter as a result of differences in the orientation of transceivers.

Depression: This is a negative state of mind experienced by many pregnant women as a result of the secretion of some hormones. This state of mind is more prevalent among first-time mothers as well as among women suffering from abuse, neglect and poverty.

Dialogue: This refers to communication between pregnant women in a group or communication between nurses and pregnant women. A dialogue in the group may either advance group goals or stalk their progress.

Dominance: This depicts the level of control that is exercised by either the pregnant woman or her caregiver in the course of an interaction.

Government policy: This refers to the guidelines or provision of government as regards the administration of health care in the country.

Hospital system: It refers to the administrative framework that governs the dispensation of care to pregnant women in each hospital.

Inclusion: It refers to the extent to which pregnant women feel a sense of belonging with other pregnant women in a group prenatal care.

Positive birth outcome: Refers to safe delivery of a baby.

Pregnant women: This refers to the differences in the perceptual screens of pregnant women based on differences in reasoning, education, age, parity etc.

Prenatal care groups: It comprises a number of pregnant women put into groups by their caregivers in order to receive both informational and emotional support.

Relational communication behaviour: This refers to actions/conduct of individuals that depict their sensitivity to the feelings of others with whom they are interacting.

Rigid complementarity: Rigid complementarity occurs when a pregnant woman and her caregiver consistently communicate in a particular way.

Satisfaction with care: This refers to the extent to which pregnant women approve all the activities and process involved in the dispensation of care in hospitals.

Submissiveness: It is the level of control that either the pregnant woman or the health-care provider relinquishes to another transceiver in the course of an interaction.

CHAPTER TWO
LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Preamble

In the introductory chapter, systemic issues in the West leading to the development of improved models of prenatal care were discussed. In particular, this researcher noted the way Nigerian scholars paid little attention to the nation' s prenatal model of care but have driven research on the centring pregnancy model. As such, while the rhetoric on the CP model is increasing exponentially, little is known on the current practices of group prenatal care in Nigeria. The central argument here is, there may be a mismatch between idealistic perspectives of group prenatal care and actual practices of care in specific contexts based on differences in groups, group characteristics, culture, resources, patient characteristics and other variables. This chapter explores literature on relevant concepts relating to the issues raised in the study.

2.1 Conceptual review

This conceptual framework reviews discussions relating to the study of groups particularly as it relates to group overview, its features, individual perception, the situation of prenatal care in Nigeria and sundry issues. The conceptual review is not an attempt to merely address relevant concepts but also aimed at contextualising them.

2.1.1 Overview of groups

The study of groups was pioneered by sociologists and psychologists simultaneously sometime in the twentieth century (Forsyth, 2010:19). Sociologists explained the role of primary groups such as the family in shaping individual behaviour, and how educational, economic, social and political groups affect individuals in the groups and the society as a whole. Psychologists, on their part, sought to explain how the

presence of certain individuals in a group could and, in fact, does affect the entire group behaviour. They are of the view that an individual' s membership of a group can influence, either positively or negatively, his psychological disposition to situations (Forsyth). Today, there is a multidisciplinary perspective on the nature of groups. This perspective is evident in the numerous ways scholars delineate groups. Some scholars in their description of groups have highlighted certain distinguishing features that may be an indication of their disciplinary bias. For instance, Adams and Galanes (2011) describe a group as primarily a collection of interacting and interdependent persons who share an orientation to a common goal and identity.

The above explanation emphasises the importance of both interpersonal communication and entitativity among group members. The level of cohesion in a group is otherwise referred to as entitativity. It is difficult achieving unity in a group in the absence of mutual cooperation which is facilitated through face-to face interaction among members. Some scholars in the area of developmental psychology also investigated the similarities and differences in adults and children conceptualisation of groups. Majority of the children aged 5 and 8 described a group as a composition of children bounded together as preschoolers or kindergarten (Plotner, Over, Carpenter & Tomasello, 2016). Apparently, these children could only consider groups from their limited fields of experiences. Further investigation revealed that the children perceived collaboration as a more defining group feature than similarity. This shows a semblance of pattern in adult and children' s conceptual view of groups. As implied in the above definition, groups are unique and defined based on individual experiences and no two groups are the same in terms of origin, purpose, and membership (Forsyth, 2010:25). The two description of groups reviewed here are by no means exhaustive, as scholars tend to ascribe different meanings to groups based on their background. Nevertheless, this study will attempt to review relevant studies in the literature on the features that are common to all groups in the specific areas of: interaction, interdependence, cohesion, goals, leadership, and power.

2.2 Features of groups and their involvement in the group process

Groups are expected to possess certain basic characteristics that distinguish them from mere crowds. The features that are common to most groups are discussed next. The

features include: interaction, patterns of interaction, interdependence, goals, cohesion and leadership. Some of these features also reflect as elements or by products of the group process. Hence in discussing those features of groups, their relationship in the group process will also be hinted at. The measurements of patterns of interaction were also discussed in this section to understand their modalities.

2.2.1 Interaction: duality of role in the group and the group process

A group cannot be regarded as one if there is no form of interaction among its members (Adams & Galanes, 2011; Fujishin, 2013; Moustafa & Steed, 2018). People who meet in an elevator, a train station or a filling station are not considered as a group, unless an emergency situation occurs that necessitates them interacting and deciding on an effective course of action. The quality of interaction within a group is, therefore, of paramount importance to the group' s existence, performance and sustenance (Marlow, Lacerenza, Paoletti, Burke & Salus, 2018). The level of interaction within a small group differs from the interaction among members of large groups (Chakrabarti, 2018). In fact, a comparison of small group versus large group learning reveal medical students' preference for small groups as it was found to be highly interactive. The extent of interaction among eight individuals in a group, for instance will markedly differ from that of a group comprising fifty individuals. This is because in the former group, members have the opportunity of having contact with and interacting with others in the group. In the latter group, however, cliques may emerge and throughout the life span of the group, some members may maintain only phatic-like communion with certain individuals in the group. Thus, with regard to small groups, there is the tendency for members to engage in better interpersonal communication (Beebe & Masterson, 2015). In contrast, Harris and Sherblom (2008) argue that the larger the size of a group, the greater the depth of the group' s interaction and the better its synergy. They concede, however, that a large group size may pose greater challenges to its leadership in terms of managing divergent viewpoints and different idiosyncratic tendencies of members.

While interaction is a defining feature of a group, it equally constitutes the process through which members actualise group goals. Typically, when members meet, they follow an agenda that is tailored towards identifiable goals. There is however a

number of processes the group must undertake to advance stated objectives. The processes through which members achieve goals are thus referred to as group processes. Interaction as a key aspect of group process furthers task and relational accomplishment within the group. Consequently, members adopt different communication styles to either advance or hinder the accomplishment of group objectives. In the latter sections of this literature review, the different communication styles are discussed in great detail. It should be emphasised that the face of interaction changes based on what style of communication is employed. For example, assertions, questions, tone of voice and gestures.

Furthermore, Wit (2006) argues that interaction amongst members of a group also has implications on cognitive tuning within the group. Cognitive tuning among members towards a commonly shared frame of reference depends on members' previous experiences. Wit illustrated this point by describing a classic experiment conducted by Sherrif in 1936 to investigate the role of interaction within a group on participant' s perception of issues/events. In the experiment, participants were isolated in dimly lit rooms. At the centre of the rooms were bulbs and each participant was meant to stare at these bulbs for at least two minutes and then determine the exact positions of the bulbs in the room. The unconscious eye movements and the neural processes of the eye gave majority of the participants the impression that the bulbs were actually moving (Wit, 2006). It was observed that initially, participant' s responses to the position of the bulb were varied; however, their responses became more unified with repeated exposure to the bulbs. According to Wit, the researcher concluded that individuals' internal cognitive conflict is resolved as variation occurs in their exposure and experience levels.

In a follow-up experiment, the same set of participants who were exposed to the bulbs in isolation were put into groups with other participants. They were exposed to the same experiment they had hitherto being exposed to. Initially, their responses to the location of the bulb were varied, but their responses became unanimous with repeated exposure to the experiment. Again, Wit (2006) avers that the opportunity to interact with other participants within the group may have accounted for the unanimity in the development of a frame of reference at this point. Similarly, Van Swol (2015) affirms

that individuals validate their perceptions in group situations through interaction with others. In this particular experiment, it was observed that all the experimenter groups gave varied responses as to the location of the bulb. Therefore, subsequent studies were conducted to investigate why there were variations in their responses. At this point, the researcher paid some individuals to infiltrate each of the groups and influence members' responses. The result of the experiment shows that the individuals who infiltrated each of the groups had remarkable influence on group members as they were able to change members' initial perception of the location of the light. When the individuals who had been paid to infiltrate the groups were removed from each of the groups, it was realized that members of the groups still stuck to the same responses they gave while the infiltrators were amongst them (Wit, 2006).

Meanwhile, when participants who were members of separate experimental groups were regrouped with new sets of participants, the former were unwavering in their initial perspective about the bulb' s location, despite their interaction with new members. These results point to the fact that individuals initially experience internal cognitive conflict when it comes to forming perceptions on issues or deciding on a course of action. The initial cognitive conflict can, however, be resolved as an individual' s experience increases. Similarly, an individual' s ability to interact with others, especially in a group situation, will influence his/her perspective on issues as well as the decision taken (Wit, 2006; Van Swol, 2015).

2.2.2 Patterns of interaction within a group

Interaction within a group can either be **verbal** or **non- verbal**. There is sufficient evidence in the literature to indicate that both verbal and non-verbal forms of communication are symbolic, as meaning derived from the communication encounter is not contained in the words /signs but in the interlocutors (Devito, 2013; Beebe & Masterson, 2015). Examples of verbal communication are seen in how people express their feelings, facts and knowledge in a particular language such as English or Yoruba, or any other language. By the same token, non- verbal communication can be described as that aspect of communication that does not require words. It is usually expressed with a sign or signal (Krauss & Fussell, 1996). However, Devito argue that

non-verbal communication does not only comprise unspoken signs and signals; it also includes vocal fillers, volume and tone of voice, which are normally employed by interlocutors when the cognitive demands of the interaction are high. Examples of vocal fillers are uhm, ehm, ehn ehn, among others. The non verbal aspects of communication to a large extent reflect the relationship existing between those involved in the communication encounter. Other channels of non-verbal communication are: body movements, facial expressions, gestures, time management, space management and interlocutors' mode of dressing. Some of these other channels of non verbal communication are discussed in turn.

1. Body movements

The importance of non-verbal cues and more specifically bodily movements is underscored by the sheer volume of research on the subject. In fact, Gozalova, Gazilov, Kobeleva, Seredina and Loseva (2016) argue that the spoken word accounts for only seven per cent of meaning, sound and intonation 38%, while the remaining percentage 55% is allocated to postures and gestures. Gestures and body postures are thus, examples of body movements that can be interpreted singly or accompanied with words to allocate meaning. Consequently, body movements within the context of this study is described as positional manipulations of the different body parts in relation to internal or external stimuli to communicate meaning. Scholarly perspectives on the interpretation of body movements differ based on disciplinary bias and cultural factors. For example, Navarro (2018) posits that adopting animated gestures in conversations is an attention getting device, to him, confident speakers generously deploy gestures whereas less confident ones are more frugal in its use. In contrast, Mast, Hall, Cronauer and Cousin (2010) describe such effusive behaviour as negative and indicative of providers' domineering stance on patients particularly within the clinical encounter. Therefore, nurses' self-awareness of non-verbal cues and the ability to deploy cues effectively have implication on message delivery (Benbenishty & Hannink, 2015). There are other ranges of body movements described by Navarro (2018) however; non verbal codes that are particularly suited to this study will be examined in detail.

To start with, raising a shoulder in a shrug could imply flexibility, a non-committal response or doubt depending on how the shoulder is moved. Students are noted for example to express hesitation and a lack of confidence when they slowly shrug one shoulder after the other. An individual could also display a lack of confidence, when seated in such a way that his/her shoulders sag lower than the table. Such behaviour is noticeable since it looks unusual. Furthermore, arms held behind the back signify aloofness and an unwillingness to share ones' personal space with others, while hands held on hips or akimbo depict a domineering behaviour. With particular respect to this study, women tend to cover their throat particularly when troubled, however, during pregnancy that subconscious behaviour is reverted to the belly. The behaviour is interpreted as a primordial instinct at protecting the foetus (Navarro, 2018). Rubbing the belly during pregnancy is a pacifying behaviour; it is actually meant to provide relief from stress and if the action is repeated, it promotes the release of oxytocin into the blood stream (Navarro, 2018). Individuals also shift regularly from one end of the seat to another particularly, if they have been seated for a while.

Be that as it may, non-verbal communication lends itself easily to ambiguity, given that a single non-verbal code may communicate multiplicity of meanings (Krauss & Fussell, 1967; Devito, 2013). For instance, nodding in some cultures signifies positive affirmation, while, in some other cultures, it denotes negativity (Hargie & Dickson, 2004; Devito, 2013). Similarly, an individual leaning forward during a conversation may not necessarily imply his/her interest in the conversation; it may result from a hearing defect, or an attempt to divulge a secret in a conspiratorial tone. Non-verbal communication can be said to be less ambiguous if transceivers prepare and package their messages appropriately (Devito, 2013). Majority of non-verbal cues are however, culture bound. Their interpretation is thus, specific. Also, research on non-verbal communication is inconclusive, many researchers have described it as complex to measure because of meaning variableness (Siminoff & Step, 2011; Blanch-Hartigan, Ruben, Hall & Mast 2018; Hall, Horgan & Murphy, 2019). For instance, while it may be relatively easy to monitor the non-verbal communication of two people discussing business over lunch, it may not be easy to observe the non-verbal cues of 30 pregnant women in a group. This is because non-verbal cues are not meant to be observed singly, but as a composite whole (Siminoff & Step; Hall *et al*., 2011).

Again, non-verbal communication is interpreted within a communication context. Thus, the availability of background noise such as a screeching horn, for instance, could necessitate a raised voice on the part of an interlocutor.

It is also worthy to note that, non- verbal communication is usually spontaneous, thus interlocutors may unintentionally send a non-verbal code in the course of interacting with other interlocutors. Both Barker (2011) and Hall, *et al*. (2011) surmise that non-verbal codes that are unintentionally sent in the course of communication are informative acts but Hall *et al* (2011) contest the validity of categories allocated to such acts since the intent behind observed behaviour is unknown. For example, it is difficult categorising sighing especially since the same behaviour could be interpreted as a sign of perplexity or a tension relieving activity. Although, informative acts indicate the true feelings of the interlocutor concerned, it gives the interlocutor no opportunity to make necessary adjustments, where necessary. In summary, both verbal and non-verbal codes are used to manage the task and relational aspects of communication within the group (Hargie & Dickson, 2004).

2. Facial expressions

The face is one of the most expressive parts of the human body where emotions and intentions are easily discerned, as such, Navarro (2018) explains that the different components of the face could be interpreted singly or as a composite whole in making judgements about individual behaviour. Siminoff and Step (2011) however, argue that non-verbal cues should not be interpreted singly as they are better understood in consonance with other cues. Nonetheless, interpretations of individual verbal cues may become necessary especially, if the individual under observation is not displaying much feeling. A creased forehead, could for example, depict stress, anger or an inner turmoil. However, such stress lines may be interpreted differently, if an individual also looks away while responding to a question. The face avoidance interpreted in concert with the furrowed forehead signifies a deep contemplation of the question. When face avoidance is however, interpreted singly, it reveals intent to avoid being noticed or an unwillingness to be part of something. This is usually the case when individuals refrain from looking in the direction of others whom they wish to avoid. Closely related to face avoidance is an absence of eye contact. In the former,

an individual shifts his entire face away from an unwanted situation or person, while in the latter, eye contact is not established by an interlocutor in a bid to hide shame or embarrassment. In many Asian and African American cultures, eye contact is usually established and retained by individuals perceived to be superior especially, when such individuals are speaking to inferior others. In such cultures, those perceived as being of lower statues are expected to listen and at the same time, maintain eye contact (Navarro, 2018). Hence, eye contact conveys a lot of information about the sociocultural and socio psychological dimensions of any interpersonal or group encounter.

In an earlier study on patient-centred care among radiology patients, Lang (2012) observes that in some cultures, direct eye contact by health care providers with their patients is perceived as insulting. Some other scholars argue that rapport is established between patients and their caregivers through eye contact (Montague, Chen, Chewning & Barrett 2013). In contrast, Lang argues that the sensory preference of interlocutors affects the level of eye contact between them. For example, patients with auditory preference are less likely to make eye contact with their caregivers, not necessarily because they are hiding information but that is their way of saying that they are being attentive. Though rapport is strategic to the development of a patient-centred communication, many health care providers have reportedly failed in this critical area, particularly, with the advent of the social media. In the opinion of Montague *et al*, health care providers' fixation on computers and allied technologies hinder the establishment of rapport within the first few minutes of the clinical encounter. Traditionally, health care providers are accustomed to perusing files and other documents than acknowledging patients presence through eye contact, nods or a welcoming smile. Building rapport therefore, not only entails eye contact but also a cheerful/smiling countenance and may also include a nod.

Similarly, head nods, according to Given (2013), are usually employed for affirmation, negation or enthusiasm. It is used for affirmation when the head is moved vertically in an upward position and gradually pulled back to its original position. Head nod expresses negation when it is moved horizontally from one side to another while a vigorous head shake expresses enthusiasm. Although, Navarro (2018)

describes nodding as repeated head movement from one side to another in order to affirm agreement with other interlocutors, it could also depict a form of greeting. When the head is moved as a form of greeting, it is referred to as inclination of the head. There is a slight difference between head nods and the inclination of the head, in the former, head movement is repeated and could be from any angle while there is no continuous movement of the head in the latter case. Nevertheless, both nodding and head inclination may be performed in similar ways based on the subconscious nature of non-verbal cues.

Expectedly, nodding is associated with active listening but sometimes individuals nod to create in the minds of others an illusion of a listener. Some interlocutors employ the non-verbal cue deceptively when others are given an impression that they are active listeners. Individuals who falsely nod are easily identified during conversational turn taking or when questions are pointedly directed at them. They tend to stutter and barely contribute meaningfully to discussions. Furthermore, it is also possible for head nods to carry a different connotations from the ones earlier discussed. For example, nodding accompanied with tightly compressed lips signifies a disapproval, distaste or dislike that cannot be expressed verbally (Navarro, 2018). This explains why the face is described as revealing a lot of information about individual personality. As a matter of fact, Navarro explains that, during police investigations it is common for suspects to exhibit facial incongruence, in which case, there is no similarity between their verbal and facial expressions. Hardened criminals may however lie so glibly that no telltale sign will be apparent on their faces.

“ Odd face in the crowd” is another facial expression that has facilitated the arrest and prosecution of drug traffickers and allied criminals at the immigration points of airport terminals. People who carry facial expressions different from those of others in a crowd are conspicuous and the bait for secret surveillance. Navarro submits here, that, whatever the case, conclusions about people’ s behaviour should be approached systematically especially, with base line data. In other words, for accuracy in perception, individuals’ behaviour should be observed repeatedly before any judgements are made about their conduct.

2.2.3 Measurement of patterns of interaction in a group

One of the earliest and probably most effective instruments for studying the pattern of interaction within a group is the Bales' Interaction Process analysis (IPA) chart (McGrath, 1984: 140). Bales and associates developed the Interaction Process Analysis (IPA) in the 1950' s to study both the task and relational dimensions of communication in a group. The chart has twelve categories that seek to identify active task/instrumental goals, passive task/instrumental goals, positive relational communication as well as negative relational communication within a group. The chart was developed at the time based on the premise that every group, irrespective of its composition, has both task and relational goals. A group may, however, be inclined towards task- orientation as against pursuing relational goals. A group that is highly focused on achieving task goals may inadvertently inhibit relationship development among its members. McGrath (1984:140) observes that the effectiveness of the chart at the time in studying interaction within diverse kinds of groups popularised its use among researchers. One other strength of the Interaction Process Analysis (IPA) to McGrath is that each of its categories was mutually exclusive. However, the limitations of the chart far outweighed its strengths. One of its limitations is that since it was based exclusively, on Bales theory, it was practically impossible to test the propositions of other theories with the Interaction Process Analysis (IPA) (McGrath, 1980:142). Similarly, in the Interaction Process analysis an observed behaviour must fit into a particular category, which is not usually the case in reality. This is because there are behaviours that may not fall into any of the twelve categories in the IPA chart (McGrath, 1980).

The obvious limitations of the Interaction Process analysis led to the development of different measurements of observation. However, most of the measurements were group specific; they were developed to address the nature of interaction in specific groups. Hence, it was difficult to apply them to diverse kinds of groups. McGrath (1984:144) argues that the inability of researchers to devise an appropriate measurement procedure in the study of group interaction may have led to a decline in the study of group processes, a decline at the time that spanned over a decade. Bales and his associates, however, developed the SYMLOG system, another measurement procedure in 1976.

One other feature of a group in discussed in the next subheading.

2.2.4 Interdependence: duality of role in the group and the group process

A group is regarded as one when its members are interdependent. Interdependence refers to a state of mutual reliance of group members on other members' resources in terms of talents, strengths, experience, expertise and personality to facilitate the accomplishment of group goals (Fujishin, 2013). Interdependence as a feature, is common to all groups; the larger the group, however, the less apparent the level of interdependence among members (Henman, 2014). This is probably because decision making in the group may be stampeded as members are bound to conflict on issues. Decision making as a feature of the group process shapes interdependence among members. It is argued that interdependence among group members normally fosters the accomplishment of group goals. In some instances, however, interdependence may, indeed, inhibit progress and the accomplishment of group goals (Fujishin, 2013). For example, in problem-solving and decision- making groups, the absence of majority of members at meetings may stall progress, as other members may not be able to make concrete decisions in the absence of others. Therefore, interdependence works best in a group when there is effective interaction among members (Fujishin, 2013). It is during interactions that unique talents are discovered among members and used for the advancement of the group.

With respect to support groups, members rely on one another for mutual psychological and moral support to satisfy individual goals. The absence of any one member of a support group from meetings may demotivate others, as members draw strength from one another' s presence. However, Herman (2014) citing Bostrom (1970) argues that the absence of certain individuals from a group situation will reduce the group' s size and provide an opportunity for others to feel free to talk, as people prefer to interact rather than listen in groups.

2.2.5 Goals

People will aspire to be members of a group if their membership will accrue to them certain benefits. These benefits are referred to as goals. According to McGrath *et al* (2000), goals may be positive or negative. Some young people belong to particular

street gangs or occultic societies to satisfy negative tendencies. In some other instances, a group may project positive image and tendencies; however, certain immoral individuals may become members of such groups and end up polluting the original ideals of the group. Further, some groups are formed to fulfil organisational goals. In corporate organizations, for instance, groups are referred to as teams. In those instances, teams are formed to fulfil organisational goals. When members are assigned to teams and they derive little or no personal benefit from the team, they may not really be committed towards advancing the team' s goals. In contrast, members of support groups usually join such groups out of their own volition. Individuals decide to become members of support groups to derive certain benefits from the group. For instance, pregnant women attend prenatal care sessions to acquire health information, to derive social support, and undergo relevant health screening.

2.2.6 Cohesion a factor of individual member participation

Cohesion is a term that is used to describe the level of unity of purpose within a group. Beebe and Masterson (2015), describes cohesion as the extent to which members are attracted towards one another and towards the group. Cohesion occurs in two dimensions in a group. There is the social and task-oriented cohesion. A group can be said to be socially cohesive when members are attracted towards one another, while task cohesion is a commitment of members to tasks and accomplishment of group goals (Hargie & Dickson, 2004). There are a host of intervening variables that work in tandem to determine the extent of cohesion within a group. Again, Beebe and Masterson (2015) identify communication, group composition, individual benefits derived from the group, and task effectiveness as pivotal to a group' s cohesion. Cohesion is a by product of a group process as it occurs as a result of individual member participation. The level of unity of purpose in a group is unarguably a group feature, but it occurs as a result of members' decision to either participate or remain docile in the group. Participation as it were is one of the elements of the group process. All members do not behave alike in a group, features such as personality traits and individuals' past experiences often times shape members' decision to be active or inactive. Observation as a research tool is deemed appropriate by social psychologists in determining the level of group cohesion but this feature is not easily discernible unless the level of group participation is examined. Aspects of

participation that determines group cohesion relates to the rate of member participation, treatment of inactive members and group response to silence.

A group' s size can affect the level of interpersonal attraction and communication among members and this may reflect on the cohesion within the group. Research has shown that small groups tend to be more cohesive than large groups, as communication among members of small groups reflects a depth that enhances interpersonal attraction (McGrath, 2000; Beebe & Masterson, 2015). Similarly, the extent to which group members have affinity for one another could also affect cohesion within the group (Beebe & Masterson, 2015). For instance, people of similar field of experiences and aspirations tend to gravitate towards one another. Therefore, if people that share similar orientations to life constitute a group, there is the tendency for the group to be cohesive (Beebe & Masterson, 2015). Cohesion can also be achieved in a group when members' ulterior motives for joining the group are met. The existence of rival groups who can better meet members' needs could also affect the extent of cohesion in a group. For instance, in Nigeria, pregnant women may either attend the group prenatal care sessions at approved health centres or prefer the maternity wing of available faith based centres.

An obvious advantage of cohesion within a group is its positive effect on the group' s performance and a reduction in the level of conflict experienced in the group (Hargie & Dickson, 2004; Forsyth, 2010; Beebe & Masterson, 2015). For, Forsyth (2010) highly cohesive groups tend to exhibit groupthink, which is a condition where members maintain group harmony at the expense of engaging in critical thinking and enforcing sound decision (Forsyth, 2010).

2.2.7 Leadership: duality of role in the group and the group process

Many groups have leaders whom they look up to for direction. Leadership is not just an element of a group but also that of a group process as it is a key indicator in the group outcome. Effectiveness in leadership is perceived not only in terms of the qualities of the leader but also through the perceptual screens of the followers. These perceptual screens are usually subjective, it is nonetheless crucial in determining the legitimacy of the leader. The leadership style required in a particular group situation

may differ from another which explains the differences in each group outcome. It is therefore essential for a leader to be proactive and sensitive in identifying suitable leadership style appropriate for each group situation. The leadership style, which is for example, required in problem-solving or a decision-making group, differs from that of social support groups. Similarly, a group leader in a support group may not possess the characteristics of every other member of the group. For instance, in a prenatal care group, the group leader is usually a nurse/midwife who may not necessarily be pregnant. Such a nurse or midwife is expected to display a leadership characteristic that will show sensitivity to patient' s needs, experience and feedback (West, Armit, Loewenthal, Eckert, West & Lee, 2015).

Meanwhile, in other types of group, the group leader is also a member of the group and he/she is likely to share similar characteristics with other members of the group. It is clear from the available literature that leadership need not necessarily be a top down process as an ideal leader serves as a mentor to the followers and allows them (followers) to lead as the occasion demands. In addition, the development of improved leadership theories has led to the belief that visionary leaders are the ones who propel changes in their followers. In health-care systems the situation is not in any way different, emphasis is now being placed on transformational leadership style as the ideal leadership style for improved quality of care and better staff retention (West, *et al*. 2015). Apart from the transformational leadership style, there are other leadership styles that can be adopted by a group leader, namely: functional, democratic, laissez faire, transitional or participatory leadership styles. Irrespective of the leadership style that is employed, it is important for an ideal leader to realise that leadership is linked to relationship. Hence leadership is about relationship building and maintenance. Covey (2005) suggests that effective leadership entails depositing into the emotional account of the led. One of the numerous ways by which a leader can deposit into the emotional bank of others is by showing empathy when and where such is appropriate. A leader should never assume that he knows the other person well enough. Every individual should be given a fair hearing regardless of the situation as this provides an effective platform for perception building especially on the part of group members. The nuances of perception formation are discussed next.

2.3 Perception

It describes how individuals attend to particular stimulus and give interpretation accordingly. Individual exposure to visual, oral, tactile and auditory signs or symbols overtime produces a schema in respect of perceived stimulus. Expectedly, the neurons in the human brain access the schema for interpretation each time a similar stimulus is perceived (Goldstein 2010; Kehoe 2011). Schemas are maps or behavioural/situational patterns built in the mind from infancy through a random selection and interpretation of similar and contrastive stimuli from the environment. The cognitive aspect of the subconscious mind is not only responsible for the development of schemas, it is central to individual decision making. As such, it selectively accumulates data from the environment, forms impression of others and gives meaning to individual behaviour through intrapersonal communication. Notwithstanding the complex function of the cognitive subconscious mind, Kehoe affirms that, its rigidity makes it difficult to change certain notions of others once formed.

Be that as it may, the process of human and animal perception starts from the sense organs which naturally perceive stimuli but the receptor cells in the body interpret the stimuli as a message. For example, photoreceptors in the eyes detect the presence of light while the receptor cells in the body serves as conduits for the transmission of the message to the brain. It is in the brain that different forms of schema are formed in respect of particular messages. This partly explains the differences in individual perception as variations in human psychological makeup account for selective exposure, perception and retention of the same stimuli. Apart from the foregoing, some scholars argue that individuals differ in their exposure and perception of stimulus based on differences in learned behaviour and experience. Contextual factors and individuals' disposition also affect perception in the sense that individual emotion and situational considerations determine the priority given to one stimulus over another. However, the study of perception has been shaped through the scholarly contributions of psychologists, philosophers and scientists. Each of these disciplines has further broadened the scope and applicability of the subject. For example, Epistemology as a branch of philosophy is concerned with knowing, more importantly, it seeks to understand if a physical world exists outside the realm of

individual perception. That probably accounts for why philosophers believe that individuals are capable of perceiving not only reality but also an illusion outside of reality. Consequently, perceptions may not always be accurate as ingrained beliefs and faulty perceptions lead to wrong conclusions about a reality. Some of the factors affecting perceptions are **constancy**, **novelty** and **familiarity**, **repetition**, **intensity**, **size** and **contrast** (Goldstein, 2010; Wright, Sparks & O' Hair, 2013). For the purpose of this section however, constancy, repetition, novelty and familiarity will be discussed since they are more germane to the objectives of the study.

1. **Constancy** refers to the stability in the physical properties or features of an object in terms of shape, size and colour relative to its illumination, context or angle of perception. This implies that judgements about the size, shape, colour of an object should remain constant regardless of differences in angle of perception and other associated factors (Goldstein, 2016). If the features of a trailer, for example, vary with the distance, many road users are less likely to perceive another heavy duty vehicle because their first encounter with one may lead to an untimely death. Goldstein argues that it is also possible to experience partial constancy of an object especially, if the degree of illumination is sharper than usual. A case in point, according to him, is light reflection on a white paper which may make the object appear greyer than usual.

2. Novelty and **familiarity** is another index affecting individual perception of issues and objects. As such, psychologists believe that when individuals are exposed to unfamiliar objects, they are likely to attend to objects that are more familiar. In fact unfamiliar objects may be given secondary importance. This perspective is however not universal as individuals tend to gravitate towards unfamiliar stimulus based on novelty or a perceived unique quality (Kehoe, 2011; Postal & Armstrong, 2013). The concept of novelty and familiarity as applied to this study may imply health care providers' creativity in deploying communication skills to reduce patients' prejudices of them. Individual perception is also affected by the intensity of a ' stimulus which in other words refers to its degree. Patients' perception of a nurse, for example, is influenced by the degree of the nurses' relational skills. A nurse that relates poorly is likely to attract patients' attention. Conversely, a nurse with high relational skills will be remembered by majority of the patients.

3. **Repetition:** It is also pertinent to understand that repetitive exposure to the same stimuli facilitates attention, comprehension and information retention. For example, when individuals are repeatedly exposed to certain stimuli, it achieves prominence in their subconscious minds and aids memory. Individuals are also more likely to make judgements about issues when there are basis for comparison. Contrastive situations therefore present opportunity for accuracy in perceptions, as white against a black background not only commands attention but also creates platform for valid judgements (Kehoe, 2011). Meanwhile, research has established perceptions as both learned and natural to man. In an experiment, individuals born with cataract initially found visual perceptions difficult based on visual impairment. After surgery, their sight was restored and gradually their perceptions became similar to those of individuals who had never suffered a visual impairment (Kehoe, 2011). This is suggestive of both an innate quality and a behaviour acquired through experience. The brain is the seat of individual perceptions and it is possible for such perceptions to be faulty if there is an error in information processing. For example, the formation of stereotypes could in fact distort facts and lead to erroneous perceptions. Stereotypes are described as positive or negative notions about individuals or a people based on cultural, positional, occupational or other observed differences. Stereotypes occur when the brain is confronted with ambiguous information and individuals are unwilling to discard any perception that does not conform to initial beliefs. Thus, communication at the interpersonal, group and intercultural levels are threatened. The formation of stereotypes also creates a Pygmalion effect as we constantly expect others behaviour to conform to stereotypes. With respect to this particular study, both pregnant women and nurses are members of different sub groups, hence the values, behavioural patterns and beliefs peculiar to these groups affect their disposition to non members. This in other words implies that nurses' training and professional membership affect their relationship with others, especially the patients.

2.4 The situation of prenatal care in Nigeria

African nations as well as the international community have for many years, put in different measures towards reducing the menace of maternal and infants' deaths globally. One of the major precursors of poor infant outcomes and maternal ill health is inadequate or lack of quality prenatal care (Idowu, 2013). However, research on prenatal care in Nigeria has dwelt mainly on accessibility and/or barriers to care,

without due cognizance to the quality of such care (Negri, Brown, Hernandez, Rosenbaum, Roter, 1997; Oladapo, Iyaniwura & Sule-Odu, 2008). The available studies on the quality of prenatal care in Nigeria are few and have also neglected an integral aspect of prenatal care which has to do with the use of relational communication between health care providers and pregnant women.

Previous studies in literature on the quality of prenatal care in Nigeria have actually pointed to the absence of effective strategies in disseminating information to pregnant women during prenatal care sessions (Oladapo, *et al.*, 2008). Similarly, such studies in literature decried the non-adherence of primary health-care centres in Nigeria to the use of Focused Prenatal Care which is the latest World Health Organisation (WHO) recommendation on prenatal care. Focused Prenatal Care is a new intervention introduced by the WHO to make the administration of prenatal care more relevant to the needs of pregnant women. With the introduction of Focused Prenatal Care, pregnant women with low risk pregnancies are required to make a maximum of four prenatal visits throughout the course of pregnancy. Similarly, during the course of each visit, care givers are to provide required care to such women within a period of at least thirty minutes. In contrast, a survey of pregnant women in Sagamu area of Lagos State reveals that the provision of Focused Prenatal care is not completely adhered to by health care providers, especially as it affects the time allotted to care. Majority of the respondents in that study observed that health care providers attended to them within 5minutes (Oladapo, *et al.*, 2008).

Prior to the introduction of the Focused Prenatal care, the provision of the World Health Organisation on the contents of prenatal care states that: it should include assessment, education, skills building and social support. Contrary to this recommendation, prenatal care in Nigeria till date only accommodates assessment and education with no evidence of social support or skills building. Evidence exists that health care providers tend to focus on the technical aspects of care, while overlooking aspects of care that has to do with interpersonal relations and social support for pregnant women (Oladapo, *et al.*, 2008; Wright, *et al.*, 2013). Pregnancy is a delicate and stressful time for most women as they experience a lot of physical bodily changes and changes in hormonal levels which can predispose them to depression (NIHCM

brief, 2010). Other life stressors such as poverty or a declining income, unwanted/ill-timed pregnancy, being in an abusive relationship could trigger depression in a pregnant woman. First- time mothers are also more prone to depression during pregnancy (NIHCM brief, 2010). Hence, there is the need for care givers to provide social support to women during and after pregnancy to foster the early detection of pregnancy related depressive symptoms.

2.4.1 Group prenatal care

The concept of dispensing prenatal care such as medical and physical assessments, health education and social support within a group context is referred to as group prenatal care. Although the practice of delivering health education to pregnant women in groups is not new, the Centring Pregnancy (CP) Model popularised the concept of group prenatal care globally. The model was developed in the 90s by Sharon Rising in response to the high call for Caesarean section and an increase in low birth weights among preterm infants. The CP model was also birthed based on other observed issues relating to congenital deformities and an increase in alcohol intake among expectant mothers. The pilot programme of centring pregnancy model had 13 groups of 111 women in a hospital at Waterbury Connecticut. Its implementation in the United States of America, Sweden, Australia and Iran recorded positive birth outcomes, improved patient-provider communication and also fostered the psychosocial support of expectant mothers (Reynolds & Rising, 2007; Heberlein, 2014; Mazzoni & Carter, 2017 & Ofosu, 2017; Hunter, Motta, Mccourt, Wiseman, Rayment, Haora, Wiggins & Harden, 2018).

Although, group prenatal care has been in existence generally for over a decade, there has been little research effort aimed at evaluating its effectiveness as an alternative communication platform for health-care providers and pregnant women (Rising & Klima, 2004:6). Some earlier studies on group prenatal care have focused on aspects of care that relate to participants' satisfaction with care, rate of attendance and knowledge acquired (Novick, 2009; Jafari, Efetekhar, Mohammed & Fotouhi, 2010). While yet others have examined health care providers' experience of group care (Thielen, 2012; McNeil, Vekved, Dolan, Siever, Horn & Tough, 2013) and the relationship between the utilization of group prenatal care and its effect on foetal birth

weight, preterm delivery and foetal demise (Tanner-Smith, Steinka-Fry & Lipsey, 2014). The CP model has driven much research on group prenatal care in recent times. In fact, based on the model' s remarkable success in other climes, some African scholars and medical practitioners have tested the innovation especially, in Egypt, Malawi, Tanzania and some remote parts of Northern Nigeria (Hooper-Bender, Kearns, Caglia, Tuncalp & Langer, 2014; Adaji, Jimoh, Bawa, Ibrahim, Olorukooba, Adelaiye, Garba, Lukong Idris & Shittu, 2019). Between 2010 and 2011, consenting pregnant women were interviewed and recruited into the CP group care programme in Tsibiri Nigeria. During the postpartum period, the women were interviewed and they reported satisfaction with the programme as well as a commitment to their birth preparedness plan.

Consequently, Adaji *et al*. (2019) conclude that the model was practicable in low resource areas as well as among HIV population. Though, donor agencies may be willing to fund the intervention especially, in deprived communities, it is certain that the model' s implementation may be impracticable in other parts of Nigeria for obvious reasons. Nonetheless, the Centring Pregnancy model of group prenatal care is one out of the numerous models of care globally. Other models described in the literature are the participatory women groups in India, Pregnancy Circles in the United Kingdom, Expecting and Connecting in Australia, Expect with me and Parenting Partners. As contained in the literature, most of the existing models of group prenatal care were fashioned after the centring pregnancy model (Lincetlo, Mothebesoane-Anoh, Gomez & Mujanja, 2006; Opinion American College of Obstetricians and Gynaecologists, 2018; Sharma, O' Connor & Olivet, 2018). While the foregoing assertion may be true, it is certainly worthwhile investigating the features of other seemingly unnamed models of group care across the world. Meanwhile, the CP model is structured in such a way that between 8-12 pregnant women are put into groups, as soon as they initiate prenatal care. Specific time is allotted to facilitative discussions in each of the groups and the group leader (nurse, social worker or health educator) encourages peer to peer learning. The topics for discussion are suggested by a curriculum. However, expectant mothers are at liberty to dictate the topic and the pace of learning. Though, women are expected to initiate care around 26 weeks of gestational pregnancy the duration for the group meetings is

between 2-4 weeks spread across a six month period. The time span of the meetings is from 90-120 minutes, while discussions are facilitated by an obstetric nurse or a gynaecologist, assisted by a health educator or a social worker. The programme is structured in such a way that at the start of each session, expectant mothers are allowed to network briefly with peers, before undergoing individual physical and medical assessments. Pregnant women also conduct self-assessments to facilitate collaboration between them and their caregivers. Prior to the commencement of the health talk, each woman interacts interpersonally with the caregiver to share her private concerns. In the CP model, there is a curriculum that guides discussion and health care providers are trained on how to facilitate peer-peer discussions within each group.

Hooper-Bender *et al* (2014) identified some of the advantages of such group meetings in relation to pregnant women' s physical and mental health. According to them, the group space serves as a community for participants, as women mutually experience the influence of others, thereby fostering collaborative learning. Furthermore, health care providers judiciously utilise time since care is dispensed to more women in less time while the pregnant women on their part, develop latent skills. Though the forum provides an avenue for peer influence, the influence may not necessarily be positive, especially, as participants' perceptions of group are not unanimous. The group care however, has the potential to reduce the effect of life stressors on pregnant women and their unborn children as well as allow for shared decision making between caregivers and clients. Group features such as size, democratic leadership style, patient empowerment and socialising opportunities help to overcome power differences between caregivers and clients. The nature of care received also has positive implication on patients' waiting time (O' Connor & Rimer, 2018). Some aspects of socialising opportunities recorded in the literature are related to singing, dancing and exercising (Akin-Otiko & Bhengu, 2012; Lori, Ofosu-Darkwah, Boyd, Banerjee & Adanu, 2017)). One of the advantages of the singing and dancing sessions during prenatal care is a reduction in the psychological effects of maternal anxiety on child psycho-motor and cognitive development (Shin & Kim, 2011; Arya, Konanki & Tiwari, 2012; Ventura, Gomes & Neto, 2013).

2.5 The nature of relational communication

Historically, the term communication is described as slippery and multifaceted in nature and scope (Krauss & Fussell, 1967). Definitional issues in communication are further heightened by its multidisciplinary nature, as scholars in the field of engineering, cell biology, anthropology, sociology and psychology tend to adopt divergent views on the nature of communication. For example, Ekman and Friesen (1967) restrict communication only to its verbal aspects, while they describe non - verbal aspects of communication as merely informational and not necessarily communicative. To Watzlawick, Bevelas and Jackson (1967), however, communication should not be restricted merely to speech acts, as communication and behaviour are often used interchangeably. They conclude that all behaviours that occur within a social context are communicative. The former and latter positions on the nature of communication has however been criticised. To Krauss and Fussell (1967) communication should include both verbal and nonverbal behaviours; nonetheless, certain categories of behaviour that occur in a communicative encounter may not necessarily be described as communicative.

Nevertheless, contemporary scholars have over time resolved the definitional issues in communication to an extent. Berko Aitken and Wolvin (2010:2) describe communication as thus: " Communication is a conscious or unconscious, intentional or unintentional process in which feelings and ideas are expressed as verbal and /or non-verbal messages which are sent, received and comprehended" . In other words, " communication is a transactive process through which we make sense of our world and share the sense with others" (Beebe & Masterson 2015:3). One important ingredient in communication is that transceivers are constantly modifying their messages based on the feedback they receive from other interlocutors in the communication encounter. The feedback may be in form of a raised eyebrow, a scowl or a verbal response. Thus, messages need to be repackaged to accommodate feedback and allow for mutual understanding on the part of interlocutors. When a message is sent but the intended meaning of the message is lost on the other interlocutor, then, noise has occurred in the process of communication. Often times, communicative noise occurs during the process of communication that alters the original intent of the transceiver who encoded the message. The noise may be

physical, psychological, physiological, cultural, syntactic or semantic in nature. For instance, let us assume the language of instruction in a prenatal care group is Yoruba and there are pregnant women in the group who do not understand the language. Everything the nurse/midwife teaches within the group will be of no benefit to them, since they do not understand the language of instruction.

Having examined the concept of communication and some of its key components, it is considered useful to define relational communication at this juncture. According to Keyton (1999:2), relational communication refers to the verbal and nonverbal messages that create the social fabric of a group by promoting relationships between and among group members. To her, relational communication encompasses the connections, relations and communication which occur among members of a group. Again, Keyton (1999) argue that while literature on interpersonal communication could be used by researchers working in the area of relational communication, such literature may not adequately capture the essence of relational communication. This is because relational communication not only entails the verbal and non- verbal interactions among members of a group. It also describes how the multiplicity of personalities within the group brings more complexity to the communication process. Rogers and Escudero (2004) however believe that relational communication is not in any way different from interpersonal communication. To them, relational communication merely describes a peculiar relationship function of interpersonal communication. To these latter scholars, relational communication is applicable to groups as well as interpersonal relationships. Thus, it is a communication paradigm that emphasises the centrality of relationship in the communication process.

Further, and according to Burgoon, Buller, Hale and Deturck (1984) there are twelve themes to be used in the study of relational communication. The themes are: **Dominance/submission**, **emotional sensitivity**, **composure**, **similarity/dissimilarity**, **formality/informality**, **level of task** or **social orientation** and **intimacy**. Intimacy is further divided into five parts, which are: **depth**, **trust**, **inclusion-exclusion** and **intensity of involvement**. In a more recent publication, Siminoff and Step (2011) identify five indices that determine the relational quality

among interlocutors in health-care settings. These indices are: **Confirmation**, **immediacy**, **affiliation**, **social influence** and **inclusiveness**.

Let us examine in detail each of these indices in turn and the level of convergence between Burgoon *et al* (1984)' s classification and Siminoff and Step (2011)' s classification.

1. **Dominance** is the extent to which one relational partner exerts control over the other partner in conversation. Relational partners in medical interactions exert dominance in conversation through the use of imperatives, statements of assertion, asking too many medical questions and the use of declarative statements (Rogers & Escudero 2004; Mast, Hall, Cronauer and Cousin 2010). Non-verbal cues such as eye contact, speech duration, gestures, interpersonal distance and nodding are also observed to determine dominance among interlocutors especially in clinical interactions. For example Mast *et al* (2010) observe that patients perceive as less dominant physicians who smile frequently, make eye contact and does not spend too much time talking during a medical interview. According to the authors, such interactions restrict patient' s ability to self-disclose as they are more inclined to agree with the physicians' point of view.

In analysing relational pattern in a conversation, utterances of interlocutors are not coded singly, but in relation to the responses of other relational partners. To Cecil and Friederichs-Fitzwater (2004) a competitive symmetry occurs when interlocutors relinquish conversational control at every turn in such a way that none of the relational partners exert more power over the other. A symmetrical relationship between interlocutors is indicative of similarity in their communication pattern (Rogers & Escudero, 2004). It is referred to as competitive symmetry, because no single person exerted control over the other in the course of the interaction.

Traditionally, nurses are expected to exert more control over their patients in a conversation, because of their access to medical information and training as health-care providers. However, the advent of patient-centred medicine and probably the assertiveness of some pregnant women may contribute to a symmetrical communication pattern during medical interview. In contrast, submission is the extent

to which an interlocutor is controlled by another relational partner in the course of an interaction (Rogers & Escudero, 2004). Submissive responses could be in the form of concession, request, agreement or pleas.

In observing the pattern of relational communication between or among interlocutors, downward arrows are used to indicate submission (↓). Upward arrows depict on the other hand dominance (↑). It is also possible for communication to be neutral between two interlocutors. In such an instance, a slanting arrow is used to indicate a neutral exchange (→). To Rogers and Escudero (2004:18), it is unhealthy for relational partners to be unyielding in such a way as to stick to a regimented pattern of interacting. When there exists a consistent relational pattern between or among interlocutors, there is a tendency for " tyranny of pattern" to occur (Rogers & Escudero, 2004:18). A tyranny of pattern is said to occur for instance, when interlocutors show a consistent thread of either complementarity or symmetry in their interactions. While a rigid complementarity leads to over settled, stifling stability, higher levels of symmetry can lead to chaos in the relationship (Rogers & Escudero, 2004:18). Given the nature of relationship between a husband and wife for example, it is likely that a wife submits to the authority of her husband. A tyranny of pattern is however likely to occur, if the husband insists on exerting control over the wife all the time. Therefore, interaction among interlocutors ought to be self-regulating (Rogers & Escudero, 2004).

2. Emotional sensitivity: determines the relational quality among interlocutors. Siminoff and Step (2011) likens this trait to the level of empathy that is shared in the course of an interaction. Pregnant women in a group prenatal care are likely to be receptive to the counselling of their care givers, when they perceive a form of empathy in the approach of their caregiver. Again, Siminoff and Step (2011) argue that patients perceive a care giver as empathetic, when the latter display such cues as a sympathetic or friendly tone of voice. However, to measure empathy in relational communication may be cumbersome. Hence, to Siminoff and Step (2011:2) " comprehensive coding of relational information depends heavily on coder non-verbal sensitivity, which is highly variable, often resulting in low inter coder reliability" .

3. Composure is another variable according to Burgoon *et al* (1984), which determines the relationship among interlocutors. The composure of interlocutors is indicative of how cordial their relationship is. When an interlocutor is fidgeting and can hardly look the other interlocutor in the eye, then there is little or no rapport existing between them. If however, each of the interlocutors is relaxed in each other' s presence, it is likely that they share a form of affinity for each other. More specifically and as it pertains to the current study, composure is the extent to which pregnant women in each group are comfortable discussing personal issues amongst themselves as well as with the nurses/midwives. In determining if pregnant women are comfortable discussing their issues with others, the observer should determine how involved the pregnant women are in the group' s discussion. A lot of indices could determine how relaxed or otherwise a pregnant woman could be in discussing personal issues in the presence of others. The size of a group for instance, could be a determining factor, as people tend to feel less secure in discussing personal issues in the presence of a large number of people.

4. **The Similarity/dissimilarity** existing among interlocutors in a group may also affect affiliation within the group (Burgoon *et al*, 1984). If the group' s composition is such that members share a common frame of reference, it is highly probable for members' relationship with other members to deepen. For instance, language would not be a barrier to communication, when two educated people of different ethnic groups are conversing. However, two uneducated people from different ethnic groups may be unable to communicate effectively, especially when they do not share a similar language.

Meanwhile, Burgoon *et al* (1984) posit that the level of formality or informality amongst interlocutors may also determine the pattern of relational communication in the group. Friendship groups, families and intimate partners are less likely to be formal in their interaction, unlike a teacher-student relationship, superior-subordinate relationship or doctor-patient relationship. Thus, a high level of formality amongst interlocutors in the group portends a low pattern of relational communication. Conversely, a low level of formality in the group may translate to a high pattern of relational communication. To Siminoff and Step (2011) immediacy is a variable that

can be likened to Burgoon *et al* (1984)' s variable of formality/informality. Immediacy can be described as the perceived physical intimacy or distance among interlocutors (Rose, Albert, Cheruvu & Siminoff 2009; Siminoff & Step, 2011). Immediacy cues as described by Rose et al are behaviours that depict interpersonal closeness or distance between or among interlocutors. These cues could in fact assess various types of non verbal behaviours hence it is considered by theorist as a communication variable of several others. Immediacy cues are indicated through facial expressions and touching. However, Siminoff and Step argue that an observer needs to be trained to observe immediacy cues displayed in each group. Such an observer may have to be adept at determining cues such as vocal warmth, interpersonal touch, reduced physical distance and reduced informality among interlocutors. Again, Siminoff and Step affirm that patients tend to be more satisfied with the care received in hospitals, where caregivers display higher immediacy cues. Hence, health care providers who tend to relate well with their clients by showing more immediacy cues are perceived as more credible and better facilitators (Siminoff & Step, 2011).

Meanwhile, Burgoon *et al* (1984) argues that the level of task or social orientation in a group may also determine the relational pattern within the group. According to them, social groups strive to communicate in ways that relational partners within the group are satisfied; whereas, communication among members of task groups is geared towards advancing group goals. Contemporary researchers have however shown that both task and social groups communicate in ways that advance not only the group goals, but also maintain group harmony (Keyton, 1999; Keyton & Beck, 2009; Beebe & Masterson, 2015). Communication that is geared towards accomplishing group task may simultaneously maintain group harmony. To Keyton and Beck (2009) one cannot rarely posit that task oriented groups communicate majorly to advance group goals. Hence, all groups regardless of their orientation communicate in ways to achieve identified goals, while also maintaining group harmony.

5. Intimacy is another determinant of relational quality among interlocutors in a group (Burgoon, 1984). Intimacy can be described as the level of closeness between or among interlocutors as the case maybe. Meanwhile a connection exists between

“ intimacy” of Burgoon (1984) and “ affiliation” , a parameter identified by Siminoff and Step (2011). This is because people tend to be intimate with others with whom they are affiliated. Griffin (2012) argues that people are naturally attracted to others whom they perceive are similar to them in one way or the other. Notwithstanding this, while it may be true that people are usually intimate with others with whom they share an affiliation, it is practically impossible for one to be intimate with everybody in one’ s circle of influence. Given the nature of this present study, it is likely that some pregnant women within each group are intimate partners. Intimacy may however not be an appropriate parameter to use in identifying the relational pattern between pregnant women and their health care providers. Intimacy may be a more appropriate parameter in the study of relational communication among members of the same family, marital partners or friends.

The point of convergence between Burgoon *et al* (1984)’ s classification and Siminoff and Step (2011)’ s classification is in the use of similar constructs such as formality/immediacy, intimacy/affiliation and inclusiveness. Other constructs identified by Siminoff and Step in the measurement of relational communication are: confirmation/disconfirmation and social influence. To start with confirmation is the extent to which an interlocutor’ s perception of his/her relational competence is consistent with that of his/her audience. Confirmation can be likened to the level of acceptance a transceiver receives from other transceivers (Siminoff & Step, 2011). In a group prenatal care for example, confirmation is the extent to which pregnant women in a group give their facilitator cues such as nods, smiles, applause to signify their acceptance. The position of Simmons (2011) on confirmation messages is similar to the foregoing, as it acknowledges that such messages promote individual self esteem examples are reassuring talk or touch, acknowledging another’ s point of view, clarification or shared laughter. On the other hand verbal and non verbal cues that convey disrespect for the personality of another interlocutor are referred to as disconfirming messages.

In the opinion of Siminoff and Step (2011), disconfirmation is the extent to which transceivers show their disapproval or lack of acceptance of the other transceiver. Such messages could be in the form of silence, interruptions, one-sided laughter, side

talk, snide remarks, an impervious response, raised voice or a disapproving tone/remark. As a matter of fact Simmons argues that disconfirming messages do not merely disrespect another, but it may be a deliberate intent to subjugate or compel others to adopt one' s point of view. There is a connection between message framing and patient receptiveness to counselling or health education. Thus and according to Rose, Albert, Cheruvu and Siminoff (2009) patients experience greater well-being and engage in more self-disclosure when providers' messages are perceived as confirming. Conversely, disconfirming messages lead to stifled conversation and more reticent behaviours. Nonetheless, Simmons observes that there may be problems associated with the use of observational methods in determining confirming and disconfirming messages. This is because it may be problematic to code observed behaviour according to delineated categories.

Furthermore, " social influence" is identified as another important construct that could determine the relational quality of an interaction. Social influence has to do with the measures that are put in place to ensure that when pregnant women for instance, disagree with the position of their health- care providers; the former have the opportunity of expressing themselves. If pregnant women are at liberty to express their reservations, how are the reservations managed? Are these women threatened to comply with their treatment regimen or are they made to feel guilty for possessing a contrary opinion? These questions lead to the next point of discussion which describes relational control and complexity in group prenatal care.

2.5.1 Relational control and complexity in group prenatal care

The historical development of the relational perspective in communication was precipitated by the publication from the Pal Alto Mental Research institute (Rogers & Escudero, 2004). This publication influenced system level thinking which led to the emergence of the cybernetic tradition. The cybernetic tradition of communication depicts the interdependence of those involved in the communication process and how this interdependence affects relationship. Consequently, the assumptions of the cybernetic tradition influenced the thinking of researchers working on relational communication. Prior to the emergence of the relational perspective, many of the

models of communication were said to be monologic as emphasis was placed on the individual in the communication process (Rogers & Escudero, 2004).

Further, Shutz (1966) as cited by Wood (2010) and Forsyth (2010) identified three communication needs that affect the relational dimension to communication. These needs are namely: affection, inclusion and control. To start with, affection is a primary need of every individual to show love and be loved in return. Thus people express their need for affection when they engage in certain communication encounters. Inclusion is the innate need for individuals to communicate in order to satisfy their desire for belonging to a particular group. Apart from primary groups which people belong to as a result of being born into particular families, naturally as individuals mature in age, they aspire to be part of other forms of groups.

For instance, pregnant women naturally register for prenatal clinic during pregnancy and this makes them eligible to become members of prenatal care groups. Control is another major reason people belong to groups. Control is usually in two forms, it could be the extent to which individuals seek to influence others who are within their frame of reference. It could also be the extent to which people consciously or subconsciously choose friends who exert powerful influence on them (Wood, 2010; Forsyth, 2010). In many of the prenatal care groups, nurses/midwives who facilitate the group sessions may not be the ones in control of the group. This is because relational communication between and amongst pregnant women in the group can ascribe power and control to certain group members. For instance, pregnant women who have had children prior to a new conception are likely to exercise more control over the " first – timers" .

Meanwhile, prenatal care groups are known to give two forms of support to pregnant women namely: informational and emotional support. The nurses who facilitate the group sessions give informational support, while facilitating sessions on topical areas that dwell on maintaining a healthy pregnancy. They also lend emotional support to the women, by showing empathy and compassion, when such situation arises. Studies in literature have shown that social support leads to improved health outcomes and positive behavioural changes (Poslnszny, Hyman & Baum, 1998; Bolger, Zuckerman

& Kessler, 2000). Some scholars have however argued that the assumption that social support leads to positive outcomes may not be true in all cases as social support can be negative at some point (Brissette, Cohen & Seeman, 2000). Social support can be negative in a prenatal care group, when interaction between and among members of the group are centred on criticizing the nurses/midwives.

Again, the nature of relational communication in a group is quite unique in view of how individuals' interactions in the group are affected by the group' s dynamics (Barker, Abrams, Tiyaamornwong, Seibold, Duggam, Park & Sebastian, 2000). A group' s dynamics includes the group' s communication pattern, norms, rules, and uniqueness of members which affect relational communication between members of a group. Similarly, when interlocutors interact, they bring to bear on the communication encounter their personal and shared field of experiences, culture, history, knowledge, system of beliefs and other indices. These contexts ultimately affect the meaning derived from the communication encounter (Wood, 2010, Forsyth, 2010; De vito, 2013). It is assumed that interpersonal communication occurs frequently in group situations. Therefore, factors such as proximity, impression formation and affinity determine whom group members interact with in the group (Beebe & Masterson, 2015). For example, during the course of group prenatal care, pregnant women are likely to communicate freely with other pregnant women who are seated in close proximity than those who are seated far away. Similarly, pregnant women are likely to communicate interpersonally with people whom they share similarity with, are attracted to or those whom they have affinity for (Barker, *et al*. 2000). Again, this latter scholar argue that relational dynamics within a group is further heightened by the heterogeneous nature of such groups, as members' exhibit prejudices and stereotypes that affect intragroup relations.

Incidentally, the nature of relational communication between members in the group affects the level of acceptance given to the group leader/facilitator and his/her message. If one of the pregnant women within the group has a negative impression of nurses/midwives generally, she is likely to resent the views of nurses/midwives and communicate her resentment to other women seated beside her in the group. This may ultimately affect the reception of the message and perception of nurses/midwives

by other pregnant women within the group. In the opinion of Devito (2013), it is important for professionals to understand the principles of impression management in the discharge of their duties. This is because oftentimes, people unwittingly exhibit behaviour that makes other people form wrong impression of them, and first impression last longer.

2.5.2 The dynamics of relational care

Relational care is a relatively recent nursing parlance that describes the caregiver' s focus on nurturing relationships with clients as a means to fostering improved care. In other words, it is a form of partnership between health care providers and clients for optimal health outcome. The advent of relational care in nursing practice is traceable to the increase in the spate of chronic ailments and the prolonged admission rate of sufferers within hospitals (Courtney, Shabestari & Kuo, 2013). This also explains why the World Health Organisation is committed to relational care especially in the management of chronic ailments. A number of elements however affect the caregiver in her quest for relational care as the interplay between power, personality and context of communication influences the extent to which client access relational care. Power dynamics within or among hospital teams have implication on relationship existing between patients and health care providers. Power differentials for example, may be further heightened in inter-professional hospital teams when there are overlapping roles among the different professionals. Usually, patients are at the receiving end of such conflict as providers' interpersonal relationship with the former will be greatly hampered in the process. Aside from power play among professional colleagues, the attitude of nurses to the traditional (biomedical) approach of dispensing care has implication on relational care. Evidence-based research on improved nursing practices has increasingly favoured the socio-psychological approach to care which is also relationship driven. This discovery, nonetheless, it is unrealistic to expect hospital staff, more importantly, nurses, who are pressured with workload and shift pattern to relate with patients adopting the socio psychological approach (McHugh, Kutney-Le, Cimiotti, Sloane & Aiken, 2011).

Consequently, patients feel discontented where nurses report poor job satisfaction or burn out. With reference to the Nigerian context, nurses' approach to relational care

is affected by poor health benefits, industrial action and retirement benefits. Incidentally, both patients and nurses are at opposite ends of the continuum when it comes to relationship building in clinical interaction. Naturally, nurses aspire to initiate friendship with people they are attracted to, but clinical encounters defy the law of affinity since patients and nurses are forced into a relationship (Bello, 2017). Therefore, nurses are often reluctant relating intimately with patients for fear of a perceived decline in professional standards (traditional notions of nursing care). Psychological barriers to care are unwittingly created as a result thereby foreclosing patients priority for mutual respect and a non judgemental attitude (Salehe & Njine, 2016). Care providers ' awareness of patients' physical and emotional condition, culture, needs, readiness to communicate and peculiarity in interpersonal interaction is crucial in fostering relational care. Nurses deploy rapport, listening, information giving and confirming skills to create relational care or therapeutic relationship with clients. Rapport is usually established with patients at the first meeting and maintained throughout the clinical encounter. The importance of rapport between patients and nurses is underscored by a reduction in the formality of the clinical encounter (Macdonald, 2018). Small talk, a tool of rapport reduces power imbalance between providers and clients. However, providers have to be emotionally intelligent to understand the appropriateness of small talk in a situation and the particular ways of negotiating the interaction. Relationship development between nurses and patients is gradual and sequential hence, patients' point of view is explored through chatting with them. At the orientation phase of a relationship, caregivers initiate a warm welcome and in some instances make small talk as a means of building rapport. Trust is gained when providers initiate rapport through friendly welcome, eye contact, small talk, active listening among other skills. In some spaces, patients are initially addressed by their surnames, after which health care providers enquire which names they prefer.

Another common rapport tool in hospitals is translating, to Macdonald (2018), the term involves providing patients with details of their condition or interpreting information relevant to a hospital environment. Nurses, for instance, interpret medical jargons into clients' everyday language. Furthermore, translating could also mean explaining, teaching or instructing patients in the least ambiguous way. Aside from

expressing words in a language that is easily decipherable to clients, nurses also adopt ‘ blending in expressing socially embarrassing subjects. Blending entails the incorporation of medical and social talk into the discourse to reduce elements of embarrassment that may accompany the discussion of certain subjects. Discussions on subjects such as sexual intercourse or family planning may warrant the adoption of blending. Meanwhile, the foregoing tools of rapport may be commonplace in facilities in the developed nations and some private hospitals in Nigeria, but not necessarily in public facilities. This is because the ownership structure of health facilities in the country determines its orientation. Whereas private hospitals are run like a business the outlook of public facilities is more of a social amenity (Polsa, Spens, Soneye & Antai, 2011).

Notwithstanding the differences between public and private hospitals, nurses are also required to be culturally sensitive in dispensing relational care. When providers are aware of differences in clients’ ethnic background, it behoves sensitivity to health beliefs and values that are culturally specific, since cultural practices are oftentimes disease predictors. For instance, in the northern part of the country, the propensity for child marriages has increased the prevalence of Vesico Vaginal Fistula (VVF). In like manner, while the practice of hand washing may be normal to an average American, it is alien to the African culture (Wossilek & Patterson, 2016). Thus, the incidences of certain health conditions are culturally specific. The onus, therefore, is on providers to understand the nuances of clients’ culture and tailor relevant information accordingly.

Clients often complain of providers’ style or method of giving out information, in fact, in patient satisfaction surveys, poor communication or lack of information is usually a major source of complaint (Macdonald, 2018). Apparently, the information clients receive from caregivers in the form of health education often serve as a basis for decision making. In the group prenatal clinics, for instance, there are cultural beliefs regarding pregnant women’ s eating of okra and snail, thus, provider’ s style or method of giving out information should not out rightly condemn such practices, but subtly emphasise the nutritional constituents of such foods.

The providers' approach to dispensing information has enormous implication on patients' participation level, especially in support groups. When nurses adopt pedagogical tools to promote learning, it may likely stimulate interest in participants (Larsson, Sahlsten, Segesten & Plos, 2011). Ideally, providers should prepare notes on the subject of discussion ahead of the meeting time while patients are encouraged to take notes during a discussion for proper documentation. Note-taking on the part of participants also enables them to reflect and ask pertinent questions. Furthermore participants are likely to be more receptive to group discussions when the subject is engaging, the environment is favourable and health care providers are regarded as supportive. Macdonald (2018) argues that insufficient information or a non-interactive learning climate may hinder clients' participation in a group forum. Again, clients participation may be low, if nurses are perceived as adopting ' over accommodation' in dialogue. The term over accommodation describes the nature of the verbal exchange between interlocutors. Specifically, it denotes a transceiver communicating with another condescendingly.

Notwithstanding that, the factors that facilitate or impede participation among homogenous groups clearly differ when the group composition is heterogeneous. The language of communication, values or cultural inclinations may ostracize minorities in heterogeneous groups (Barker, Abrams Tiyaamornwong, Seibold, Duggan, Park & Sebastian, 2000) thus leading to a lull in participation level or commitment to group goals. The language adopted in communicating in such groups is a pointer to minority members' level of acceptance. Consequently, the use of language by the group leadership clearly creates relational impressions in the minds of the minority with implication on the group climate. When patients who belong to minority ethnic groups are not given opportunity within the health system, scholars refer to it as inequity. In contrast, Bradshaw (2014) argues that the underlying principle guiding the operation of health care systems globally is that of neo-liberalism. The concept of neo-liberalism as a form of political philosophy lends itself more to economic terms, in which case, those at the helms of affairs seek to transfer the factors of production from the public sector to the private sector.

Neo-liberalism allows for minority suppression since those with economic power attain societal prominence. The health sector is thus, a reflection of the practices in the

larger society. In other words, the challenges in the nations' health care delivery resonate with those confronting every stratum of the society. Notwithstanding this, nurses' professional training and interpersonal skills are meant to empower them to reduce some of the perceived challenges in the health sector. However, majority of them are lacking in the skills set (Cubaka, *et al.* 2018). Health care providers in Cubaka' s study felt they were not sufficiently trained in interpersonal skills while in the nursing school. The skills taught in school, according to the nurses, lacked practical value. Similarly, Eizenberg (2010) argues that most nurses rely on what they learnt in nursing school hence, they find it difficult to change inbuilt schema on the traditional approach to dispensing care. Even when evidence-based capacity development programmes are organized, some nurses find it practically difficult implementing such experiences. Beyond this, organisations have a pivotal role to play in promoting the implementation of evidence-based nursing.

Nevertheless, nurses are expected to offer compassionate care in the face of workloads and limited staff. Emotionally intelligent nurses manage their emotions in such a way that, it does not interfere in their interaction with clients as emotion can be a double-edged sword. Positive emotion promotes collaboration between patients and health care providers while negative emotions make patients perceive nurses as indifferent or negative. Indices that make communication between health care providers and patients work are expectations of the receivers of care, care providers' attention to detail and emotion. The outcome of effective interaction between patient and health care providers leads to disclosure, trust and confidentiality. Nurses' interest, active listening and humility also facilitate disclosure of information. Privacy of the spaces for interaction has also been described as important for trust and confidentiality. Privacy is however a challenge in consultations because of organisational and structural factors. This is because other patients are likely to listen to conversations.

Nonetheless, in achieving relational care, nurses require cognate skills pertaining to information giving, eliciting feedback, listening and rapport building. The skills are discussed in turn.

2.5.3 Health education (Nurses information-giving skills)

In clinical practice, health education is a learning process where health care providers target and motivate specific groups of patients to adopt healthier lifestyles through particular behavioural changes. Health education is often employed as a tool in health promotion. In the opinion of Halse, Fonn and Christiansen (2014), it is the act of providing health information that are relevant to patients' needs and also developing relevant skills in patients that will foster appropriate attitudinal behaviours and necessary confidence for self care or healthy habits. According to Sassen (2018), health education in clinical settings has gone beyond the purview of nurses merely dispensing information to patients, as such, information must be tailored to suit ' identified' patients' needs. Knowledge alone cannot lead to behaviour change because patients need to understand the benefits attached to adopting healthier behaviours and the consequences of not. Even when patients are well informed on why certain behaviours should be avoided, many of them find it difficult to change habitual behaviours. Some even give excuses that they lack a support framework to facilitate a behaviour change while others overly spiritualise health by believing certain disease cannot afflict them and yet ignoring the acquisition of health promoting behaviours. Consequently, health care providers need to be aware of such dialectical tensions in message development. Similarly caregivers should explore social and practical skills needed by particular patients to facilitate the required behavioural changes. These patients are also guided on setting goals relating to the behaviour change. When change is attained, modalities for maintaining such behaviours are devised and communicated to patients accordingly. Although nurses are required to give necessary information to patients, the latter are not passive receptors of such information as patients are in fact collaborators in the care process. Hence, they play an active role in the educational process.

Behaviours are categorised into habit and intentional behaviours. The former are patients' habitual behaviours which may not necessarily promote healthy lifestyles while the latter may not be easy to adopt as they are behaviours that lead to positive health outcomes. Another central concern of health education is eliminating fears relating to medicine and orienting patients to engage in partnership with care providers especially in clinical interaction. Health care providers should target

behaviours that are directly related to the problem, for example, the easiest behaviour to change or dangerous habitual behaviours. Health education is however confronted with certain problems such that, it is possible for preventive behaviours to be adopted and people still die prematurely. Such exceptional situations defy explanations and this may account for patients' over dependence on spirituality in this part of the world. Another problem may be relating to disparities or health inequalities. For instance, patients with more resources but less health demands access health facilities more than those with fewer resources but higher health demands.

Here, Sassen (2018) advocates for health care providers to devise measures in ensuring that these health disparities are addressed. There are two main ways nurses educate their patients namely: facilitating health education and intentional health education. With respect to the former, patients are informed through facts on the causes of a poor health and they are at liberty to either accept or reject the information. This method is commonly visible in health bulletin boards, flyers or brochures. It is also possible to employ this behaviour for behavioural change but it is rarely effective. Design of an intervention program usually requires health care providers to initially identify a problem through needs assessment, identify the groups that are most at risk and establish a relationship between the problem and the behaviour. Perez and Luquis (2008) argue that diversity and shifts in population especially in the urban areas present emergent challenges for health educators. The existence of cultural differences and migration issues require culturally competent educators who will be guided by the patients' needs. In Nigeria, for example, the economic crunch has made more women to take up paid jobs with greater challenges on their reproductive health behaviours. Therefore, health educators should be aware of constituents of each population and statistics should be available on the socio-economic index of their health needs in order to design interventions appropriately. Although Nigeria has a poor history in record keeping, it is apparent that evidence based clinical medicine has transformed the scope and practice of medicine globally (Majid, Foo, Zhang, Mokhtar, Luyt, Chang & Theng, 2013).

2.5.4 Feedback skills

Feedback, a key element in the communication process, is described by early communication scholars as crucial to ensuring mutuality in meaning between or

among interlocutors. Contemporary researchers on feedback fragmented discussions on the concept as its application in diverse disciplines introduced different dimensions into the concept. For example, Maurer (2011) describes feedback in organisational communication as a tool frequently employed in a top down approach to appraise employees' performance on the job. He argues that feedback need not be in that form since employees also experience constraints that hinder effective performance. Maurer's view on feedback is limited because all the ' publics' of an organisation have the prerogative to constantly express expectations, reservations and satisfaction relative to product. On the other hand, feedback to Postal and Armstrong (2013) is the sensitivity of neuropsychologist to patients' perceived concerns and expectations in such a way that relevant information is not withheld from patients and the latter's right to full emotional expression are also allowed. Traditionally, the paternalistic approach to medicine did not accommodate feedback. The advent of patient centred medicine has however allowed more collaboration between patients and providers. Nowadays, patients require full information on their health, in the area of neuropsychology. However, there are certain constraints in detailing information to patients that are cognitively impaired. There is of course the associated concern of patients' comprehension of the facts but some other professionals argue that giving patients full information is likely to impact positively on health outcome. This is because patients who are fully aware of their condition will certainly adhere to the counsel of health care providers.

2.5.5 Nurses' listening behaviours

Listening requires silence, and attentiveness to the other interlocutors' perceived needs. While listening, both verbal and non verbal cues are employed by the listener to depict an active listening stance. In nursing research, there has been little research on listening and how nursing students can develop such skills in the nursing schools. Listening has been linked to a higher quality of life. In fact, it is a critical tool in therapeutic communication. Mckenna, Brown, Boyle, Williams, Palermo and Molly (2014) profile four basic listening styles namely: people, action, content and time. According to the authors, nurses with people oriented skills tend to employ the people listening style, while those who prefer patients to explain symptoms with appropriate expression tend to favour the action approach to listening. Content listening style is

adopted when interlocutors are merely interested in the facts of a case while the time style is usually employed when nurses are constrained for time or workload relative to time is enormous. People adopt listening styles based on habits, availability and lack of knowledge. Communication styles need to be context specific hence its variety. In the study of Mckenna *et al* (2014), student nurses showed preference for people oriented listening style followed by the content style. It is envisaged that some of the student nurses in that study will likely retain their listening styles since it is a habitual behaviour while others may probably change especially, as the demands of clinical practice increases. Active listening is an empathetic behaviour in which the listener assumes a non judgemental role and as such creates room for the speaker to unburden his mind or unleash emotions and generally find solace in communicating (Doas, 2015).

Active listeners refrain from judgemental attitude that may lead to interrupting or interrogating the speaker unnecessarily. Similarly, an active listener acknowledges the other interlocutors presence and point of view through appropriate non verbal cues such as eye contact, a gentle touch or a reassuring smile. Active listeners require emotional intelligence in identifying their boundaries or strengths and the ability to communicate these appropriately to others. In clinical practice, faulty diagnosis or wrong recommendations have been linked to health care providers' poor listening skills. Active listening, therefore, allows for a careful investigation into patients' perceived needs or expectations. Health care providers ought to be clear about the facts of a patients' case before showing empathy. If however a nurse presupposes patients' health expectations then little or no time will be spared to listen to them. In contrast, the availability of more patients, shift patterns and emergency situations may predispose health care providers to proffer hurried comments before decoding patients' facial expressions. Consequently, nurses are expected be hopeful and envisage patients' reaction as patients and their relatives require different communication styles (Doas, 2015). Furthermore and according to Larsson, Sahlsten, Segesten and Plos (2011), a critical consequence of nurses' poor listening behaviours is that patients are denied the opportunity of shared decision making. The issue of shared decision making between health care providers and patients in this part of the world should however be approached with caution. This is because health care

providers are reluctant empowering patients to make health decisions for fear that they may make faulty ones. Aside from that, poverty and the poor literacy level of patients in developing countries account for low confidence reposed in them by health care providers.

Meanwhile, nurses may find active listening impracticable when pressured with work or enmeshed in a hospital culture that antagonises patient centeredness. A patient centred approach to care requires proper relationship building efforts of the health care provider. To Wright *et al*, (2011) when nurses adopt the biomedical approach to care they are anxious not to jeopardise their professional role by developing personal relationship with their patients. They therefore employ emotional blocking behaviours in relating with patients especially, when they are faced with pressure at work (Larsson *et al* 2014; Chan, Wong Chen & Lam, 2018). Furthermore, nurses who find it difficult to develop rapport with patients are less likely to listen. Conversely, patients will be unwilling to confide in such individuals. In effect, nurses with little or no cognate listening skills can be helped through clinical nursing group supervision teams where health care providers are privy to feedback from colleagues and are able to self reflect and develop appropriate skills.

Some scholars have also identified other salient factors that may jeopardise effective listening on the part of both nurses and patients. One of such factors is the age-long rivalry between nurses and doctors in clinical care. When nurses perceive that they are playing subordinate role in clinical practice, they are likely to repress patients thus, nurses also need to be empowered in order to dispense their duties appropriately (Larsson *et al* 2014). In the opinion of Chan *et al* (2018) patients who possess poor communication skills may also be unwilling to discuss their concerns with nurses. Similarly, when patients have negative perceptions of nurses, it could hinder present communication efforts.

2.5.6 Rapport building

Rapport building in clinical care as described by Goldstein and Glueck (2016) is a deliberate act of connecting with patients with the intent to create a platform for future interaction. Connecting first with patients through rapport helps one to know what to

say (content talk). In an experiment conducted in the Radiology Department of a United States Hospital on patients with malignant biopsy and fibroids, it was reported that establishing rapport with patients in the first few minutes of a clinical encounter has great effect on how patients handle pain/distress especially, those diagnosed of life threatening conditions. It is therefore pertinent to spare time in the first few minutes of clinical interaction in building rapport to enable patients develop better coping strategies. In developing rapport with patients, one has to be open-minded and attentive to the body language and the content of the discussion in order to identify patients' preferred conversational style. Similarly, providers establish rapport by decoding the sensory perception of the patient in which case providers match conversational style to suit that of patient. Lang (2012) argues that when providers match their non verbal codes to suit those of patients a bond is created with the patient. Another implication of rapport building on clinical encounter is that it allows patients to raise appropriate questions and disclose information (Chan *et al,* 2018).

Rapport is created through eye contact, comfort talk, useful suggestions and sensitivity to the patients' sensory perceptions. Incidentally, conventional medical suggestions on non-verbal cues have been described as counterproductive (Lang, 2012) as for example, smiling at a distressed patient is likely to elicit negative emotions in the latter. Similarly, warning patients ahead of administering an intravenous fluid or an injection will increase patients' threshold of pain. If patients mind has been prepared to experience pain as a result of a medication, the stimulus produced will elicit a higher level of pain as the patient's expectation is already high. Thus, it is suggested that nurses should rather adopt a diversionary measure that will lessen patients' anxiety. For example, the illusion of an imaginary island where there is a sense of peace, calm, luxury and comfort can be created in the patients mind to divert him or her from the task at hand. This is described as comfort talk. Better still; the nurse may avoid mentioning that the medication will provoke any feeling at all in the patient. Reading relaxation script was found useful to anxious patients undergoing radiology. The script created pleasant illusions in patients' subconscious mind while also empowering them to focus less on the medical intervention (Lang, 2012).

Alimoradi, Taghizadeh, Rezaypour and Mehran (2013), in a study on midwives' use of rapport in maternity care, patients reported that the midwives often greet patients but failed to introduce themselves. The scholars conclude that greeting and introducing oneself are the key elements of rapport building. They also aver that provider' s communication skills do not necessarily improve with experience. The authors are therefore sceptical that participating in communication training programmes would improve providers' communication skills. Goldstein and Glueck (2016) also argue that as a means of establishing rapport, children suffering from mental illness may be allowed to bring their toys for a clinical encounter.

2.6 Systemic issues in the health sector

Organisational structures and inherent hospital practices describe systemic issues in the health sector. Variations in these structures and practices account for differences in hospitals' process indicators culminating into differential health outcomes (Hearld, Alexander, Fraser & Jiang, 2008). Processes of care in health services research are all the dynamic activities health care providers engage in while dispensing care to clients. Parts of the process indicators in health facilities include leadership, communication, team collaboration, equity, timeliness among many others. These processes of care do not operate in isolation as there is an interdependent relationship between hospital structure, process and outcome. In contrast, structures are all the necessary static elements needed to facilitate positive health outcome or improve health services delivery. Examples of hospital structure are ownership, size, resources, technological and physical infrastructures. The availability of office spaces in hospitals, for instance, describes the structure of health facilities and this increases clients' access to privacy. Umar, Oche and Umar (2011) contend that gender plays a significant role in clients' quest for privacy. Thus, female clients place much premium on privacy and respect in clinical interaction with providers.

Some scholars have however argued that the existence of an appropriate structure can facilitate care but cannot of itself guarantee a positive health outcome (Hearld *et al*; Vartak, 2010; Ogbonna, Ejim, Okafor & Samuel, 2016). Hence, processes of care are, in fact, the moderating variable in the provision of quality health care delivery. Some of the processes of care are discussed shortly.

2.6.1 Communication

One of the fundamental process indicators in hospitals is communication. It occurs in health facilities in different categories, but for the purpose of this discussion, the emphasis will be on patient-provider and provider-provider communication. Scholarship has established three main components of patient-provider communication. They are attention to patients' needs, perspectives and experiences; opportunity for patient participation and enhanced partnership in the patient-provider relationship (Pluut, 2016; Cubaka, Schriver, Cotton, Nyirazinyoye & Kallestrup, 2018). These components are further influenced by variables such as culture, language, health literacy and working conditions. For instance in Nigeria, while attention is paid to patients' needs, perspectives and experiences, there is less opportunity for patient participation or involvement in care. Similarly, the relationship between patients and providers does not depict partnership unlike in other climes where the former are increasingly being empowered to participate in care delivery (Abiola, Udofia & Abdullahi, 2014). Low health literacy, among Africans also accounts for why patients do not demand patient-centred care where caregivers are clearly subjugating them. The result of research on patient-provider interaction is not always unambivalent. While some scholars have observed that many pregnant women report a deficit in the quality of communication of health care providers during prenatal care (Iyaniwura & Yussuf, Jallow, Chou, Liu & Huang, 2012; Mulherin, Miller, Diedrichs & Thompson, 2013), other scholars have reported that patients are satisfied with the interpersonal skills of their health-care providers for example Nwaeze, Enabor, Oluwasola & Aimakhu, 2013; Sholeye, Abosede & Jeminusi, 2013). Despite these scholarly efforts on patient-provider communication, especially in the area of maternity care, some researchers contend that the leading researches on the subject occurred in high-income countries hence they attest to a paucity of scholarly articles on patient-provider communication in the developing countries (Cubaka, *et al*., 2018).

Additionally, the extent of the relationship between patients and providers is determined by interpersonal communication. Ideally, the nature of the interaction between hospital workers and clients should be therapeutic but in most cases, it is not, as providers' traditional (biomedical) approach to dispensing care focuses more on

clients' physical health than the latter's emotional health. This is, in fact, ironical as physical health is better enhanced with due attention given to emotional health (Sears, 2010). Language as a vehicle of interaction between interlocutors in the health sector is shaped by transceivers inbuilt schemas on the nature of the illness. While providers' perception of illness is influenced by technical training/education and experience, a client's perceptual screens are influenced in part by interpersonal communication with significant others in his/her network (Wright, Sparks & O'Hair, 2013). These differences in providers and clients' perception of illness account for the prevailing power play between them. Thus, providers have overtime, been accused of deploying the language of domination in relating with clients. Such language according to Sears (2010) includes words like, 'you' 'have to', 'should' 'must' and 'deserve' which are all outwardly directed, hence, should be discouraged as they inhibit learning and delay the healing process. Apart from the foregoing enumerated words, medical workers also delight in the use of jargons in communicating with patients (Wright, *et al.* 2013). The entrenchment of such lexicon in providers' interaction with clients has fostered a culture in hospitals where staffs employ impersonal and judgmental words. This, in literature is otherwise referred to as paternalism. The paternalistic relationship is not however peculiar to a provider-client relationship as a similar pattern is evident in certain provider-provider interaction. For instance, status based systems exist among health workers as physicians are perceived as being superior to nurses and other health workers. Again Sears (2010) argue that the prevailing status based system in hospitals inhibits learning as caregivers are afraid to exhibit ignorance where others would attribute such behaviour as ineptitude. For example, a senior nursing officer newly deployed to an entirely unfamiliar ward may be reticent in seeking the counsel of junior officers in the ward especially if such solicitation will be perceived by her subordinates as incompetence. Just as socialization occurs in families, in like manner, newly recruited nurses are integrated into hospitals' prevailing culture. Hence even workers with clearly opposing views on how care should be dispensed soon find themselves socialised into the existing culture

2.6.2 Team collaboration

Closely allied to communication is the degree of collaboration amongst health workers. In fact, without effective communication health care teams cannot cooperate. Conversely, the absence of team collaboration amongst the different categories of health workers will ultimately impact negatively on clients' health outcome. Friction in nursing teams, for example, can hamper clinical judgment or predispose members to avoidable errors that can lead to the institution of malpractice suits. Aside from communication, good team leadership is required for team direction usually; a physician provides such direction on multidisciplinary health teams. Susic (2017) argues that nurses on the team are expected to have the requisite skills set, knowledge and training appropriate in handling an assigned task. Nonetheless, the foregoing argument, Kaini (2017) contends that an interdisciplinary health care team can only perform optimally if members can derive a common objective irrespective of differences in philosophical orientation and professional backgrounds/training. Theoretically, the concept of collaboration on health teams may be appealing and actually sound like the ideal. However, from a realist perspective, it may be emotionally and physically demanding hence the need for members to be emotionally intelligent and relationally competent. Collaborative team practice to Kaini (2017) has implication not only on clients' health outcome but also on provider satisfaction and less staff turn-over. All these may not be feasible if members' roles are not appropriately defined and where roles are well interpreted there should not be overlapping roles to avoid confusion and unnecessary conflict.

2.6.3 Equity

It can be described as the ability of every segment of a population to access and utilise health care facilities irrespective of differences in socio-economic or socio-cultural indices. Research on health equity in the developed nations is driven by social-cultural factors, whereas in this part of the world socio-economic variables are the major indicators of health equity (Chukwudozie, 2015; Lawanson & Opeloyeru, 2016). Economic health equity provides equal access to health care services regardless of cost. It also reduces incidences of mortality associated with non-utilisation of health care service due to high cost. Nonetheless, equity is perceived in some quarters as a legal term and not medical parlance (Gabrani, Gabrani & Bloom, 2015). The rationale here is, if the provision of health care services is not only a social

responsibility, but a business with an economic motive, from whose perspective will the concept of equity be defined? Is it from the patients; the physician, the government or insurance companies? In developing countries such as Nigeria, patients are not sufficiently empowered to articulate their health demands appropriately. Physicians on their part work simultaneously in both public and private hospitals hence their judgment on equity will be skewed as they are likely to experience a conflict of interest in the discharge of their duties. Government and insurance company' s motives are clearly opposing. While the former' s quest is for the public good, profit underlies the operation of insurance companies (Gabrani, *et al*, 2015).

2.6.4 Timeliness

Patients' waiting time is a subject of debate both among scholars and health care providers as its implication on health care delivery is enormous (Alkhani, 2015). The subject of delays experienced by patients in hospitals is a global problem and not peculiar to developing nations. In the United Kingdom, for instance, delays in patient waiting time are commonplace not only in eye clinics but also in outpatient, radiology and orthopaedic units of different hospitals. The time patients spend in hospitals is crucial in the formers' evaluation of the service quality of the facility. In fact, Umar, Oche and Umar (2011) argue that patients have reportedly left the emergency unit of hospitals in the past because of the delays in waiting time. Additionally, when patients are delayed in hospitals, they get anxious or bored and in most cases, the unpalatable experience of one patient becomes a basis for the choice of a facility by several other patients. Hence, identifying the factors creating unnecessary bottlenecks within hospitals should be a major step towards reducing patients' waiting time. Ogunfowokan and Mora (2012) attribute the absence of a time-bound appointment system in Nigeria as the major reason for the delays in a patient' waiting time. This explanation to an extent justifies the trend in patients' waiting queue experienced in Nigerian public hospitals. However, the problem may not be sufficiently addressed without recourse to situation analysis of those hospitals. Incidentally, countries that practice time-specific appointment systems are also reportedly inefficient in their time management plans especially as it affects patients. Consequently, the challenge of reducing patients' waiting time is systemic. One of the proven measures adopted in the United Kingdom for reducing patients' waiting time is referred to as ' mapping

the patients' pathway process (Alkhani, 2015). This strategy entails the measurement of the actual time spent by patients at different ports of call in the hospital and the reduction of unnecessary delays occasioned by administrative bottlenecks. The mapping strategy can be implemented with some success in Nigeria if other processes and structural indicators are equally considered.

2.6.5 Social support

As a social animal, man has an innate desire to relate with other homo sapiens. At other periods in life, individuals crave for solitude and personal space for introspection but rarely do people value a solitary life. Individuals can be in a multitude and feel isolated. Conversely, solitude can be enjoyed in the company of others (Phelps & Hassed, 2011). Part of the benefits derived from being in the company of significant others is social support. The term social support is described as voluntary acts/gestures received from others that serve immediate or long-term benefits. Social support is identified through three main domains namely emotional, informational and instrumental support. Emotional support refers to the availability of love and care from significant others such as partners, sibling or parents. On the other hand, instrumental support refers to the existence of money, resources or the availability of individuals who assist in domestic chores. Informational support exist in the form of education that health workers provide expectant women on the coping strategies to adopt in crisis situations. Out of these three domains, emotional support has been described as the most important and crucial especially to women during the prenatal period (Formica, Barberis, Costa, Nucera, Falduto, Maganuco, Pellerone & Shimmenti, 2018).

Empirical works have established significant relationship between social support and longevity (Kim, Connolly & Tamim, 2014), and the acquisition of healthy behaviours (Harvey & Alexander, 2012). The nature and form of support required by expectant women vary with socio-economic and socio-demographical factors. For instance, married women may require less emotional support than teenage pregnant mothers. Also, urban, educated and employed women are likely to favour more instrumental support than rural, semi-educated and self-employed women. A document from the Canadian Institute for Health Information (2012) report a high prevalence of

psychological distress among women especially those with low income and education. It is, therefore, possible for women in such categories to require more emotional support. Positive interaction and emotional support have been linked to reduced psychological distress among women in previous studies (Wang, Cai, Qian & Peng, 2014; Formica, Barberis, Costa, Nucera, Falduto, Maganuco, Pellerone & Schimmenti, 2018). Emotional support acts as a buffer against such life stressors as job strain, unemployment, problems with children and financial issues. Thus, individual relational skills with significant others serve as coping strategies, especially in challenging situations. Hence, employed individuals have better coping strategies with life stressors as they have less opportunity for self -introspection since they relate with others more frequently. However, the chances of psychological distress increase with higher levels of unemployment or underemployment in society. Meanwhile, the importance of support groups in clinical practice is underscored by the sheer volume of research on social support in geriatric medicine and in the treatment of chronically ill patients (Muhammed, Mayoralas, Rojo-Perez, Forjaz & Martinez-Martin, 2013; Ma, Li, Wang, Zhu, Yang, Cao, Qian & Feng, 2015; Vahedparast, Mohammadi, Ahmaddi & Farhadi, 2017). There is empirical evidence to suggest that in geriatrics, social support has been found to have increased the ageing process and reduced loneliness and the well-being of the aged (Smith, Rochelle, Harvey & Van Uffelen, 2018). In Smith *et al.'*s study, participants agree that social support was especially beneficial when they experienced major life issues such as retirement, residential relocation or declining partners' health condition. This is more so, because as people grow older their propensity to discover relational partners declines hence, the need for a support group.

Social support is built into health systems through support groups, therapy groups and health education groups. Recent development in prenatal care models such as family-centred maternity care in the United Kingdom points to the entrenchment of support practices to foster the dispensation of collaborative care. The model allows providers to evaluate a pregnancy' s risk assessment to determine the frequency in pregnant women' s attendance at prenatal care, while also empowering couples and midwives to choose options on birthing decisions. Meanwhile, the health education classes in this model are designed for both expectant women and their partners and the care

based delivery guide affords providers the opportunity of dispensing a more focused care. Printed instructional materials such as posters and audiovisuals are made available in English and other languages for non-English speakers. Additionally, the model incorporates a preconception class that furnishes women information on diet and food supplements intake to enhance fertility.

Nonetheless, the peculiarities of the support system in the models of a prenatal care, providers' perceived listening skills are crucial in building clients' trust and ability to disclose confidential information.

2.7 Prenatal depression

Depression in both males and females is a source of public health concern. More worrisome is the issue of prenatal depression as its effect is not limited to the mother, but more importantly, the unborn foetus. Currently, it has been established that the causative factors for prenatal depression are more social than biological (Accortt, Cheadle & Schetter, 2015; Heyningen; Myer; Onah; Tomlinson; Field & Honikman, 2016; Coll, Freitas da Silveira, Bassani, Netsii, Wehrmeister, Barros & Stein, 2017). Hence, the global economic meltdown and its resultant effect on families in developing countries call for researchers' concerted effort into the subject of prenatal depression to ascertain its prevalence in low-resource economies and to devise cost-effective measures for diagnosis and treatment. Pregnancy by nature is perceived as a stressful condition for most women owing to the secretion of pregnancy-induced hormones. The existence of life stressors such as unemployment, poverty, domestic violence, long working conditions, living without a partner or being multiparous without help may however exacerbate pregnant women' s stress level and could, in fact, result into prenatal depression (Coll, *et al*., 2017). Other factors that predispose women to depressive symptoms during pregnancy are low maternal education and low maternal nutrition (Heyningen, Myer, Onah, Tomlinson, Field & Honikman, 2016).

Depression is also found to be prevalent in older women especially when faced with mistimed or unwanted pregnancy. Interestingly, in a survey of pregnant women across four countries, women decried the absence of relevant information on the psycho-

social aspects of pregnancy during the prenatal health education classes (Al-Ateeq & Al-Rusaiess, 2015). Ideally, the forum of prenatal care should furnish women with information on coping strategies to adopt when faced with challenging situations in pregnancy. In contrast, the issue of mental ill-health is afforded less attention by providers in the course of dispensing prenatal care (Dibaba, Fantahun & Hindin, 2013; Royal College of Midwives, 2015). Research on prenatal depression is sparse especially, in low resource economies despite its inherent danger to maternal and foetal health and its resultant burden on nation' s economy in terms of treatment. Rather, research focus has been geared towards postpartum depression whereas prenatal depression is, in fact, a predictor of postnatal depressive symptoms, especially, in symptomatic patients. Scholars argue that the paucity of research on prenatal depression has led to its neglect over the years (Coll, *et al* 2017). Meanwhile, the majority of studies on prenatal depression have been carried out in high-resource economies. The result of the few conducted in low-resource economies show a higher prevalence in prenatal depressive symptoms in those countries. However, poor record keeping has made it difficult to access data on prenatal depression in low-income countries.

Some of the implications of prenatal depression on birth outcome include low-birth weight, pre-term delivery, intra-uterine retarded growth and child emotional and cognitive disorders. Incidentally, the result from a systematic review of articles published within the period 1977-2013 on prenatal depression and adverse birth outcome indicate some inconsistencies. For instance, 53% of the articles show a significant correlation between depression during pregnancy and low- birth weight, while its effect on preterm delivery or prolonged gestation could not be ascertained for lack of strong methodological investigations (Accortt, *et al* 2015). Notwithstanding this, recent research on the treatment of prenatal depression shows sufferers' preference for individual rather than group therapy. Also, women have expressed a preference for more psychosocial support during pregnancy as part of a treatment plan than the use of antidepressants. The identification and treatment of depression in pregnancy is doubtful especially in low-resource economies where specialised mental nurses are not incorporated into maternity care teams. Additionally, there is a growing body of evidence to suggest pregnant women' s lack of confidence in nurses' ability to manage depression during the prenatal period

(Forsell, Hollandare, Szymanska, Schultz, Nasiell, Blomdahl-Wetterholm, Eriksson, Kvarner, Van der Linden, Soderberg, Jokinen, Wide & Kaldo, 2017).

2.8 Theoretical framework

2.8.1 Attribution theory

The attribution theory is a theory of social and self-perception. It has also been applied to the study of motivation. It is a theory that seeks to explain how individuals cope with ambiguity and the complexity inherent in understanding other people. It was propounded by Fritz Heider in 1958 in a bid to explain how individuals gauge the cause or underlying motive behind human communicative behaviour and talk. It seeks to explain why and how certain events produce certain outcomes in daily living, and how to prevent the reoccurrence of unpleasant happenings. The proposition of Heider' s attribution theory is that human behaviour can be explained using a major construct which he referred to as: the **causal locus**. **Causal locus** has to do with explanations given as the cause of behaviour. The explanation for an exhibited behaviour in this sense can be traced to the underlying motive (intentionality or otherwise) of actions. To Heider (1958) cited in Malle (2011:73) " motives, intentions, sentiments… are the fundamental elements which manifest themselves in overt behaviour" . An individual' s behaviour is assumed to be purposive (intentional) if the observer of the action can perceive the underlying motive behind the observed action. For example, in Africa, women generally strap their babies unto their backs. When, therefore, a nursing mother straps her baby to her chest with a baby carrier, it raises critical questions on the part of the observer. The woman' s action can be perceived as purposive, that is deliberate, if she is educated, middle class and is urban. The same action performed by a mentally challenged woman, however, will not be regarded as an intentional behaviour. Unintentional behaviours, according to Heider, cited in Malle (2011:73), are often caused by impersonal factors, such as physical events outside the realm of control of the individual. Further studies into the nature of attribution led to the expansion of the theory to include such concepts as the **locus of stability** and **locus of control** (Manusov & Spitzberg, 2008:39). The locus of stability utilizes two dimensions – stable and unstable factors– in giving explanations for human behaviour. Stable factors as the name indicates, are those factors that do not change over time. For example, if a midwife' s facilitation skill is low, it is unrealistic to expect such a midwife to produce results in terms of imparting knowledge to pregnant women. Unstable factors on the other hand, vary with behavioural outcome; for example, if the midwife' s inability to

impart knowledge to pregnant women is as a result of inadequate preparation for the group prenatal session, she may improve her performance if she is more diligent in her preparation prior to her delivery. Finally, the **locus of control** is based on the level of control individuals had over the situation as at the time they exhibited the said behaviour.

Over the years some useful contributions to the theory have been made by such scholars as Jones and Davies (1965), Kelly (1967) Weiner (1986) to mention just a few of them (Malle 2011). Kelly (1967) developed a model for attribution which he called the **Covariational model of causal attribution.** Kelly' s model of causal introduced a new dimension into the attribution theory. In the model, behaviour can either be internally motivated or externally motivated. In other words, behaviour can be attributed either to internal factors (psychological disposition) or to external factors (situational factors). In the model, explanations for human behaviour are made, based on information derived from three main constructs: **Consensus**, **Consistency** and **Distinctiveness**.

Consensus has to do with the degree to which other people apart from the person being observed would behave in like manner, given a particular situation. For example if a particular nurse A exhibits an uncouth behaviour to a pregnant woman during the course of group prenatal care and other nurses in the group are not guilty of exhibiting similar behaviours to the woman or to other pregnant women, nurse A' s behaviour would be said to be low in consensus. Internal attribution (psychological disposition) is usually made for behaviour that is low in consensus. If, on the other hand, majority of the nurses in the group behaved in like manner to other pregnant women during the group session, then consensus would be regarded as high. In interpreting behaviour, if consensus is high, the behaviour under observation is given an external attribution (situational factors).

Consistency is the second construct of Kelly' s model. Here, a person is observed critically to determine the frequency with which he/she exhibits a behaviour given a particular situation. Nurse A' s hypothetical case would still suffice here. If Nurse A always exhibits an uncouth behaviour to patients and staff given a particular situation,

then her behaviour is high in consistency. If, however, Nurse A rarely exhibits such an uncouth behaviour to people, her behaviour is low in consistency. A behaviour that is highly consistent is given an internal attribution (psychological disposition).

Distinctiveness is the final construct in the model. This has to with the extent to which an individual behaves in a similar way, given the same situation. To illustrate, still using Nurse A' s hypothetical case; her behaviour would be interpreted as being low in distinctiveness if she was saucy to everybody, regardless of who the person is. On the other hand, if she is rarely saucy to people, then her behaviour would be considered high in distinctiveness. In this particular case, Nurse A would be judged as having a dispositional problem because she was saucy to a pregnant woman while majority of the other nurses did not exhibit similar behaviours at the time. Information derived from the three constructs of the covariational model is useful in attributing behaviour to either internal or external factors.

2.8.1.1 A critique of the attribution theory

The strength of the attribution theory lies in its explanatory power. For Manusov and Spitzberg (2008: 85), " most of the dimensions and principles of attribution theories are recognizable immediately in everyday interactions" . For example, the illustration given above on Nurse A' s uncouth behaviour to a pregnant woman indicates how people make attributions about others and how they use the information on attribution as a basis for generalising about others' behaviour. The attribution theory is a useful platform for humans to make rational and informed decisions based on observable cues from other' s behaviour. The attribution theory is a theory of social and self-perception, thus, the constructs of the theory serve as a useful framework for understanding the cause of exhibited behaviour. If the attributions people make as reasons for their behaviour are known, then, one can influence the behaviour of such people. For instance, if a pregnant woman is infected with HIV (Human Immune Virus) and she attributes the cause of her infection to reckless sexual practices, she may indulge in regretful thinking and self-pity, which may pose serious threat to her health. Such a person can, however, be assisted to get out of her state of lethargy, to living a wholesome life, if the underlying reasons for her behaviour are known.

The attribution theory is particularly useful in describing how ones' perception of others shapes each stage of relationship development. During the process of interpersonal or group communication, interlocutors process what their partners say and do and use the information derived to form perceptions about others (Wood, 2010). Scholars posit that to every relationship, there is an entry phase, personal phase (maintenance) and an exit phase (occasioned by death or relationship decline) (Griffin, 2008; Berko, Aitken & Wolvin, 2010). As a relationship progresses from the entry to the personal phase, partners involved both consciously and subconsciously try to maintain or exit the relationship. The perceptions each partner has of the other person would influence them to consciously try to maintain or exit the relationship. Over time, those perceptions are either altered or reinforced based on new experiences (Griffin, 2012). For instance, the perceptions people hold about others will influence their interaction, and determine if the relationship will go beyond that of mere acquaintances. On the other hand, relationship may decline as a result of the death of either partner or because partners are not willing to take the relationship any further. In the latter case, the attribution theory is useful in throwing light on the underlying cause of the deteriorating relationship.

The attribution theory, like many other theories, is not without its limitations. It is a cognitive theory which portrays individuals as rational beings who explain the behaviour of others or their own behaviour in rational terms. The process of attribution may be fraught with errors because human perceptions are subjective. Ideally, people tend to adjust their initial perceptions of others, based on available new information, which may be contrary to their initial perceptions. However, some people refuse to change their initial attributions of others even when they have information to the contrary. When people refuse to change their initial attributions of others even in the face of overwhelming evidence to the contrary, an error will occur in the attribution process. Gilbert and Malone (1995) describe such a situation as resulting in a fundamental attribution error. When individuals allow their feelings, esteem issues or idiosyncrasies to becloud their reasoning, they are bound to be irrational in their judgments. Fundamental attribution error, according to Foss and Littlejohn (2009:62), occurs when individuals overemphasise dispositional factors as

the reasons for others' negative conduct and underestimate the role of situational contingencies.

Differences may also occur in perception based on individual differences. Oftentimes, the explanations people give for their own actions often differ from the explanations they proffer for others' behaviour. The difference in perception based on who is the performer of the action and who is the observer of the action is called ' actor-observer bias' . ' Actor-observer bias' , according to Malle, Knobe and Nelson (2007), is a term used to explain the differences in judgments based on who is the performer of an action and who is the observer of the action. Actors ascribe their negative behaviour/outcome to situational factors, while their observers ascribe the same conduct to dispositional factors (Sirin & Villalobros, 2011:2).

Furthermore, Malle (2003) argues that Kelly' s covariation theory is lacking in empiricism, as research shows that respondents hardly think about justifying their actions or those of others with the tools of covariation each time they are making judgments. Studies have shown that unless respondents are supplied with information that supports covariation, they hardly give reasons that justify the explanation of covariation (AhnKalish Medlin & Gelman, 1995; Malle, 2003). Thus, AhnKalish *et al (*1995*)* and Malle have used this obvious lack of internal validity as a basis to describe Kelly' s covariation theory as lacking in verifiability.

Attribution theory is also limited in its scope and applicability. It was initially used in the field of social psychology and it has since been applied to interpersonal communication research, but only in specialised areas, such as loneliness, shyness, domestic violence, depression, stigmatisation, academic failure or success and organisational management (Berger, 2001; Foss & Littlejohn, 2009). The theory has also been tested in health care communication research; but available literature on attribution as it relates to health care is scanty. Ogden (2004) cites a few of the relevant studies in literature on attribution as it pertains to health they are, King (1982), Wallston and Wallston (1982) and Bradley (1985).

2.8.1.2 Applicability of the theory to the proposed study

The attribution theory helps in the measurement of self and social perception. It is also a theory that could explain, for example, how someone' s perceived ability in preventing or managing a particular illness could affect his/her adherence to medical counsel or prescribed treatment regimen (Vaughn, Jacquez & Baker, 2009). More specifically as it relates to the proposed study, if a pregnant woman, say, were to perceive that her pregnancy is outside her control, but is under the control of some powerful spiritual forces, she may not adhere to the counsel of her health care provider. While such a woman may attend group prenatal classes, her belief about the pregnancy remains unchanged. If her beliefs about the pregnancy remain unchanged, she would derive little or no benefit from the group prenatal care sessions. Similarly, pregnant women who attribute their pregnancy to external factors (an act of God, for example) but attribute the safety of the pregnancy to internal factors (I am directly responsible for the baby' s safety)---such women are likely to be receptive to the counsel of their health care providers. The attribution theory can also be applied to the proposed study in terms of how pregnant women' s beliefs affect their contribution to group discussion. For example, a pregnant woman who believes that she has to pray and fast fervently for a successful birth outcome may not be attentive during the group prenatal sessions. She may not even make any contribution to the discussion unless she is pointedly called upon by the group leader/facilitator to do so.

Furthermore, the attribution theory is applicable to this study because it will enable one to understand how pregnant women perceive the delivery techniques as well as the communicative skills of nurses/midwives who deliver the health-talk. The attribution theory will help in understanding how pregnant women' s beliefs affect their adherence to group norms as well as medical counsel. A regular feature at many group prenatal classes is the rendition of different types of songs to motivate pregnant women. In some maternity centres, Christian songs are predominantly sung. The proposed study will investigate the extent to which people of different religious beliefs adhere to this particular group norm (practice) as well as others.

2.8.2 Systems theory

Ludwig von de Bertalanffy, a biologist, propounded the general systems theory in the 1950s, to explain the interaction that exists within the ecosystem (Cordon, 2013). In

contrast, Skyttner (2005) and Rouseau (2015) argue that the general systems theory was propounded to proffer solutions to emerging technological as well as societal problems at the time. Nevertheless, the vision of Bertalanffy led to the formation of the society for the advancement of general systems theory in 1955 (Corning, 2014:1). Members of this society became known as the founding fathers of systems movement. They include Rapoport, Boulding, Mead, Gerald and Miller, among many others (Corning, 2014). While tracing the historical development of the systems theory, Skyttner (2005) observes that prior to the emergence of the scientific age, the church was the sole preserve of knowledge. Hence, in the medieval era, it would be suicidal for anyone to embark on a scientific research, as everything in the universe was perceived from the metaphysical point of view. A scientific, revolution, however occurred around the 18th century which led to the emergence of a crop of scientists such as Galilei and Descartes, for example (Skyttner, 2005).

Galilei was a foremost scientist at the time, and his work was aimed at separating science from religion because of the enormous influence of the church on the society. Descartes expanded upon the work of Galilei when he introduced the concept of dualism. The concept of dualism explains the duality of the body and mind of a human being (Skyttner, 2005). According to the philosophy, the body exists only in the realm of the physical, while the mind exists in the realm of the psychological. Thus, the two are separate, although the mind can exert control over the body. Further, scientific enquiry in that era was characterised by reductionism, a concept which seeks to explain the whole by breaking it down into parts (Skyttner, 2005; Cordon, 2013). Reductionism as a scientific principle has influenced research in such fields as biology, physics and chemistry. Descartes' concept of dualism also relates to reductionism, which explains why he likened the human body to a machine that can be dismantled in order to investigate the functions of its various parts. According to Descartes, though the human body is just like a machine, it is nevertheless more complex than a machine (Cordon, 2013). Notwithstanding this, it can be inferred that the reductionism approach to scientific enquiry suggests that the individual function of each of the body parts, can be studied in isolation to identify its physical and chemical components. The reductionist perspective has however been criticised as being inadequate to explain the complexity inherent in living organisms (Cordon,

2013). It is inadequate in the sense that, while it may be possible to dismantle a clock, for example, to study its components parts, it is impossible to dismember a human body without first killing the individual concerned.

The obvious inconsistencies in the approach to scientific enquiry in the scientific era contributed to the emergence of the general systems theory. The evolution of the general systems theory was influenced by the philosophy of Aristotle who believed in the concept of wholeness as against adopting a piecemeal approach to scientific enquiry (Mele, Pels & Polese, 2010; Cordon, 2013; Sexton & Stanton, 2016). Following the argument of Aristotle, if any part of the human body, for instance, is severed from the body and then restored later that body would no longer be able to perform its original function. Thus, a severed limb, for example, cannot be referred to as a limb, since it would only be able to perform the functions of a limb in concert with the signals received from the brain (Cordon, 2013). This philosophy of Aristotle' s is in direct contrast to that of Descartes who believes that the whole is better understood when its components are known and investigated.

The philosophy of Aristotle has been found to be more reliable, as many of the propositions of the general systems theory were founded on his belief. Further, the general systems theory was propounded to integrate scientific research in both physical and social sciences (Bertalanffy, 1968; Skyttner, 2005; Cordon, 2013). The systemic perspective argues that " we are not able to fully comprehend a phenomenon simply by breaking it up into elementary parts and then reforming it; we instead need to apply a global vision to understand (sic) its functioning" (Mele, *et al*, 2010:126).

Furthermore, and still according to the general systems theory, a system can be described as a network of relationships existing among the different components of a thing, an organism, an organisation or a group (Bertalanffy, 1968). A system can either be open or closed. An open system, according to Cordon (2013), is a system that has the capacity of interacting with its environment and maintaining equilibrium (balance) based on the feedback received from such an environment. The equilibrium may be in the form of a modified behaviour, an improved service delivery or any other form of change depending on the nature of the system. To Cordon, therefore, all

living organisms are examples of open systems. Similarly, health-care organizations, such as hospitals, are open systems (Hayajneh 2007). The extent of openness of any system is determined by the activities of its environment. However, Tamas (2000) argues that what really determines if a system is open or close is the permeability of its boundary. The boundary of a system is the demarcation between the system and its external environment. A semi-permeable boundary allows energy, information, resources and other important materials to flow between the system and its external environment. In health care systems, for example, the providers of care such as nurses, do not operate in exclusion of their external environment. This is the reason nurses/midwives, for instance, use the native language of their environment as the medium of communication in the course of dispensing care. Scholars such as Tamas (2000) and Cordon (2013) agree that a semi-permeable boundary is the most suitable form of boundary for any system.

In contrast, a closed system is a system that does not have the capacity to interact with its environment. In the opinion of Tamas (2000), all the energy within a closed system will eventually be used up, since there is no energy transfer between the system and its external environment. The scholar has in fact likened a closed system to a burning candle in an encased object such as a bottle. After a while, the candle will burn out. Similarly, in reality, a closed system that fails to engage in any form of energy transfer with its external environment will, in effect, deplete its internal resources, possibly resulting into a system collapse. The general systems theory states that a state of entropy occurs when a system decomposes, degenerates, or collapses (Tamas, 2000; Skyttner, 2005; Cordon, 2013). However, entropy can be avoided in a system when checks and balances are put in place. To relate this to our main concern in this study, entropy may occur in group prenatal care clinics in Nigeria when the system of administering care degenerates resulting into low patronage. If such a situation occurs, research would have to be conducted to ascertain why pregnant women are not attending group prenatal care. The result of the research will determine the measures that would be put in place to increase patronage. If the measures yield positive result, then a state of negative entropy will occur.

Further, open and closed systems can be subdivided into sub systems and supra systems. A sub system just as the name implies, is a smaller system situated within a larger system. A group prenatal care program is for example a sub system within the larger hospital operating system. The activities that go on within the group prenatal care may impinge on the hospital and conversely, the activities that go on in the hospital may also affect the conduct of the group prenatal care. In addition, pregnant women who attend group prenatal care are also members of different subsystems (multiple groups). Pregnant women are members of different households, communities, organisations and diverse religious affiliations. The beliefs and practices of the different groups they belong to, may affect the attitude of pregnant women to prenatal care. Further, a supra system is a larger operating system that houses smaller sub systems. Hence, the hospital where group prenatal care is taking place is a supra system. The community or nation where the hospital is located can also be referred to as a supra system.

2.8.2.1 A critique of the systems theory

The general systems theory was an attempt at creating a universal language of empiricism for researchers. The objective of system thinkers at the time was to synthesize research from diverse disciplines by creating a common way of knowing. One of the strengths of systems theory is its uniqueness in studying complex issues in various disciplines (Covington, 1998; Cordon, 2013; Corning, 2014). The theory is not only useful in studying complex issues, but it also examines the web of relationship that exists among identified variables. The general systems theory according to Covington (1998:4) serves as a useful framework in studying phenomena as they really are, especially when the situation has gone beyond a cause-effect relationship.

Another strength of the general system theory lies in its ability to make useful predictions about the future. To Covington (1998) researchers are able to make predictions about the future from the theory, when they establish a connection between the past and the present. Further, systems theory has stood the test of time as a useful research tool in studying varying subjects in the sciences, medicine, engineering, social sciences and art discipline. Hence, over the years, this theory has

evolved into smaller theories such as the dynamic system theory, chaos theory, and family theory among many others. The propositions of the systems theory also served as the bedrock for the design of media ecology theory. Although, there are contentions on the actual identity of this latter theory as some school of thought regard it as a philosophy and not as a theory. Furthermore, the tendency of the general systems theory in explaining diverse issues in different disciplines may have led to its being criticised as being too generic in nature. Covington (1998) argues that its generic nature have reduced its heuristic value. Again, Skyttner (2005) argues that the theory is too generic to address specific problems such as cancer and AIDS that are prevalent in contemporary human society.

In addition to all that has been stated so far, there is an argument that the purpose for propounding the general system theory has been defeated. This is because, far from integrating research across disciplines, system researchers have, over the years, only succeeded in fragmenting research by creating smaller theories to explain specialised areas (Rousseau, 2015). In the opinion of Rousseau (2015), the idea of a general system theory is still a mirage as the so called systems theory thus far, has not fulfilled its potential in integrating research across disciplines. To Caws (2015), the idea of a theory that would integrate physical science and social science research is a lofty one and may be unrealistic in view of the obvious philosophical differences in the physical sciences and the social sciences. He argued that it is unprofitable to use scientific modes of enquiry in solving societal problems, as both the physical and social sciences are of different epistemological orientations. In much the same way, Kast and Rosenzwerg (1972) aver that some of the structural components of the general systems theory are faulty. For instance, naturally, open systems are likened to biological systems, while closed systems are said to be mechanistic. This, however, is not usually the case, in most instances, as the dichotomy between open and closed systems does not exist in reality in organisations. There is no system that is entirely closed or opened (Kast & Rosenzwerg, 1972). The degree of openness or closeness of a system is relative. Further, to Kast and Rosenzwerg, there is an implicit notion that open systems are good, while closed systems are bad. This is probably an anomalous perception, as a relatively open organisation may for instance, be closed with regards

to its technicality. For instance, Coca-Cola as a bottling company does not reveal the mixing formula of its products to the general public.

Finally, Von Bertanlanffy' s biological comparison of systems to living organisms may not be applicable to organisations. This is because while living organisms strive for survival, organisations are more concerned with effectiveness (Kast & Rosenzwerg, 1972). Organisations do not merely exist, but they strive to stay relevant within their external environment. Similarly, Boulding, a contemporary of Von Bertanlanffy and one of the founding fathers of system science, also compared systems using the chemical metaphor (cited in Rousseau, 2015:524). The chemical metaphor has been criticised as being specific only to the physical sciences and not applicable to the social sciences (Rousseau, 2015). In view of the foregoing critique of the general systems theory, Kast and Rosenzwerg (1972) have suggested that the theory should not be dogmatically applied to the social sciences but should be modified as appropriate.

2.8.2.2 Applicability of the theory to the proposed study

The principles of systems theory has been the main theoretical guide for relational communication research (Rogers & Escudero, 2004). The general system theory, when applied to the study of prenatal care groups, will assist this researcher to adopt a holistic approach to addressing problems inherent in such support groups. Prenatal care groups do not exist in a vacuum; they are a function of several other interrelated networks also known as systems. The prenatal care group is a subsystem within the hospital and there are other sub systems within the prenatal care group such as ethnic and religious affiliation of members. These subsystems all work in tandem to influence either positively or negatively the operations of the prenatal care group.

In addition, Johnson Miller and Horowitz (2008) posit that systemic thinking has helped organisations such as the telecommunication and aviation industry to be performance driven, as such industries measure performance based on outcome. Hence, there is opportunity for such industries to improve outcome based on internal and external feedback about the quality of their services. In much the same way, the principles of the general system theory will assist the researcher to understand the

network of factors that contribute to the pattern of relational communication in group prenatal care. The researcher is set to investigate if prenatal care groups in Nigeria accommodate feedback from clients and providers. If feedback is accommodated, the researcher seeks to identify the particular aspects of group prenatal care that has experienced a change due to received feedback.

Meanwhile, Johnson *et al* (2008) have described health- care organisations as complex adaptive systems in view of the following reasons. To start with, membership of health care organisation changes periodically, as clients are at liberty to visit any hospital of their choice to receive care. Also, health- care providers enjoy mobility of labour, as they are constantly in search of hospitals that can offer improved conditions of service. Further, clients and providers are members of multiple systems (groups) where interaction takes place. Studies in literature have shown that when individuals interact with others in a group, individual behaviour will be modified in a definite way. Consequently the interactions of both clients and providers with other people in their network, may affect delivery and or reception of health education during the prenatal care. In addition, the policy of government may affect how care is administered, as governmental policy may shape the behaviour of nurses, the organisation of care, as well as time allotted to care. (Johnson, *et al*. 2008). For example, in the United States of America, between 8 and 12 pregnant women of the same gestational age of pregnancy are assigned into groups. This practice in the United States of America has led to a reduction in neonatal deaths occasioned by congenital infections; it has also reduced incidences of low birth weight among infants (Ickovics, Kershaw, Westdahl, Rising, Klima & Reynolds, 2003). Nevertheless these remarkable results, the Nigerian government may be unable to adopt such a model, in view of inadequate finance to recruit more nurses/midwives.

Finally, the applicability of the systems theory to this particular study is summarised in Hayajneh (2007:1) and described as thus:

> Systems theory can be used to clearly and concisely understand health care structures, processes and outcomes, processes and their interactions within a health care system. Systems theory can be used as a framework to describe the components of systems and the relationships between these components, the boundaries of the systems, the goals of the system and

the system' s ability to change and adapt in response to internal and external forces.

2.8.3 The Communication Accommodation Theory (CAT)

The Communication Accommodation theory (CAT) which was initially referred to as the Speech Acts Theory was developed in the early 70s' by Howard Giles to depict how interactants modify speech to align or differ from other interlocutors' perceived social and communicative needs. This theory has since evolved from adopting mere speech acts to employing both verbal and non-verbal codes in the explanation of behaviours. The social and cognitive demands of an interaction predispose individuals to consciously or subconsciously shift their language patterns to align or depart from other interlocutors. The adjustment of communicative modes to suit perceived or expressed needs of other interactants is described as accommodation. Scholars posit that upward accommodation occurs when transceivers align their speech or non-verbal codes with perceived superiors or respected others (Foss & Littlejohn, 2009; Barker, 2015; Farzadina & Giles, 2015). Downward accommodation, on the other hand, occurs between individuals of similar status as language is modified to suit the informal requirements of conversation. For instance, nurses in Ibadan are likely to converse informally in either Yoruba or pidgin among themselves. Conversely, an upward shift in language will occur when the Chief Medical Director of the Hospital is engaged in a conversation with the nurses. In the latter case, they are likely to employ the country' s official language in their interaction. Both upward and downward language shifts are also referred in the literature as convergence. Oftentimes, convergence tools are not mutually adopted by interlocutors, as only an individual modify his/her language for that purpose. Thus, asymmetrical convergence occurs when only one interlocutor strives to attune to other perceived or stated linguistic or psychological needs. With symmetrical convergence however, there is mutuality in interlocutors' quest for linguistic and psychological similarity. Put simply, transceivers mutually consider psychological and linguistic rules to ensure shared meanings.

Meanwhile, it is also possible for an interlocutor to deliberately employ a different language /non-verbal code to portray non-alignment with another interlocutor. Such a situation is referred to as non-accommodation. This divergent conversational strategy

is regarded as a common feature of interaction in multilingual or bilingual societies, where members adopt language to maintain social identity. For example, Hausa-speaking people who are also proficient in the English language, reportedly adopt their native language in conversations with non-Hausa speakers to exhibit a non-alignment stance. That is the reason linguistic marker such as " *Ba Turenchi*" (a lack of proficiency in the English Language) is commonly adopted to maintain identity in that part of the country. The two main dimensions of non-accommodation are manifested as over accommodation or under accommodation strategies. Over-accommodation is a conversational shift that occurs when an interlocutor is perceived as relating with others condescendingly. For instance, over accommodation has been reported in provider-patient interactions, especially, in the areas of paediatrics, geriatrics and patients with hearing defects. A plausible explanation for over accommodation among interlocutors, according to Baker (2015), is that stereotypical notions about others affect perception and shape interaction accordingly. Foss and Littlejohn (2009), however, argue that over accommodation may be employed not necessarily to denigrate the other interlocutor, but oftentimes, in good faith. In contrast, under accommodation occurs when interlocutors strive to maintain cultural or social identity employing certain linguistic markers. Caregivers may as an example, mimic the language of indigent patients, particularly, when such, are reputed for defaulting in the settlement of hospital bills.

Currently, various socio-linguistic markers depict the elaboration of CAT to include other convergent and divergent strategies. Those socio-linguistic terms are approximation, discourse management, emotional control, interpretability and interpersonal control strategies (Farzadina & Giles, 2015). **Approximation strategies** are employed when language is attuned to match or differ from those of an interlocutor. Hence approximation can either be a convergent or divergent tool depending on the motivations and inclinations of interlocutors. In a critical study of literature on the application of CAT in health care, caregivers reportedly employed approximation strategies with little success (Farzadina & Giles). Such strategies were observed as common in geriatrics and among patients with speech and cognitive difficulties. Result indicates that patients and providers experienced problems approximating during clinical interactions. Providers' adoption of ' Elder speak'

was negatively perceived by patients as denigrating. In contrast, providers believed that deploying such linguistic features would provide a relaxed ambience to inmates in the elderly peoples' homes. The elders however perceived the communicative behaviour as over accommodation. Nonetheless, Chevalier, Watson, Barras, Cottrell and Augus (2018), in a qualitative analysis of pharmacist-patient interactions argue that provider-patient engagement of approximation strategies was accommodative as paralinguistic features such as tone, voice volume and rate were harnessed by providers to reduce linguistic distance in the interaction.

Discourse management strategies are accommodation tools adopted to manage others perceived or stated conversational needs. Interpretability, interpersonal control and emotional control tactics are subsumed under discourse management strategies. Put differently, this implies that discourse management strategies entail the adoption of interpretability, interpersonal control and emotional control strategies for effective management of discourse between/among transceivers. The effectiveness of discourse management strategies have been investigated in patient-provider interaction particularly in geriatrics, psychiatry and among patients suffering from pain. (Farzadina & Giles, 2015). Research has shown that patients would require providers' guidance in appropriately communicating painful symptoms. Providers thus, deploy linguistic and paralinguistic features to enable patients communicate experience with less difficulty. Consequently, when providers deploy communicative cues such as pauses, nods and open-ended questioning, it allows for more patient-centred care and patient disclosure. Conversely, an opposite situation occurs, when providers ignore such discourse management strategies (Farzadina & Giles, 2015).

Emotional control strategies are the deployment of various communicative modes in relation to expressed or perceived needs of others. Both verbal and its non verbal accompaniments are modified by partners to achieve relational goals. Emotional control strategies can be deployed for accommodative and non-accommodative communication behaviours. Hence interlocutors' communicative competence in deploying strategies of emotional control is crucial for the accomplishment of shared meaning. For example, Farzadina and Giles (2015) observe that overly sympathetic providers are perceived by patients as exhibiting over accommodation. Patients regard

as more truthful an empathetic provider than a sympathetic one, which explains why the latter reportedly often limit sympathy to a sentence expression. Consequently, when bad news is to be broken, providers employ emotional control strategies through empathetic touch, nodding, eye gaze, and pauses to reduce the negative import of such news. Emotional expression is thus, conveyed predominantly through non-verbal means. Former studies have interrogated the various indicators of providers' emotional expression while those of patients have received little attention (Watson, Augus, Gore & Farmer, 2015).

Interpretability strategies relate to how language is deployed in a way easily discernible to the other interlocutor. In clinical interactions, providers and clients deploy interpretability strategies to provide clarity in their narratives. How these strategies are deployed by either interlocutor will determine if the outcome of the interaction will be accommodation or non accommodation. Interpretability strategies have been investigated in patient provider interaction especially in palliative medicine and neonatal care. Findings suggest a gap in the use of interpretability strategies, patients' need for non-ambiguous and honest appraisal of their situation were unfulfilled as providers reportedly employed medical jargons that under-accommodated the former. Patients in like manner, under accommodated providers by presenting symptoms in general and non-specific language (Farzadina & Giles, 2015). Finally, **interpersonal control strategies** attend to how interaction is shaped by socio psychological variables like role, stereotypes, power or status. Interpersonal control as a socio-linguistic marker is reportedly prevalent between patients and providers in clinical interaction as the latter allow stereotypes and role play interfere in dispensing care. The role of interpersonal control in determining accommodative or non accommodative communication behaviours has been investigated in geriatrics and palliative care. Studies have shown gender based differences in patients' perception of care. While women perceive providers recourse to stereotypes and status based interaction as over accommodative, men believe caregivers relate based on the demands of their profession. Additionally, Farzadina and Giles (2015) argue that patients perceive providers who ignore their right to decision making and collaborative care as displaying divergent communication behaviours. For instance, during health counselling or education, patients may not be favourably disposed to an

inflexible health care provider who adheres strictly to an agenda for clinical interaction.

2.8.3.1 Criticism of the CAT Theory

The Communication Accommodation Theory has been described as a veritable framework for investigating the dynamics of individual communicative behaviour in group situations, especially, in multi or bilingual settings. This explains why Farzadina and Giles (2015) also describe the theory as very valuable in qualitative studies. The theory also helps to proffer explanations as to how, when and where of interaction between providers and patients. It has also been found useful in preventing the onset of conflict. The applicability of the CAT theory to a wide array of disciplines points to its practicality (Cafone, 2017). Nonetheless, this benefit has been criticised for introducing strange dimensions to the theory' s original ideas. Similarly, the theory has been described as lacking in parsimony, as its expansion may account for observed differences in scholarly interpretation of its components. Despite this limitation, the CAT theory is empirically useful as its propositions have been tested among diverse cultures, group situations, gender studies and interpersonal relationships. It has also spurred the evolvement of several allied models of communication. Although the communication accommodation theory has the ability to create better understanding of language deployment in health communication, it has failed to fully account for how contextual factors affect interlocutors' communicative behaviour. For example, interpersonal control as a socio linguistic marker in the theory explains how power, status and role play affect providers and patients' conversations. While it is certain that the training and experience of providers put them at advantage over patients, the nature of the medical encounter and the type of health facility are likely to neutralise the effect of status and role play especially, in private hospitals.

Similarly, it may be difficult to clearly determine the reasons for providers' over or under accommodative behaviours especially in observational studies as their conduct may either be motivated by intrinsic factors such as status and power or extrinsic variables like overwork or anxiety. As a matter of fact, Cafone (2017) argues that it is not clear if convergent or divergent behaviours are consciously or subconsciously

driven. Oftentimes, physicians are brusque in their approach to delivering bad news not so much because of insensitivity, but, because of an absence of cognate skills in communication (Amoah, Boakye & Gyamfi, 2018). Furthermore, it may be problematic adopting this theory to interpret human behaviour in unfamiliar cultural settings as such interpretations may be faulty.

2.8.3.2 Applicability of the theory to the present study

The Communication Accommodation Theory (CAT) helps to explain how group affiliation, intrapersonal motivation and social identity determine individual communicative behaviour. It is also a theory that could explain, for example, how individual pattern of interaction changes in relation to particular interlocutor. This theory has been applied to the study of health communication in diverse areas such as geriatrics, palliative medicine, patient-provider communication in maternity care, neonatal care, pharmacy among others. More specifically as it relates to the proposed study, if a nurse, for example, were to reduce information quality and quantity regarding a pregnant woman' s prognosis based on stereotypes, it has implication on the clinical encounter. Such a nurse has inadvertently affected the patient' s ability for shared decision making. As Cafone (2017) observes that care givers are obligated to provide detailed information to pregnant women on their condition and the latter also has the prerogative for informed decision as to the preferred form of care. Consequently, the theory is regarded as highly malleable in explaining both interpersonal and intergroup relations, especially, between patients and providers, hence, its heuristic value. Some scholars have argued that health care providers' relational communication with patients is borne out of stereotypes, status, professional role and intergroup relations (Farzadina & Giles, 2015; Wright *et al*, 2013). In other words, caregivers whose verbal and non verbal cues depict provider-centred care are perceived as ego-centric by patients. While the foregoing assertion may be true to an extent, this present study, however, seeks to explore how the different context of hospital situations may likely affect both providers and patients' verbal and non verbal cues. The CAT theory can also be applied to the proposed study in terms of how individual pregnant women' s goals affect their contribution to group discussion. For example, a pregnant woman whose goal is merely to attend prenatal care for medical assessments, may be less active in the group discussions, and possibly, avoid

attending the health-talk classes altogether. Furthermore, the CAT theory is applicable to this study because it will enable one to predict and understand how providers and expectant mothers' verbal and non verbal cues depict their motivations. Farzadina and Giles (2015) argue that previous studies on patient-provider interaction have failed to examine patients' emotional expression in relation to the clinical encounter.

2.9 Conceptual model

Perception of Relational Communication Behaviour in Group Prenatal Care

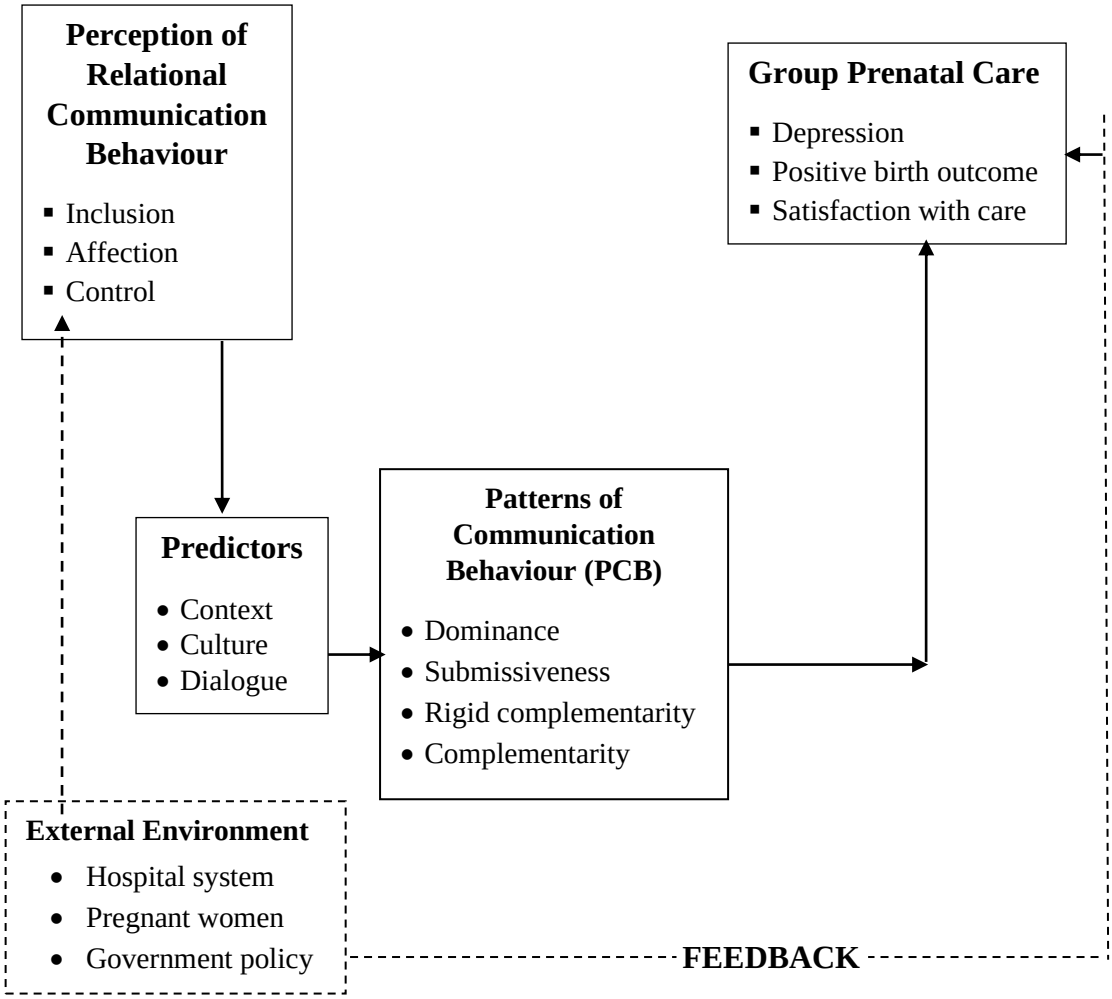

Figure 2.1: Perception of relational communication behaviour in group prenatal care
Source: Author (2016)

2.9.1 Relevance of the conceptual model

The conceptual model depicts the connection between relational communication behaviour and group prenatal care. It is assumed that pregnant women' s perceived need for control, inclusion and affection motivate them to join prenatal care groups in hospitals. In other words, women' s desire to have a reasonable level of control over their pregnancy and the birth outcome is a major reason they become members of prenatal care groups. Similarly, these women join such groups because of a primary need for a sense of belonging; which can be described as the need for inclusion. They are members of such care groups because of an innate need for social support (affection), especially, as they experience a lot of hormonal changes during the period of pregnancy which may predispose them to depression. A review of relevant literature in this section has shown that other moderating variables such as the context of communication, the culture of interlocutors and the dialogue employed in the communication encounter determine the dynamics of relational communication in a group. These predictors also affect the women' s perception of the quality of care received.

Notwithstanding this, all of the aforementioned factors are also influenced by the external environment. For instance, governmental policy as regards the recruitment of health workers will determine the ratio of nurses to pregnant women in a group prenatal care. The policy of government on health care will also determine the group composition as well as disposition of health workers to dispensing care. Other indices in the external environment are the system of administration of care within each hospital and the differing characteristics of each pregnant woman. Pregnant women' s perception of relational care will vary based on their demographics, psychograhics and psychological composition. Furthermore, studies have shown that clients' perception of the relational communication of their care givers affect the former' s perception of the quality of care received in such hospitals. Meanwhile, the quality of group prenatal care is measured with such indices as satisfaction of clients with received care, positive birth outcome and the management of depression among highly susceptible pregnant women. The feedback loop in this model is to describe the importance of both internal and external feedback to the survival of prenatal care groups in the country.

2.10 Empirical Review

Similar studies to this present one have been conducted in times past by scholars, one of such, is Dorbosh (2015) who examined the role of perceptions of task and social relationships on groups, while also exploring the effects of cognitive complexity on network accuracy, centrality and structuration. She underscored the importance of perception in determining relational dynamics within groups. Perceptions according to her are the notions or beliefs individual group members hold about fellow group members. Often times, group members' perceptions about the relationships that exist between or among fellow members may be inaccurate, nevertheless, these perceptions still influence perceivers' actions. Hence the need to study individual perception within a group as perceptions whether faulty or not are major determinants of action. The web of relationships existing between and among individual group members was x-rayed using a model of network structuration.

The study explored both the task and social side of groups with particular focus on the emergence of intimate friendship ties among members. It concluded by stating that cognitive complexity did not influence the process of communication significantly as stated by previous researches. In addition, perceptions of relationship ties were found to shape expectations about communication as well as actual communication behaviours (Dorbosh, 2015:106).

In a related study, Adaji, Jimoh, Bawa, Ibrahim, Olorukooba, Adelaiye, Garba, Lukong, Idris & Shittu (2019), conducted an experimental study in Tsibiri, a remote part of Kaduna State, Nigeria among groups of pregnant women. In an observational study, the researchers tested the viability of a group prenatal care model patterned after the Centering Pregnancy model of care. The study objectives among other things measured women' s experience of care relating to their individual participation, information recall and adherence to a birth preparedness plan. The model of care employed in this study was not facility based because caregivers dispensed care within the local community. Doctors and not midwives served as caregivers in this study the results indicate the feasibility of such a model of care in resource constrained areas.

Finally, in a study by Norvick (2010) on " women' s experience of group prenatal care" the author adopts a qualitative approach and employs descriptive analysis to explore women' s experiences of group prenatal care. Semi structured interview was combined with observation in achieving the objectives of the study. According to the author, while group prenatal care is growing in popularity, little is known about women' s experience of it, hence the need to conduct the longitudinal descriptive study. Six themes emerged in the course of describing women' s experience of group prenatal care. They are: *Investment, Collaborative venture, a social gathering, relationship with boundaries, learning in a group* and *changing self.* Respondents in the study described a positive experience of the group prenatal care as the forum offered an opportunity for them not only to learn in groups, but also to develop enduring relationships with their care givers. The group prenatal care also offered an opportunity for most of the women especially first -time mothers to express their anxieties about pregnancy, delivery as well as parenting. Apart from the above enumerated points, it was also discovered that the group care is a forum that enhances existing interpersonal relationship among pregnant women. The women however expressed the wish for greater privacy during the physical examinations.

One of the recommendations of the study is that health care providers who facilitate group care should provide varied educational materials as well as adequate support staff. In addition, the author suggests that future researchers should conduct their study in different settings which will give room for the inclusion of a varied nature of participants. Future studies may also wish to investigate the effect of women' s experience on utilization of care and birth outcome.

CHAPTER THREE
RESEARCH METHODOLOGY

Preamble

This chapter presents a discussion of the methods that were used in executing this study. It focuses on the research design, study population, sampling techniques and sample size. It also describes the instruments that were used in gathering data for the study as well as the validity and reliability of those instruments.

3.1 Research design

The study examined the relational communication behaviour in group prenatal care in selected hospitals in Ibadan, Oyo state. The study adopted a mixed methods design to execute the objectives of the study. Creswell (2013:31) describes a research design as the logical steps a researcher undertakes to ensure that the questions raised within the study are properly answered using appropriate methods. To him, the research design is the general framework for a study which is usually influenced by the researcher' s philosophical stance, nature of the research, theoretical framework and methodology.

In this study as earlier mentioned, the mixed methods research design, the embedded variant has been adopted. Thus, survey, focus group discussions, in-depth interviews and observational methods were used to provide answers to the research questions posed in this study. A survey was employed to elicit quantitative data from pregnant women on the nature of relational communication behaviour in a group prenatal session. The survey is considered suitable for this study because scholars agree that it is an appropriate method for studying behaviours and perceptions of subjects in a study (Wimmer & Dominick, 2005:185; Senam & Akpan, 2014:462).

Furthermore, new mothers attending postnatal care in selected hospitals were also put into different focus groups to discuss their experiences and relational assessment of

the nurses/midwives. The data generated from the focus group discussion further enriched the study. In addition, key informant interviews were conducted with a number of health care providers who occupy managerial positions in each health facility in Ibadan. This was done to enable the researcher to gain an insight into the policy framework surrounding the administration of prenatal care in Nigeria and more importantly in Ibadan. In this study, top management health care providers were interviewed based on the premise that they are aware of the various policies that affect the practice of prenatal care in Nigeria. Similarly, nurses/midwives who facilitate group prenatal sessions were interviewed to investigate their perception about the conduct of the group prenatal care sessions.

Apart from the in-depth interview, the participant observation method was employed to get an accurate account of how group health-talk sessions are conducted in Ibadan. The Observation method is considered appropriate for this study because it afforded the researcher the opportunity of acquiring a first-hand experience of how providers and clients interact during prenatal sessions.

3.2 Study area and population

3.2.1 Study area – a brief description of Ibadan

Ibadan Metropolis was chosen by the researcher as the study area. It is one of the ancient towns in Yoruba land and is situated in the South Western part of Nigeria. The researcher chose Ibadan as the study area for two main reasons. First, it is the largest city in West Africa with a population of 6,615,059 people (National Bureau of Statistics, 2012). Second, and more importantly, Ibadan has been chosen because of the availability of hospitals which provide group prenatal care in the area. Ibadan is the capital city of Oyo state, and the state has 33 local government areas, namely: Afijio, Akinyele, Atiba, Atisbo, Egbeda, Ibadan North, Ibadan North East, Ibadan North West, Ibadan South East, Ibadan South West, Ibarapa Central, Ibarapa East, Ibarapa North, Iddo, Irepo, Iseyin, Itesiwaju, Iwajowa, Kajola, Lagelu and Ogbomosho North. Others include Ogbomosho South, Ogo-Oluwa, Olorunsogo, Oluyole, Ona-Ara, Oorelope, Oriire, Oyo East, Oyo West, Saki East, Saki West and Surulere local government areas. Out of the 33 local government areas in Oyo state, 11 are situated in Ibadan. They are: Akinyele, Egbeda, Ibadan North, Ibadan North-East, Ibadan North West, Ibadan South East, Ibadan South West, Iddo, Lagelu,

Oluyole and Ona-Ara local government areas (www.oyostate.gov.ng). Apart from the foregoing, Ibadan has numerous educational and research institutions that conduct similar studies and organise relevant health programmes. Foremost on the list is the University of Ibadan, others include The Polytechnic Ibadan, the National Institute for Social Economic Research (NISER), the International Institute for Tropical Agriculture (IITA), University College Hospital (UCH) and College of Nursing, Eleyele. Others include the Forestry Research Institute of Nigeria, the Institute of Agricultural Research and Training Obafemi Awolowo University Situated in Ibadan, Cocoa Research Institute and the National Horticultural Research Institute NIHORT.

Apart from the existence of educational and research institutions in Ibadan, the city also notably houses a number of popular markets where different household goods are bought. Many individuals, particularly the women, earn their daily living from such markets. The major markets in Ibadan are the Agbeni market, Bodija market, Bola Ige International market, Aleshinloye, Ogunpa, Oja oba, Dugbe, Oje, Apete and Bashorun markets. Some of these markets are also situated within the same axis as the sampled hospitals in this study for example Oje market is not far from St Peters Hospital Aremo and Our Lady of Apostles Catholic Hospital Oluyoro. Though the markets are usually a beehive of economic activities, trade and commerce in the ancient city is not limited to such places. One of the precursors of a thriving economy in any state is the transportation network. Residents daily commute from one end of the city to another through the mini buses, ‘ Okadas’ (commercial motorcyclists) and taxis. There are also publicly owned coastal buses popularly referred to as the ‘ Ajumose’ buses. This initiative was launched under the administration of the late Governor Abiola Ajimobi to ameliorate the living conditions of the people through the provision of cheap transportations. Ibadan is in fact, one of the few cities in the country where Uber recently launched its Taxify. The cost of these various forms of transportation in the city is affordable. Ibadan also has an airport that services only domestic flights. The train system in the city was recently launched however; it is yet to be fully operational.

3.2.2 Study population

All pregnant women of child-bearing ages and currently attending prenatal sessions (health-talk) in sampled facilities constitute the population of the study. Only pregnant

women who have made at least one attendance at the health-talk sessions were recruited as participants in the study. Nursing mothers receiving postnatal care in each of the surveyed facilities also formed a segment of the population in this study. Similarly, nurses/midwives who conduct group prenatal care, as well as top management health officials in the sampled hospitals, formed part of the population of this study. According to a 2016 report from the Research and Statistics unit of the Oyo State Ministry of Health, there are 11 publicly owned hospitals in Ibadan. Understanding enough, only those hospitals that offer group health- talk sessions were selected for the study. Out of the 11 available public health facilities in the city, only 7 offer health-talk sessions within a group context. Thus, one other privately owned facility was sampled alongside. Hence, a total of 8 hospitals were eventually sampled in the study.

Out of the available public hospitals in Oyo state, only facilities domiciled in Ibadan were sampled because it is the state capital and it is assumed that the practice of prenatal care in Ibadan will be more organised. The hospitals are as follows: Adeoyo Maternity Teaching Hospital Yemetu, General Hospital Moniya, Jericho General Hospital, Jericho Nursing Home, Maternal and Child Health Apata, Ring Road Specialist Hospital, St Peters Hospital Aremo and Our Lady of Apostles Catholic Hospital Oluyoro. 7 out of the 8 sampled hospitals offer secondary health care services, only Adeoyo Maternity Teaching Hospital falls under the category of a tertiary health care centre. The history of the majority of sampled facilities in this study is intertwined. To start with, Adeoyo Teaching Hospital was established in 1927 during the colonial administration to provide for the health- care needs of both the indigenous people of Ibadan as well as white public servants. However, in 1928, Jericho Nursing Home was established to cater more specifically for public servants. The establishment of Adeoyo Maternity Teaching Hospital has led to the creation of other health facilities such as Ring Road Specialist Hospital also known as New Adeoyo which was established in 1971. Ring Road Specialist Hospital is regarded as an offspring of Adeoyo Maternity Teaching Hospital. At its inception, Adeoyo Maternity Teaching Hospital had the status of a General Hospital. It was not until 2008 that the administration of Governor Alao Akala in collaboration with the Oyo State Hospitals Management Board and the State Ministry of Health upgraded the

status of the facility to that of a Maternity Teaching Hospital. In the same vein, Ring Road State Hospital was upgraded to a Specialist Hospital. Our Lady of Apostles Catholic Hospital was established in the year 1956 by the Missionaries of Mary in the Ibadan Archdiocese. The facility, at the time was a cottage hospital meant to proffer health services to the Oluyoro community at affordable prices. The hospital has overtime extended its line of patronage to include not only indigent patients but also the affluent, hence the existence of both private and public wards in the facility. St Peters Hospital Aremo at inception served similar visions with Our Lady of Apostles' Catholic Hospital. While the former was established by the Ibadan Anglican Diocese the latter is owned by the Catholics. At some points in the history of both facilities, there was a take -over by the State Government and this affected the process of care delivery. While the Catholic Mission was able to eventually recover ownership of their facility, St Peters Hospital Aremo was (as at the time of this study) still under the jurisdiction of the Oyo State Hospitals Management Board.

3.3 Sample size and sampling technique

3.3.1 Sample size

A sample size of 355 respondents was drawn from the population of pregnant women who were undergoing prenatal sessions in government hospitals across the various local government areas in Ibadan. The formula and process of deriving the sample size are described below. This formula was used because the estimate of the population of study is unknown.

$$N = \frac{P(100\%-P)}{(SE)^2}$$

With P = 70% and SE = 2.55

$$N = \frac{70\%\ (100\%-70\%)}{2.55\%}$$

$$= \frac{2100}{6.50} = 323.08 = 323.$$

(Note that N is the required sample size, P is the power of the study and SE is the standard error)

The sample size is 323; meanwhile, in order to account for non-response items on the questionnaire a 10% attrition rate was adopted.

10% of 323 =10 x 323 divided by 100 =32.3
323+32 to 355.

Thus the total sample size 355

Ten nurses/midwives were proposed to be sampled for the purpose of deriving qualitative data for the study. However, eight nurses were eventually interviewed when the researcher arrived at a saturation point. Another five top management health care officials in selected hospitals also formed the initial plan for the qualitative study, however four were eventually interviewed. Creswell (1998) suggests between 20-30 respondents as a required sampled size for a qualitative study. Another source, however, notes that there are no specific rules for determining sample size for a qualitative study (www.statisticssolutions.com). The guiding principles that should assist a researcher to derive a sample size for a qualitative study should be the time allotted for the study, available resources and study objectives (www.statisticssolutions.com). The next point of discussion are the research instruments however, prior to describing the instruments, there is a need to define how each of the research objective influenced the choice of method. The relationship between the research objective and methods are described in the XY Table.

Table 3.1 XY Table- Methods and Objectives

	Methods				
Objectives	**QES**	**IDI**	**KII**	**FGD**	**Observation**
Objective 1		✓	✓		✓
Objective 2		✓		✓	✓
Objective 3	✓	✓	✓	✓	
Objective 4		✓	✓		✓
Objective 5		✓			✓

3.3.2 Sampling technique

In this cross-sectional study, the researcher adopted purposive, convenience and quota sampling techniques in selecting respondents for the questionnaire administration. Purposive and convenience sampling techniques were also employed in selecting the discussants for the focus group discussion. In determining the interviewees for the in-depth and key informant interviews, purposive, convienence and stratified sampling tecniques were employed. With respect to the sample size, an online sample size calculator was employed in determining the number of respondents for the questionnaire administration. However, characteristics such as the number of pregnant women in each of the sampled facilities and the level of care (secondary or tertiary) affected the nature of the questionnaire distribution.

3.3.2.1 Selection of questionnaire respondents

A sampling frame of all government hospitals in Oyo State was obtained from the Oyo State Hospitals Management Board. Afterwards, the researcher purposively selected public hospitals that are situated in Ibadan from the sampling frame. Out of such hospitals in Ibadan, it was observed that only 7 of them offer group prenatal care. The hospitals are: Adeoyo Maternity Teaching Hospital Yemetu, General Hospital Moniya, Jericho General Hospital, Jericho Nursing Home, Maternal and Child Health Hospital Apata, Ring Road Specialist Hospital, and St Peters Hospital Aremo. Initially, Igbo Oloyin Cottage Hospital formed part of the population for the study; it was however realised during the course of the study that the Cottage Hospital had very few clients hence group health education sessions were not available in the facility. Thus, Our Lady of Apostles Catholic Hospital Oluyoro was sampled to fill the void.

Purposive sampling technique was used in selecting the respondents for the questionnaire administration because the researcher sought to investigate certain characteristics that are peculiar to them. For example, only pregnant women currently undergoing prenatal care in selected hospitals were recruited for the study. Initially, the researcher sought to adopt systematic random sampling technique – which is probabilistic in nature – in selecting pregnant women for the study, however, this was not practicable, as only a few pregnant women were available at some facilities.

Convenience sampling technique was also employed to recruit respondents particularly in places where pregnant women patently refused to participate in the study despite the pleas from the researchers. Nevertheless, women who had no prior experience of the health education class were excluded from the study as they would not be able to proffer appropriate responses to the survey.

3.3.2.2 Selection of interviewees

Furthermore, purposive and convenience sampling technique was adopted in selecting the nurses/midwives who facilitate group health education sessions as not all nurses/midwives were eligible to participate in the study. Nurses/midwives who teach or who have taught the health education classes were interviewed. Convenience sampling technique was employed to reruit interviewees where the contacted health-care providers were either on leave as at the time of the survey or were unwilling to be recruited for the study. The inclusion criterion for the selection of key informant interviewees was that they should be a top management officer in any of the sampled hospitals thus, purposive and stratified sampling techniques were employed in selecting interviewees. Initially, the plan was to interview the Chief Medical Director of Adeoyo Maternity Teaching Hospital but his busy schedule made it imperative to interview one of the Chief Nursing Officers of the hospital. Other emerging realities on the field prompted the researcher to recruit one of the lecturers at the Oyo State School of Midwifery Eleyele as a key informant and some newly delivered mothers in lying- in-wards.

3.3.2.3 Selection of discussants

Discussants for the focus groups were purposively sampled, only nursing mothers who were recently delivered of babies in the last one year were recruited for the study. Nursing mothers were recruited as discussants for the study because the researcher sought to elicit information on women' s recall rate of taught topics during the prenatal period. Convenience sampling was used in the instances where midwives allowed only women who had been attended to at the postnatal unit to participate in the study. The inclusion criterion for the selection of hospitals for the focus groups was that the environment for the study should be conducive for the discussion and devoid of nurses' interference.

3.4 Research instruments and method of data collection

The research instruments that were used in this study are questionnaire, interview guide, focus group guide and observation guide. Each of these instruments was useful in answering the questions raised in the study. This section also describes the method of collecting data with each of the aforementioned instruments.

3.4.1 The questionnaire

The questionnaire is divided into three major sections namely, A, B, and C. Section A, sought to elicit responses on the socio-demographic variables of respondents, Section B measured the perception of women on the relational communication within each prenatal health education class. Section C elicited responses on the nature of the interaction between pregnant women in a group, as well as the general perception of nurses in sampled facilities. The items on the questionnaire were translated into Yoruba by a professional and seasoned linguist while another instructor in the said language validated the instrument. The questionnaire was interviewer administered and respondents were interviewed at hospital sites. The questionnaire has been standardized and was translated into the Yoruba language to ensure that respondents who are not literate/proficient in the use of English are given equal opportunity to participate in the study. Similarly, the researcher employed the services of three research assistants to help in administering copies of the questionnaire. Before embarking on the study, the researcher ensured that each of the research assistants was adequately trained on what was expected of him/her on the field. The researcher and her assistants ensured that ethical principles were upheld in the course of executing the study. The objective of the study was fully explained to participants prior to recruitment. Also, participants were free to exit the study at any point. Both verbal and written informed consent was obtained from them.

3.4.2 In-depth interview guide

The In-depth interview guide contains a list of semi-structured questions that were used to elicit responses from health care providers who facilitate health talk during group prenatal care in the selected hospitals. In-depth interviews were conducted with eight nurses and their responses were audio- recorded and transcribed. A research assistant helped to transcribe the audio- recorded interviews. Though the interview

guide was structured, it was flexible enough to accommodate unscripted follow- up questions that came up in the course of the interview. The researcher conducted all the in-depth interviews in this study but was accompanied by a research assistant in the course of conducting some of the key informants' interviews. The interviews were conducted between December, 2017 and December, 2018. Interview questions were reviewed by the researcher' s supervisor and a team of examiners who made useful criticisms and suggestions that contributed to the interview guide.

In two pilot interviews with senior nursing officers at Primary Health Care centre, Oniyanrin and Ajibode several questions were found to be ambiguous. This helped the researcher refine and develop an improved interview guide. Meanwhile, in-depth interviews were conducted with available and consenting nursing officers in sampled facilities. Initially, two nursing officers -a senior and junior- were proposed to be interviewed in each of the facilities. Appointments were scheduled with selected health care providers for the in-depth interview. Out of the ten nurses that were approached, one went on an annual leave before the initiation of the interview. Another did not oblige the interviewer, while the other two were not available as at the time of the interview. Hence, six health care providers eventually consented to the in-depth interview, while two other nurses were contacted to fill the void created by the four nurses who were not available as of the time of the interview. Thus a total of 8 nurses were eventually interviewed. More nurses were not recruited since the researcher realised that interviewees responded to fielded questions in similar ways.

3.4.3 Key informant interview

A key informant interview guide that allowed for unscripted follow – up questions was employed for the interview. The researcher with the support of a research assistant interviewed newly delivered mothers in the lying-in-wards at Adeoyo Maternity Teaching Hospital, since nurses were unwilling to allow the researcher to recruit participants from the postnatal unit. Other key informants in the study were drawn from opinion leaders in the health sector such as Chief Medical Directors (CMD) and Chief Nursing Officers (CNO). Reflexivity was adopted in determining informants for the study as initially interviewees were restricted to nurses and Chief Medical Directors until the situation on the field necessitated a change of approach to

the study. Reflexivity is both a concept and a state of ethical consciousness on the part of the researcher. It is part of the process of qualitative enquiry that guarantees the internal validity of a study. The researcher is aware of his background and how this can shape the interpretation of the study. The hallmark of a reflexive study is the researcher' s ability to maintain equilibrium between his/her initial assumptions/stance and the creation of knowledge. Top management health care providers were purposively selected across the sampled facilities. A Chief Nursing Officer (CNO), two Chief Medical Directors (CMDs), and a Senior Nursing officer who also lectures at the College of Nursing, Eleyele were interviewed. Six mothers who were recently delivered of their babies also formed part of the key informants in the study. Hence, a total of Ten key informants were interviewed in the study. While some of the interviews were conducted within the facilities, the researcher also utilised unconventional spaces such as car parks and balconies to interview other key informants.

3.4.4 Focus group discussion guide

Five focus group discussions (FGD) were conducted across the communities where the sampled hospitals are situated. The inclusion criterion for the selection of a hospital site for the FGD was that the hospital environment should be devoid of provider interference and noise. A focus group discussion guide was developed to guide the trend of conversation in each of the groups. Recently pregnant women who have been delivered of a baby in the last year who were receiving postnatal care within the facilities were recruited as members of the focus groups. The data generated from the exercise further enriched the study. Initially, the researcher proposed to conduct an FGD in each of the communities where the facilities are situated however this was impracticable based on certain constraints experienced on the field. For example, the structure of some of the facilities did not provide ample space to convey discussion in an environment devoid of providers' interference. Hence, in order to mitigate the observed limitation, the researcher conducted the FGD in facilities where participants were to a large extent free to unburden their minds. In another instance, the researcher had to arrive at a facility earlier than the caregivers to give participants the opportunity to freely discuss their concerns. Oral informed

consent was obtained from members of each focus group prior to commencing the discussion. The responses obtained from the FGD validated the findings of this study.

3.4.5 Observation guide

The observation guide spells out the parameters that helped the researcher in observing participants during the group prenatal sessions. Prior to conducting the observation, the researcher embarked on a pilot study at the Primary Health Care Centres situated at both Ajibode and Oniyanrin in December 2017. These health care centres did not form part of the sample for the study. Though an ethical approval was obtained from the Oyo state ethical review committee in July 2017, practical steps were undertaken to secure the consent of each of the hospital management before gaining access to the study sites. The observation at both Oniyanrin and Ajibode helped the researcher develop a structure for the main study. Although there were minor differences between the pilot and the main studies, perceived differences were mainly in the area of study participants' demography, timeliness in care delivery, context of communication and nurses' skill set. The conduct of the group health talk observed during the pilot study was largely the same with that of the main study. Field notes were taken during the pilot study and researcher had the opportunity of checking perception through interaction with study participants. These observations helped to refine the researcher' s approach to the main study.

During the period of observation, gaining access to the various hospital sites was a herculean task, the researcher had to pay a fee at virtually all the sampled hospitals. The fee according to a hospital administrator at Maternal and Child Heath Apata (MNCH) was a new directive by the State government meant to improve the internally generated funds of public health facilities in the state. At the Our Lady of Apostles Catholic Hospital Oluyoro, it was a long wait before the hospital approved the study. The ethical review committee of O.L.A Oluyoro took their time before granting access to the hospital. In the course of the study, the focal points of observation the verbal exchanges between nurses and pregnant women, non- verbal cues of pregnant women and those of their caregivers as well as backstage discussion among pregnant women. In this study, a non-participant observation approach was adopted to interrogate the dynamics of relational communication in the care groups.

Though the study was approached from the grounded theory perspective, the research design was flexible to accommodate the realities on the field. Consequently, the circumstances on the field influenced the researcher' s decision to take notes or audio record. The conduct of prenatal care in each of the sampled hospitals was observed over a period of five months. Conversations between nurses and pregnant women were audio recorded while pictures depicting non-verbal cues displayed by interlocutors were also taken. The context of the different communication encounters were described in the study alongside a report of the multiple realities at the different hospital sites. Field notes were taken during the period and observations were correlated to minimise elements of bias. The aspects of interaction that formed the basis of the observation were verbal messages, vocalic cues and the body language of interactants. The amended version of the SCCAP observational check-list designed by Siminorff and Step (2011) as well as the Cloutier (1987) tool for analysing interaction in health care settings were amended and adapted to suit the peculiarity of the study. Observations were categorised along the dimensions of body movements and facial expressions. Hand gestures, head movement (head nods) and varying body positions of nurses (for example a sedentary position) and pregnant women fell under the category of body movements. Eye gaze, eye movement, relaxation of facial muscles and smiles fell under the category of facial expressions. The researcher took notes during the period of observation and the research period spanned 5 months.

3.5 Validity and reliability of instruments

Copies of the questionnaire and the interview guide were given to the researcher' s supervisor who made useful criticisms and contributions before they were reproduced for the field. The questionnaire items are a combination of relational constructs previously validated in another study and the researcher' s own input. Thirty copies of the questionnaire items were administered to respondents in a pretest. The data obtained were analysed with the Cronbach alpha statistical tool to determine the reliability of the instrument. The case processing summary indicates a reliability statistics estimated at .886. In other words, the instruments were found to have a reliability of over 80%. Furthermore, this researcher was fully involved in this research process thus, to reduce elements of bias in the study confirmability was addressed through constant comparative analysis of the observation across the various

hospital sites. Peer debriefing was also done particularly in the course of conducting observation across the hospital sites. This was to promote objectivity and transparency in the research process. Finally, the researcher adapted previously validated measurement tools and allowed the process of research to be open and transparent through reflexivity.

3.6 Method of data analysis

The analysis of this study was based on responses of respondents to each item on the questionnaire. Simple percentages and analyses of variance (ANOVA) were used to analyse the quantitative data derived from the study. A one-way ANOVA method was employed in the study to compare the different opinions of respondents regarding the four hypothetical nurses that dispense care across the eight sampled hospitals. ANOVA was deemed appropriate because it is useful in determing whether the mean relationship among the variables is statistically significant. Some of the qualitative data were content analysed, others were subjected to thematic analysis and the constant comparative technique. Data obtained from the ethnographic study were hand coded and categorized in such a way that emerging themes in behaviour were selected and thematically analysed. Also, the transcripts of conversations and interviews were content analysed to address the issues raised in the study. Content analysis in this sense should be regarded only in terms of method of data analysis and not as a method of data collection. Data analysis in qualitative research designs follow prescribed building blocks. In this study, Creswell (2014) approach to the analysis of qualitative data was employed. The first step in the analysis of qualitative data is the transcription of audio recorded data. At the second stage, data is read through and sifted to determine similarities and differences in ideas this was in turn correlated with backstage discussions and researcher' s perception. Step three involves coding, organizing and sorting data along the lines of themes in some cases.

The themes are naturally developed adopting diverse strategies. While some individuals develop themes based on readers' expectation, others may adopt a reverse approach. In this study, themes were developed in line with theoretical underpinnings since the assumptions of specific theories were tested. The themes in this study were also formed along the lines of the research objectives. Emerging

themes thus contained multiple perspectives and were supported with relevant quotes. Thematic analysis was favoured as an analytical tool because of its flexibility to accommodate diverse subject matters and theoretical frameworks. The researcher adopted the six-pronged steps of analysis as described by Clarke and Baun (2013). The steps are as follows:

- getting acquainted with the data
- developing a coding scheme
- identifying emerging themes
- checking to reduce overlaps in emergent themes
- naming themes
- writing the report

The discussions of findings relating to both quantitative and qualitative data were according to the research questions, relevant theories and literature. While some findings were found to be consistent with literature some departed from what obtained in previous studies.

3.7 Reflexivity

One of the greatest challenges encountered in the course of the ethnographic study is the transition from being a consumer of prenatal care services to a researcher. Although some of the explored hospital spaces were familiar, it was not particularly easy establishing a relationship and securing the trust of providers in such health-care settings. Hence, repeated visits were paid to each of the facilities over a period of five months. In some instances, the researcher secured the confidence of providers through referrals from known professional colleagues in other facilities. Also, the complexity of the ethnographic approach became apparent as more facilities were visited and providers of differing idiosyncrasies interspersed with clients from intercultural backgrounds. One of the measures adopted to address these constraints was the framing of questions in such a way as to limit bias. Similarly, participants had very low confidence in health researches probably stemming from previously unimplemented findings. In persuading participants, the researcher could only show empathy where necessary. In other instances, participants were given realistic expectations of the research outcome.

Reflexivity was also mirrored in the coding and data analysis stage of the research as categories were determined accurately from available data. Only data that were crucial to the study were identified.

3.8 Limitations to the study

The process of prenatal care really discouraged the execution of a cross-sectional design as pregnant women are not compelled to receive care in a specific order. In the course of the survey, repeated contact was established with the same respondents, as some people who came in the first week were seen in the fourth week. Consequently, measures were taken to ensure that women were not recruited twice in order not to confound the results of the study. Respondents were for example, asked if they had earlier participated in the study. Aside that, the research period was elongated to ensure that more respondents were sampled. In spite of this limitation, the study is a valuable addition to the existing studies in the area of health communication.

3.9 Ethical considerations

Confidentiality of Data: Data derived from this study are strictly meant for academic purposes. Hence, there is no reason for the researcher to divulge information or his sources of information to any other persons or individuals outside of the academia. The identities of respondents were protected by the researcher and the information derived from this study was given utmost confidentiality

Beneficence to Participants: This study will be of immense benefit to pregnant women and nurses who work in antenatal care, as useful recommendations have been made on how to enhance the delivery of prenatal care in Nigeria.

Non-Maleficence to Participants: Participants in this study were not exposed in any form to any kind of risk or danger. The researcher did not conduct any experiment on participants.

Voluntariness: Participants were not coerced to participate in the study. Participants were free to withdraw from the study at any time if they felt inclined to do so.\The ethical approval for this study was obtained from the Oyo State Ethical Review Board on the 31st of July 2017 with Ref No AD 13/479/507.

CHAPTER FOUR
RESULTS AND DISCUSSION

Preamble

This chapter presents the interpretation of results obtained from the analysed data and the discussion of findings. The findings are presented as they answer the research questions.

4.1 The characteristics of Ibadan group prenatal care

The peculiarities of the " group prenatal care" programme in Ibadan hospitals were examined. Some themes (pattern of responses that depict the features of the Ibadan group prenatal care model) emerged from the observation, in-depth and key informant interviews of health-care providers in the sampled facilities. The themes are: 1) The nature of the Ibadan group prenatal care model, 2) the features of the media employed in the model, 3) the mothercraft, and 4) the common prenatal songs. Each of these is discussed in turn, starting with the first, the nature of the Ibadan group prenatal care model. However, before proceeding to describing the nature of the Ibadan group prenatal care model, it would be pertinent to present the socio– demographical variables of interviewees, participants and respondents recruited for the study.

Table 4.1: Socio-demographic variables of IDI, KII and FGD respondents

Nature of facility	Name of facility	Number	Gender	Nature of respondents	Nature of interview
Public	Jericho Specialist Hospital	1	Female	Nurse	IDI
Public	Jericho Nursing Home	1	Female	Nurse	IDI
Public	Maternal and Child Health Apata	1	Female	Nurse	IDI
Public	Maternal and Child Health Apata	1	Male	CMD	KII
Public	Ring Road Specialist Hospital	1	Female	Nurse	IDI
Public	Moniya General Hospital	1	Female	Nurse	IDI
Private	Our Lady of Apostles Catholic Hospital Oluyoro	1	Female	Nurse	IDI
Public	Adeoyo Maternity Teaching Hospital	1	Female	Nurse (CNO)	KII
Public	School of Midwifery Eleyele	1	Female	Nurse (lecturer)	KII
Public	Adeoyo Maternity	6	Females	Nursing mothers	KII
Public	St Peters Aremo	1	Female	Nurse	IDI
Public	St Peters Aremo	1	Female	CMD	KII
Public	RRSH	8	Females	Nursing Mothers	FGD
Public	JSH	8	Females	Nursing Mothers	FGD
Public	MNCH Apata	8	Females	Nursing mothers	FGD
Public	Oluyoro	8	Females	Nursing mothers	FGD
Total		**49**			

Table 4.2: Socio-demographic characteristics of respondents

Age Range	**Number**	**Percentage**
21-25	64	18.8
26-30	111	32.6
31-35	107	31.5
36-40	39	11.5
41-45	11	3.2
Missing value	8	2.4
Total	**340**	**100**
Ethnicity	**Number**	**Percentage**
Yoruba	275	80.9
Others	49	14.4
Missing value	16	4.7
Total	**340**	**100**
Highest Level of Education	**Number**	**Percentage**
No formal education	4	1.2
Primary	43	12.6
Secondary	78	22.9
Tertiary	209	61.5
Missing value	6	1.8
Total	**340**	**100**
Occupation	**Number**	**Percentage**
Artisans	72	21.2
Civil servants	107	31.5
Trader	100	29.4
Unemployed	37	10.9
Missing value	24	7.0
Total	340	100
Names of Facility	**Number**	**Percentage**
Adeoyo Maternity Teaching H	65	19.1
General Hospital Moniya	47	13.8
Jericho Nursing home	36	10.6
Jericho Specialist	45	13.2
M.N.C.H Apata	48	14.1
O.L.A Oluyoro	42	12.4
Ring Road Specialist	54	15.9
Missing value	3	0.9
Total	340	100

4.1.1 The structure and nature of the group prenatal care model in Ibadan

Majority of the interviewed health care providers described a similar pattern of prenatal care across all the sampled facilities. According to the caregivers, the Ibadan group prenatal care model has different subdivisions, namely: medical assessment, health education and social support. The medical assessment of pregnant women is scheduled for first time visit and subsequent appointments, while the health education classes in Ibadan are divided into two main sessions. The first session is taken up with prayers, spiritual and sundry songs accompanied with physical exercises. The second session is devoted to lectures by caregivers on topical areas such as self-care, danger signs during pregnancy, false labour, nutrition, exercise, and the importance of regular intercourse, among other issues. It is at the third and final session that caregivers receive feedback in the form of questions and complaints. The rest of the responses under the nature of the Ibadan group prenatal care is organised as follows: in 4.1.1.1 findings describing medical assessment as a subtheme of the nature of group prenatal care in Ibadan is presented. Health education, another subtheme of the nature of group prenatal care is presented in 4.1.1.2, while 4.1.1.3 presents findings and discussions on social support. A description of the nature of medical assessment pregnant women receive during prenatal care is presented first.

4.1.1.1 Medical assessment

The medical and physical screening of pregnant women during prenatal care was found to be a common feature of care across all the surveyed facilities. Basically, expectant women are meant to undergo assessment at certain points, such as, when prenatal care is initiated and on scheduled appointments. A Senior Nursing Officer described a typical schedule for care at the Jericho Specialist Hospital (will be referred to as JSH henceforth) as follows:

> We deliver health-talk in group forum to pregnant women. Today is Wednesday which is pre- booking day, but we give health-talk between 8-8.30am. We screen the women for HIV/AIDS before we register them and we cannot do the screening without giving counselling so that they will be able to accept the outcome of the result. We counsel these patients on what to eat and the need to adopt a positive outlook on life**. (**Female, Nurse, Public, Jericho S**)**

The excerpt of interview with the Senior Nursing Officer at the JSH shows the primacy of assessment in prenatal care. Additionally, medical investigations are conducted in order to dispense some form of preventive care to expectant mothers. Hence, interviewed caregivers did concede that medical examinations and preventive care during prenatal care is not only universal across all the sampled hospitals in this study, but is also time dependent, for instance, a Junior Nurse at the Jericho Nursing Home (will be referred to as JNH) described a form of preventive care that is time-specific " At five months, pregnant women are introduced to the Tetanus Toxoid injections. Two doses of the injection are administered on each woman while prophylactic treatment is also given for malaria at 5months to such women" . Therefore, if a woman initiates prenatal care any time after 5months, it becomes difficult for caregivers to discharge their duties appropriately, and this, may likely have fatal consequences on the unborn child. Hence, " pregnant women at the initiation of care are expected to undergo comprehensive medical tests and at re-visit, palpations of patients are done recurrently" affirmed another Chief Nursing Officer at the Maternal and Child Health Hospital Apata (the acronym MNCH Apata will be adopted in other parts of this report).

Apart from detailing the assessment women undergo at prenatal care, interviewees emphasised the role of hospital card and case file in the documentation of patients' medical history and how such documentation, facilitate necessary medical investigations. For instance, a Senior Nursing Officer at the Moniya General Hospital elaborated on the importance of patients' hospital card in presenting relevant gynaecological history that may be found useful in further medical screening:

> Pregnant women' s prenatal card spells out the nature of the medical screening to be undergone at booking. The history of each patient is taken on issues such as previous deliveries, any history of a caesarean section or a serious ailment. The prenatal card is useful in the assessment of patients' past and present gynaecological history. Usually, pregnant women are expected to have undergone certain medical examinations prior to booking, the results of such test, are presented at the initiation of prenatal care. For example, we do have HIV, diabetic or HBS (Hepatitis B) patients or those with a previous history of a caesarean section… Other routine tests like blood pressure, body mass index (BMI) are conducted on patients with ' low-risk pregnancies' . (Female, Nurse, Public, Moniya)

Also, supporting the foregoing opinion is a Junior Nurse at St Peters Hospital Aremo (the hospital will be referred to as Aremo henceforth) who observed that " a case file is opened for every pregnant woman immediately prenatal care is initiated" . The case file, according to her, is available at the prenatal unit of the hospital and it is useful in documenting the routine physical examinations that the pregnant woman is made to undergo. Such routine tests include " blood screening, weight, height and foetal heart beat" . She added. Similarly, at the Jericho Specialist Hospital, a Senior Nurse seemed to support the opinions of her colleagues on the forms of medical assessment received during prenatal care, she however added another dimension to the conversation. She observed that, a key objective of medical assessment in prenatal care is to ensure the early detection of high-risk pregnancies and its managements. However, ignorant pregnant women often hinder the accomplishment of such objectives. According to her:

> However, this objective is often defeated when multiparous women (having history of repeated deliveries) or primigravidae (first pregnancy) initiate prenatal care at health centres where there are no gynaecologists or obstetrician to proffer expert advice. Ideally, the deliveries of both categories of women are meant to be managed by an obstetrician because their uterus can sag or rupture in the process. (Female, Nurse, Public, Jericho S).

4.1.1.2 Health education

All the interviewees underscored the importance of counselling and relevant health education during prenatal care. According to a Junior Nurse at the Jericho Nursing Home, the health education classes are best described as ' fit for purpose' as they address the challenges experienced at the different stages of pregnancy. In her words, " Our teaching outline is structured in such a way as to cover issues peculiar to women in the first, second and third Trimester" . While speaking from the perspective of private health facilities, a Senior Nurse at Our Lady of Apostles Catholic Hospital Oluyoro (to be referred to as O.L.A henceforth) opined that at the facility, " Caregivers are eager to give patients full value for their money, hence, topics are taught in-depth on a monthly basis" . In contrast, a Chief Nursing Officer (CNO) at the Adeoyo Maternity Teaching Hospital, a Senior Nurse at Aremo and another Senior Officer at the Jericho Specialist Hospital all shared similar opinion on how group composition can frustrate care providers' intent to disseminate information to

patients. They argued that audience characteristics and the group size could actually undermine the effectiveness of the health-talk session. In the opinion of the CNO at Adeoyo:

> During the health-talk here, the patients are usually too many, such that, some of them may not be listening. It is when you are asking questions that you will realise you have been wasting time. (Female, Nurse, Public, Adeoyo)

A similar point was reiterated by a Senior Nurse at the Aremo Hospital who lamented that " Nurses are often stymied when some women ask irrelevant questions" A way of addressing such situations, according to her, is by assigning women to groups based on their peculiarities, in order to facilitate proper information dissemination.

The interviewees' opinion on the management of the health education classes raised further questions on the number of facilitators in each of the facility. During the period of observation, only a nurse was observed facilitating the health-talk sessions at a time, while at least two other nurses conducted medical investigations on the patients. At the Jericho Nursing Home, however, the health-talk classes were facilitated by both nurses and certified dieticians. Nonetheless, the differences in the management of the health- talk classes, expectant mothers were taught similar topics across the hospitals. For example, a Senior Nurse at Aremo observed that " the topics of the health-talk class include: diet/nutrition, family planning, clothing, immunization and baby load" . Other important subject areas are " personal hygiene, home management and adopting a balanced nutritional lifestyle" added another Senior Nurse at MNCH Apata.

4.1.1.3 Social support

For many women, pregnancy is sensitive, as they face cultural, socio-economic and physical challenges. During the period of pregnancy, social support serves as a buffer against life stressors. Basically, the types of social support received at hospitals are informational or emotional in nature. Majority of the interviewed nurses in this study confirmed that women with diverse challenges were offered some level of supports during pregnancy. A Senior Nurse at the Jericho Specialist Hospital explained some

of the challenges experienced by women during pregnancy. Her explanation is as follows:

> There are some women who are victims of domestic violence. These women are easily discernable in a group, especially, since they find it difficult to fulfil certain obligations such as drug procurement or payment of the prenatal registration fee. (Female, Nurse, Public, Jericho)

Apart from victims of domestic abuse, another indication of women in need of social support may be " pregnant women who are withdrawn or unwilling to socialise due to pregnancy related illnesses" added a Junior Nurse at the Jericho Nursing Home. Similarly, some women are usually bed ridden in the first trimester, while the last gestational stage of pregnancy may be extremely wearisome for other women, especially sufferers of ' oedema' . In her own response, a Senior Nurse at Aremo affirmed that,

> We are aware of some of the issues confronting these women at the home front. One of such issues is sex during pregnancy, therefore, we ensure they realise the importance of regular coupling with their partners, especially, within the period of pregnancy. (Female, Nurse, Public, Aremo)

Apparently, pregnancy accounts for an increase in stress level which lowers a woman' s sexual urge. Although, many women experience a lull in sexual drive during that period, regular sexual intercourse during pregnancy not only expands the birth canal but also lubricates existing spousal relationship.

Additionally, the interviewed Senior Nurse at the Specialist Hospital in Jericho proffered another plausible reason for women' s perceived emotional turmoil during pregnancy. She reasoned that " it is normal to be emotionally disturbed during pregnancy" . According to her, " the hormones released during that period make women easily irritable" . Regardless of the hormonal disturbances during pregnancy, the nature of the African society allows for expectant mothers to receive some form of social support from families and significant others, while caregivers give informational support to the women during prenatal care. A Senior Nurse at the JSH described their role as follows:

> We provide emotional support to pregnant women to enable them develop coping strategies however, we cannot compel them to cooperate with us. We also give informational support which helps them prepare for

> delivery. These women are expected to utilise acquired knowledge to ensure a safe delivery. In fact, we make the work of the nurses in the labour room easier. (Female, Nurse, Public, Jericho, S).

So far, the nature of medical assessments, health education and social support in the group prenatal care program has been discussed the theme: challenges of the media types employed in the group prenatal model is discussed next.

4.1.2 Features of the media types employed in the Ibadan group prenatal model

The two main media types employed in facilitation within group prenatal clinics were the spoken word and IEC (Informational, Educational and Communication) materials. While word of mouth communication plays a key role in convincing people into buying into an idea, its major disadvantage is that it requires electronic amplification, particularly, in large groups such as characterise the prenatal health classes in some of the sampled facilities. Even the IEC materials that were meant to accentuate the spoken word were found to be in short supply at facilities like MNCH Apata, General Hospital Moniya and O.L.A Oluyoro. Aside from its scarcity in these hospitals, a major weakness of IEC is its tendency to deplete after constant usage. These limitations are obvious sources of worry to care providers as they affect providers' ability to discharge duties appropriately. Consequently, some providers devised measures to address perceived challenges, especially, with respect to nurses' audibility. " Often times, these women engage in side-talk within the group, so we employ the call and response strategy of Bibi-o Abiye! to draw their attention back to the discussion at hand" explained a Senior Nurse at the RRSH. The call and response strategy was, however, ineffective in larger Hospitals and referral centres owing to the existence of a larger clientele as well as other extraneous factors. For instance, at Adeoyo, the CNO explained that " we require megaphones to amplify facilitation as women tend to be distracted by the activities of vendors and other people during the health education classes" . She also reiterated the importance of audio visual devices in stimulating and sustaining patients' interest in the discussion. The theme ' mothercraft' that depicts the peculiarity of the Ibadan group prenatal model is discussed next.

4.1.3 ' Mothercraft'

Although, the term ‘ mothercraft’ ordinarily describes only the health education aspect of the Ibadan group prenatal care model, the name implies otherwise to a lay man. This is because the name is suggestive of intent to build latent skills in expectant mothers. Only two of the sampled hospitals in this study tagged its health education classes ‘ mothercraft’ and none of them actually fulfilled the recommendation of the World Health Organisation on skills building. Initially, a Senior Nurse at the Nursing Home in Jericho claimed that periodic skills acquisition workshops were organised for pregnant women in that hospital. According to her, “ the workshops are tagged “ mothercraft” and the women are taught the skill of knitting” . Another provider from the same facility however, denied the existence of any mother craft, according to this source: “ We teach only things that pertain to pregnancy. We don’ t do any skills building here, Ahn, who will sponsor it” ? She queried. The term ‘ mother craft’ , however, is not applicable to all the facilities sampled in this study but peculiar to both Jericho Nursing Home and the Jericho Specialist hospital. At the latter facility, a Senior Nurse described the components of the mothercraft programme as follows:

> During the mothercraft, we teach pregnant women how to take care of themselves, their husbands and their babies. … We demystify notions on the food to avoid during pregnancy. We do not organise skills building training programmes for pregnant women because of the large number of our care receivers here. (Female, Nurse, Public, Jericho S)

It is on record that skills’ building is one of the four core areas of prenatal care recommended by the World Health Organisation; it is therefore worrisome that none of the facilities under review in this study had the wherewithal for such training for expectant mothers. In fact, care providers held a consensus of opinion on the subject of skills building and its implementation in hospitals. For instance, at the Aremo Hospital, a Junior Nurse explained that “ For the skills building, we do not have the facilities to impart necessary skills into patients” . A Senior Nurse from the same hospital also affirmed that Aremo lacks the infrastructure and human resources to organise workshops in that area for expectant mothers. She however added that “ in terms of skills building, we encourage our patients to learn a trade or craft in order to augment the family’ s income. We do this during family planning counselling especially, when we observe that the women are having unplanned pregnancies” .

An advantage of capacity building training is to ease the financial pressure that may occur as a result of an addition to a family. When the issue of skills building was raised at General Hospital Moniya, a Senior Nurse was quick to respond that the idea was yet to be explored in the hospital. Rather than dismissing its possibility, she expressed optimism that skills building may be introduced in the prenatal clinic, if the hospital' s management accommodates the idea. Another theme common to the prenatal groups are songs. This is discussed next.

4.1.4 Common prenatal songs

Different songs were a common feature of the Ibadan group prenatal care programme; both nurses and pregnant women actively participated in the singing of songs. At Jericho Nursing Home, for example, there was a song dubbed the ' Pregnant Women' s Anthem' , a song that actually encourages women to practise exclusive breastfeeding. It was sung before the health- talk and its lyrics were positioned strategically along with other wall posters discouraging the use of baby formulas. Regarding the genesis of the anthem, a Junior Nurse in the facility linked its emergence to the general clamour in the country for exclusive breastfeeding. The anthem is probably the result of the clamour for exclusive breastfeeding. Its origin is likely linked to the evolvement of the campaign". In some other hospitals like Adeoyo, Moniya General Hospital, MNCH Apata, St Peters Hospital Aremo, Ring Road Specialist Hospital and O.L.A Oluyoro songs were sung at the end of the health education programme. Examples of such songs are:

Adéòyó Maternity, ibe ma bímo sí	I will have my baby delivered
Adéòyó Maternity, ibè ma bímo sí	at Adeoyo Maternity 2x
Wéré o wéré o ma bí tèmi	It will be a safe delivery
Wére o wéré o mà bí tèmí o	It will be a safe delivery
Adéòyó Maternity, ibè ma bímo sí	I will have my baby delivered at Adeoyo Maternity2x
Orí mi má je ń fòbe bímo 2x	O God may I never undergo a caesarean Section 2x
Orí mi má je n fòbe bímo 2x	O God may I never undergo a caesarean Section 2x
Ìgbà kíigbà ti ba ń robí lówó	whenever I am in labour
Orí mi má je n fòbe bímo	O God may I never undergo a caesarean Section
E ba ń gbé gbósà fóko mi ò	Do eulogise my husband
Oko olóríire to fún mi lóyún	The fortunate man who impregnated me

Ìyá Tólá jísé mí fún Màmá Tolú	Tola's mum give Tolu's mum my message
Màmá Tolú jísé mi fún Màmá Tólá	Tolu's mum give Tola's mum my message
Pé Abéré Àjesára ń be	On the availability of immunisation
Abéré Àjesára ó se pàtàkì o	Immunisation is important
Abéré àjesára ó se pàtàkì o	Immunisation is important
Èkíní ń ko láti ojó ìbí o	The first is given immediately after birth
Èkejì ń kó láti osù kejì o	The second is given after two months
Èketa ń kó láti osù keta	The third is given after three months
Gbòfun, gbòfun, àrùn ikó	Whooping cough, cough,
Rópá rosè, àrùn èyi	polio, and measles
Kò mà ní mú omo mi	will not attack my children
Abéré Àjesára o se pàtàkì o	Immunisation is important
Atinúké so ó ń rí mi ò	Atinuke can you see me
Bí mo se ń jó	As I dance
Mò ń jo tapá, tapá	with both arms
Bí mo se ń jo	Can you see as I dance
Mò ń jó tesè, tesè, tesè	I dance vigorously with my legs
Bí mo se ń jó	As I dance

To an observer, the women and their care givers appear like parents singing lullabies to their children. Nonetheless, for many ' first-time expectant mothers' , such songs will be useful lullabies during the postpartum period. Some of the songs were not only inspirational but also informational, especially those that educate pregnant women on the importance of immunization. Additionally, some of the songs are significant because they eulogised the fathers – to- be, particularly if such men were at the meetings.

In summary, the characteristics of the Ibadan Group Prenatal Care Model are medical assessment, health education, social support, features of the media employed in the model and common prenatal songs. The findings show that medical assessments of expectant mothers are not only to investigate specific gynaecological issues but, also, to suit the requirements of pregnancy. While the health education provided to pregnant women in groups may be beneficial, the largely unwieldy sizes of the groups challenged providers' ability to discharge their duties effectively. Women are usually supported through the stages of pregnancy through the provision of social support.

However, in this study, they reportedly received minimal emotional support from caregivers. The two main media types employed in facilitating the Group Prenatal care sessions were word of mouth communication and the IEC materials. The challenges of these media types have necessitated that interviewees recommend microphones and audio-visual devices to complement their efforts especially in large hospitals. Another distinguishing feature of the Nigerian group prenatal care model is the commonly sung anthem and songs. The songs were inspirational and informational, above all, they were meant to promote physical exercises in women who did not engage in any form of bodily exercises. This summary leads to the next point of investigation which pertains to the relational dynamics in the group spaces.

4.2 The ‘ Relational dynamics’ in the group spaces in selected hospitals

The dynamics of interaction between caregivers and clients within the group spaces were explored in this section. The observational checklist employed in this study guided the scope of the investigation. Thematic and comparative analyses of hospitals were employed, and the socio linguistic markers in the communication accommodation theory formed the basis of themes in this section. The themes are discourse management strategies, emotional control strategies and interpersonal control strategies**.** On the other hand, a comparative analysis of the hospitals was also done, in all, a total of four analyses for that section. Each of the analysis is divided into three parts namely: Composition of the group, pregnant women’ s perceived attitude to the issues discussed and the ‘ relational dimension to message delivery in the group’ . The thematic analysis is presented in the following order: 4.2.1: Discourse management strategies, 4.2.1.2: Emotional control strategies and 4.2.1.3: Interpersonal control strategies.

4.2.1 Discourse management strategies

Across all the hospitals, health care providers employed discourse markers in negotiating interaction with expectant mothers during the health education classes. The discourse markers predominantly employed were open and closed ended questioning, as well as reviewing earlier discussions or restating points. In other instances, nurses ‘ accommodated’ pregnant women by employing inclusive pronouns such as ‘ we’ in interaction. Such inclusive pronouns featured constantly in nurses’ speeches across some health facilities. The hospitals are The Maternity Teaching Hospital at Adeoyo, St Peters Aremo, Jericho Nursing Home, Moniya General Hospital, O.L.A Oluyoro and Ring Road Specialist Hospital. Other discourse management tools were couched in greetings, warnings, counsel, humour, and health information. Apart from verbal tools, non-verbal or visual tools such as gestures, body language and posture were also manipulated in ways that conveyed meanings. In many instances, the paralinguistic features of voice such as speech pauses, vocal pitch and tone communicated health care providers’ messages. However, discourse management tools cannot be examined in isolation of their socio historical context, hence, the transcript of conversations in the sampled hospitals will be interrogated

against their socio-historical background. Instances of discourse management strategies are highlighted below.

***Background*:** A young bespectacled nurse neatly clad in a white uniform entered the prenatal clinic. She warmly greeted all participants with a smile. She asked about the women' s welfare and that of their unborn babies before proceeding to discuss health issues with them. The nurse stood throughout the interaction while an elderly nurse listened to her presentation. The health discussion started off with a recap of the last topic which was exercise and self-medication. The nurse instructed participants in English.

Excerpts 1

Nurse: What are the types of exercises a pregnant woman ought to engage in?

Responses: Walking, dancing..... (pauses) *murmurings*

Participants' were not really responsive as some of them claimed to have come late for the last class. The nurse nevertheless did a recap of previous discussions.

(a) ***Background*:** The head of the prenatal clinic was the only nurse on duty because other nurses were unavoidably absent. It is also unusual for her to deliver the health-talk or conduct medical assessment. She registered expectant women for care and also conducted the medical assessments and health education all by herself. Prior to the commencement of the health-talk however, the pregnant women' s anthem is sung alongside other songs.

Nurse: What do you people want us to discuss today?

Responses: *(chorus)* labour!

Nurse: (*points a finger at a middle aged pregnant woman)* you, come over here and teach your peers what labour is

Pregnant woman: (*shows reluctance while standing up but makes no attempt to teach)*

Nurse: (*is surprised*) Yes you. Are you not a teacher?

Pregnant woman: (*denies*) No! I am a business woman!

Background: The prenatal building here is large and, according to one of the nurses, there are about seven nurses at the prenatal clinic. Different nurses are seen handling the different aspects of care. The observations at this clinic depict the nurses as relaxed, especially in the course of dispensing care. Diet/nutrition was discussed at this session.

Excerpts 2

Nurse: ...when we want to eat rice can you suggest the examples of protein that can be added to the rice?

Responses: ...Beans, Egg, Meat and Vegetables

Nurse: ok, how can we prepare vegetable for a pregnant woman?

4.2.2 Emotional control strategies

Emotional control strategies refer to the manipulation of language and non-verbal signals by interlocutors to serve perceived relational goals. In the context of this study, many pregnant women in the latter stages of pregnancy were observed to be restless and less attentive to the health-talk classes. However, the nurses rarely bothered about such women. One gets the impression that, for the nurses, it is business as usual. This was not peculiar to any one facility but was observed across the hospitals. In contrast, on a few occasions, pregnant women with unwholesome eating habits were readily spotted in the group. Women in such category were counselled appropriately. Some nurses also exhibited a tendency to readily pick up pregnant women' s body languages as cases of women who reported for prenatal care with unhealthy symptoms were promptly attended to. With respect to nurses' ability in handling difficult and emotionally sensitive topics like labour, caesarean section and oedema, emotional control strategies such as pauses, eye gaze, reassuring speeches and prayers were deployed to reduce the women' s apprehension.

Some nurses were, however, less adept at addressing the relational needs of non-Yoruba speaking pregnant women. A case in point was a scenario observed at the Jericho Nursing Home where expectant mothers were requested to bring their babies' supplies for inspection ahead of the delivery date. A non-Yoruba speaking pregnant woman, who for linguistic purposes seemed to be slow in learning, was

among those with their babies' supplies. The nurses could not accommodate her inability to readily comprehend instruction, so another pregnant woman was delegated to guide her.

The singing and dancing session is another key emotional control strategy that allowed for bonding between health care providers and the expectant mothers. The forum provides opportunity for socialisation among the women as some participants reportedly became friends through the meetings. Some excerpts of nurses' discussion of difficult subjects are presented next.

(b) **Background**: The nurse was an elderly nurse with a matronly stature. The topic of discussion was labour. Prior to the discussion below, she had earlier discussed certain issues with the pregnant women.

Excerpt 3

Nurse: ...do not waste time at the second stage of labour, within the space of ten minutes you should be able to be delivered of your child....for those that the area is not big enough to accommodate the head of the baby, we will have to cut it and stitch it. The doctor will help you stitch it, so be calm.

Excerpt 4

(c) **Background**: *Prayers and songs were found to be common emotional control strategies employed by nurses to negotiate interaction. An example is below.*

Nurse: We will not come to any harm. Please let us adhere to instructions so that all will go well.

Excerpt 5

Nurse: ...you don' t have to be disturbed about anything. You should avoid brooding and be more concerned about the foetus' s proper development.

The call and response *Bibi o; abiyẹ lomo mi*! is another example of an emotional control strategy.

4.2.3 Interpersonal control strategies

Interpersonal control strategies refer to how status, stereotypes and roles affect patients and providers in their interactions. In this study, language was manipulated in ways that indicate power struggle between providers and patients. Examples of such are highlighted below.

(d) **Background:** Generally across all the hospitals it was observed that pregnant women usually report late for their prenatal appointments. In this facility, the situation was not different. Different nurses handled the health-talk on designated days. While a nurse instructed the pregnant women, other nurses rebuked the latecomers.

Excerpts 6

Nurses: ...you latecomers (*directing the question at the women*) what form of punishment do you deserve?

Response: (*faint not distinct*)

Nurses: (*jeers at them*) Ah Ah. That' s good at least you people made that decision.

(e) Background: A nurse is seen addressing a particular pregnant woman who was yet to procure the delivery pack sold at the hospitals' pharmacy. The nurse had a bandaged wrist. During a palpation session, she was snapping at the expectant mothers such that one other nurse had to ask her if the task was not aggravating the pain on her wrist.

Excerpts 7

Nurse: ...tell me, what are the components of baby load?

Responses: (*indistinct murmurings*)

Nurse: (*raises her voice)* that is what ' am telling you, ' *patanla*' is sold for #3,700—if it is not more expensive now. It is available at the pharmacy.

Nurse: components of the load include: cotton wool, sanitary towels and other things. You' ve been taught before but you' ve forgotten. Ah! (*She exclaimed*) you made me talk until I bit my tongue!

4.2.4 A comparative analysis of the administration of prenatal care in Moniya General Hospital and Maternal and Child Health Apata (MNCH)

The conduct of prenatal care sessions at Moniya General Hospital and MNCH was observed for four weeks and the verbal and non-verbal behaviours of both facilitators and participants were scrutinised for consistency. While the prenatal clinic is held on Wednesdays and Fridays at the General Hospital Moniya, at MNCH Apata, the clinic takes place on Tuesdays and Thursdays.

1. Composition of the group

A comparison of the administration of prenatal care in both the General Hospital Moniya and Maternal and Child Health, Apata was conducted. The average number of participants at MNCH Apata was 20 while the hospital at Moniya recorded an average of 25 participants. Majority of them were Yoruba speaking, while people from other tribes (Hausas, Igbos and Igalas) were in the minority. Throughout the period of the observation, majority of the pregnant women were neatly dressed in either traditional or western wears, six were in Purdah. At the General Hospital Moniya, the health education classes and medical assessments were held in an enclosed area of the hospital the same can however not be described as the situation at MNCH Apata, prenatal care in the latter hospital took place in an open arena prone to external noise. Hence while the environment of General Hospital Moniya was relatively comfortable and suitable for discussion between nurses and expectant mothers, that of MNCH Apata was porous, since patients at the card room or those waiting to see the doctor were likely to create undue interference.

2. Pregnant women' s perceived attitude to discussions

At both health facilities, the medium of instruction and nurses' perceived expertise in message delivery influenced pregnant women' s attitude to the issues discussed. Yoruba was the predominant medium of instruction employed by the nurses in the delivery of the health-talk. Although, at some points, both Yoruba and English were utilised interchangeably as a medium of instruction in both facilities, not all the nurses

in both hospitals employed the two languages. A particular Senior Nurse at the General Hospital Moniya, facilitated the health-talk by code-switching between Yoruba and English. Another nurse (a Junior Nurse) who equally handled the health-talk at the same facility communicated more in Yoruba. This probably explains why some of the participants at the two facilities displayed a keen interest in the issues discussed with only a few of them actively engaging in the discussions. Across all the hospitals, power play was observed in the discussions between the nurses and the pregnant women as majority of the facilitators allowed for conversational ' dominance' in their interactions with the women. Nevertheless, some of the nurses consistently reassured expectant mothers through prayers and encouraging words during the health-talk. On the average, the general climate for learning was found to be moderately conducive at the Moniya General Hospital but at MNCH Apata, the climate for learning was not conducive especially on occasions when constant interruptions came from the card room or the patients' waiting room.

Finally, the implication of the interaction between nurses and the pregnant women within the group is otherwise referred to as " the relational dimension to message delivery" and that is discussed in the next theme.

3. The ' relational' dimension to message delivery in the group

At the General Hospital Moniya, two nurses handled the health-talk throughout the period of observation. The same situation was observed at the Maternal and Child Health Apata. While one of the nurses handling the health education classes at Moniya usually was seated in the course of facilitating the health-talk, the other nursing officer moved freely amongst participants. At MNCH Apata, neither of the two nurses was seated while delivering the health-talk; both of them moved freely among participants and actively engaged them in the group discussion. The two nurses at the Apata Hospital rarely employed gestures and teaching aids in facilitation however, gestures were frequently utilised by one of the nurses at the Moniya Hospital. Majority of the nurses at both facilities found it difficult to harmonise their speech with their non-verbal cues. Notwithstanding, 60% of the time, the nurses actively employed eye-contact with the pregnant women. With respect to the body

movement of the pregnant women, uneasy shifting movement was observed more often among women in the latter stages of pregnancy.

Furthermore, the uneasy shifty movements of women in the latter stages of pregnancy observed at both the hospitals are not only peculiar to pregnant women as individuals naturally shift from one end of their seats to another to express discomfort particularly when they have being seated for a while. This point reinforces the primacy of timeliness in attending to patients especially pregnant women. Ambulatory services could be provided to women and minimal time should be spent on health education as attention span of the women is limited, more importantly, because of the physiological conditions of pregnancy. In all the observed sessions participants were found to be generally attentive, with minimal interruptions or distractions from the crowd. Having discussed the themes that emerged under the comparative analysis of the administration of prenatal care at the Moniya and Apata hospitals, the next point of investigation is a comparative analysis of the administration of prenatal care in Jericho Nursing Home (JNH) and Ring Road Specialist Hospital (RRSH).

4.2.5 A comparative analysis of the administration of prenatal care at the Jericho Nursing Home (JNH) and Ring Road Specialist Hospital (RRSH)

The researcher paid repeated visits to the Jericho Nursing Home and Ring Road Specialist hospital to observe the conduct of prenatal care at both hospitals. The prenatal clinic is held at the Jericho hospital every Monday and Tuesday while it is held at the latter on Monday and Friday. Observed differences and similarities in the conduct of prenatal care are described below under appropriate sub-headings. A comparism of the sampled hospitals was done to determine if there was any uniformity in the conduct of care.

1. Composition of the group prenatal care

Each group meeting at the Jericho Nursing home had an average of 11-24 participants, while the Ring Road Specialist hospital recorded an average of 25-30 pregnant women. Similarly, at both hospitals, the majority of pregnant women are Yoruba-speaking; while those from other tribes were in the minority this is to be expected since the study is being conducted in the South-western part of the country where the people are mostly Yoruba-speaking. Most women at the RRSH were

dressed in western or traditional attires, only a few was in Purdah. Both the Jericho Nursing home and Ring Road Specialist hospital conducted their health education classes in an enclosed but relatively comfortable area of the hospitals; however, unlike the serene atmosphere at General Hospital Moniya, the environment of the Nursing home and Ring Road Specialist hospital was noisy. The above observation compared with the ones from other facilities show the prevalence of environmental noise in many of the prenatal clinics. Sometimes, participants at the prenatal clinic of J N H were distracted by the activities of nursing mothers in the postnatal ward while at Ring Road Specialist Hospital; interruptions came either from other nurses or the different vendors who market wares at the clinic.

2. Pregnant women' s perceived attitude to discussions

There were observed differences in the women' s bodily movements and reactions to the prenatal songs. While, majority of the participants at the Ring Road Specialist Hospital constantly displayed a smiling countenance during the dancing sessions, some expectant mothers at the Jericho Nursing Home participated albeit grudgingly during the sessions. With respect to the health– talk, majority of the pregnant women at both hospitals exhibited a similar attitude to the issues discussed as they usually wore indifferent expressions except for few occasions when participants' expressions oscillated between keen interest and disinterest. At the J N H, for example, the women appeared somewhat confused when asked to describe the location of the labour room in the hospital. Only a few of them were able to. This infuriated the nurses who felt that many of the women, at the initiation of care, must have received appropriate orientation and a facility tour. A totally different scenario was, however, observed during the course of another health-talk session at the Nursing home as the women readily laughed with the facilitator and there was an air of ease between them and the nurse who handled the session. The participants at the Jericho Nursing Home were more attentive during the health education class and contributed to the discussion. However, at the Ring Road Specialist hospital, during an observed session, one of the participants seated closely to the researcher expressed dissatisfaction at the way the health- talk was facilitated. According to her, the classes lacked much value since nurses did not vary the topics of discussions. Upon further enquiry, the participant conceded that she was not conversant with Yoruba; the language of instruction.

Yoruba was inadvertently employed by nurses to ostracise non-Yoruba-speaking expectant mothers from the group. The adopted medium of instruction also had implication on other participants in the group, as they were engaged in side-talk, since the facilitator had earlier assigned interpreters to each of the rows where non-Yoruba speaking women were seated.

3. Relational dimension to message delivery in the group

The relational dimension to message delivery is the perception of relationship ties between care providers and pregnant women occasioned by observed verbal and non-verbal cues. Most of the time, nurses at both facilities wore placid/bland expressions especially, during the health-talk. Their expressions were however, observed to be less defined during the dancing sessions. Nurses at the Ring Road Specialist hospital in comparison with those at JNH, moved more freely around the audience while delivering their health-talk. As a result, more eye-contact was made by nurses at RRSH than the other facility. At both hospitals, the nurses infrequently employed gestures in facilitating the sessions. With respect to their facilitation skills, nurses at Ring Road Specialist Hospital often displayed better communication skills than those at Jericho Nursing Home. The nurses at both facilities also seemed to encourage participation among members. More uneasy shifting movements were observed by women in the latter stages of pregnancy especially, those at the Jericho Nursing Home.

It is apparent that environmental noise during the health education classes is a deterrent to teaching and learning, because the facilitator' s thought flow is interrupted while the learner is unable to process received information beyond the short-term memory. The implication is a focus on the behaviourist as opposed to the cognitive approach to learning. Cognitive theorists emphasise both content and mental information processing which explains their advocacy for techniques that guarantee memory retention. Regarding the physical environment of learning, cognitive theorists argue that differences in individual psychological make-up account for their differential reaction to the same stimuli. The physical environments of the prenatal clinics under review created illusions of clinical learning environments. This is because of the multiplicity of wall posters on health education which were meant to connect patients' previous knowledge with current ones. Many of such posters were

however in the English language and so the import of such messages was lost on non-English speaking pregnant women. Accordingly, the prevalence of factors such as linguistic noise, environmental noise and other barriers to communication contributed to the relational dynamics in the group spaces. For example, the constant disruptions of the health education classes elongated the teaching period and consequently reduced the attention span of patients. It will also affect patients' willingness to wait after clinical appointments for any socialising opportunity. Additionally, a protracted teaching time will be physically exhausting especially on both the care providers and the patients.

Nevertheless, relative group homogeneity in both facilities will foster interaction and interdependence among the pregnant women. This view was upheld by discussants at the Jericho Specialist Hospital where some nursing mothers were said to have developed friendship ties during the prenatal period. Even at the Jericho Nursing Home, women were observed moving in groups to undertake the ultrasound test. Pregnant women became members of prenatal care groups because of a need for inclusion. However, such membership supersedes a mere quest for integration as the women sought to reduce the uncertainty level associated with pregnancy. Additionally, the pregnant women sought to exercise control over their health which explains why they initiated prenatal care. It is upon registration for care that the women mutually demand for affection and affiliation within the peers' space. Hence, there is reciprocity in affection among some of the women.

Furthermore, during the observation period, pregnant women at both the Ring Road Specialist Hospital and the Jericho Nursing Home employed disconfirmation strategies at some points in their interactions with their caregivers. Non-committal responses, snide remarks, ambiguity, side-talk or irrelevant messages are some of the ways disconfirmation is expressed in an interaction. Expectant mothers at the RRSH engaged in side-talk during two out of the four observed sessions at the facility. A similar situation was also observed at the Jericho Nursing Home. Interviewed Nursing Officers at Aremo and Adeoyo confirmed that side-talk among participants and irrelevant questioning were common features of the health-talk programme.

The formality of the communication encounter contributed to observed indices in respect of disconfirming messages from pregnant women. The health education session and indeed prenatal care can be made less formal through the introduction of elements such as round table discussions and participatory care. In addition, providers can adopt appropriate rapport tools in reducing perceived level of formality. Small talk, a tool of rapport reduces power imbalance between providers and clients. However, providers have to be emotionally intelligent to understand the appropriateness of small talk in a situation and the particular ways of negotiating the interaction. Relationship development between nurses and patients is gradual and sequential, hence, a patient' s point of view is explored through chatting with her. At the orientation phase of a relationship, caregivers initiate a warm welcome and in some instances make small talk as a means of building rapport with clients. Trust is gained when providers initiate rapport through friendly welcome, eye contact, small talk, active listening among other skills. In some spaces, patients are initially addressed by their surnames, after which health care providers enquire which names they prefer.

With respect to the relational dimension to message delivery at RRSH and JNH, it is apparent that there are marked differences in facilitators and expectant mothers' approach to the conduct of the prenatal classes. Observed differences have effect on relational communication in both hospitals. For example, facilitators' ability to actively move around participants have implication on the expectant mothers' active engagement in the discussions as ' loafers' (those who merely observe group activities without participating) will be easily spotted within the group. In addition, the caregiver will be able to maintain eye contact with all participants. On the contrary, at the Jericho Nursing home, it was observed that the nurses who facilitated the health-talk consistently adopted a sedentary position while the dietician who facilitated the nutritional aspects of the health-talk moved freely around participants. Notwithstanding the sedentary posture adopted by one of the nurses at a particular session, the health education class was highly interactive as the nurse encouraged the participants to choose their preferred subject for discussion. Apart from seeking to understand participants' point of view, the nurse called upon one of the women who has had a previous delivery to handle the session, since the women expressed the

intent to learn more on ‘ labour’ . The participant who was to handle the discussion was unable to do so, but other members contributed actively to the group discussion. In contrast, the expectant mother who was asked to teach others the process of labour may have perceived such request as high handed, especially since no prior lecture was given on the subject. The formality of the nurse-patient encounter gives the former the prerogative to dictate the modalities of discussions within the group. Nevertheless, the language deployed in making such demands should conform to the standards of patient-centred communication. On the whole, the messages delivered by nurses in the health facility were largely persuasive as their style of facilitation was on correcting myths and cultural beliefs regarding pregnancy.

Throughout the period of observation, the nurses at the Ring Road Specialist Hospital made good use of eye contact, while at both hospitals under review gestures were sparingly used in facilitating. In all, the nurses’ communication skills can be described as merely moderate, as it was observed that some of them adjusted their communication based on audience feedback. Also, two of the observed nurses at the RRSH were highly sensitive to the group climate, especially when vendors sought to hijack the group processes. The proliferation of vendors across the hospitals is worrisome as they exploit the loose structure of many of the hospital spaces to distract patients and providers. There is a need therefore for their movements to be restricted to certain places within the hospitals as practiced at Our Lady of Apostles Catholic Hospital Oluyoro.

Finally for this section, the non-utilisation of teaching aids by providers during the health talks at majority of the hospitals suggests a dearth of instructional materials. Instructional materials are not merely attention-getting devices but they also aid memory in the sense that information processing is made less abstract. The rapid changes in the information age has however obsolesced the use of IEC (information, education and communication materials). To this end, facilities such as RRSH that entertain pregnant women with African Magic on digital television can channel such resources more appropriately through the provision of health-related audio-visuals.

4.2.6 A Comparative analysis of the administration of prenatal care at Adeoyo Maternity Teaching Hospital and St Peters Hospital Aremo

An ethnographic study of the Maternity Teaching Hospital Adeoyo and St Peters Aremo reveal a lot of information on how a group size is likely to affect not only participation and discussion among members but also facilitators' ability to dispense care adequately. The Adeoyo hospital is a foremost health facility in Ibadan that pulls a large crowd of clients across the state. It is situated at the heart of the city, on the other hand, St Peters Hospital Aremo is a relatively small clinic located in a relatively remote part of the metropolis. The researcher observed that the location of these health facilities had a lot of influence on their respective clientele. Against this background, it becomes pertinent to examine in detail the composition of the prenatal care groups in each of the facilities under review.

1. The composition of the group

At Adeoyo, prenatal clinic days were held on Monday, Tuesday and Friday and the facility recorded an average attendance of 30-45 pregnant women. While at St Peters Hospital Aremo, an average of three to six participants usually constituted a group. The clientele at Adeoyo can also be described as more inclusive in nature than that at St Peters Hospital Aremo, as women of different physical impairments, ethnic groups and vocations attend the former. Similarly, the Maternity Teaching Hospital recorded more attendance of women in Purdah than all the sampled facilities in this study.

The foregoing observation is a comparison of the prenatal group composition at Adeoyo with that of Aremo. In the course of the study, for example, one of the participants at the prenatal care clinic at Adeoyo was found to be physically challenged (speech impairment). Incidentally, the health education class is not designed in a way to meet the needs of such physically challenged individuals as there were no sign interpreters during the lectures. In view of a large number of participants at the clinic, it is possible for this woman and many more with similar challenges to be lost in the crowd. Such cases could only be detected during the physical examinations whereas the concept of health care equity does not foreclose physically challenged individuals. In the next sub theme the perceived attitude of pregnant women at the prenatal clinics in both hospitals is briefly discussed.

2. The perceived attitude of pregnant women to discussions

As earlier stated, pregnant women' s perceived attitude to the issues discussed were influenced partly by nurses' conduct during the sessions. On the average, majority of the expectant mothers at Adeoyo were inattentive as side-talk was observed to be more frequent among the women than those at St Peters Hospital Aremo. The pregnant women at Aremo seemed attentive but only a few actively asked questions during the health education sessions. During one of the observed prenatal sessions at St Peters Hospital Aremo, the nurse who handled the delivery of the health education class was in a sour mood she was nursing an injury on her wrist, which must be the explanation for her patently unfriendly behaviour on that day. She kept on snapping at the women, who became confused and consequently fearful of seeking clarification on the grey areas in her presentation.

This leads to the next point in the discussion which dwells on the relational dimension to the message delivery in the group (which otherwise refers to how verbal/non-verbal interactions between interlocutors depict their nature of relationship).

3. Relational dimension to message delivery in the group

Some regular features of the health education classes at the Adeoyo Hospital were the noise from the generating set, noise resulting from the marketing activities of different vendors, and constant distractions from passers-by. This is clearly because the clinic was conducted in an open arena. In view of the large number of participants, facilitators did not adopt a sedentary position while facilitating the health education classes. The constant humming of the generating set impeded learning as the women were only able to catch mere snippets of the discussion. Also, it was observed that the predominant medium of instruction employed by nurses facilitating the health education classes in both hospitals under observation was Yoruba. This is likely to discourage non-Yoruba speaking women. At Adeoyo, the nurses taught with the aid of instructional materials while at Aremo no such instructional materials were utilised though interviewed nurses explained that they were available. Thus far, the discussions under relevant sub headings have examined the relational dynamics in six public hospitals.

4.2.7 A comparative analysis of the administration of prenatal care at Jericho Specialist Hospital and Our Lady of Apostles Catholic Hospital Oluyoro (O.L.A)

Jericho Specialist Hospital is a referral health facility in Ibadan situated in an industrial area of the metropolis while our Lady of Apostles is a private hospital owned by the Catholic diocese of Oyo state and situated in a remote part of the city. The researcher observed that the location of these health facilities had a lot of influence on its clientele. The composition of the group prenatal clinic in both facilities is discussed next.

1. Composition of the group

At (O.L.A) Oluyoro, prenatal clinic days were held on Monday, Tuesday and Thursday and the facility recorded an average attendance of 15-20 pregnant women. More primigravidae (those with no history of child birth) were scheduled for clinic on Monday and Tuesday while multiparous (having more than one child) women were more on Thursdays. At the Jericho Specialist Hospital, between 40 and 50 participants constituted a group. Although, clients from different ethnic, religious and educational backgrounds visited both hospitals for care, English was adopted as a language of instruction at Oluyoro while at JSH; Yoruba was interspersed with the country' s official language. At both hospitals more women were seen dressed in western and traditional attires but at JSH a few were spotted in Soutana (uniform for white garment churches) and Purdah. The seating capacity in the prenatal clinic of JSH is small in comparison to the large number of expectant mothers registered, at Oluyoro, available pews were sufficient for the women. While behavioural and environmental noises were common features at Jericho Specialist Hospital, Oluyoro had a more conducive environment for prenatal care.

Another noticeable factor that is likely to have affected the group composition in both hospitals is noise. At Jericho Specialist Hospital, women were exposed to both behavioural and environmental noises as backstage conversations were rampart among nurses within and outside the prenatal clinic. The hospital' s location on the main road also posed a challenge as facilitated discussions are often punctuated with the sound of heavy duty vehicles and other allied commuters. However, in a focus group discussion at the Jericho Specialist hospital, a participant explained that:

> Most things that distract us during prenatal care are monetary. For instance, on every clinic day, pregnant women are expected to procure certain things like blood tonic, capsule among other things. While the issue of procurement may serve as a distraction to some women,

> for me, each time I take such drugs, I have diarrhoea, so that constituted a distraction. I told them I could not take the drugs but they insisted that its part of the drugs that must be taken. (Female, Pregnant woman, Public, Jericho S)

In contrast, during the period of observation at Oluyoro, little or no distraction emanated from nurses in the course of the health-talk. Participants in a focus group discussion at the same facility were, however, of a contrary view. The next point in the discussion dwells on the perceived attitude of the pregnant women to the health-talk.

2. Pregnant women' s perceived attitude to discussions

Expectant mothers at Oluyoro were observed as more attentive than those at the Jericho Specialist Hospital, the women at both facilities, however, displayed a similar attitude to the dancing sessions. Throughout the period of observation majority of the participants at the two hospitals wore smiles and readily wriggled their hips at the rendition of prenatal songs. There were however, marked differences in the women' s' responses to the health-talk sessions, the participation level at Oluyoro perceptibly surpassed that of JSH. Caregivers' style of facilitation, patients' ' perception of care and clinical environment influenced each group' s level of participation. Prenatal appointments in Oluyoro were scheduled by parity, hence pregnant women were less distracted, for example, grouping of first-time mothers will stimulate interest and learning. Conversely, the availability of more multiparous (having more than one child) women in a group will reduce one member' s tendency to display superior knowledge over another. The relational dimension to message delivery is discussed next.

3. Relational dimension to message delivery in the group

Facilitators at the Jericho Specialist Hospital adopted more of a sedentary position during the health talk than their counterparts at Oluyoro. While it was the norm at Oluyoro for caregivers to be fluid in their movements, at JSH, nurses felt inclined to sit through the sessions. The large group size at the Jericho Specialist Hospital allowed participants to engage in side-talk without care provider' s knowledge. Whereas, at Oluyoro nurses' mobility during the sessions helped to check for the non-verbal cues of participants and adjust presentation accordingly. Also, at Oluyoro, prenatal topics were assigned to particular months, hence, nurses devoted ample time

to the discussion of each topic. During the period of observation at Oluyoro Hospital, prenatal health– talk instructors clearly communicated how the session would be run and the learning outcome, the situation at JSH was however dissimilar. Vendors at Oluyoro, were restricted to the hospital' s corridors and not allowed into the prenatal clinic. Women' s purchase decisions were therefore, performed outside the clinic. Whereas, at the Jericho Specialist Hospital, vendors were granted access into the prenatal clinic and while the class was on, pregnant women especially, those at the groups' rear freely executed their purchase intention. The location of the prenatal clinic in both hospitals is within an enclosure hence there were fewer distractions from passers-by. As observed across other facilities both hospitals under comparison rarely adopted instructional materials in facilitating.

From the foregoing observations, it is evident that care receivers at both facilities did not have similar experiences, especially as women who came late for prenatal care at JSH were often seen squatting, loitering or in a standing position. The uncomfortable positions adopted by women during health-talk did not in any way depict mother-friendly care. This problem is traceable to the inadequate supply of infrastructure in public hospitals. In contrast, the prenatal health-talk classes at Oluyoro were better suited to the conditions of pregnant women as the seating capacity was adequate. The situation of limited infrastructure in public hospitals, it has been argued, occurred as a result of the global economic meltdown when government had to resort to obtaining loans in providing social amenities such as health care to the populace. While that position is tenable in some countries, in Nigeria, bad governance and politicisation of the health sector account for its deplorable state. As a matter of fact, Nigerian hospitals have been neglected long before the global economic meltdown such that there was a brain drain in the health sector. The issue of brain drain in the Nigerian health sector still persists because of the embargo on employment and massive emigration of Nigerians. Nonetheless, non-governmental agencies in neighbouring African countries like Kenya are active partners with government in the provision of health-care. Similarly, a key informant at Adeoyo testified to the efforts of the MTN Foundation in the renovation of four maternity wards. More of such social responsibility function on the part of corporate bodies will improve the structural processes of care delivery in the country.

Aside from the fact that some of the facilities, such as the Jericho Specialist Hospital, were ill-equipped, a general feature of the hospitals was the seating arrangements. Seats arranged directly facing the instructors depict a focus on expectant mothers' attention. If the goal is to promote group interaction, then the modular arrangement may be more appropriate. In this study however, across majority of the facilities, seating arrangements were directly facing the instructors.

At Oluyoro, prenatal clinic days were scheduled based on parity, which, according to the Head of the Department, is to allow for better coordination of care. The private nature of the hospital may have necessitated such arrangement as there is a tendency for constant improvement in care delivery in order to secure more patronage and referral. The mission nature of the hospital notwithstanding, availability of more patients will accrue more revenue that would facilitate payment of staff salaries. Observation at the Jericho Specialist Hospital was different as women of different parity were grouped. As a matter of fact, prenatal health education classes were held only on Fridays while the women were required to make only two attendances at such classes prior to delivery. This provision was observed to be peculiar to the Jericho Specialist Hospital. Nurses were overwhelmed by the large number of patients that besieged the facility for care. One of the key informants in this study remarked that people patronise public hospitals because of affordability and a perception of more qualified personnel. There are, however, contradictory evidences on patients' perception of the service quality of public hospitals and the private ones. More noteworthy is the fact that the service quality of private and public hospitals in developing countries is difficult to measure because of the duality in providers' roles in both spaces. In other words, many providers who are employed by the government simultaneously run a private practice.

The foregoing findings depict the structural and procedural variations in prenatal care as defined by ownership factor. For instance, the semblance of order in taught topics was peculiar to O.L.A Oluyoro as the majority of the other sampled hospitals did not exhibit such a plan. An advantage of such an arrangement, especially for care providers, is that absentee participants would not have to complain that they were not taught. Notwithstanding the private ownership pattern at Oluyoro there were

perceived providers' conversational ' dominance' . The perceived power play between nurses and expectant mothers at Oluyoro is attributable to the technical expertise of the former and the near public administration of the facility. A similar situation was observed between nurses and the women at the Jericho Specialist Hospital. The ability of nurses, for example, to create and maintain a friendly relationship with their clients has implication on the latters' recall rate and adherence to medical counsel. The relational pendulum between nurses and the women was observed as balanced during the dancing sessions, more importantly, as both groups sang and danced.

Finally, the health education sessions in both facilities under comparison were similar, except for minor differences occasioned by organisational factors. Hospitals are complex organisations influenced by individual, interpersonal and organisational frameworks. One of the organisational provisions at Oluyoro that regulates the conduct of care, according to the Head of Department, is the patients' ability to report any unwholesome behaviour on the part of the provider and the availability of sanctions for any medical malpractice. That form of patient empowerment and participation in care promotes a consciousness in providers to achieve balance in relational communication between them and patients.

The synopsis of the discussions in this section is that group specific indices determine existing relational dynamics between participants and nurses in Ibadan hospitals. Put simply, factors such as group composition, clients and caregivers' verbal and non-verbal messages and the medium of instruction determined message reception and emergent relationship between expectant mothers and the nurses. The findings reveal that a group characteristic such as size determines the depth of interaction within the group, while the physical environment of the hospital determines the noise levels which can hamper learning and retention. Caregivers' verbal messages were oftentimes validated by the non-verbal accompaniments. Consequently, when nurses' verbal and non-verbal cues are at variance, clients are more likely to believe the non-verbal messages. If the latter' s perception of nurses is negative there will be a strain on their relationship development. The medium of instruction predominantly adopted by caregivers in this study were Yoruba and English and the language

adopted has implication on minority members, especially when their language is not the local language of that region. This summary leads to the next section which examines pregnant women' s perception of the relational communication behaviour in the group spaces.

4.3 Pregnant women' s perception of the relational communication behaviour in group prenatal care clinics

Prior to now, the Oyo state government and the hospitals management board on different occasions had made several efforts at upgrading state-owned facilities. It is unknown if such statutory efforts accommodated staff retraining especially on key processes of care such as communication. In this section, pregnant women' s perception on the relational communication behaviour in hospitals' group prenatal sessions was assessed. Key indicators of provider communicative behaviour such as rapport building, listening, confirming and checking of perception skills were measured. The constructs of Kelly' s covariational model of causal attribution namely: consistency, consensus and distinctiveness were the parameters adopted in validating respondents' perception. The demographic variables of respondents are presented first as part of the preliminary findings peculiar only to research question three.

4.3.1 Distribution of respondents based on demographical variables

Out of the 365 expectant mothers recruited for this study, 355 consented to participate but only the responses of 340 women were complete and valid to be analysed, as some respondents exited midway to the completion of the study. Meanwhile, there was a high response rate from participants in this study, in view of the ' interviewer assisted' nature of the survey. From table 4.2, the ' mean average' age of respondents is 30.5 with 32.6% of respondents falling within the age-range 26-30 years, while only 3.2% of respondents were between 41-45 years. An overwhelming number of participants in this study, 80.9% were of the Yoruba speaking parts of Nigeria while other tribes constituted only 14.4% of the entire population. Also, the majority of respondents 61.5% had tertiary level education; they had qualifications ranging from a National Certificate of Education to a Master' s degree in different fields of study. Only a negligible proportion of participants, 1.2% of the population

had no formal education. Hence, respondents in this study are adjudged sufficiently educated to understand the nuances of research and the implication of their responses on the outcome of the study.

Again, with respect to the occupational distribution of participants in the study, 31.5% of the population were civil servants, 29.4% were traders, and 21.2% were artisans. Only 10.9% of the entire population were unemployed. Thus many of the respondents in this study were gainfully employed. Furthermore, seven hospitals were sampled in this study; the facilities differ in terms of categorisation and ownership structure. Six hospitals offer secondary health care services with only Adeoyo Maternity Teaching Hospital in the category of a tertiary provider. Similarly, only our Lady of Apostles Catholic (O.L.A) Hospital Oluyoro differs in terms of its private ownership structure; all the other facilities are publicly owned. Expectedly, these differences had an impact on the responses elicited from the survey, and by extension on the research outcome. Adeoyo Maternity Teaching Hospital, for instance, recorded the highest number of respondents, 19.1% of the population consented to participate in the study at the facility. The Jericho Nursing Home recorded the minimum number of study participants with 10.6% of the entire population. At the Ring Road Specialist Hospital, 15.9% participated in the study. There are marginal differences in the distribution of respondents at Jericho Specialist Hospital, The General Hospital Moniya, O.L.A Oluyoro and Maternal and Child Health Apata.

It is evident that the referral nature of the Adeoyo Maternity Teaching Hospital as a tertiary health care provider, especially in the area of maternity care contributed to its teeming clients. However, administrative bottlenecks such as elongation in the patients' waiting time made many expectant mothers unwilling to participate in the study. Similarly, the fact that the survey was interviewer administered across all the hospitals also accounted for the small sample of respondents at the facilities. As at the time of conducting the survey, there were several researchers at the prenatal unit of the Maternity Teaching Hospital, which also restricted the number of participants in this study, as pregnant women were assailed with different types of questionnaire at each meeting. The said situation was peculiar to the Adeoyo hospital as the experiences at other hospitals were different. The Jericho Nursing Home for example,

recorded minimal number of respondents because of the peculiarity of respondents in that facility as a good number of them did not consent to participate in the study. The described demographical variables give adequate background to research question one and the implications of some these variables on the research outcome. To start with, all the respondents in this study are women. Women, as a matter of fact, are known to be more critical of nursing care than men. Though differences in gender may affect patients' perception of care, patients' expectations of care also account for their differential opinion regarding care quality. For example, elderly patients reportedly prefer kind and respectful nurses, hence caregivers who exhibit such characteristic are regarded as not only personable but also technically competent. Majority of the respondents in this study were educated, only a few had no formal education. This explains the critical nature of respondents' responses to the issues raised in the questionnaire. On the other hand, respondents with little or no formal education were readily satisfied with the service quality and nurses behaviour in the facilities. Educated patients of high socio-economic status are also more critical because of their exposure and knowledge. Such patients' knowledge level motivates them to demand for a patient centred care which also explains why caregivers are more careful dealing with educated patients. A summary of the demographic distribution of respondents in this study is presented in Table 4.2.

Thus far, the socio-demographic constituents in the population have been discussed to provide a background to research question three, subsequent discussions in this section focus on the frequency in the attendance of expectant women at the prenatal health education classes. Therefore, Table 4.3 shows the distribution of respondents based on their attendance at the prenatal health education classes in the sampled facilities. The table is a key indicator of participants' fulfilment of the eligibility criteria. Although, some respondents skipped the question in the course of the survey, this did not in any way imply that they lacked eligibility, as prior to recruitment, subjects were carefully asked if they had attended at least a session of the prenatal health-talk. Hence, the maximum number of respondents who attended the prenatal health education classes for less than 24 weeks prior to the survey is 28.5% of the population. Another 28.2% attended the session for less than 24 weeks, while 23.2% of the population attended for less than 4 weeks. The minimum attendance was

recorded by women in the third trimester of gestational pregnancy, as only 18.5% of such women attended the classes for less than 36 weeks. Women in the latter stages of pregnancy made a few attendances at the health– talk. Going by this result, indeed, pregnant women in this part of the country are initiating prenatal care late. Furthermore, there is an inverse relationship between adequate health education and initiation of prenatal care. Hence, the higher the quality of health education women receives at facilities, the lower their propensity to register late for prenatal care.

Part of the parameters for determining the effectiveness of information exchange in any encounter is the relational dimension of the message. In other words, the non-verbal accompaniments of a message depict its relational aspects. The relational aspects of care are often overlooked but are vital to women' s' satisfaction and regular attendance at prenatal care. Therefore, this current study examined pregnant women' s perception of the relational communication behaviour of their caregivers in the prenatal health education classes. A summary of the distribution of respondents based on their attendance at the health education classes is described in Table 4.3.

Table 4.3: Attendance of respondents at facilities

Duration attending Health- talks for ANC	Frequency	Percentage
Less than 4 weeks	79	23.2
Less than 12 weeks	96	28.2
Less than 24 weeks	97	28.6
Less than 36 weeks	63	18.5
Missing value	5	1.5
Total	340	100

One of the contributions of this study to knowledge is its recognition of differences in the psychological composition of individual nurses' and its role in their communicative behaviour. Previous studies adopted a generic study of caregivers with little cognizance for individuality or situational contingencies. Table 4.4 is a description of the distribution of nurses who usually deliver health talk in the sampled facilities. Majority of the respondents, 32.1% posit that three nurses facilitated the health-talk programme regularly, while another 31.8% reported that three nurses consistently facilitated the education programme. Again, 23.8% of the population stated that two nurses handled the delivery of the health-talk session in their facility. Only 9.1% of the population held that a nurse was assigned to the facilitation of the health education session. Table 4.4 contains a summary of the distribution of nurses who have handled the health-talk.

Table 4.4: Distribution of nurses who have delivered health-talk

Number of nurses who have delivered the health talk	Frequency	Percentage
One	31	9.1
Two	81	23.8
Three	109	32.1
Four	108	31.8
Missing value	11	3.2
Total	340	100

For the purpose of this discussion, Table 4.5 describes the various indicators of rapport between nurses and pregnant women. These indicators of rapport are in categories; the first is referred to as nurses' concern for patients, followed by the measurement of nurses' ability to make eye contact, while the third category reflects women' s perception on individual nurses' tension relieving skills. In the final category, the ability of nurses to adequately convey information through the use of gestures is examined.

Less than half of the participants in the study, 37.1%, believed that nurse A showed concern to women in the course of discharging her duties. Another group of 30.3% respondents argued that they perceived nurse B as being more concerned with care receivers' needs. Again, 25.3% regarded nurse C as more concerned than the other nurses. Only 17.1% participants perceived nurse D as showing more concern than other care givers in the discharge of her duties. The second indicator of a concerned nurse is one who is calm in the discharge of her duties. A few respondents, 4.4% regard nurse B and C as calm individuals in each case, while 3.2% believe nurse A and D to be calm.

In the " making eye contact" category, the majority of respondents, 67.4%, perceived nurse A as making eye contact with expectant mothers in the course of her delivery. More than half of the total population, 57.6% believed nurse B made eye contact. Similarly, almost half of the respondents, 43.5% argued that nurse C made eye contact while only 25.6% held that nurse D made eye contact. Still within the " making eye contact" category is a negative index of communicative behaviour; ' don' t make eye contact' . Not many respondents perceived that nurse B did not make eye contact as 8.8 % were of that opinion. Only 7.6% believed that nurse A did not make eye contact. While for nurse C, 6.2% argued that she did not make eye contact. Finally, for the eye contact category, 3.2 % averred that nurse D did not make any eye contact.

Furthermore, in the relieving tension category, majority of the respondents, 66.8% perceived that nurse A relieved tension at the period she facilitated the health education session. More than half of the respondents, 59.4% also believed nurse B as having relieved tension in the course of discharging her duty. A good proportion of

others 43.8% considered nurse C as having relieved tension more than the other nurses. Only 27.4% respondents were convinced that nurse D relieved tension. Also, in this category, is a negative construct that measured nurses' ability to increase tension in the discharge of their duties. A few respondents, 10.0% believed nurse B as having increased more tension, while 4.7% maintained that nurses A and C increased tension, respectively in each case. Only a few others, 3.5% held that nurse D increased tension.

Meanwhile, the last category measures the ability of nurses to use gestures in facilitating the health education classes. More than half, 58.5% of the respondents argued that nurse A made good use of gestures. Another 49.1% concluded that nurse B made use of gestures while 38.8% perceived nurse C as better skilled in the use of gestures. Only 20.6% respondents felt that nurse D also made use of gestures. The negative construct in this category measured the inability of nurses to facilitate with the use of gestures. This, in other words, is referred to as " hardly uses gestures" . More respondents, 6.8% perceived that nurse B hardly used gestures while the minimum number of respondents, 3.8% believed that nurse D hardly used gestures. For Nurses A and C, 5.0% and 5.3% respondents respectively argued that they hardly used gestures. A synopsis of nurses' rapport building skills is presented in Table 4.5.

Table 4.5: Rapport building skills of nurses

Concern for patients	**Nurse A N (%)**	**Nurse B N (%)**	**Nurse C N (%)**	**Nurse D N (%)**
Concerned	126(37.1%)	95(27.9%)	79(23.2%)	58(17.1%)
Calm	11(3.2%)	14(4.1%)	15(4.4%)	11(3.2%)
Impatient		9(2.7%)	3(0.9%)	3(0.9%)
Neutral	203(59.71)	222(65.3)	243(71.5)	268(78.8)
Total	340(100%)	340(100%)	340(100%)	340(100%
Making eye contact				
Makes eye contact	229(67.4%)	196(57.6%)	148(43.5%)	87(25.6%)
Does not make eye contact	26(7.6%)	30(8.8%)	21(6.2%)	11(3.2%)
Neutral	85(25.0)	119(35.0)	174(51.2)	242(71.2
Total	340(100%)	340(100%)	340(100%)	340(100%
Tension relieving				
Relieves tension	227(66.8%)	192(56.5%)	149(43.8%)	91(26.8%)
Increases tension	16(4.7%)	34(10.0%)	16(4.7%)	12(3.5%)
Neutral	97(28.53)	114(33.5)	175(51.5)	237(69.7)
Total	340(100%)	340(100%)	340(100%)	340(100%
Use of gestures				
Use of gestures to explain	199(58.5%)	166(48.8%)	132(38.8%)	70(20.6%)
Hardly uses gestures	17(5.0%)	23(6.8%)	18(5.3%)	13(3.8%)
Neutral	124(36.5)	151(44.4)	190(55.9)	257(75.6)
Total	340(100%)	340(100%)	340(100%)	340(100%

Thus far, care receivers' perception of nurses' rapport building skills have been reported, the next point of investigation is to ascertain what informed respondents' perception of the subject under review. The constructs of the Attribution theory and more importantly Kelly's 'covariation model of causal attribution': '**consistency**', '**distinctiveness**' and **'consensus'** are applied in this section to measure the determinants of opinion formation among the participants. Majority 62.4% of the respondents attributed the high rapport building skills of nurse A to an internal factor (psychological disposition) because they believed the care provider exhibited the behaviour consistently over time. However, 19.4% held a contrary view as they argued that nurse A's behaviour is that of 'consensus'; in other words, with respect to the behaviour under review (concern for patients, making eye contact relieving tension and the use of gestures), the caregiver did not behave any differently from other nurses. Again, 14.1% of the respondents attributed that same behaviour to a distinctive factor as they affirmed that the nurse behaved like that only once. Only 0.6% of the respondents attributed nurse A's disposition to other factors, such as situational contingencies.

For nurse B, more than half of the respondents, 55.6% attributed the care giver's high rapport building skills to an internally motivated factor as they considered the provider's behaviour consistent. Another 17.4% respondents' opinion formation relied heavily on consensus. In contrast, 14.7% argued that nurse C's high rapport skill is distinctive as the behaviour was exhibited once. Only 1.2% of the study participants attributed nurse B's behaviour to situational factors.

In the case of nurse C, less than half of the study participants, 46.5%, theorised that the care giver always exhibited low rapport building skills. Similarly, another 11.5% respondents argued that the low rapport scores of nurse C can be attributed to a distinctive factor since the behaviour is inconsistent. Again, 13.5% observed that the caregiver did not behave in any way differently from other nurses hence her low rapport scores are highly 'consensual'. A few respondents, 1.5%, affirmed that nurse C's behaviour is driven by other factors which may be situational.

Nurse D scored lowest in rapport building skills amidst all the caregivers under review. More respondents, 30.0% attributed nurse D' s behaviour to psychological factors as they argued that the nurse exhibited the behaviour consistently, whereas only 13.2% perceived nurse' s behaviour as high in ' consensus' as they maintained that every other nurse did not possess rapport building skills. Only 7.6% respondents attributed nurse D' s low rapport skills to distinctiveness. Simply put, the care giver exhibited the said behaviour only once. Finally, for this section, 1.5% of the study participants attributed nurse D' s behaviour to situational factors. Table 4.6 contains a summary of what informed pregnant women' s perception of the rapport building skills of care givers.

Table 4.6: Information on determinants of clients' perception of the nurses ' rapport building skills

Opinion	Nurse A	Nurse B	Nurse C	Nurse D
Consistency in the nurse' s behaviour	212 (62.4%)	189 (55.6%)	158 (46.5%)	102 (30.0%)
Inconsistencies in the nurse' s behaviour	48 (14.1%)	50 (14.7%)	39 (11.5%)	26 (7.6%)
Non- distinctiveness of the nurse' s behaviour	66 (19.4%)	59 (17.4%)	46 (13.5%)	45 (13.2%)
Others	2 (0.6%)	4 (1.2%)	5 (1.5%)	5 (1.5%)
Missing value	12 (3.5)	38 (11.2%)	92 (27.1)	162 (47.7
Total	340 (100%)	340 (100%)	340 (100%	340 (100%)

Closely associated with rapport building are nurses' listening skills. Table 4.7 describes women' s perception of their health-care providers' listening skills. There are different categorizations of such skills, especially as it relates to how care givers listen to care receivers in health-care settings. The first category examines patients' perception of how well nurses listen; the second category measures the extent to which patients are encouraged to talk in an encounter. In the final category the extent to which providers pay attention to patients' body language is investigated. In each of the aforementioned categories, there are negative and positive indicators to measure the variables. With respect to the first category, respondents rated nurse A high on listening skills as an overwhelming number 83.8% confirmed that nurse A listened well to patients. Similarly, a significant proportion of respondents, 66.2%, argued that nurse B displayed better listening skills, while an average percentage, 53.5% of the respondents, opined that nurse C' s listening skills were high. Only 32.9% of the study participants maintained that nurse D listened well to patients.

Still, in the first category, the negative indicator of care providers' listening skills shows that a few 3.2% respondents affirmed that nurse B displayed unwillingness to listen to patients, while 2.9% believed that nurse C hardly listened to them. Only 2.4% respondents argued that nurse A was unwilling to listen to patients, while a disproportionate percentage of respondents, 0.9% posited that nurse D also displayed unwillingness to listen in any encounter. In the second category, respondents described the level of empowerment care givers gave them during the health education classes. Nurses empower care receivers when the latter are allowed to communicate their concerns or inhibitions without any encumbrances. Majority of the respondents, 66.2% held that nurse A encouraged patients to talk, while 64.9% argued that nurse B was more favourably disposed to encouraging patients to talk. Another 47.6% respondents affirmed that nurse C was equally good at allowing patients to voice their concerns. Only 29.7% participants agreed that nurse D actually encouraged patients to talk.

The negative construct in the second category measured if care providers denied patients the opportunity to talk. More respondents, 9.1% argued that nurse B did not give patients the opportunity to talk, whereas 7.4% perceived nurse C as not

pleasantly disposed to allowing patients to talk. Interestingly, only 6.8% respondents affirmed that nurse A did not give patients the opportunity to talk, while 5.0% others held that nurse D also exhibited the said dysfunctional behaviour. The last category of listening skills measures nurses' ability to pay attention to patients' body language. In this category, not many, 47.7% respondents agreed that nurse A paid attention to patients' body language. Again, a small proportion, 39.1% of respondents perceived nurse B as having paid attention to patients' body language. Fewer respondents, that is, 32.4% opined that nurse C readily picked up patients' body language. Only 19.7% described nurse D as being capable of picking up patients' body language. Table 4.7 contains a summary of the data on nurses listening skills.

Table 4.7: Listening skills of nurses

Listening to patients	**Nurse A**	**Nurse B**	**Nurse C**	**Nurse D**
	N (%)	**N (%)**	**N (%)**	**N (%)**
Listens well to patients	285(83.8%)	225(66.1%)	182(53.5%)	112(32.9%)
Unwilling to listen	8(2.4%)	11(3.2%)	10(2.9%)	3(0.9%)
Neutral	47(13.8%)	104(30.6%)	148(43.6)	225(66.2%)
Total	**340(100%)**	**340(100%)**	**340(100%)**	**340(100%)**
Encouraging patients to talk				
Encourages patient to talk	225(66.2%)	219(64.4%)	162(47.6%)	101(29.7%)
Gives no opportunity to talk	23(6.8%)	31(9.1%)	25(7.4%)	17(5.0%)
Neutral	92(27.0%)	90(26.5%)	153(45%)	222(65.3%)
Total	340(100%)	340(100%)	340(100%)	340(100%)
Attention to body language				
Picks up patient' s body language	165(48.5%)	135(39.7%)	111(32.6%)	70(20.6%)
Ignores patients' body language	20(5.9%)	29(8.5%)	21(6.2%)	13(3.8%)
Neutral	155(45.6%)	176(51.8%)	208(61.2%)	257(75.6%)
Total	340(100%)	340(100%)	340(100%)	340(100%)

In order to ascertain the veracity of respondents' claim on nurses' listening skills, Kelly's 'covariational model of causal attribution' was adopted to identify the determinants of participants' opinion on nurses' listening skills. Majority of the respondents, 68.8% as shown in Table 4.8 attributed nurse A's listening behaviour to an internal factor, as they argued that the caregiver behaved consistently in that manner. Meanwhile, 15.3% and 12.4% respondents held a contrary view on nurse A's behaviour as they believed the care giver's behaviour to be distinctive and consensual, respectively. Only an insignificant 0.6% of the respondents attributed nurse A's listening skill to situational factors. Whereas, for nurse B, more than half, 64.4% of the respondents believed her behaviour to be consistent, while 12.6% argued that the nurse's behaviour was not in any way different from other nurses. In contrast, 11.8% respondents attributed the nurse's behaviour to distinctiveness, since the caregiver exhibited such listening skills once. Only a negligible 0.9% of the respondents attributed nurse B's behaviour to other factors.

Furthermore, less than half, 49.7% of the respondents attributed nurse C's listening skills to a psychological disposition. A lesser proportion, 13.8% of respondents believed that the caregiver's conduct was a 'consensual' behaviour while 9.4% of them attributed the behaviour to a distinctive factor. Only an insignificant 0.6% of the respondents attributed the behaviour to other factors. In summary, nurse C's behaviour is attributable to a psychological disposition based on respondents' perception. With respect to care receivers' perception on the determinants of nurse D's low listening skills, 33.5% of the respondents believed that the caregiver's listening behaviour was high in consistency, only 13.2% of the respondents believed the behaviour was high in consensus, while 2.9% of them argued that the behaviour was distinctive. In the case of nurse D, 1.5% respondents attributed his/her behaviour to other factors. A summary of the factors that informed care receivers' perception of nurses' listening skills is presented in Table 4.8.

Table 4.8: Information on determinants of care receivers' perception of nurses' listening skills

Opinion	Nurse A N (%)	Nurse B N (%)	Nurse C N (%)	Nurse D N (%)
Consistency in the nurse's behaviour	234(68.8%)	219(64.4%)	169(49.7%)	114(33.5%)
Inconsistencies in the nurse's behaviour	42(12.4%)	40(11.8%)	32(9.4%)	10(2.9%)
Non- distinctiveness of the nurse's behaviour	52(15.3%)	43(12.6%)	47(13.8%)	45(13.2%)
Others	2(0.6%)	3(0.9%)	2(0.6%)	5(1.5%)
Missing value	10(2.9%)	35(10.3)	90(26.5)	166(48.8)
Total	340(100%)	340(100%)	340(100%)	340(100%)

Table 4.9 presents information on nurses' ' confirmation skills' . The constructs in this section measured nurses' capacity to empathise with care receivers, empower them and generally increase their level of social support. As it applies to earlier discussions, Table 4.9 has both positive and negative constructs to investigate if care givers possess either good or poor ' confirmation skills' . Less than two thirds, 43.5% of respondents perceived that nurse A reassured patients in the course of the health– talk programme. Another 43.8% of them confirmed that nurse B also gave expectant women some level of reassurance. In the case of nurse C, 34.7% respondents affirmed that she showed pregnant women reassurance in the course of discharging her duties. Only 19.1% respondents argued that nurse D actually reassured patients.

However, not many respondents, 32.5% held that nurse A talked down on care receivers; far fewer respondents, 16.2% also acknowledged that nurse B talked down on expectant women; only 12.6% of them posited that nurse C talked down on patients, while a little above 10% of respondents believed that nurse D talked down on care receivers. Meanwhile, the second category in Table 4.9 measures the extent of empowerment clients received at the health education classes. Interestingly, 39.7% respondents appraised nurse A as being supportive of patients. There are marginal differences in the percentages of respondents who held that nurse B, 30.9% C, 28.5% and D, 18.2% respected patients' point of view in the course of facilitating the health education programme. In contrast, the results of the negative construct in the second category showed that a higher proportion, 3.2% of the respondents claimed that nurse B threatened patients more than nurse A. Also, more respondents 2.1% surmised that nurse D threatened patients more than nurse C.

The third category investigates the extent to which the nursing profession can be described as a caring profession. The responses in this category confirmed that expectant mothers derived little social support from the maternity care model practised in the sampled facilities. Less than an average number, 30.0% of respondents reported that nurse A did not judge patients. A similar result applied in the case of nurse B, as 27.9% women posited that he/she did not judge patients. Only a few respondents, for nurses C, 21.5%, and D, 12.9% acknowledged that the care

givers were non-judgmental. Interestingly, there were little variation in respondents' responses as to if providers ridicule patients. A smaller percentage of respondents, that is 5.0% perceived that nurse A at one point or the other ridiculed patients. More respondents, 5.3% however, believed nurse B ridiculed care receivers. There were marginal differences in respondents' perception of nurses C, and D with regards to the caregivers' ability to ridicule patients. Expectant women in the focus groups and key informant interviews gave information on the underlying reasons for some nurses' uncouth behaviour, particularly when such nurses were expected to offer relevant social and emotional support to the women.

> Nurses get angry and talk anyhow to patients when patients disobey specific instructions pertaining to procuring drugs or conducting regular PCV (Pack Cell Volume) test or even those people who are perpetual late comers (Pregnant Women, Public, Jericho S, 1).

In the opinion of discussants at the same facility, nurses' reaction to pregnant women is usually precipitated by the women's action or inaction. It is therefore imperative for pregnant women to understand this as crucial in order to improve their lived experience during pregnancy. In the words of one of the expectant women:

> Nurses react differently to patients based on how individual patients comport themselves. For example, nurses are aware that it is a normal thing for women to experience pain during labour. However, they, as care givers get frustrated and angry when patients do not adhere to such instructions as keeping calm during the delivery process. I would say it is important for patients to just play along with them (Pregnant Woman Jericho S, 2).

A key informant at Adeoyo, however, argued that people generally ascribe negative behaviour to nurses unfairly. She reiterates that nurses' communicative behaviour should not be observed in isolation, as clients' behaviour and other indices affect individual nurses' communicative behaviour. According to her:

> To me, I do not agree that nurses nag. Although I am aware people usually complain about the attitude of some nurses, personally, I believe that the nurses in question are justified whenever they react negatively to patients. This is because patients are not timely in keeping of appointments and apart from that it is also possible for a nurse to be in a sour mood at the time she is approached. For me, however, I have not had such an experience with them before. **(**Pregnant Woman, Public, Adeoyo**)**

It is evident that the causative factors affecting nurses' confirming skills are numerous but the nursing mothers in the focus group discussion (FGD) groups identified only a few, namely mood swings, personality traits or work- related pressure. A summary of nurse' s confirmation skills are described in table 4.9.

Table 4.9: Information on nurse' s confirmation skills

	Nurse A (N %)	**Nurse B (N %)**	**Nurse C (N %)**	**Nurse D (N %)**
Patients reassurance				
Reassures patients	148(43.5%)	149(43.8%)	118(34.7%)	83(24.4%)
Talks down to patients	80(23.5%)	55(16.2%)	43(12.6%)	35(10.3%)
Neutral	112(33.0%)	136(40.0%)	179(52.7%)	222(65.3%)
Total	**340(100%)**	**340(100%)**	**340(100%)**	**340(100%)**
Supporting patients' view points				
Supports patients point of view	135(39.7%)	105(30.9%)	97(28.5%)	62(18.2%
Threatens patients	9(2.6%)	11(3.2%)	6(1.8%)	7(2.1%)
Neutral	196(57.7%)	224(65.9%)	237(69.7%)	271(79.7)
Total	**340(100%)**	**340(100%)**	**340(100%)**	**340(100%)**
Caring for patients				
Judgemental	102(30.0%)	95(27.9%)	73(21.5%)	44(12.9%)
Ridicules patients	17(5.0%)	18(5.3%)	8(2.4%)	7(2.1%)
Neutral	221(65.0%)	227(66.8%)	259(76.1%)	289(85.0%)
Total	**340(100%)**	**340(100%)**	**340(100%)**	**340(100%)**

Having examined the confirmation skills of providers, Table 4.10 presents information on the frequency with which caregivers exhibit the said behaviour. More than two thirds, 64.4% of respondents affirmed that nurse A regularly displayed a ‘ confirming’ behaviour; while 14.7% respondents argued that nurse A adopted a confirming behaviour only once. The same percentage of respondents submitted that nurse A did not behave any differently from other nurses. For nurse B, 55.3% expectant women hinted that she has behaved consistently in that way, while, 16.8% perceived her behaviour to be similar to that of other nurses. Only 15.6% claimed that she exhibited the behaviour once. Less than an average number, 45.3% of respondents attributed the behaviour of nurse C to a psychological trait, hence her conduct was adjudged constant and unchanging. However, 16.5% argued that her behaviour was not in any way different from that of other nurses. Only 9.4% held that the behaviour was distinctive. A disproportionate percentage, 30.6% of respondents, also argued that the behaviour of nurse D was not different from other nurses, while, 12.9% affirmed that the nurse exhibited the said behaviour only once.

The implication of the foregoing is that the constructs of Kelly’ s covariational model of causal attribution were adopted in determining what informed respondents’ perception of nurses’ confirming skills. It became apparent through the responses of respondents that nurse A was perceived as being stable in exhibiting ‘ confirming’ behaviours. Hence, the behaviour can be described as being internally driven (intrinsic motivation). On the other hand, nurses B, C, and D were regarded as consistent in displaying ‘ disconfirming’ behaviours. A summary of the determinants of care receivers’ perception of the confirming skills of the different nurses is presented in Table 4.10.

Table 4.10: Information on determinants of care receivers' perception of the nurses' confirming skills

	Nurse A (N %)	**Nurse B (N %)**	**Nurse C (N %)**	**Nurse D (N %)**
Consistency in nurse' s behaviour	219(64.4%)	188(55.3%)	154(45.3%)	104(30.6%)
Inconsistencies in nurse' s behaviour	50(14.7%)	53(15.6%)	32(9.4%)	18(5.3%)
Non distinctiveness in nurse' s behaviour	50(14.7%)	57(16.8%)	56(16.5%)	44(12.9%)
Others	3(0.9%)	2(0.6%)	4(1.2%)	4(1.2%)
Missing value	18(5.3%)	40(11.8%)	94(27.6%)	170(50.0%)
Total	340(100%)	340(100%)	340(100%)	340(100%)

Table 4.11 presents details of the information giving skills of nurses. This table measures nurses' speech clarity, information adequacy and knowledge of the subject matter. These indices form the basis of the categories in Table 4.11. In the first category, ' giving out information', an overwhelming percentage, 78.2% of respondents described nurse A' s speech as clear; more than an average number 62.1% also affirmed that nurse B spoke clearly. Nurses C and D, however, were described in a less favourable light by respondents as only 47.9% and 29.4% respectively attested to the clarity of their speeches. In contrast, more respondents, 3.5% perceived nurse B' s speech as unclear, incidentally, for nurses A and D, an equal percentage, 2.1% of respondents argued that the caregivers' speeches were not easily decipherable. Only 1.5% of the respondents perceived nurse C' s speech to be unclear.

In the second category, a little over two thirds, 68.2% of the population affirmed that the regular visit to the health education classes was worthwhile. They perceived nurse A as dispensing sufficient information to participants. Again, 62.9% of respondents held that nurse B facilitated the health education classes in a way that expectant womens' knowledge base increased. On the other hand, respondents' perception of nurses C, 45.6% and D, 27.9% facilitation skills were poor, less than an average percentage of respondents in each case believed the nurses gave sufficient information in the course of handling the health-talk sessions.

Nurse A was rated as better skilled in technical expertise than the other care givers because of her perceived high relational skills. Interestingly, equal percentages, 4.4% of respondents confirmed that nurse A and D do not treat the content of the health education classes in great depth. Also, with respect to nurses C, 6.5% and D, 6.2% there is a minor percentage difference in respondents' perception of the care givers' facilitation skills.

In the third category, a greater percentage of respondents, 60%, perceived both nurses A, and B, as being knowledgeable on the subject matter. Less than an average number of respondents held that nurse C also displayed a mastery of the subject matter, while a few, 24.4% of them conceded that nurse D was conversant with the topic of discussion. The negative construct in that section of Table 4.11 indicates that more

respondents believed nurse B, 1.8% was better informed than both nurses D, and A on the content of the health education classes. It is remarkable that no respondent perceived nurse C as not knowledgeable on the subject matter. There is a correlation between nurses' information-giving skills and care receivers' recall of information. The result of the focus group discussion shows that majority of the nursing mothers had a high recall rate of received information. Nursing mothers readily itemised some of the taught topics during the health education classes.

> We were taught about what to do in the labour room. Also we received information on the rules and regulations that must be adhered to and necessary things that must be available for delivery (Pregnant Women, Public, Ring Road).

In another group, nursing mothers recalled that: " We were taught about cleanliness, the kind of food to eat during pregnancy, they also spoke about things to do after child birth such as family planning" . Only a respondent could not remember any topic specifically as regards the health education classes. In the course of the study, it was discovered that some nurses adopted the lecture approach to the health-talk classes with little or no attempt at varying the style of presentation. This explains why nurses' knowledge on evidence based practices, especially as it pertains to information dissemination, needs to be updated periodically for optimum result. Providers' deficiency in information giving skills is attributable to the absence of a consistent capacity building training. This view was also upheld in the following submission of a lecturer at the Oyo State School of Midwifery:

> There is a ' mandatory continuous nursing programme' which is geared at updating nurses' knowledge for periodic license renewal. Certificates are issued to participants once they have completed the programme. Meanwhile, the certificate is presented for license renewal. While nursing licenses are renewed every three years, we still have lots of nurses that have not renewed their licenses. Some are still using expired licenses. …although now there is a circular that nurses who fail to renew their licenses should not be promoted to the next level, hence, people are now going out for this training programme **(**Female, Nurse, School, Eleyele).

Apparently, regulators of nursing practices in the country have identified gaps in nurses' training and the importance of regular refresher courses to improve the practice of nursing. Regulations on periodic license renewal may be a mirage, if nurses do not share similar sentiments on retraining programmes. A summary of

respondents' perception of nurses' information giving skills is presented in Table 4.11.

Table 4.11: Nurses' information-giving skills

	Nurse A (N %)	**Nurse B (N %)**	**Nurse C (N %)**	**Nurse D (N %)**
Giving out information				
Clear speech	266(78.2%)	211(62.1%)	163(47.9%)	100(29.4%)
Unclear speech	7(2.1%)	12(3.5%)	5(1.5%)	7(2.1%)
Missing value	67(19.7%)	117(34.4%)	172(50.6%)	233(68.5%)
Total	**340(100%)**	**340(100%)**	**340(100%)**	**340(100%)**
Giving enough information				
Gives sufficient information	229(67.4%)	212(62.3%)	151(44.4%)	93(27.3%)
Gives insufficient information	15(4.4%)	21(6.2%)	22(6.5%)	15(4.4%)
Missing value	96(28.2%)	107(31.5%)	167(49.1%)	232(68.2%)
Total	**340(100%)**	**340(100%)**	**340(100%)**	**340(100%)**
Knowledge about subject matter				
Knowledgeable on subject matter	204(60.0%)	181(60.0%)	148(43.5%)	83(24.4%)
Not knowledgeable on subject matter	1(0.3%)	6(1.8%)	-	2(0.6%)
Missing value	135(39.7%)	153(45.0%)	192(56.5%)	255(75.0%)
Total	**340(100%)**	**340(100%)**	**340(100%)**	**340(100%)**

In Table 4.12, a greater percentage, 72.9% of respondents believed that nurse A' s facilitation skill was consistent, hence the behaviour is psychologically determined. A lesser percentage of respondents, 8.8% perceived the teaching skills of the care provider as an occasional behaviour, while 12.6% others described the care provider' s facilitation skills as common to every other nurse. Only 0.9% of respondents argued that the behaviour was situational. Similarly, a little above average number of respondents, 61.2% held that nurse B' s teaching skill was more consistent than that of others, as her behaviour was intrinsic. Only 16.2% respondents however believed that her ability to disseminate information during health education classes was consensual, since other nurses conducted themselves in similar ways. A negligible 9.7% reported that nurse B facilitated the health-talk efficiently on a single occasion, while 1.2% attributed the nurse' s behaviour to external factors. For nurse C, 49.4% respondents affirmed that the caregiver' s facilitation skills were internally determined as the behaviour was consistent. Fewer respondents 15.0% believed that nurse C' s teaching ability was common to all other nurses, while 7.1% attributed the behaviour to a distinctive factor. Only 0.9% of respondents argued that the particular behaviour was situational. Again, 30.6% respondents affirmed that nurse D' s facilitation skill was innate; while, 12.6% expectant women however believed that the behaviour under consideration was not peculiar to nurse D as it is common among other nurses. Only a few, 5.6% respondents held that nurse D' s behaviour was distinctive.

The report in this section has further confirmed respondents' belief in nurse A as the caregiver was perceived as the best out of all the other caregivers with respect to her facilitation skills. Respondents rated their caregivers in the order of preference, hence while nurse A, is the most preferred, nurse D is afforded the least preference. Other nurses occupied middle-level positions in patients' frame of reference. The findings on factors affecting patients' perception of care givers' information-giving skills are presented in Table 4.12.

Table 4.12: The determinants of care receivers' perception of the nurses' information-giving skills

	Nurse A (N %)	**Nurse B (N %)**	**Nurse C (N %)**	**Nurse D (N %)**
Consistency in nurse' s behaviour	248(72.9%)	208(61.2%)	168(49.4%)	104(30.6%)
Inconsistencies in nurse' s behaviour	30(8.8%)	33(9.7%)	24(7.1%)	19(5.6%)
Non-distinctiveness of nurses behaviour	43(12.6%)	55(16.2%)	51(15.0%)	43(12.6%)
Others	3(0.9%)	4(1.2%)	3(0.9%)	5(1.5%)
Missing	16(4.7%)	40(11.8%)	94(27.6%)	169(49.7%)
Total	**340(100%)**	**340(100%)**	**340(100%)**	**340(100%)**

Table 4.13 presents information on nurses' ability to check care receivers' perception of care. This is synonymous with a provider' s sensitivity to feedback. There is evidence from Table 4.13 that less than an average number 44.7% of respondents affirmed that nurse A bothered to check patients' perception. For nurse B, 35.9% held that she was aware of what clients thought of her. There is a small percentage difference between respondents who perceived nurse C, 29.7% and D, 20.9% as checking patients' perception of them.

The negative construct in this first category sought to investigate those nurses who were unaware of what patients thought of them. More respondents, 20.6% believed nurse B was unaware of what patients thought of her. For nurse A, 17.6% of respondents, felt she was unaware of patients' perception of either her personality or her service delivery. Only a fraction of respondents believed nurses C, and D, were unaware of what patients thought of them.

Care givers' individual feedback management styles formed the basis of investigation in the second category. Feedback is crucial to the success of any organisation and hospitals are not exempted. With particular respect to the health education classes, nurses require feedback from expectant women to ascertain if comprehension occurred on the part of the women. More than an average percentage 69.7% of respondents argued that nurse A allowed for feedback from respondents, especially in the course of the health programme. This is followed by 62.9% who believed nurse B allowed for feedback. For nurse C, 46.5%, which is less than the average number of respondents acknowledged that the care giver allowed feedback from patients. Only a few, 32.4% respondents, reported that nurse D allowed feedback from care receivers.

In contrast, more respondents, 7.1% argued that nurse C did not allow feedback from expectant women. To other respondents, 6.2%, nurse B was insensitive to patients' feedback. Fewer respondents reported nurse A, 5.6% and nurse D, 2.9% as not accommodating patients' feedback. Out of the four nurses under review, nurse A was perceived as being more approachable in terms of receptiveness to patients'

feedback. One of the hallmarks of a patient-centred facility is care providers' awareness of care receivers' perception of care. Such perception of health care services is multifaceted; however, with respect to this particular study, care providers require feedback from care receivers on the relational quality of care delivery in the facility. To that end, care givers employ impression management tools in relating with patients. Key informants and discussants in the focus groups comprising nursing mothers justify the foregoing position on disparities in individual nurses' approach to feedback.

" When you make complaints about their service delivery in this facility they will adjust" (Pregnant Women, Public, Ring Road). Meanwhile, a contrary opinion was held by one of the key informants at Adeoyo Maternity Teaching Hospital, who reportedly avoided giving feedback because of a perceived fear of embarrassment from the nurses. It is however unclear if she had earlier had an unpalatable experience with any nurse in the past. The nursing mother expressed her opinion thus:

> I was asked to run some tests while the talk was on, as such I never experienced the health-talk. I couldn' t make an official complaint about it at the time, because for one I didn' t want any form of embarrassment, also I didn' t want it to seem as if I was attacking the personality of any particular provider. (Pregnant Woman, Public, Adeoyo 1)

This statement points to the prevailing culture among many Nigerian women who are not sufficiently empowered to demand quality care from providers. In the course of conducting the ethnographic study of the facilities, it was observed that medical practice in Nigeria is still at its infancy as many pregnant women educated, semi-literate and illiterate do not challenge the authority of their care givers even when the latter is clearly in the wrong. Consequently, the way Nigerian patients construct their identities and project such constructions has helped to perpetuate the paternalistic approach to nursing practice in the country. The submission of a key informant at Adeoyo Maternity Teaching Hospital further reinforces this notion. According to her:

> Personally, I had an unpalatable experience here, prior to delivery. My genotype is SC, so during pregnancy, I experienced constant pain in the leg, so, when I registered those complaints with the nurses, they felt the next thing to do was to induce me for labour. They insisted that I must undergo surgery premised on the fact that my genotype is SC. I believe they were acting in my best interest but they failed to give necessary

> explanations; for instance, on why I should be induced earlier than my expected date of delivery (EDD). My husband was equally angry because they didn' t give me certain injections. In general, for me, I will say they are saving lives regardless of little inadequacies or shortcomings. (Pregnant woman, Public, Adeoyo 2)

Nevertheless, some nursing mothers in a focus group discussion at the Jericho Specialist Hospital refute these earlier positions claiming a high level of satisfaction with nurses' approach to feedback in the hospital. It can be inferred from their responses that majority of the nursing mothers were satisfied with the handling of feedback in the hospital.

> Nurses give priority attention to patients' complaints in this hospital. This is because they do adjust their services based on valid complaints. For instance, initially, they were using manual instruments for palpitation however people complained that it was pressing hard on them so they started using an electronic instrument for palpitation (Nursing mothers, Public, Jericho, S.).

The importance of feedback in prenatal care management is underscored by the depth of responses elicited from respondents, discussants and key informants in this study. There is no doubt that improvement in hospital service delivery is only attainable in concert with clients. In summary, Table 4.13 presents a synopsis of preceding discussions on care receivers' perception of providers' approach to feedback.

Table 4.13: Information on nurses' feedback skills

	Nurse A (N %)	**Nurse B (N %)**	**Nurse C (N %)**	**Nurse D (N %)**
Awareness of patients' feedback				
Sensitivity to patients' feedback	152(47.7%)	122(35.9%)	101(29.1%)	71(20.9%)
Insensitivity to patients' feedback	60(17.6%)	70(20.6%)	45(13.2%)	24(7.1%)
Neutral	128(37.6%)	148(43.5%)	194(57.1%)	245(72.0)
Handling feedbacks				
Receptiveness to feedback	237(69.7%)	214(62.9)	158(46.5%)	110(32.4%)
Non- receptiveness to feedback	19(5.6%)	21(6.2%)	24(7.0%)	10(2.9%)
Neutral	84(24.7%)	105(30.9%)	158(46.5%)	220(64.7%)

Table 4.14 presents information on factors that determine patients' perception of care providers' attitude to feedback. More than two thirds, 66.5% of the population, asserted that nurse A' s ability to check perception is inherent. Again, 59.7% which is more than half of the respondents argued that nurse' s B receptiveness to feedback is an intrinsic trait. Far fewer respondents believed that nurses C, 46.5% and D 30.6, deficiency in feedback skills is a personality trait. More respondents believed that nurse B' s ability to check patients' perception is not consistent as the behaviour was exhibited once. Also, nurse A' s behaviour is adjudged inconsistent by 10.6%, for nurse C, 8.5% of respondents perceived her as receptive to feedback only once. In contrast, there is not much statistical difference in the percentages of respondents who perceived that the attitude of nurses A, 16.2% B, 15.6% and C, 15.0% to feedback is common across the board. It is only in the case of nurse D, that fewer, 13.5% respondents attributed the care givers' behaviour to a consensual factor.

A negligible percentage of respondents, 2.1% argued that the priority attention to feedback by both nurses A and D are merely circumstantial. A smaller percentage of respondents, 1.2%, attributed nurse B' s behaviour to situational factors, far fewer respondents, 1.8% ascribed nurse C' s disposition to situational factors. As in other instances, respondents attributed the high feedback skills of nurse A and B to intrinsic factors. Consequently, the care givers' ability to check expectant women' s' feedback was described as being inherent to their personality. Similarly, nurses C, and D' s low feedback skills were attributed to intrinsic factors. A summary of the findings earlier discussed is presented in Table 4.14.

Table 4.14: Determinants of care receivers' perception of nurses' feedback skills

	Nurse A (N %)	**Nurse B (N %)**	**Nurse C (N %)**	**Nurse D (N %)**
Consistency in nurse's behaviour	226(66.5%)	203(59.7%)	158(46.5%)	104(30.6)
Inconsistencies in nurse's behaviour	36(10.6%)	38(11.2%)	29(8.5%)	19(5.6%)
Non-distinctiveness in nurse's behaviour	55(16.2%)	53(15.6%)	51(15.0%)	46(13.5%)
Others	7(2.1%)	4(1.2%)	6(1.8%)	7(2.1%)
Missing value	16(4.7%)	42(12.3%)	96(28.2%)	164(48.2 %)
Total	**340 (100%)**	**340 (100%)**	**340 (100%)**	**340 (100%)**

Preceding discussions focused on expectant women' s perceptions of the relational communication behaviour in the group health education classes. Subsequently, extrapolations will be made to correlate those perceptions with women' s shared experiences of the classes. Table 4.15 details respondents' motivation for participation in the health-talk programme. It also includes the focal point of discussion among pregnant women as well as the latter' s general perception of nurses.

In the first category, pregnant women' s' sources of motivation for participation in the prenatal health-talk programme are measured to investigate the relationship between nurses' relational skills and women' s lived experience of the programme. More respondents, 44.4% argued, that their motivation for participation in such classes is premised upon the effectiveness of midwives in facilitating the health talk programme. This is followed by 19.1% other respondents who held that they participated in the programme when they perceived the midwife as friendly. On the other hand, 12.6% expectant mothers only participated when the midwife pointedly directed questions at them. To 11.5% respondents, they are motivated when other women participate in the programme. Only 6.2% subjects identified mood swings as a preponderant factor for their participation in the health-talk.

The second category identified respondents' common subjects of discussion during prenatal care. Challenges associated with pregnancy during prenatal care formed the subject of discussion among 46.2% respondents, while 20.0% respondents argued that personal issues are more often discussed than other issues. Again, 13.2% respondents acknowledged that they discussed diet and nutrition with other women; only 9.7% respondents reported that the attitudes of midwives and nurses to work formed the subject of discussion. An insignificant proportion of respondents posited that other

issues apart from the ones hitherto discussed were the focal points of interaction with their colleagues.

The third and fourth categories investigated respondents' general perception of nurses. In the third category, more respondents, 27.9% believed nurses have the ability to view issues from the patients' perspective. Another 20.6% believed nurses asked questions pertaining to their daily lives. This implies that the women perceived nurses as being concerned. This is followed by 19.4% respondents who posited that they would recommend that hospital to family and friends because of its nurses. Again, 12.9% held that nurses showed understanding in relating with care receivers, while some 12.4% reported that nurses seemed concerned with both the patients and their families. In the fourth category, respondents described the other ways that depict how nurses relate with them. Majority of the responents, 60.6%, affirmed that nurses explained things in a way that was easy for them to understand. Another 13.5% respondents argued that nurses encouraged them to talk about their health concerns, while 9.7% respondents were confident of nurses' knowledge and skills. Only 5.0% respondents believed that nurses spent enough time with them. A fraction of the expectant mothers, 3.2%, believed that nurses showed respect for their opinion. The highlights of the findings are presented in Table 4.15.

Table 4.15: Experiences of study participants with health education programme at the health facilities

	N	%
What motivates participation in the health-talk?		
The active participation of others	39	11.5
A well presented topic for discussion	151	44.4
Being pointedly asked questions	43	12.6
Being in a good mood	21	6.2
A friendly midwife	65	19.1
Missing value	21	6.2
Total	**340**	**100**
What distracts attention during health talk?		
Other participants	70	20.6
Vehicular noise	21	6.2
Interruptions from other nurses	45	13.2
Group Noise	90	26.5
Others	26	7.6
Missing	88	25.9
Total	**340**	**100**
Regular subjects of discussion among pregnant women at the end of the health-talk		
Personal issues	68	20.0
Challenges of pregnant women	157	46.2
Attitudinal disposition of nurses/midwives to work	33	9.7
Diet and nutrition	45	13.2
Others	9	2.7
Missing value	28	8.2
Total	**340**	**100**
Measurement of nurses' relational skill?		
Nurses' ability to share patients' perspective	95	27.9
Nurses' ability to interrogate patients' daily experiences	70	20.6
Nurses' ability to show concern about patients and their family	42	12.4
Nurses' capacity to show understanding	44	12.9
Patients' willingness to recommend hospital to significant others based on its quality of nurses.	66	19.4
Missing value	23	6.8
Total	**340**	**100**
Other ways that describe nurses' attitudinal disposition?		
Nurses' explanatory power	206	60.6
Nurses' perceived knowledge and skills	33	9.7
Nurses' perceived power to facilitate patients' disclosure of health concerns	46	13.5
Nurses' time management plan	17	5.0
Nurses' ability to show respect	11	3.2
Missing value	27	7.9
Total	**340**	**100**

Table 4.16 measures the extent to which people in the network of expectant mothers sought maternity care and delivery in government-approved health facilities. More than half of the respondents, 52.4% reported that their friends have had deliveries outside health facilities. Only 13.8% respondents reported that none of their friends has utilised mission homes or traditional medical centres for deliveries. The common reasons advanced for preference of faith-based homes and traditional birth centres, according to 14.7% respondents, are financial, 13.8%, others cited incessant strikes, while 10.9% respondents contended that long distance to facilities is a causative factor. Again, 7.6% expectant mothers believed that many pregnant women prefer faith homes to government-approved hospitals based on recommendations from other people in their networks. Only 1.5% argued that faith-based homes and traditional birth attendants are popular in view of the adequate attention given to expectant mothers in those spaces.

The next category explains the extent to which respondents' family members sought the services of faith homes and traditional birth attendants. Less than half of the respondents, 47.6% agreed that their family members have been delivered of their babies in either a faith home or by a traditional birth attendant. Others, 14.7% reported that none of their family members has had a delivery outside an approved medical facility before. A smaller percentage of respondents, 12.9% reported that their family members who had babies delivered outside of health facilities did so because of long distance to health facilities; while 10.9% others argued that incessant industrial action of health workers is a major factor. The cost of medical care in government- approved health facilities was described as prohibitive to 9.1% of respondents. Hence, it is obvious that financial reasons lead many women to unorthodox medical practitioners. Only 7.1% expectant mothers reported that their family members patronised faith homes because of the adequate attention afforded pregnant women in such spaces. Less than one-third of the respondents, 27.1%, have had babies outside a recognized health facility, while a smaller percentage of respondents, 14.7% reported that they have not had such experience before. Far fewer respondents, 11.5% who have been delivered of their babies outside a health facility affirmed that the experience was not similar to that of a hospital. Another 5.9% others held that some faith homes and traditional birth attendants lacked adequate

infrastructure or equipment, therefore, in the event of complications, patients bleed to death. A respondent sadly narrated the experience of how she lost her first born child to complications due to the negligence of the mission home birth attendants. The argument of 4.7% respondents is that in some of the traditional birth and mission homes, expectant mothers are not given sufficient attention. An insignificant 5.3% respondents described the attendants in both mission homes and traditional birth homes as lacking in experience. Only a respondent was undecided as to the nature of her experience at the faith home so she opted for ' others' . Finally, for Table 4.16, respondents identified some of the benefits of the health-talk classes. Respondents' perceived benefits of the classes are discussed shortly in order of importance. Less than average percentage of respondents 34.7% perceived as more beneficial the first aid treatment received in the course of the health talk. Another 28.2% contended that health education on birth preparedness plan prior to delivery far outweighs other perceived benefits. A lesser percentage of expectant mothers, 12.9% identify signs of labour as an important aspect of the health-talk; hence it is a perceived benefit of the education classes. This is followed by 12.6% pregnant women who valued the taught classes on diet and nutrition. A negligible percentage, 3.8% respondents, affirmed that they received other benefits apart from the ones enumerated. A summary of the above findings are presented in Table 4.16.

Table 4.16: Indices affecting pregnant women' s perception of hospital quality

	N	%
Do you have friends who have been delivered of their babies outside a health facility?		
Yes	178	52.4
No	47	13.8
Neutral	115	33.8
Total	**340**	**100**
If yes, do you know why they took the decision to have their deliveries outside a health facility?		
Incessant strikes	47	13.8
Recommendations from others	26	7.6
Financial reason	50	14.7
Long distance to facilities	37	10.9
Adequate attention	5	1.5
Neutral	175	51.5
Total	**340**	**100**
Do you have family members who have been delivered of their babies outside a health facility before		
Yes	162	47.6
No	50	14.7
Neutral	128	37.6
Total	**340**	**100**
If yes, do you know why they took the decision to have their deliveries outside a health facility		
Incessant strikes	37	10.9
Recommendations from others	16	4.7
Financial reason	31	9.1
Long distance to facilities	44	12.9
Adequate attention	24	7.1
Neutral	188	55.3
Total	**340**	**100**
Have you also delivered outside a health facility before?		
Yes	92	27.1
No	50	14.7
Neutral	198	58.2
Total	**340**	**100**
If yes, how would you describe the experience you had then?		
It was unlike the one of hospital	39	11.5
Inadequate attention	16	4.7
Lack of adequate infrastructure/equipment	20	5.9
Inadequate experience	18	5.3
Others	1	.3
Neutral	246	72.3
Total	**340**	**100**
In your opinion, what other benefits have you derived from the health-talk programme?		
First-aid treatment	118	34.7
Birth preparedness plan	96	28.2
Signs of labour	44	12.9
Nutrition	43	12.6
Others	13	3.8
Missing Value	26	7.6
Total	**340**	**100**

Table 4.17 shows the respondents' differing perspectives regarding the nurses under review. The result shows that respondents ascribed significantly higher scores in rapport building to nurse A compared to nurses B, C and D ($P<0.001$). With respect to other relational skills, more respondents believed nurse A' s listening skills (66.304; $P<0.001$), confirming skills (12.107; $P<0.001$), information dissemination skills (73.937; $P<0.001$) and checking of perception skills (45.469; $P<0.001$) are higher than all the other nurses.

From the foregoing, nurse A had significantly better (higher scores) in rapport, listening, confirming, information giving and checking of perception skills. According to one of the key informants in this study, contemporary nurses are better informed on evidence-based communication skills than those with earlier training. The key informant who is a lecturer at the Oyo State School of Midwifery elaborated further on this:

> You know there are nurses that have practised for up to twenty years and above. Also, younger nurses are equally coming into practice and you remember that I said earlier that research is ongoing. What people were practising last year will definitely be different from what people will be practising now. The curriculum on nursing is also updated every 5 years to allow for the inclusion of evolving things. Consequently, the way nurses were trained thirty to forty years ago will be different from current practices... but I believe with time and with the introduction of the Mandatory Continuous Nursing Education these challenges will be surmounted.(Female, Nurse, School, Eleyele).

There is therefore no doubt that nurses trained in contemporary times received improved communication skills training more than their senior colleagues. However, it is anticipated that the experiences of older nurses on the job is equally an advantage that scholars and practitioners may have ignored. It is certainly worth considering that the hypothetical nurse A who is highly perceived by respondents across the facilities, distinguished herself from others not only as a result of education, training or experience, but also, a personal commitment to duty. The details of the comparison of perception scores of the different nurses are presented in Table 4.17.

Table 4.17: Comparison of perception score of the different nurses

	N	Mean	Std. Deviation	F test	P value
Rapport					
Nurse A	340	2.3294	1.17635	67.050	<**0.001**
Nurse B	340	2.0088	1.34029		
Nurse C	340	1.5794	1.44195		
Nurse D	340	0.9618	1.35510		
Mean total rapport score		1.7199	1.42568		
Listen					
Nurse A	340	1.9912	1.01751	66.304	<**0.001**
Nurse B	340	1.7059	1.12963		
Nurse C	340	1.3382	1.23626		
Nurse D	340	0.8324	1.13855		
Mean total listening score		1.4669	1.21207		
Confirm					
Nurse A	340	1.2618	0.89855	12.107	<**0.001**
Nurse B	340	1.1441	0.89564		
Nurse C	340	0.9176	0.92122		
Nurse D	340	0.9176	0.92122		
Total mean score		1.0603	0.92032		
Inform					
Nurse A	340	2.0647	1.06510	73.937	<**0.001**
Nurse B	340	1.7824	1.18234		
Nurse C	340	1.3706	1.25191		
Nurse D	340	0.8176	1.14017		
Total mean score		1.5088	1.25190		
Check					
Nurse A	340	1.1618	0.70836	45.469	<**0.001**
Nurse B	339	0.9941	0.74180		
Nurse C	340	0.7647	0.77797		
Nurse D	339	0.5369	0.74637		
Total mean score		0.8645	0.77975		

Table 4:18 presents the differences in the perspectives of pregnant women regarding the nurses in each of the sampled health facility. This Table is a follow up to Table 4:17 however, the results in this section are disaggregated by the different hospitals. A one way analysis of variance was calculated on pregnant women' s perception of nurses. The results indicate that pregnant women at Adeoyo Maternity Teaching hospital reported a statistically significant difference [F(3,256)=7.48 in nurses' rapport, listening[F(3,256)=8.84], informing[F(3,256=10.38] and feedback skills[F(3,254)=2.87]. Conversely, there was no significant difference in nurses' confirming/disconfirming behaviours at Adeoyo. For rapport skills, nurse A reported significantly higher scores compared to the other nurses. Similarly, nurse A reported significantly higher scores in listening, information-giving and feedback skills compared to nurses, B, C and D.

At the Ring Road Specialist Hospital, the results of the one way ANOVA also shows a lower statistical difference in the perspectives of pregnant women in nurses' rapport [F(3,212)=11.91, listening F(3,212)=15.09, information giving, F(3,212)=21.08 and feedback skills, F(3,212)=13.25. There were no significant differences in nurses' confirming and disconfirming behaviours at the Ring Road Specialist Hospital. Similarly, the pregnant women at the Jericho Nursing Home reported a much lower statistical difference in nurses rapport skills as F (3,140) =7.83, listening, F (3,140) =9.54 and information-giving skills, F (3,140) =7.51. There were no significant differences in nurses' confirming and feedback skills at the hospital.

These results indicate that care providers at referral facilities such as Adeoyo Maternity Teaching hospital do encounter certain communication challenges with their clients in view of the large volume of clients relative to the smaller number of care providers. Typically, dialectical tensions accompany provider-patient communication in terms of faulty perceptual screens which may be on the part of either patients or care providers. These perceptual screens naturally inhibit relational interaction between patients and their care providers. Prevalent communication barriers between patients and providers are further exacerbated by the disproportionate ratio of patient to providers which is a common feature of referral or teaching hospitals such as Adeoyo.

Table 4.18: Perception of respondents about nurses by health facility

	Adeoyo Maternity Hospital				Ring Road Specialist Hospital				Jericho Nursing Home			
Perception	**Mean (SD)**	**F test**	**df**	**P value**	**Mean (SD)**	**F test**	**Df**	**P value**	**Mean (SD)**	**F test**	**df**	**P value**
Rapport												
Nurse A	2.38 (1.18)	7.486	**3;256**	**<0.001**	2.35 (1.08)	**11.910**	**3;212**	**<0.001**	2.19 (1.23)	**7.831**	**3;140**	**<0.001**
Nurse B	2.12 (1.32)				2.03 (1.30)				2.11 (1.37)			
Nurse C	1.75 (1.53)				1.61 (1.40)				1.78 (1.42)			
Nurse D	1.30 (1.53)				0.96 (1.30)				0.83 (1.32)			
Listen												
Nurse A	2.09 (0.96)	8.843	**3;256**	**<0.001**	1.94 (0.96)	15.095	**3;212**	**<0.001**	**2.03 (1.03)**	**9.546**	**3;140**	**<0.001**
Nurse B	1.62 (1.08)				1.74 (1.10)				206 (1.04)			
Nurse C	1.52 (1.14)				1.18 (1.15)				1.75 (1.31)			
Nurse D	1.10 (1.17)				0.68 (1.08)				0.80 (1.14)			
Confirm												
Nurse A	1.18 (0.75)	1.136	3;256	0.335	1.06 (0.74)	3.051	**3;212**	**0.030**	**1.33 (1.04)**	**0.146**	**3;140**	0.932
Nurse B	0.98 (0.74)				0.96 (0.69)				1.42 (0.97)			
Nurse C	0.96 (0.84)				0.72 (0.71)				1.27 (1.06)			
Nurse D	0.97 (0.85)				0.72 (0.71)				1.28 (1.05)			
Inform												
Nurse A	2.27 (1.02)	10.388	**3;256**	**<0.001**	2.02 (1.01)	21.084	**3;212**	**<0.001**	**1.94 (1.19)**	**7.510**	**3;140**	**<0.001**
Nurse B	1.89 (1.18)				1.76 (1.16)				1.92 (1.15)			
Nurse C	1.66 (1.29)				1.09 (1.15)				1.72 (1.21)			
Nurse D	1.12 (1.30)				0.53 (0.92)				0.80 (1.14)			
Check												
Nurse A	1.20 (0.83)	2.872	**3;254**	**0.037**	1.14 (0.66)	13.257	**3;212**	**<0.001**	**1.08 (0.77)**	**5.060**	**3;140**	**0.002**
Nurse B	0.97 (0.85)				1.00 (0.70)				0.88 (0.74)			
Nurse C	0.86 (0.88)				0.67 (0.67)				0.78 (0.72)			
Nurse D	0.78 (0.88)				0.41 (0.65)				0.44 (0.61)			

Table 4.19 presents the results of pregnant women' s perspective regarding nurses' relational communication behaviour in each of the sampled hospitals. It is a continuation of Table 4.18. Hence, this table presents respondents' perception at Jericho Specialist Hospital, General Hospital Moniya and Our Lady of Apostles Catholic Hospital Oluyoro (O.L.A). The results shows that at the Jericho Specialist Hospital (JSH), there was a lower statistical difference in nurses' rapport F (3,176) =13.21 listening F (3,176) =11.97, information-giving F (3,176) =13.35 and feedback skills F (3,176) =12.12. However, the results at the General Hospital Moniya indicate that pregnant women at the facility had a better perception of the nurses' communication behaviour as they recorded a better statistically significant difference compared to JSH in rapport F(3,184)=7.999, listening F(3,184)=5.41, information-giving F(3,184)=5.73 and feedback skills F(3,184)=6.29. At O.L.A Oluyoro, there was a statistical significance in pregnant women' s perception of the nurses' relational skills as rapport skills was allocated F(3,164)=11.03, listening(3,164)=12.18, information-giving, F(3,164)=13.11 and a much lower significance in perception of nurses' confirming skills F(3,164)=7.89.

The results from Table 4.19 show that aside from the size of a facility that may affect nurses' relational communication behaviour, the ownership structure is also bound to influence nurses' disposition to clients and the dispensation of therapeutic care.

Table 4:19: Perception of respondents about nurses by health facility (Cont' d)

	Jericho Specialist Hospital				General Hospital, Moniya				O.L.A. Oluyoro			
Perception	**Mean (SD)**	**F test**	**df**	**P value**	**Mean (SD)**	**F test**	**df**	**P value**	**Mean (SD)**	**F test**	**Df**	**P value**
Rapport												
Nurse A	2.38 (1.09)	13.211	**3;176**	**<0.001**	2.55 (1.23)	**7.999**	**3;184**	**<0.001**	1.90 (1.30)	**11.032**	**3;164**	**<0.001**
Nurse B	1.75 (1.38)				2.43 (1.24)				1.40 (1.39)			
Nurse C	1.08 (1.32)				2.15 (1.42)				0.78 (1.13)			
Nurse D	0.84 (1.27)				1.29 (1.55)				0.52 (0.96)			
Listen												
Nurse A	1.96 (0.97)	11.975	**3;176**	**<0.001**	2.04 (1.12)	5.410	**3;184**	**0.001**	1.64 (1.12)	**12.189**	**3;164**	**<0.001**
Nurse B	1.48 (1.17)				2.00 (1.12)				1.21 (1.15)			
Nurse C	0.93 (1.17)				1.83 (1.22)				0.50 (0.94)			
Nurse D	0.68 (1.06)				1.17 (1.29)				0.50 (0.94)			
Confirm												
Nurse A	1.31 (0.79)	7.458	**3;176**	**<0.001**	1.59 (1.11)	0.115	3;184	0.951	1.19 (1.04)	**7.890**	**3;164**	**<0.001**
Nurse B	1.13 (0.84)				1.57 (1.09)				0.93 (0.99)			
Nurse C	0.67 (0.79)				1.48 (1.15)				0.43 (0.70)			
Nurse D	0.67 (0.79)				1.48 (1.15)				0.43 (0.70)			
Inform												
Nurse A	2.08 (1.06)	13.353	**3;176**	**<0.001**	2.13 (1.05)	5.735	**3;184**	**0.001**	1.78 (1.20)	**13.117**	**3;164**	**<0.001**
Nurse B	1.42 (1.25)				2.06 (1.13)				1.55 (1.23)			
Nurse C	0.96 (1.22)				1.91 (1.16)				0.69 (1.02)			
Nurse D	0.67 (1.00)				1.23 (1.33)				0.54 (0.91)			
Check												
Nurse A	1.15 (0.67)	12.129	**3;176**	**<0.001**	1.32 (0.73)	6.295	**3;184**	**<0.001**	1.02 (0.68)	**8.195**	**3;164**	**<0.001**
Nurse B	0.84 (0.70)				1.36 (0.73)				0.90 (0.69)			
Nurse C	0.51 (0.72)				1.19 (0.82)				0.45 (0.67)			
Nurse D	0.37 (0.57)				0.72 (0.90)				0.45 (0.67)			

Table.4.20 is the last table in this section and it presents the summary of the one way Anova of the comparison of perception score on nurses at Maternal and Child Health Apata (MNCH). Respondents at the hospital report a statistical significance in rapport, F (3,188) =17.04, listening, F(3,188) =15.60, information-giving, F(3,188) =15.18 and feedback skills, F(3,188) = 9.68. Respondents at this facility also reported poor perception of nurses confirming skills which seems to be the case across all the hospitals. Nurses' confirming skills describe their ability to relate with clients in ways that affirm them. In other words, it measures the extent to which the communication behaviour of the nurses increases or diminishes patients' self esteem. The results from this table indicate that pregnant women perceive that nurses at this facility dispense better relational care than some of the other facilities sampled in the study. The summary of this finding is presented in Table 4.20.

Table 4.20: Perception of respondents about nurses by health facility (Cont' d)

	MNCH Apata			
Perception	**Mean (SD)**	**F test**	**df**	**P value**
Rapport				
Nurse A	2.52 (1.05)	17.041	**3;188**	**<0.001**
Nurse B	2.20 (1.20)			
Nurse C	1.85 (1.37)			
Nurse D	0.83 (1.28)			
Listen				
Nurse A	2.21 (0.92)	15.607	**3;188**	**<0.001**
Nurse B	1.95 (1.03)			
Nurse C	1.67 (1.20)			
Nurse D	0.79 (1.14)			
Confirm				
Nurse A	1.25 (0.81)	1.776	**3;188**	**0.153**
Nurse B	1.18 (0.81)			
Nurse C	0.95 (0.77)			
Nurse D	0.95 (0.77)			
Inform				
Nurse A	2.13 (0.91)	15.187	**3;188**	**<0.001**
Nurse B	1.92 (1.07)			
Nurse C	1.56 (1.21)			
Nurse D				
Check				
Nurse A	1.18 (0.57)	9.684	**3;188**	**<0.001**
Nurse B	1.00 (0.61)			
Nurse C	0.87 (0.67)			
Nurse D	0.50 (0.71)			

4.4 Hospital' s structural organisational characteristics of group prenatal care

A hospital' s physical environment and other structural components are likely to affect how pregnant women and care givers relate within the group care programme. Examples of structural organisational characteristics include: hospital size, ownership, status, specialisation, type of staffing, and technological sophistication. The result obtained from the In-depth interview, key informant interview, focus group discussion and the ethnographic study of the facilities were utilised in examining how hospitals' structural organisational characteristics affect the group care programme. The answers are provided under the following sub-headings: How hospitals' structural characteristics affect the group prenatal care, Organisational provisions adopted in checking patient' s perception of care in the surveyed facilities, Patients' need for privacy and hospital' s structural organisation. Subsequent discussions are presented under each sub heading.

4.4.1 How hospitals' structural characteristics affect the Group Prenatal Care (GPC)

The hospitals under review in this section are: General Hospital Moniya, Maternal and Child Health Apata, St Peters Hospital Aremo, Adeoyo Maternity Teaching Hospital, Ring Road Specialist Hospital, Jericho Nursing Home, Jericho Specialist Hospital and Our Lady of Apostles Catholic Hospital Oluyoro. The aforementioned facilities differ in ownership structure, size, physical and technological infrastructure.

1. The relational implication of a structural comparison of Adeoyo Maternity Teaching Hospital with Jericho Nursing Home

As earlier mentioned, hospitals' structural characteristics that were compared include: size, level of care, specialisation, ownership, staffing and technological sophistication. Some of these indices are examined in relation to their influence on nurse-patient interaction. Both the Adeoyo Maternity Teaching hospital and the Jericho Nursing Home are situated in central parts of Ibadan metropolis. While Adeoyo is a large referral centre that offers tertiary level of care, Jericho Nursing Home is smaller and operates at the secondary level of health-care. Similarly, in this study, both Adeoyo and the Nursing Home specialises in maternal health care delivery, though at different levels. The tertiary level of care and referral nature of

Adeoyo makes it attractive to a larger clientele, compared to the Jericho Nursing home. One of the key informants at Adeoyo, a nursing mother affirmed that " people come to the facility as early as six in the morning to register their presence, especially on prenatal " booking days" . She observed that the " large clientele at the facility on booking days often calls for rescheduling some people to other days as caregivers are unable to attend to the majority of patients in a day. The negative consequence of aforementioned structural indices on nurse-patient interaction at Adeoyo, according to the hospitals' Chief Nursing Officer (CNO), is the pressure on prenatal care staff and its effect on timeliness in care delivery. " We have shortage of staff as people are retiring every year and there is no replacement. The requirement of the World Health Organisation is a nurse to four patients, here four nurses attend to over 150 patients" . The perceived staff pressure in terms of increase in service volume may account for why one of the key informants (a nursing mother) at the facility observed " discrepancies in nurses' decision making" . Meanwhile, the CNO hinted that when there are delays in patients' waiting time, the latter may misconstrue it as deliberate. Furthermore, the recurrent problem of poor staffing and its effect on work load was re-echoed by the interviewed Junior Nurse at the Jericho Nursing Home. According to her, the hospital' s speciality in maternal care delivery makes it attractive to clients of different demography. She however complained about the poor staffing level and funding. In her words: " the task is too much for available hands" . She nonetheless, explained that the nurses at the facility refrain from allowing perceived challenges affect their relationships with the expectant mothers. " ...As professionals we bear our own problems and address patients own, since they are not always with us. Patients spend a maximum of 4 hours with us on each visit"

The structural characteristics of the hospitals under review also have positive relational implication. For example, the Chief Nursing Officer identified a positive aspect of Adeoyo' s tertiary level of care in terms of non-governmental and corporate support from bodies like the MTN foundation who recently installed solar panels in some of the wards in the facility and also renovated the lying in wards. This alternative power supply, according to her, " will reduce the pressure placed on the hospital' s power generating set" . The existence of more solar panels at strategic places such as the prenatal clinic will also reduce the noise level posed by the

generating set during health education sessions. Although Noise punctuated aspects of the health-talk at the Nursing Home such noises were human-made. Also, compared with Adeoyo, the Jericho Nursing Home does not have similar technological sophistication.

2. The relational implication of a structural comparison of St Peters Hospital Aremo with Maternal and Child Health Apata

In this section, the structural characteristics of St Peters Hospital Aremo is compared vis-à-vis that of Maternal and Child Health Apata. Observed structural indices that affect relational care in both facilities relate to funding, level of care, staffing, hospital location and technological sophistication. To start with, both the St Peters Hospital Aremo and MNCH Apata are secondary health-care centres though the former was established by the Anglican dioceses of Oyo until taken over by the Oyo state government. Similarly, both hospitals are located far away from the city centre in fact, St Peters Aremo is situated within a cemetery in a rustic Ibadan community where residents according to hospital staff, prefer the services of Traditional Birth Attendants or private clinics. A key informant in the hospital, the Chief Medical Director, however, explained that, " many pregnant women in the environs avoid the facility over time based on its location, which is within a cemetery" .

At the MNCH Apata however, a key structural index affecting nurses' relational care according to the Chief Medical Director is inadequate personnel. He observed that the staff strength of the prenatal clinic is four while an average number of 200 patients are attended to in a month " We have shortage of manpower with such a situation you only encourage the nurses, there isn' t much they could do" . Aside from the poor staff ratio, funding is another structural challenge at the facility affecting care delivery. " Before now, this hospital was a Maternal and Child Health Unit of the Jericho Nursing Home hence, we receive meagre amount for running cost" . This explains why pregnant women sit on uncomfortable benches during prenatal care which contrast sharply with the recommended mother-friendly approach to care delivery. Whereas, at St Peters hospital Aremo, relatively relax able modern iron pews adorn its prenatal clinic. Additionally, the poor funding of MNCH also contributed to its inability to procure appropriate equipment for checking foetal heart beat. Government provided foetalscope but its readings were unreliable as foetal heart

beat were difficult to read hence, many of the women were labelled as having inter uterine foetal death. You can imagine the kind of stress the pregnant woman will undergo as a result of such diagnosis explained the CMD of MNCH Apata.

Both hospitals under comparison share similarities in structural characteristics in the particular areas of location, hospital level and client base. Though both are situated within the metropolis their location is not strategic. While the Aremo Hospital is situated within a Cemetery, MNCH Apata is hidden within the quarters of the Nigerian Railway Corporation as a matter of fact, until recently, the sign post for the Apata Hospital merely read " Hospital" . Interestingly the Maternal and Child Health Hospital (MNCH) offers secondary health care services to people residing around Apata, Moor Plantation and Odo Ona areas of Ibadan. According to the hospital' s CMD, MNCH was initiated by the colonial government to serve as the maternal wing of the Jericho Nursing Home in order to cater for the reproductive and general health needs of residents. As at the time of conducting this study, the hospital was yet to be upgraded, as it operated more or less in the same way it did during colonial rule. For example, during the observation at MNCH both pregnant women and nurses sat on uncomfortable benches. The relational dimension to the seating arrangement in the hospital negates a mother-friendly approach to care as the seats which constitute a crucial context of care ought to be comfortable to support learning among participants. Consequently, the availability of such seats in public hospitals could in actual fact be counter-intuitive.

3. The relational implication of a structural comparison of the General Hospital Moniya with Ring Road Specialist Hospital

The indices of structural comparism between the General Hospital Moniya and Ring Road Specialist Hospital are location, client size, staff strength, technological sophistication and atmospherics. While the General Hospital Moniya, is situated inconspicuously within the Ibadan North Local Government Secretariat, Ring Road Specialist (RRSH) Hospital is located along the Adeoyo axis of Ring Road. Compared to the RRSH, the Moniya Hospital has a relatively smaller clientele but the location of the Moniya Hospital attracts a diversity of people particularly those of the Hausa-speaking parts of Nigeria. The psychographics of clients at the Ring Road Specialist Hospital is diverse but not as much as the Moniya Hospital. The peculiarity

of Moniya clients poses a relational challenge to providers especially as clients according to a senior nurse initiate care in the latter stages of pregnancy. Another challenge posed by clients at the Moniya Hospital is their cultural diversity, providers therefore need to be culturally competent to communicate intended meaning appropriately to clients.

On the other hand, at the Ring Road Specialist Hospital the atmospherics has positive relational effect on both providers and clients. This is because clients while waiting to be attended to are at liberty to watch movies on digital television. Providers also relieve stress through movies as soon as there is less service volume. Apart from this, the nursing staff strength at RRSH is larger than the one at Moniya Hospital. According to one of the interviewed nurses at the Ring Road Specialist Hospital, the staff strength of the prenatal unit is 12 nurses. This staff strength will lessen work load and improve individual nurses' relational ability. In contrast, the absence of technological sophistication such as laboratory support for routine test of pregnant women accounted for perceived relational friction between the women and their care providers.

There are also indications that structural variables like location, client size, nursing staff strength and atmospherics have implication on relational care. The location of the General Moniya Hospital is a reason why many Hausa-speaking people visit the clinic for care. A high number of northerners are known to reside at Moniya and Sasa axis of Ibadan hence the proximity of the facility to the people. The preponderance of Hausa-speaking clients at the hospital calls for greater cultural awareness and competence on the part of providers. For instance bilingual Northerners are known to exhibit a conversational strategy where they deliberately refuse to employ a common language mutually understood by them and other interlocutors. Another characteristic feature of northerners more importantly the Hausa-speaking ones is patriarchal nature of the society as well as the fusion of religion and culture in that society.

The results here indicate that structural variables such as hospital location and size determine patient characteristics. In other words, patients' demography and health cultural attributions are functions of the hospital location and size. The Moniya

hospital reportedly recorded a higher incidence of women who did not only initiate prenatal care late, but who also had faulty perceptions of care. The interviewed senior nurse at the facility observed that " many pregnant women in this area present late for care because prenatal care is perceived as curative rather than a preventive form of care" . The foregoing statement was, in fact, validated when a woman in her 7th month of gestational pregnancy, interrupted the course of the interview, with the intent to register for care. One reason, for the apparently untimely behaviour, was her poor health, as she reported malaria symptoms. If the above scenario depicts the nature of participants at that facility, relational communication on part of providers may produce minimal result. Consequently, reorientation and awareness campaign on maternal and child health are required for residents of that area, such campaign can be facility based or staged at central places such as the community market.

4. The relational implication of a structural comparison of Our Lady of Apostles Catholic Hospital with Jericho Specialist Hospital

The compared structural factors in this section include ownership, status, hospital size, furniture and location. The Our Lady of Apostles Catholic Hospital Oluyoro (O.L.A) is privately owned and offers secondary health care services while the Jericho Specialist hospital (JSH) is publicly owned and also offers secondary health care. Both O.L.A and JSH are large hospitals with a huge client size but as at the time of conducting this study, the latter facility had a small prenatal clinic relative to its client size. The relational implication of an inadequate space is the absence of a mother-friendly approach to care delivery as clients were seen adopting different uncomfortable positions such as squatting and standing through the prenatal sessions. While the O.L.A is located in the interior parts of Ibadan, JSH is situated on a major transit road in an industrial part of the metropolis. The location of Jericho Specialist Hospital exposed it to environmental and vehicular noise. Noise has implication on learning and retentive capacities of pregnant women but the effects of noise on providers are multifaceted. Furthermore, the location of O.L.A is strategic as targeted clients are people who otherwise would patronise patent medicine stores or Traditional Birth Attendants. Finally, the ownership structure of O.L.A allows for proper coordination of care with positive relational dimension on expectant mothers. The ownership structure of O.L.A according to a senior nurse at the hospital also

explains the presence of an audit system for medical malpractice and other unwholesome staff conduct which has produced a semblance of patient-centred care over the years.

The location of Jericho Specialist Hospital along a major transit highway affected relational care in the facility. This is because of vehicular and environmental noise that often punctuated provider-client interaction. Noise as a pollutant is an unpleasant or harmful sound that is hazardous to human health under constant exposure. Noise extent is measured in decibels thus and according to the requirement of the World Health Organisation, there is a permissible decibel level of noise in hospitals.

Hospital ownership is another factor affecting relational dimension to communication in the facilities under review. The ownership structure of the Oluyoro hospital allowed for better coordination of care as for example, women schedule for prenatal care was based on parity. In the sense that primigravida (first time mothers) were attended to on Mondays and Tuesdays while multiparous women (those with experience of previous deliveries) were attended to on Thursdays. This is likely to foster a more focused care delivery and orderliness amongst participants as the tendency for experienced mothers to dominate group discussions is minimised. However in publicly owned facilities like the JSH, first time mothers and multiparous women were put together in the same groups. The ownership structure of O.L.A according to a senior nurse at the facility also explains the presence of an audit system for medical malpractice and other unwholesome staff conduct which has produced a semblance of patient-centred care over the years. Unlike publicly owned hospitals where nurses are vested with power, private facilities such as Oluyoro empowered patients to officially report any malpractice or perceived uncouth behaviour. The interviewed senior nurse at O.L.A explained that nurses who seek to remain employed in the establishment abide by institutional guidelines regarding staff conduct.

4.4.2 Organisational provisions adopted in checking patient' s perception of care in the surveyed facilities

One of the indicators of providers' relational communication behaviour is an ability to check patients' perception. Checking of perception skills is also known as feedback skills but there must be entrenched structures for obtaining feedback. This

theme examined existing organisational provision for obtaining feedback. Only a few of the surveyed hospitals (two out of the eight hospitals sampled) devised a structure for checking patient' s perception of their services. At both Adeoyo and O.L.A Oluyoro, pregnant women could register complaints anonymously and directly with the management through specified hospital hot-lines. The notice was, however, written in English hence, the import of the message was lost on uneducated pregnant women. Also, a Chief Nursing Officer at Adeoyo affirmed that the prenatal clinic is visited weekly by a team of nurses who also interview pregnant women. The team of nurses actually paid repeated visits to the clinic, however, no one was seen interviewing pregnant women. It is possible that the informal interview may be infrequent. The result of the survey at Adeoyo shows that expectant mothers have a very low opinion of nurses when it comes to the latter' s ability to check for perception. A similar opinion was expressed by participants at the Jericho Specialist Hospital when the Head of prenatal unit inquired from them if the health education classes were actually beneficial. On the other hand, at Aremo, the CMD explained that there is a plan to schedule periodic management meeting with the Association of Landlords in the area to gauge the community' s perception on the service delivery of the hospital.

The final theme in this section is on how hospital organisational structure affects patients' need for privacy. This is discussed next.

4.4.3 How hospital' s structural components affects patients' need for privacy

A key indicator of existing provider-patient relational communication is the willingness of patients to disclose crucial information confidentially. Information disclosure in clinical interaction will be limited without necessary structural accompaniments. In this section, specific structural components in sampled hospitals that allowed for confidentiality in information disclosure were explored. To start with, some of the interviewed nurses confirmed that individual prenatal care is offered to reticent women who could not express themselves within the group context. A Senior Nurse at Ring Road Specialist Hospital explained thus: " We also establish one-one contact with each pregnant woman" Other care providers however believe that women will be freer to express their concerns when the group size is smaller.

According to one of the nurses at Aremo, " It is not possible to have a group of between 30-50 people and be able to communicate effectively with them" . In her opinion, expectant women vary in their concerns and needs hence " I put pregnant women into groups based on the gestational ages of pregnancy because if you put people of different gestational ages into a group such a group may not be effective" . While that approach to care may serve the needs of some patients it may not be beneficial to those who intend to disclose intimate concerns. Consequently, a Senior Nursing Officer at Maternal and Child Health (MNCH) Apata explained that " if there is anyone that needs confidentiality after the group discussion, such a person see us one-one to discuss whatever the complaints are" A provider at Jericho Nursing Home while reacting to the issue of privacy and clients' disclosure of information stated that: " We try to provide privacy for them by giving them individual attention in the observation room or in the nurses' restroom" .

A Senior Nursing Sister at O.L.A Oluyoro also expressed a similar idea she, however, added an addendum that …" because if you go in there (the examination room) and they (patient) talk even the person in that room will not hear, except if you are asked and you tell them" .

In summary, the sub themes provided responses to research question four which sought to investigate the structural characteristics that influence relational communication behaviour in each of the hospitals. The sub-themes are: relational implication of structural comparison of sampled facilities, organisational provisions to check clients' perception of care and how hospital structural components affect patients' need for privacy**.** Observation, key informant and in-depth interviews were the methods adopted to proffer appropriate responses to the questions. The observed structural characteristics are hospital size, location, and specialisation, level of care, staffing levels, service volume/client size, furniture and atmospherics. Out of all the sampled facilities, only Adeoyo Maternity Teaching Hospital offered tertiary level of care but both Adeoyo and Jericho Nursing Home specialise in maternity care. These distinguishing characteristics and the referral nature of the Adeoyo created more pressure on staff and their ability to dispense relational care. Other large hospitals in the present study are the Jericho Specialist, the General Hospital Moniya, Ring Road

State Hospital, and Oluyoro. These facilities experienced similar challenges in dispensing relational care while relatively smaller facilities like MNCH Apata, Aremo and the Jericho Nursing Home had different experiences. Majority of the hospitals, however, did not have a means of checking clients' perception of care and only a few of the facilities could actually guarantee privacy to the women during information disclosure. This summary leads to the next point of investigation which pertains to feedback relating to the group prenatal care.

4.5 Feedback relating to group prenatal care

In this section, how prenatal care groups in Ibadan adjusted their operations to the feedback from care receivers was examined. The themes (pattern of responses that answers the research question) that emerged out of the responses obtained from the in-depth interview and key informant interview are as follows:

- Specific types of feedback elicited from patients on the conduct of prenatal care
- How the prenatal clinics modified their operations in response to the Feedback.

4.5.1 Specific types of feedback elicited from patients on the conduct of prenatal care

At some of the facilities, interviewed nurses could not recollect specifically any feedback they received particularly as it affects the delivery of care in the prenatal clinics. At such facilities, interviewees believed that``newly-delivered mothers bringing their babies and showing appreciation to the nurses is a form of feedback. " Our feedback is to see our babies delivered safely. Some people come back to show appreciation," remarked a Senior Nurse at MNCH Apata. A similar opinion was expressed by a Junior Nurse at St Peters Hospital Aremo. " The delivery rate is positive, so we assume that what they were taught during the health-talk must have been applied." At the Moniya Hospital, a Senior Nurse explained, " when we go out, people appreciate us; they greet us warmly and describe how we assisted them during the period of pregnancy." In yet another facility (Ring Road Specialist Hospital), nurses reported that positive feedback was received when clients recommended the hospital to people in their network. " There was a time a woman was delivered of her baby here and she encouraged her neighbour to also register with us for prenatal care. As a matter of fact, she brought the neighbour; that was how we knew she was impressed with our services."

At Maternal and Child Health Apata, a nurse explained how the local community gave various donations to show appreciation for their delivery service. According to her, " The Ahammadiya Muslim community donated chairs to the prenatal clinic and at another time, the Rotary Club donated mackintosh and sundry items to expectant mothers" . Similarly, the interviewed caregiver at Aremo, recalled that:

> Since I assumed office, I have had meetings with opinion leaders in this community in order to strategise on how to increase our clientele. I sought to identify the reason for the low patronage in the hospital and it was realised that people were not comfortable with the hospital' s proximity to a cemetery. (Female, CMD, Public, Aremo).

There is a pattern in the responses of nurses which is indicative of two issues. Firstly, that care receivers feel comfortable reporting positive rather than negative feedback to providers. Secondly, positive information came readily to providers' minds much more than negative ones. The latter observation is equally consistent with the result of the survey where the majority of respondents remembered first providers who had the best interpersonal quality, while those who lacked interpersonal appeal were given the least consideration. Panneerselvam (2018), explains why it is easy for people to give positive feedback much more than the negative ones. In contrast, at some other facilities, interviewees were specific on the types of feedback received over time. For instance, at Jericho Specialist Hospital, the interviewed Senior Nurse gave a specific example of a feedback on rendered services:

> There was a case of a woman who fell into labour prematurely and the woman was fined in the labour room because she was yet to attend the required number of health-talk (mothercraft). When the woman was discharged, she came and gave us the feedback that she was wrongfully fined and we investigated the matter and a refund was given to her. The regulation is if you do not attend the stipulated number of the health-talk, at the onset of labour you will be fined, but the woman in question was not deserving of a fine because she fell into labour prematurely. (Female, Nurse, Public, Jericho, S)

The next theme explains the influence of care receivers' feedback on service delivery.

4.5.2 How the prenatal clinics modified their operations in response to the feedback

Out of all the interviewed caregivers across the sampled facilities, only three out of seven could satisfactorily explain how feedback had affected the conduct of the prenatal clinics. A Senior Nurse at the Jericho Specialist Hospital explained that necessary action was taken against specific complaints. According to her, disciplinary actions were instituted against nurses lacking relational care. At Aremo, an alternative

access route to the facility was to be created for clients who could not access the hospital via the cemetery route. Also, a Senior Nurse at MNCH Apata expressed her opinion thus:

> Initially, the rule was for expectant mothers who fell into labour to report at the hospital when their dilation is around 4cm (sic). A particular primigravida reported with less than 4cm around two in the morning. She was told to go back home, she, however, decided to go to a mission home unfortunately, she was mismanaged there and was later referred to the General Hospital for a caesarean section. Since that incident, we attend to pregnant women regardless of the dilation; we just ensure that they stroll around the hospital premises. (Female, Nurse, Public, Apata).

From the foregoing findings, only few nurses could identify particular ways feedback had modified prenatal care operations. This is because many of the nurses rarely bothered to check clients' perception of service quality. If this was done, majority of the caregivers could have proffered appropriate responses. For instance, the interviewee at the Jericho Nursing Home explained, " because our clients feel free with us, they readily give us feedback and we adjust our operations accordingly." This blanket statement did not sound convincing as one gets the impression that the response was meant to satisfy the interviewer.

4.6 Discussion of findings

The Ibadan group prenatal care model is characterised by medical and physical assessment, health education, social support, prenatal songs among other features. The findings in this study show the alignment of the Ibadan group prenatal care model with the recommendations of the World Health Organisation (WHO), on the nature of medical assessment during prenatal care. The findings have also shown the importance of conducting routine assessment on patients during prenatal care. Lori, Ofosu-Darkwah, Boyd, Banerjee and Adanu (2017) observed a similar approach to prenatal care in Ghana. They report that women sit in groups while providers observe their blood pressure, urinalysis and body mass index. The abdominal palpation to check baby' s growth and fundal height of foetus also constitute part of the medical examinations for prenatal care in that country. In contrast, an earlier study conducted in South Africa by Mathibe-Neke, (2008) argued that the form of care expectant women receive during prenatal care is dependent on whether it is the first visit or

latter appointments. At the first visit, the client' s medical history and vaginal examinations are done while other sundry examinations are performed during subsequent visits. The fundamental difference between the two studies is while the Ghanaian study is more general the South-African study is more time- specific. Additionally, it is evident from the findings in this present study that, medical assessment is not routine, but tailored to suit the specific needs of expectant mothers. Therefore, women with peculiar gynaecological issues are offered care to suit the requirements of their conditions.

Certain factors may, however, make redundant the nature of assessment undergone in the course of prenatal care. One of such factors is the ignorance of patients as to the appropriateness of a facility to initiate care. As observed by Sageer, Kongnyuy, Adebimpe, Omosehin, Ogunsola and Sanni (2019), women' s recourse to mission homes for care is a major cause of maternal and infant mortality in Nigeria. Consequently, expectant mothers are at high risk of mortality, not only when they initiate care at mission/traditional medical homes, but also, when they visit registered health centres that are ill equipped to address the specific requirements of their conditions. Thus, and according to a Senior Nurse at the Jericho Specialist Hospital, " ideally, tertiary providers of health such as the University College Hospital (UCH) Ibadan are meant to handle high- risk pregnancies" . She also added that secondary health centres such as the JSH have " the prerogative of handling some forms of high-risk pregnancies, except that, the hospital does not have incubators for preterm babies" .

Another factor affecting the effectiveness of medical assessment during prenatal care may be relating to timeliness in the initiation of care, which seems to be a perennial health problem in the country. There is a growing body of literature on how multiparous women (having more than one child) register late for prenatal care, since their belief stems from having acquired sufficient experience through previous deliveries (Tekelab & Berhanu, 2014; Aduloju, Akintayo, Ade-ojo, Awoleke, Aduloju & Ogundare, 2016). The foregoing explanation, with respect to timeliness in the initiation of care, lends credence to the assumptions of the attribution theory which state that an individual' s perceived ability in preventing/managing an illness, could

affect his/her adherence to counsel or prescribed treatment regimen. With respect to this particular issue, ‘ multiparous’ women’ s perceived ability in possessing requisite experience to manage another pregnancy is responsible for late initiation of prenatal care.

Notwithstanding the foregoing factors, medical assessment constitute only a fragment of the care expectant mothers receive at prenatal clinics, as responses from majority of the health-care providers, seemed to suggest, that a core aspect of care, made available to pregnant women, especially, within the context of a group are the health education classes. The conduct of the content of the health education classes in this study mirrors that of Akin-Otiko and Bhengu (2012) except for minor cultural differences in the taught topics occasioned by differences in the study population. While the majority of respondents in the Akin-Otiko study are Hausa- speaking, the participants in the present study are Yoruba speaking. This explains, for example, the reason care providers in the North educate women on the dangers of child marriages, a common feature in the northern part of the country. Furthermore, as observed by Al-teeq and Al- Rusaiess (2015), health education is a crucial aspect of prenatal care, hence, it should cover not only issues affecting pregnancy, but, also, those relating to postpartum care. In this study, however, none of the interviewed nurses mentioned any topic relating to postpartum care. Apparently, the absence of a curriculum on health education at the facilities may be responsible for the lacuna.

The findings in this study also contradict what obtains in literature that majority of the current models of group prenatal care were fashioned after the ‘ Centring Pregnancy’ (to be referred to as CP henceforth) Model of care (Lincetlo, Mothebesoane-Anoh, Gomez & Mujanja, 2006; Sharma, O’ Connor & Olivet, 2018). The CP model was developed by Sharon Schindler Rising in the United States of America in the 90s to allow for better collaboration between care providers and receivers during clinical appointments (Reynolds & Rising, 2007; Heberlein, 2014; Mazzoni & Carter, 2017). The responses of interviewees have however shown points of divergence and convergence with the existing structure of the CP Model of group prenatal care. For instance, the group composition in the CP model allows between 8-12 pregnant women, whereas majority of the interviewees in this study, claimed that

40 participants constitute the average number of women in a group. Furthermore, in the CP model, the education of pregnant women during care is facilitated by a trained obstetrician/gynaecologist and either a health educator, nurse or a social worker. The findings in this study, however, have shown that facilitative discussions within the group sessions were handled mainly by a nurse.

It is also clear from the responses of interviewees in this study, that unlike the Centring Pregnancy model, health care providers in this part of the country adopt the group forum to educate women during pregnancy for administrative convenience, as individual prenatal care is still dispensed to the women at the expiration of daily lectures. One reason for this development, according to a Chief Nursing Officer at Adeoyo, is the " inability of hospitals to satisfy the World Health Organisation' s requirements on staff-patients ratio, which is one nurse to four patients" . The norm in many large hospitals in Ibadan is for three to four nurses to dispense care to an average group of forty pregnant women. Hospitals with smaller clientele such as Igbo Oloyin Cottage Hospital, however, did not adopt the group forum at all in facilitating the prenatal health education programme, since women are assigned different appointment dates based on gestational stages of pregnancy. Other reasons health care providers dispense group and individual prenatal care are to provide an enabling environment for introverts and people who wish to discuss personal issues.

Notwithstanding, the CP model and the group prenatal care in Ibadan share similarities, especially in the area of providing health education to pregnant women in groups. The Jericho Nursing Home and O.L.A Oluyoro group care model for example, share similarities with the CP model on the use of outline to select topics for discussion. At other sampled hospitals however, some of the interviewees claimed that they were sufficiently trained in the nursing school to give pregnant women appropriate counselling and education. " There is no one that will come and teach me what to say as a nurse. I know what to teach my patients" affirmed a Senior Nurse at Aremo. It can be inferred that care givers believed that they all received sufficient training prior to securing employment. While it is incontestable that nurses must have undergone professional training before employment, nonetheless, they differ in terms of qualification, experience and training.

Therefore it is impossible for them to possess an equal level of knowledge on pertinent topics. Additionally, there is a very limited connection between the taught prenatal health education classes and nurses' training, as ' evidence-based practice' which incorporates best research data and clinical judgement has transformed the scope and structure of health- care globally (Majid, Foo, Zhang, Mokhtar, Luyt, Chang & Theng, 2013). Regarding the taught topics at the health education classes, topics such as signs of labour, birth preparedness plan, diet and nutrition and first aid treatment were all perceived as beneficial by respondents. This is similar to earlier positions regarding the health information aspect of prenatal care as Oladapo, Iyaniwura, & Sule-Odu, (2008), Nwaeze, Enabor, Oluwasola, & Aimakhu, (2013) also reported women' s satisfaction with the quality of health information received during prenatal care. As observed in the Nwaeze *et al* (2013) study, crucial topics such as cervical cancer screening and breast self examination received minimal attention from providers during the health-talk. Currently, cervical cancer constitutes one of the major threats to maternal health globally; hence, one would wonder why such a public health issue should receive scant attention during prenatal health-talk. Quite unlike the Nwaeze *et al* study, observations and interviews across sampled facilities in the present study did not suggest that cervical cancer formed part of the content of prenatal care. Cervical cancer must have been featured in prenatal health education classes in the Nwaeze *et al* (2013) study, because the study was conducted at the University Teaching Hospital Ibadan, where such cases are rampant. In addition, one wonders why the topics of the prenatal health education classes did not reflect the increase in suicidal cases in the country and the projection of the World Health Organisation (WHO) that the menace will constitute a public health burden in developing countries by 2020. Care providers should have facilitated discussions on topics relating to postpartum depression and other mental health issues. This may however pose difficulties for care providers especially as the number of mental health nurses in the country is abysmally low.

Aside the health education provided to the women within the group, prenatal health care is also meant to provide social support to expectant mothers. In this study, the provision of support strategies dwelt more on informational support. Other interviewees elaborated on the emotional support. " We give social support at a

minimal level, especially, when patients are downcast, we tend to probe where necessary" explained a Senior Nurse at the Ring Road Specialist Hospital (to be referred to as RRSH henceforth). She, however, alluded to how the group spaces constrained nurses in the provision of a support system in some facilities. A similar view was upheld by a Junior Nurse at Aremo who argued that " It is practically impossible for a nurse to relate effectively with a group of between 30-50people" The situation according to her " is made worse when there is any form of acrimony between health workers, as patients are very sensitive and this can affect patients' ability to disclose information"

As confirmed by the interviewed nurses in this study, informational and emotional support during pregnancy are of paramount importance to mother and child health. In fact, Harvey and Alexander (2013) argued that out of the three domains of social support, emotional support is the most essential, especially, to women during the prenatal period. However, a host of intervening variables affect nurses in the provision of the much needed support to patients. Some of such factors are shortage of health workers, poverty, and lack of governmental support among others.

In an earlier Ghanaian study, Amoah, Anokye, Boakye and Gyamfi (2015) also described shortage of personnel as a major barrier to therapeutic nurse-patient communication. The situation is more worrisome in Nigeria where nurses are pressured daily by a larger number of clients who also demand for patient-centred care. So much is therefore expected from available nurses. Meanwhile, provision of support strategies in nursing is achievable in concert with patients since the latter are likely to exhibit attitudes that are counter-productive to care. One of such attitude is patients' perception that nurses of particular cultures are technically incompetent to handle certain aspects of care (Amoah *et al* 2015). Such stereotypical notions frustrate providers in their attempt at dispensing therapeutic care. Apart from the attitudinal disposition of patients, language barrier also limits the provision of social support especially where expectant mothers are unable to fully express their concerns in mutually understood language. Conversely, the provision of social support to pregnant women is also restricted when nurses either deploy medical jargons or when hospital culture forecloses patient-centred care.

The centrality of hospital culture to the provision of supportive prenatal care is expounded in the systems theory. The propositions of the systems theory explain why a default in one unit of the society leads to disequilibrium in the prenatal care program. Cordon (2013) stated that a state of balance or imbalance occurs in an open system where the permeability of the boundary allows for constant interactions with other sub systems. In the context of this study, hospitals are systems that do not exist in a vacuum as they are embedded within a subsystem (the government) and among a supra system (the larger society). In effect, systemic issues in the health sector and the larger society account for why care givers are constrained in the provision of social support to expectant mothers. Nonetheless, in the African society, the family unit is perceived as a veritable social support platform for expectant mothers. The prevalent economic depression in the country has however, predisposed many spouses to domestic violence. For families with only a single source of income, an unwanted or mistimed pregnancy may threaten not only resources, but also a family' s peaceful coexistence.

Another characteristic of the Ibadan group prenatal care model is the rendition of prenatal songs. This finding is consistent with that of Akin-Otiko and Bhengu (2011) who considered the singing and dancing session as an essential part of the health-talk programme, as respondents in that study stated that the session was particularly important for women who did not otherwise engage in any form of bodily exercise during pregnancy. In this present study, an informant (nursing mother) at Adeoyo confirmed that " they are made to exercise their body by dancing and singing". Evidently, the prenatal songs have implication on women' s physical health. " It is to allow the foetus to be active before palpation is done so that we can detect its foetal heart beat" clarified a lecturer at the Oyo State School of Nursing and Midwifery Eleyele. Interestingly, the songs also reveal a lot of information about the dynamics of intergroup relations at such meetings. Though both pregnant women and nurses danced to the rendition of the songs, the composition of such lyrics were credited to the pregnant women. A Senior Nursing Officer and Lecturer at the Oyo state School of Nursing and Midwifery affirmed that " nurses do not compose songs, it is the women who do so". The introduction of relaxation and motivational music into prenatal care is, apparently, a product of research on maternal anxiety and its

correlates. As contained in literature, music has the potential to combat some of the psychological effects of maternal anxiety on child psycho-motor and cognitive development (Shin & Kim, 2011; Arya, Konanki & Tiwari, 2012; Ventura, Gomes & Neto, 2013).

Thus far, the characteristics of the Ibadan group prenatal care model have been discussed. There are however other defining features of the model that reveal lots of information about the relational communication behaviour in the group prenatal care clinics. These relate to the different ways care providers negotiate interaction using various conversational strategies. These conversational strategies actually reveal information on the relational dynamics within the group spaces. The transcripts of the interaction between nurses and the expectant women in this study show that discourse management tools, emotional and interpersonal control strategies were employed at different stages of interaction. For Farzadina and Giles (2015), discourse management strategies subsume other forms of socio-linguistic markers deployed in negotiating interaction. Language and prosodic features of language are thus employed to accommodate the communication behaviour of other interactants. The excerpts of interaction between nurses and expectant mothers depict how differences in socio historical context affect communication behaviour and relational dynamics of encounters. Though the nurses shared commonality in professional group, differences in their ages, experience and health facility ownership affected conversational convergence or divergence with interlocutors. For example, in this study, in some instances, nurses ' accommodated' pregnant women' s mental lethargy because of a patient-centred approach to care. Other factors such as staff accountability (as in private hospitals) and the presence of a supervisor may also have influenced nurses' communicative behaviour.

Nurses in this study also adopted the use of inclusive pronouns to facilitate participants' engagement in interaction. The use of inclusive pronoun has implication on patients' responsiveness to discussion and relative equality in the communication encounter. For Wright, Sparks and O' Hair (2013), differences in providers' training and experience put them at an advantage over patients, which explains the power imbalance between the two. Nevertheless, providers that favour

the socio psychological approach to care reduce perceived barriers to communication through discourse management strategies. With respect to the emotional control strategies, Farzadina and Giles (2015) explain that health care providers deploy emotional control strategies for accommodation or non-accommodation purposes. In other words, providers communicate in ways that suggest either an alignment or non-alignment with conversational partners. Accordingly, the scholars argue that patients perceive overly sympathetic providers as over-accommodative (denigrating) while empathetic ones are regarded positively. This explains why health care providers, in delivering bad news, limit their expression to a sentence. Empathy is thus shown by providers majorly through non-verbal communication. In this study, the socio-historical background of the first scenario under emotional control strategy depicts an experienced nurse who became dispassionate through years of delivering health-talk. The care provider, without any trace of sentiments, adopted a clinical approach to the subject. That method in literature is described as the biomedical approach to care (Wright, *et al*, 2013). An obvious limitation of this method is its zero tolerance for patient-centred care. When providers adopt the biomedical model of medicine in dispensing care, other important indices of care are neglected. In which case, providers fail to comprehend how illness interacts with cultural norms, coping abilities, emotional state and family life. The importance of socio-psychological approach to care is underscored by empirical evidence on patient-centred care (Onwuzu, Ugwuja & Adejoh, 2014; Chineye, Ogbera & Kadra, 2014; Onigbinde, Oyedemi, Tarimo & Mukoka, 2014) and the enormity of health support groups in online and offline interactions. Notwithstanding, a nurse may adopt an unsentimental approach to care based on training and previous experiences. This observation is consistent with the position of Wright *et al* (2014) on how providers' training and experience account for their scientific perception and approach to diseases and care.

Part of the strategies deployed by care providers in reducing anxiety is recourse to the supernatural. This explains why the nurse in the second scenario described under emotional control strategies employed prayers as a tool to reduce patients' perceived fear of labour. Aside from prayers, she also gave realistic expectations of their choices; this approach to care would foster patients' receptiveness of her counsel. Providers' sensitivity to spirituality in care delivery is of tremendous importance in

this part of the world, as previous studies observed pregnant women' s preference for mission and faith-based maternity centres despite the danger inherent in some of those centres. However, research has shown that strategies for emotional control are best conveyed through non-verbal means. Such non-verbal cues as facial expressions and voice pitch are usually clear indications of emotions. In this study for example, women in the latter stages of pregnancy were spotted in the group spaces through their non verbal cues. Care providers did not however communicate in response to the women' s perceived needs. Such women could, for instance, be attended to promptly as timeliness in care delivery is a perennial health problem in the country. Interviewed providers attributed the lack of timeliness in care delivery to a shortage of personnel. Though the problem may be systemic, it is also cultural and endemic, since many Africans do not honour time bound appointments (Ogunfowokan & Mora 2012).

Furthermore, care providers may respond inappropriately to women' s perceived emotional demands because of a deficient training in emotional intelligence. Examples abound of nurses' verbal and non-verbal cues that depict insensitivity to patient needs. Emotional sensitivity is the shared level of empathy in an interaction. Thus, the relationship between interlocutors is measured by partners' emotional sensitivity (Siminoff & Step 2011). To this end, pregnant women' s perception of empathy in a caregiver will influence their adherence to counselling or treatment regimen. Indicators of empathy in caregivers are such non verbal cues as a sympathetic or friendly tone of voice, a reassuring touch and smile.

The interpersonal control strategies employed by nurses in this study depict a lopsided relationship between pregnant women and the nurses. This is because nurses welded more power over the expectant mothers. Their relationship could, as a matter of fact, be likened to a teacher-student one where the student assumes a submissive role. This is reflected in the first scenario where nurses treated pregnant women who were late for prenatal care as a teacher treats erring students. The second excerpt is not any different from the first because the nurse transferred aggression to the women. Similar to how nurses' job roles and statuses affect relational goals, patients also communicate based on stereotypes. Stereotypes occur when the brain is confronted with ambivalent information and individuals are unwilling to discard perception that

does not conform to initial beliefs. Thereafter, interpersonal and group level communications are threatened. The formation of stereotypes also creates a Pygmalion effect since individuals are expected to behave in particular ways which further exacerbates divisiveness in interaction. Similarly, Farzadina and Giles (2015) argue that clinical interaction between providers and patients are influenced by stereotypes and role play with consequences on emergent patient-provider relationship. The perception of interpersonal control strategies in clinical interaction is also gender-based. While women perceive the adoption of such strategies as over-accommodative, men believe that providers' conducts are influenced by the demands of their profession (Farzadina & Giles 2015). Interpersonal and intergroup relations naturally influence human communicative behaviour. At other times, individuals relate with others based on relational goals or needs. Therefore, people' s preference for symbiotic relationships stems from a desire for mutual benefits. As concerns the nurse-patient relationship the situation is not much different; nurses may be unmotivated to relate interpersonally with patients if there is no perceived benefit. Providers neglect nurturing friendship ties with patients also for ethical reasons as the formers' clinical judgement may be hampered. Whatever the reason for providers' communicative behaviour, conversational strategies are not static but are varied by interlocutors throughout an interaction.

Aside from the conversational strategies that were employed in the group spaces, there were also observed differences in the group composition of each of the sampled hospitals that affected the relational dynamics. The differences in the group composition of both Maternal and Child Health Apata and Moniya General Hospital for example, are expected as, according to Forsyth (2010), no two groups are the same in terms of origin, purpose, membership and other defining elements. In the context of this study, however, there is a similarity of purpose, which is to equip expectant mothers for self-care. Achieving the goal of care therefore, is a function of each group' s relational dynamics while a core determinant of group dynamics is its membership. Pregnant women belong to prenatal care groups only upon initiation of care. Membership is thus influenced by women' s choice of facility, which is, in turn, a function of proximity to official or residential abode. Concerning the psychographics of the pregnant women, a nurse at the Maternal and Child Health

Apata affirmed that the businesses of some regular attendees are situated close to the facility. According to her, such shop owners are usually reluctant to honour their prenatal appointments because of monetary gain. Hence, such shop owners rarely mingle with other participants as they hurriedly leave the hospital for their work places.

Such behaviour has implication on collaborative learning within the group this is because some members are mentally disconnected from the group. The situation at the Moniya General Hospital however departs from that of MNCH Apata. One of the nurses at Moniya in an interview explained that, the facility attracts a more varied number of patients owing to the existence of the Hausa community in that area. Specifically, in such facility, language incompatibility portends more relational challenges for both nurses and group members because of the perceived interpersonal aloofness of Hausas. Similarity or dissimilarity existing among interlocutors in a group affects affiliation within the group (Burgoon, Buller, Hale, & Deturck, 1984). If the group' s composition is such that members share a common frame of reference, it is highly probable for members' relationship with others to deepen. For instance, language would not be a barrier to communication when two educated people of different ethnic groups are conversing. However, two uneducated people from different ethnic groups may be unable to communicate effectively, especially when they do not share a similar language.

Aside from language, the nurse at the Moniya Hospital also alluded to the low literacy level of patients and its effect on timing of prenatal care. Unlike other public health facilities situated at the city centre, pregnant women at the Moniya hospital are not sanctioned for obvious reasons. This implies that the facility recognises the implication of culture on individual health practices as sanctions will discourage attendance altogether. This observation mirrors that of Inott and Kennedy (2011) on how patient' s culture, needs, interest, literacy and motivation influence health behaviour. Therefore, such indices should guide nurses' teaching styles. In other words, learning should be fostered in an environment where patients are not passive receptors of information but co-creators of knowledge. As a matter of fact, the environment at MNCH Apata was not conducive for learning due to noise level and

distraction from other sections of the facility, while that of Moniya General Hospital was relatively less noisy.

The group composition in each of the prenatal care clinics actually determines pregnant women' s participation at the health education classes. Pregnant women' s perceived attitude to discussions at both MNCH Apata and Moniya General Hospital for example, differs. This may be due partly to differences in the language of instruction and nurses' expertise in message delivery. It was observed that care provider' s style of delivery influenced expectant mothers' participation within the group. For example, at the General Hospital Moniya, the same nurse (a Senior Nurse) who employed both English and Yoruba as a medium of instruction, consistently displayed a mastery of the subject and an ability to motivate pregnant women to participate in the discussion. The other nurse (a Junior Nurse), was, however, less adept in handling either the subject or the participants. The result of these perceived differences in delivery may account for the divergent responses of the pregnant women to the discussion. For example, at one of the sessions, side-talk and confusion were observed among the women as some of them were unable to give correct answers to the questions posed by their facilitator. It took the intervention of one of the Senior Nurses in the clinic for the situation to be resolved. The Senior Nurse intervened by making some clarifications before participants could give correct answers. Thus, and according to Harris and Sherblom (2008), the foregoing scenario is expected as larger groups such as characterise the Ibadan group prenatal clinics, pose greater challenges to leadership and management of individual differences. Aside from the effect of group size on group dynamics, it is also clear from these findings that nurses' experience in clinical health education play a huge role in affecting patients' receptiveness to information.

Additionally, at the MNCH Apata, during one of the health education sessions, an expectant mother showed indifference to the subject of discussion having been rebuked earlier on for misbehaving. Her offense was that she had instigated other women in the group to demand for the commencement of the health– talk programme at a time the nurses were apparently not ready to start as some of the participants had gone for a pelvic scan. To the nurses, the woman exhibited a ' dysfunctional

behaviour' but in actual fact providers have failed to identify with emerging realities on patient empowerment in the health sector. For Abiola, Udofia and Abdullahi (2014), the debate on patients' empowerment in Nigeria is ongoing because of the general low level of health literacy among Africans. Nowadays however, information accessibility via different platforms online is gradually changing the status quo and providers need to communicate in ways that depict partnership and not superiority. In addition, the ' dysfunctional' behaviour may have contravened group norms but the nurses could have communicated their disapproval in a more subtle manner. Apart from the woman who displayed the perceived ' dysfunctional' behaviour, other members listened attentively to the delivery. The facilitator also gave room for participants to seek clarifications where needed. On the average, the level of participation among women in the group sessions at both hospitals can be described as moderate.

Furthermore, a comparison of the relational dimension to message delivery in both facilities indicates that though a sedentary position is expected from pregnant women, for nurses handling the health-talk, adopting such a position has implication on their ability to maintain eye contact with all participants in the group. A sitting position for the caregivers could indicate ' dominance' in the existing power relationship between participants and the care giver. Dominance as described in the literature is an imbalanced communication pattern between patients and care providers occasioned by differences in providers' and patients' background and with consequence on the clinical encounter (Mast, Hall, Cronauer & Cousin, 2010; Siminoff & Step, 2011). Relational partners in medical interactions also exert dominance in conversation through the use of imperatives, statements of assertion, asking too many medical questions and the use of declarative statements (Rogers & Escudero, 2004; Mast, *et al*, 2010). Nevertheless, a sedentary position may actually be considered in a positive light if the facilitator is seated in the midst of participants. This view is based upon the principle of immediacy, a non-verbal communication cue that measures physical closeness or intimacy between/among interlocutors. According to Siminoff and Step (2011), the cue is considered a dynamic variable adopted in determining other variants of non-verbal behaviour.

Another indicator in the interactions within the group that points to dominance on the part of the facilitator is the delivery style. A facilitator who opens the discussion with a direct introduction of the subject matter takes the lead in the interaction and usually, participants follow suit by adopting a ‘ submissive stance’ . A more appropriate approach, therefore, could be for a facilitator to initiate the interaction by asking questions based on the previous discussion or asking the care receivers their preferred subject of discussion. While nurses at the Moniya Hospital were more familiar with that method of facilitation, rarely did the nurses at the MNCH Apata open the education session with questions. Mast, *et al* (2010), observe that patients perceive as less dominant an open ended approach to questioning rather than its closed ended counterpart. Across the surveyed hospitals in this study, provider dominance was a common practice, which is consistent with the findings of Mathibe-Neke (2008) that midwives are exploiting the routine nature of maternity care to dispense prenatal care in a ritualised fashion

At both the MNCH Apata and Moniya General Hospital, the teaching style adopted by the nurses in facilitating the sessions was aimed at persuading pregnant women to adopt healthy behaviours. More emphasis was on correcting superstitious/cultural beliefs on diet/nutrition and lifestyle of the women. This observation reflects the view of Siminoff and Step (2011) on ‘ social influence’ —a measurement parameter of relational communication—that depicts caregivers’ persuasive ability in fostering patients’ compliance to recommendations. Care providers wield social influence during medical interactions with such tools as guilt or threat. At other times, patients’ erroneous assumptions are corrected through statistical evidence or anecdotes. In this present study, providers across the facilities adopted more persuasive strategies, threat and anecdotes than other tools of social influence. It was, however, observed that the non-verbal communication of the nurses in most cases contradicted their verbal messages, especially during the health-talk sessions. This observation was found to be common among nurses across five out of the eight sampled facilities. For instance, it was observed that a particular Junior Nurse at Moniya looked bored and remote as she facilitated a session of the health-talk.

Backstage discussion amongst the nurses at the end of the delivery, however, unveiled the reason behind the lacklustre delivery of the nurse in question. Apparently, health workers just resumed from a nationwide industrial action at the time and the state government was yet to effect the payment of their salaries. Thus, the nurse who had sounded bored, it was revealed, had not received any salary at all in that year. In a brief interview with her, she acknowledged that she was a newly employed staff of the Oyo state government and was yet to receive any salary. In a way, the provider' s behaviour is excusable considered against the backdrop of an absence of motivation from her employers. However, impressions of her personality are gradually being formed in the minds of patients. Though they may be erroneous, once such schemas are subconsciously ingrained, they are difficult to change even in the face of contradictory information. This result reveals a lot of information about the influence of environmental conditions on nurses' behaviour and the need for private sector collaboration in health care management.

Nevertheless, throughout the period of observation, on the average, the nurses at both health facilities made good use of eye contact not only in teaching but also in ensuring effective participation within the group. Hence one can describe their facilitation skills as fair. In effect, they displayed adequate knowledge of the issues discussed. Notwithstanding that, teaching aids such as instructional materials were rarely employed at virtually all the sampled hospitals. This finding is consistent with that of Akin-Otiko and Bhengu (2011) who report that none of the focus groups in a study they conducted in Kaduna State made reference to the nurses ever employing IEC (Informational Educational and Communication) materials to facilitate the learning process.

Furthermore, in this current study, pregnant women' s responses to the survey indicate that not all nurses made eye contact with the expectant mothers in the course of dispensing care. Out of the four nurses who dispense care, three were perceived by respondents as having made an effective use of eye contact. Weger, Bell, Minei and Robinson (2014), have acknowledged the connection between eye contact and rapport building especially in initial interactions. Additionally, Weger *et al* (2014) held that eye contact is a key indicator of responsiveness, friendliness and interlocutors' social

skills. In contrast, only a few of the participants in the present study, were convinced that nurses actually showed empathy in the course of discharging their duties, as indicators under the category " concern for patients" point out. In an interview with one of the nurses, she debunked the notion that nurses generally lacked empathy, she stressed that the situation at hand will determine a nurse' s professional approach.

Each of the indicators' for the rapport skills were tested adopting the constructs from Kelly' s covariational model of causal attribution. Respondents perceived nurse A' s rapport building skills as inherently part of the care giver' s disposition to patients. Similarly, they attributed nurse D' s poor rapport building skills to a deficiency in personality traits. Hence, nurses who are adjudged by care receivers as being high in rapport skills were consistent and rarely exhibited a contrary behaviour, except in the face of challenging situations. In like manner, nurses that were perceived as being low in rapport building skills frequently displayed deficient behaviours. Situational contingencies such as workload, inadequate incentive and stress can as it were, mitigate care givers' ability to build rapport with clients. The reliability of ' perceptual studies' has however been contested by scholars who debate its objectivity. There is an argument that individuals' ' schemas' (mental frame) are built about others' behaviour from past experiences and learning. Hence, with particular reference to this present study, expectant women relate with nurses based on initial experiences and learning. This conforms to the principle of the attribution theory that humans tend not to adjust their initial perceptions of others even when confronted with contrary information. Therefore, individuals' fears, desires, motivations, aspirations, needs and interest affect perception which explains the differentials in individuals' interpretation of the same cue (stimuli).

Nevertheless, perception studies acquire reliability through various methods of validation. For example, if there is a consistency in the report of many people on a particular incident then there is a ' consensual validation' . Credibility is also accorded to a perception that occurs frequently. Perception studies can also be validated through comparison as it is used to measure differing perceptions of people on the same subject. In other words, an individual who has an in built ' schema' about the way nurses behave tends to relate with them based on the mental framework. Hence, such a person' s perception is compared with that of others to

determine its authenticity. All of the foregoing methods of validation were adopted at different stages of data interpretation in this study. Furthermore, participants' recall of information was enabled by the researcher when respondents were asked to judge the caregivers who have attended to them in the last two weeks. Finally, there is a pattern in the responses of subjects to suggest that indeed the first person that comes to respondents' mind is the one they perceive as possessing the best quality.

In clinical interaction, another important relational parameter is the provider' s listening skill. Majority of the respondents in this study did not regard caregivers as attentive to patients' body language. This has implication on providers' perceived responsiveness to clients' needs. Additionally, the hypothetical nurse D scored the lowest in listening skills while nurse A, had the highest listening scores; nurse B and C were in middle-level positions. The endpoint of nurses' rapport building, listening, information giving, confirming and perception checking skills is to establish therapeutic relationships with clients (Salehe & Njine, 2016). Such relationships are not by any means comparable to friendships as the goal of therapeutic relationships far outweighs those of platonic friends. When nurses, for instance, listen to care receivers' concerns it hastens the latter' s' healing process. That is why periodic evaluation of nurses' communication skills is vital as they interface more regularly with patients than any other care giver in a facility. The result from the focus group discussions and key informants across the facilities indicates that discussants perceived some nurses as good listeners, " I complained to a nurse just last week and she was of assistance. Sometimes they even correct doctor' s mistakes" affirmed a key informant at Adeoyo Maternity Teaching Hospital.

A group of discussants at another facility believed " that majority of the nurses can be rated above average in their listening skills" (FGD at Ring Road Specialist Hospital). The above qualitative responses correlated with the quantitative result suggest that individual traits play a strategic role in nurses' ability to listen well to care receivers. However, as opined by Mchugh, Kutney-lee, Cimiotti, Sloane, and Aiken, (2011), Golfenshtein and Rrach-Zahavy (2015), there is a relationship between nurses' ability to display such relational skills as listening and the availability of organizational and governmental policies that motivate staff. In other words, patients

are likely to report dissatisfaction with care in facilities where nurses experience poor health benefits, burn out and disharmony among hospital workers. Thus, and in conformity with the propositions of the systems theory, hospitals as health organisations are constantly striving for balance or entropy as they interface with their numerous publics. They function not only to exist but also to attain relevance in the larger supra system (society). Therefore, such balance/entropy can only be achieved in hospitals when research focuses not only on care receivers' needs/expectations, but also on the challenges confronting hospital staff. It is therefore apparent that individual psychological factors and situational contingencies played a role in influencing people' s perception of nurses' behaviour. However, respondents' ' evaluation of nurses listening behaviour depicts those behaviours are motivated more by psychological disposition rather than situational factors. According to the theory of attribution, when individuals attribute others' behaviour to internal more than situational factors, it points to consistency in behaviour. If the action under consideration is negative, the individual(s) whose conduct is under review may be assisted to modify the observed behaviour. With particular reference to this current study, when pregnant women attribute nurses' behaviour more to internal than situational indices then there is a lot to be done in terms of designing appropriate interventions. Such interventions on skills building will be targeted at care providers who lack the required skills set. Nurses emotional awareness will also enable them to receive regular feedback from colleagues and significant others in their network. Larsson, Sahlsten, Segesten and Plos (2011), argue that the existence of clinical nursing group supervision allows nurses to critically appraise themselves through monitoring from others.

Unlike the pattern of responses obtained under the rapport building and the listening skills categories, respondents generally scored nurses low in confirming skills. Out of the six parameters adopted in determining nurses' confirming skills, nurse A was adjudged by a good number of the respondents as possessing better confirming skills, while other nurses fared poorly in this segment. The responses elicited from the survey depict how care receivers perceived nurses ' confirming' behaviours. Put simply, confirming behaviours are regarded as such, because they confer a level of esteem on the recipient of such actions, while ' disconfirming' behaviours reduce

receivers' self- esteem (Simmons, 2011). ' Confirmation' and ' disconfirmation' messages are expressed in an exchange verbally and non-verbally. Confirming responses consist of direct response, clarification, supportive response and expression of positive feelings. Disconfirming behaviours on the other hand are exemplified by one-sided laughter, irrelevant responses, side remarks or any attempt at reducing the self-esteem of another. Research has shown that expectant mothers require a high level of social support from those in their network and more importantly from their caregivers as the physiological conditions of pregnancy account for the release of certain hormones which trigger depression during pregnancy (NIHCM brief, 2010). Apparently, when pregnant women seek care, they expect some level of respect and non-judgmental attitude from providers, but in most cases, this need is seldom expressed (Shay, Dumenci, Siminoff, Flocke & Lafata 2012; Salehe & Njine, 2016). Notwithstanding this, some previous studies on patient-provider communication indicate care providers' poor communication skills Envuladu, Agbo, Lassa, Kigbu and Joakah, 2013; Nnebue, Ebenebe, Adinma, Iyoke, Obionu & Ilika, 2014). In this current study, some nursing mothers in the focus group discussions and key informant interviews attributed nurses' disconfirming behaviour atimes to patients' misdemeanour. According to them, some other factors that may explain nurses' poor confirming behaviour is related to mood swings, personality traits or work- related pressure.

With respect to nurses information giving skills the hypothetical nurse A and B were confirmed by study participants as better skilled in information giving. Majority of the respondents perceived nurses A and B highly in terms of speech clarity, depth of teaching and knowledge of the subject matter. However, nurse A ranked the highest out of all the four nurses. These findings mirror the position of Keyton and Beck (2009), and Barbosa, Piccolo and Barbosa (2019), on the connection between relational communication and perception of technical expertise. According to the scholars, individuals that are regarded as better skilled in relationship building and maintenance are perceived as more knowledgeable, hence it can be inferred that there exists an inverse relationship between clients' perception of caregivers' technical skills and the latter' s relationship building skills. In other words, nurses whom clients acknowledge as likeable are perceived as having more technical expertise than their counterparts that are regarded as less friendly. Ali (2017) contends that nurses'

information-giving skills have implication on clients' compliance with the treatment regimen while also ameliorating psychosocial problems. Additionally, he argues that the basis for patients' complaints in surveys is their inability to access adequate information from care providers or the latter' s poor communication skills. There is however a correlation between nurses' information-giving skills and care receivers' recall of information. The result of the focus group discussion shows that majority of the nursing mothers had a high recall rate of received information as many of them could vividly recollect topics learnt during the health– talk. This does not however foreclose the importance of constant retraining programmes for nurses to update their knowledge on evidence based practice.

Several factors may however militate against care givers in their quest for further education. Such factors include financial constraints, organisational attitude to training programmes and nurses' willingness to learn. The propositions of the attribution theory as applied to the issue state that when individuals are besieged by problems that are extrinsic, such problems can be mitigated, especially if the individual is internally motivated to change the situation. Consequently, the perceived financial and organisational bottlenecks are best addressed through willingness to learn. There is however evidence to suggest that even nurses who attend periodic seminars or workshops rarely implement acquired knowledge in nursing practice (Mashiach-Eizenberg, 2010). Be that as it may, feedback is another relational construct that was measured in this study. Out of the four nurses under review, nurse A was perceived as being more approachable in terms of receptiveness to patients' feedback. One of the hallmarks of a patient-centred facility is providers' awareness of care receivers' perception of care. Such perception of health care services is multifaceted; however, with respect to this particular study, providers require feedback from care receivers on the relational quality of care delivery in the facility. As contained in the literature, the relational aspect of care determines to a large extent clients' perception of the ' functionality' of care (Iloh, Ofoedu, Njoku & Godswill-Uko, 2013; Onwuzu, Ugwuja & Adejoh, 2014; Onigbinde, Oyedemi, Tarimo & Mukoka, 2014). Feedback in actual fact ensures commonality in meaning between clients and care providers. When there is shared meaning between nurses and expectant mothers mutual trust is built and this has consequence on fostering collaborative care.

Timeliness in care delivery is another index of relational communication behaviour that was investigated in this present study. Only a few respondents agreed that nurses spent enough time with them in the course of clinical care. This development is consistent with the position of Oladapo, Iyaniwura and Sule-Odu (2008), who in a study described as inappropriate the time care providers spend with pregnant women particularly, as it did not conform to stipulated requirements of the World Health Organisation (WHO). Conversely, perception of brevity in nurses' attention to patients' needs is expected since provider-patient ratio falls far below WHO requirements. The general consensus among interviewed nurses in this study is a call for the recruitment of more nurses to serve the maternal and general health care needs of the citizenry. Nonetheless the inadequate number of nurses, previous studies have shown how well nurses have fared in the delivery of the technical aspects of care (Oladapo *et al* 2008; Nwaeze, Enabor, Oluwaola & Aimakhu, 2013). Time as an intangible aspect of care quality is also a determining factor in relational care. This may well explain why Evans and Bullock (2017), describe the nature of prenatal care as rushed and focusing only on child and mothers' physical health. Relational or therapeutic care is impracticable where adequate time is unavailable for providers to understand patients' expectations and dispense care accordingly. Interestingly, respondents in this study affirmed that nurses failed to relate with patients based on the latters' point of view, as only a few of the study participants believed that nurses could view issues from patients' perspective. This observation mirrors that of Farzadina and Giles (2015), who argue that there is dominance in medical personnel's pattern of communication with patients. This is however to be expected as and according to Siminoff and Step (2011), the formality of a relationship to a large extent determines its relational communication pattern. For example, while the relationship between siblings and co-workers may be informal, that of nurses and patients are more formal. Hence, a highly formal relationship between interlocutors will lend itself to a low pattern of relational communication.

Therefore, in this present study, the researcher sought to investigate respondents' active participation at the health- talk classes to ascertain the formality or otherwise of the sessions and possibly understand underlying factors which may affect the effectiveness of the sessions. There is an inverse relationship between nurses' relational skills and women's participation at the health– talk programme as more

respondents valued efficiency in the facilitation skills of nurses as well as the latter' s friendly disposition. The implication of pregnant women' s participation in the health education classes is multifaceted. First, when women actively participate in terms of asking and responding to questions, it breaks through the monotonous presentation of the nurses and allows for the introduction of real life or practical experiences. Secondly, it encourages the nurses and helps to further boost their confidence level. In contrast, nurses are less challenged in a group where majority of the women are unresponsive. The result in this section points to the fact that more women were concerned about discussions relating to challenges encountered during pregnancy. Consequently, the group provided a forum for such women to relieve their burdens and learn from others' experiences. In other words, apart from the assessment and health education expectant women received in the group spaces, they also derived social support from one another as they interacted amongst themselves. Social support during pregnancy reportedly plays profound role in positive birth outcomes and behavioural changes (Bolger, Zuckerman & Kessler, 2000).

Meanwhile, the differences in hospital' s level of care, staffing, funding and service intensity affect nurses' ability to dispense relational care. In this study, two key informants (a nursing mother and a CNO) at Adeoyo ascribed some of the perceived problems in patient-provider relational communication to structural indices like staffing, level of care and specialisation. This finding mirrors that of Nwosu, Iyama and Emeka (2017), in the area of major structural indices affecting nursing care. It is however difficult comparing the result of this study with earlier ones because of differences in study population and design. While the Nwosu *et al* (2017), study was conducted in Benue State, this present study occurred in Ibadan, Oyo state. The Benue study sampled patients' opinion on nurse-patient relationship through a cross-sectional design but this present one adopted a mixed method approach. In contrast, McHugh, *et al* (2011), argues that disproportionate staff-patient ratio has implication on hospital' s service volume and provider work load. The argument here is that, an inadequate nurse to patient ratio affects nurses' ability to provide therapeutic care to patients, as nurses suffer burn out as a result of work load and shift patterns. The therapeutic nature of nursing requires patient-provider encounters to be relationship driven as patients have reportedly experienced increased hospital admissions, drug

abuse and non-adherence to medical counsel as a result of miscommunication. Miscommunication occurs frequently in health encounters particularly as stereotypical notions influence the patient-provider interaction. However, the existence of a positive provider-patient relationship reduces miscommunication as psychological noise is less apparent.

As earlier stated, relationship building and maintenance between patients and providers are influenced by certain indices such as for example adequate staffing which affects individual provider relational care. It is unrealistic to expect nurses to dispense therapeutic care to patients when the nurses are too few in comparison to available patients. Even if the nurses make personal efforts at therapeutic care, other indices of relational aspects of care will be negatively affected. Timeliness in care delivery will of course be adversely affected as providers will spend more time relating interpersonally with a patient while others experience delayed access to care. Part of the recent improvements in prenatal care in Nigeria is the Focused Antenatal Care (FAC) model. The FAC requires that providers should spend at least thirty minutes in clinical interaction with patients. The implication of such policy on practice is in two dimensions. The first is an increased depth in patient-provider interaction while the second is a delayed access to care. The identified dimensions to practice are at opposite ends of a continuum as the caregiver is torn between fulfilling her ethical responsibility to patients and also reducing the perennial clinical problem of timeliness in care delivery. This of course explains why a facility such as the Adeoyo Maternity Teaching Hospital leverage on the availability of student nurses from the School of Nursing and Midwifery Eleyele, University of Ibadan and Obafemi Awolowo University Ile-Ife, to assist in relieving work load. The availability of such interns may reduce job-related stress but does not significantly reduce patients' waiting time as caution is taken in assigning tasks to the student nurses. Thus and according to the CNO at Adeoyo " we check the roaster to identify wards where the work load is lesser and we second members of that unit to the prenatal section" . It is therefore apparent that at Adeoyo Maternity Teaching Hospital for example, the existence of structural elements like tertiary level of care, specialisation and staffing affected nurse' s ability to relate with expectant mothers. At the JSH however, the relatively smaller clientele reduced patients waiting time.

Additionally, Umar, Oche and Umar (2011), affirmed that patients' waiting time is a crucial determinant of hospitals' service quality because time is an intangible aspect of service quality that clearly communicates how a facility relates with patients. More importantly as concerns tertiary providers of health care, Ogaji and Mezie-Okoye (2017), stressed the importance of investigating the constituents of delays and devise corrective measures in order to improve patient health experience. Another way of mitigating delays in hospitals according to Ogunfowokan and Mora (2012), is the implementation of a time-bound appointment system however, this is foreseen as unrealistic, especially in Nigeria, where there are systemic issues. A more appropriate approach would be to identify the constituents of the delays and devise strategic steps of reducing them (Ogaji & Mezie-Okoye, 2017).

Technological sophistication is another structural index affecting nurses and pregnant women's relational communication. Between MNCH and St Peters Hospital Aremo only MNCH reported unsavoury issues with the government provided manual isotonic as its readings recorded inter-uterine foetal deaths for many pregnant women. Expectedly, the development had relational implication on the women's psyche, as many of them were thrown into unnecessary panic hence providers had to subject them to periodic pelvic scan for accuracy in diagnosis. The management substitution of regular palpation for pelvic scan challenged expectant mothers' financial capacity hence a more realistic approach to the situation was approached. An electronic isotonic was procured by the hospital management as soon as funds could be harnessed. It can therefore be inferred that the experience not only affected relational communication between providers and pregnant women but also created friction among health workers. The dearth of physical infrastructure and a lack technological sophistication of MNCH Apata may have affected patronage over the years as the highest number of pregnant women in attendance at all the observed sessions in the clinic was twenty. Although, an interviewee at the facility, a Chief Nursing Officer claimed that, " the Sallah break may be responsible for the low turn-out, as more women initiate prenatal care in the hospital" . However, at the different visits paid to the facility only a few women were in attendance on each occasion.

A reduced clientele has positive implication on the relational communication within the group prenatal care programme. As observed by Cubaka, Schriver, Cotton,

Nyirazinyoye and Kallestrup (2018), one of the indices affecting the dimensions to patient-provider communication are hospital staff working conditions. Nurses are more inclined to dispense relational care when patient volume is minimal. In other words, the higher the number of patients the greater the tendency for caregivers to adopt the biomedical approach to care, conversely the opposite applies when clients size is minimal. At both hospitals, there were small numbers of pregnant women in attendance at the prenatal sessions. There is evidence that client size of a hospital is a function of the clients' perceived satisfaction with the care quality (Ezegwui, Okoye, Aghaji, Okoye & Oguego, 2014; Ogaji & Mezi-Okoye, 2017). Though, a potential benefit of a small clientele is the perceived improvement in relational communication, strategic measures ought to be directed at increasing patronage at both hospitals. Such objective may, however, be daunting as funding is a lingering problem in the health sector.

Structural variables like location, client size, nursing staff strength and atmospherics have implication on relational care. For instance the preponderance of Hausa-speaking women around Moniya axis calls for increased sensitivity to cultural differences especially on the part of the care providers. A characteristic feature of northerners more importantly the Hausa-speaking ones is patriarchal nature of the society as well as the fusion of religion and culture in that society. Sinai, Anyanti, Khan, Daroda and Oguntunde (2017), in a systematic review of related literature stressed the role of interpersonal network on Hausa women' s prenatal and birthing decisions. These scholars also observe that Hausa-speaking people unlike other tribes in the country have a strong sense of cultural identity. For example, culturally, among the Hausa-speaking people, home delivery is perceived more favourably than facility-based birth. As it is a thing of pride for a first time mum to have her baby delivered at home unsupervised by a skilled birth attendant.

Nurses who are armed with such knowledge will better understand the inner struggles of migrant Hausa-speaking women. Such women require a higher level of support from providers as their cultural beliefs conflict with the content of health education and counselling given during prenatal care. This may well explain why more expectant mothers reportedly initiate maternity care late at the Moniya General Hospital. The result of research on delayed access to prenatal care is region specific.

For example, in a qualitative study among vulnerable groups in the United Kingdom, Haddrill, Jones, Mitchell & Anumba (2014), attributed hospital characteristics and nurses ineptitude as part of the reasons women register late for prenatal care. Yunusa, Irioye, Suberu, Garba, Timothy, Dalhatu & Ahmed (2014), in a Nigerian study, however, argued that a major reason why women initiate prenatal care late is poverty. As a matter of fact, Yunusa *et al* (2014) confirmed that health financing in the country is still at its infancy as many Nigerians still engage in out-of pocket health expenditure which explains the introduction of a National Health Insurance Scheme (NHIS) in 2007. While the scheme is beneficial to paid employees such as civil servants, the vast majority of self employed and unemployed Nigerians are not covered by the scheme.

Meanwhile, as at the time of conducting this study, the prevalence of atmospheric noise at the Jericho Specialist Hospital militated against effective interpersonal interaction not only between care providers and expectant mothers but also among the pregnant women. There is a permissible decibel level of noise in hospitals. Two earlier Brazilian studies on noise are consensual that noise is a preventable occupational hazard in many hospitals (Costa, Moreira de Lacerda & Marques, 2013; Andrade, Souza & Maria de Matos, 2016). The earlier of the two studies affirmed that noise in hospital settings are often facilitated by nurses (Costa, *et al* 2013). This is in tandem with hospital observations in the present study as nurses were often seen chatting in loud voices with colleagues, patients and vendors. However hospital noise may also be produced from sources like crying infants, hospital evangelists, vendors, equipment, alarms or power generating set. Noise level in hospitals peaks in the evenings during visiting hours when family and friends converse with patients and or providers. Noise pose auditory, psychological and physical hazard to nurses' health. Many nurses under constant exposure to noise in the Costa *et al* (2013), study, suffered from tinnitus and extra auditory irritations. Other nurses complained of headache, insomnia, mental lethargy and a diminished productivity.

In addition, patients also experienced psychological and health problems associated with high noise levels. For example, lactating mothers in maternity wards reportedly experienced decreased milk secretion occasioned by noise. Noise may also interfere

with the recovery of hospitalised patients as well as hinder proper infant development. Though the precise effect of noise on pregnancy and neonatal developments are unknown nevertheless, Andrade *et al* (2016), affirm that noise does have a negative effect on pregnancy. For Wachman and Lahav (2011), noise has grievous implication on respiratory and blood circulation in preterm infants. It could also interfere with proper development of the nervous system in such children. An interesting dimension to all the aforementioned health implications of noise that is yet to be explored in literature is its effect on nurse-patient relational communication. For instance, nurses who suffer from insomnia constantly may find it difficult ascertaining its cause and if the root cause of the ailment is unknown, only the symptoms will be addressed. Hence such nurses' productivity at work will gradually decline. This will ultimately affect their ability to dispense care in a relational manner. Similarly for pregnant women, noise hinders learning and retention as a matter of fact the facilitator may be demotivated to teach, if pregnant women seem distracted.

Furthermore, differences in hospital client size have relational implication, the larger the clients base, the lower the relational dimension to communication between providers and clients. This finding is in consonance with previous studies on how hospitals with large service volume such as JSH are prone to attend only to the technical aspects of care (Okochili & Haoliang 2017). Providers in a bid to dispense care in a timely manner resort to the traditional method of nursing which is the biomedical approach. A large clients' base also has implication on the availability and sustainability of hospital infrastructures. Clients at the Jericho Specialist were so much constrained for space that some of them crouched or stood during the health education session. This finding is in tandem with that of Nnebue, *et al* (2014) where women in focus groups reportedly complained of limited seats during prenatal care. A similar situation was also reported in a Kenyan study where pregnant women complained that their spouses were discouraged from accompanying them for care because of inadequate seats (Kiptoo & Kipmerewo 2017). Finally, hospital seating arrangement has implication on the extent of interaction among patients. Chairs positioned along hospital walls inhibit social interaction while positioning chairs around tables in the middle of a room fosters communication among patients

especially those inclined to it (Huisman, Morales, Hoof, & Kort, 2012). Incidentally, all the sampled facilities in this study had chairs placed against the hospital walls.

Aside the foregoing, hospital feedback structure and provision for clients' privacy are also parameters that affect relational care. Majority of the hospitals in the present study lacked a standard operating procedure for checking patient' s perception of services. Only the hospitals at Adeoyo, Oluyoro, Jericho Specialist and Aremo had some semblance of feedback structure in place. Nonetheless, the structure at Adeoyo and Oluyoro ostracised non-English speaking pregnant women as the written notice would have been translated into Yoruba and pidgin. Facilitators of prenatal care could also talk about the availability of feedback services during prenatal care. It is however possible that the written notice was not targeted at the non-English speaking women as previous studies have shown that uneducated women are usually uncritical of health workers (Adekanye, Adefemi, Okuku, Onawola, Adeleke & James, 2013; Olumodeji & Oluwole, 2015; Okochili. & Haoliang 2017). Such women, considering their little exposure, ignorantly accept available health services; moreover, uneducated patients and others with low purchasing power feel inadequate to critique the services of health workers. Be that as it may, the other feedback mechanism at Adeoyo that involved a team of nurses may not achieve desired results especially as the composition of the team will hinder information disclosure. The team composed of chief nursing officers in the facility and patients may be unwillingly to divulge information orally to management staff of the hospital. A more appropriate approach is questionnaire development and administration to a convenient sample of pregnant women. Copies of the questionnaire should be available in major Nigerian languages and interviewer administered particularly to poorly educated participants. This is because a representative opinion of the various categories of patients is required for informed decision making as patient feedback is necessary for health care planning, policy implementation and change management in the health sector (Karaca & Durna, 2019).

Patients' evaluation of nursing care should be consistent and management driven in order to identify the gaps between expected and received care. However, there is an indication from previous studies that patients' satisfaction surveys are sometimes

misleading for baseline data as patients report high satisfaction even where there are disparities between their expectations and received care. Nonetheless, regular hospital management research on service delivery can be integrated into care delivery where patients are required to fill surveys on their experience of care. This has been the practice in NHS (National Health Survey) hospitals in England for more than a decade. Although the practice is accompanied with challenges, it has certainly enhanced certain components of care delivery (Reeves, West & Baron, 2013). This is a feedback mechanism observed to be clearly lacking in sampled hospitals in this study. The concept of feedback in prenatal clinics was explored to determine the openness or closeness of hospital systems in the country. According to Cordon (2013), open systems relate with external environments and modify operations based on the relations. Hence, feedback is crucial to the development of such systems, whereas, with closed systems, there is no energy transfer between the system and the environment, consequently leading to a system collapse or degeneration. To Hayajneh (2007), all health care organisations are open systems as they relate with different publics.

The proposed feedback method at Aremo is laudable and unique to that hospital, the sustainability of such approach to feedback is however in doubt. Hospitals that institute methods for checking clients' perception are invariably empowering the latter to demand for quality care and also promoting equity in care delivery as feedback from patients allow for shared decision making. However, Rouse and Serban (2014), argue that public hospitals were not established to provide for quality care but merely to cater for patients' needs. It therefore, becomes difficult to demand for quality health care when the tools to achieve quality are clearly lacking. There are indications that the trajectory for care delivery in public hospitals will take a patient-centred dimension with the popularity of various health insurance schemes in the country. Apart from the National Health Insurance Scheme (NHIS), emerging health maintenance organisations also provide health insurance. With time, Nigerians will recommend hospitals of their choice based on the patient-centred quality of facilities while those lacking in that area will suffer neglect. Consequently, it will be difficult differentiating public from private hospitals as the lines of demarcation will be blurred.

Care providers in this study, displayed a high awareness of patients' privacy. Hospital physical structures could however inhibit information disclosure since majority of the facilities had no space for private discussions. Also, the limited availability of office spaces for nurses reduced clients' access to privacy, as more than one nurse occupied an office. Therefore, confidential conversations between pregnant women and nurses are likely to be overheard by many other providers. This finding is similar to that of Novick, Sadler, Powell Kennedy, Cohen, Groce and Knafl (2011), where women in a group prenatal care programme expressed an inability to discuss personal issues within the group context. Although the women in the Novick *et al* (2011), study discussed freely within the peer space, some sensitive or emotional issues could not be publicly expressed. Issues like intimate partner violence, financial constraints, drug abuse and even certain physical examinations require some level of privacy. Thus, Huisman, *et al*. (2012), suggests that privacy is achievable if physical barriers are erected or background music is provided. Physical barriers were observed at the Oluyoro hospital, the Ring Road Specialist and the Adeoyo Maternity Teaching Hospital. These barriers were however thin and confidential information could be overheard across them. Unlike the Novick *et al* study where women underwent physical examinations in the peer space, pregnant women in this study enjoyed relative privacy during medical assessments.

The importance of privacy during clinical interaction has also been restated by other scholars who argue that female patients place much premium on privacy and respect in clinical interaction (Umar, *et al,* 2011; Sword, Heaman, Brooks, Tough, Janssen, Young, Kingston, Helewa, Akhtar-Danesh & Hutton, 2012; Okochili & Haoliang 2017). Similar to this, is the position of Cubaka, *et al* (2018), who established a relationship between care providers' trust and patient' disclosure hence the need to examine how the group nature of prenatal care in the country affect care receivers' disclosure of confidential information. Majority of the interviewed nurses explained that individual prenatal care and counselling is provided to pregnant women within the group care programme. It is during such individual care that expectant mothers freely discuss their concerns. As a matter of fact some women delay sharing their personal issues till the end of the group session. A Senior Nurse at MNCH Apata explained " if there is anyone that needs confidentiality after the group discussion,

such a person see us one-one to discuss whatever the complaints are" . Another nurse at O.L.A Oluyoro also alluded to providing individual prenatal care especially in the examining room she however affirmed that the barriers erected for privacy is sound proof hence confidentiality of information is guaranteed.

Another strategy employed by nurses to ensure privacy in interaction is the grouping of pregnant women based on gestational ages. This practice is not universal across all the hospitals but peculiar to the St Peters Hospital Aremo. A reduced group size will facilitate better interaction amongst members but women may be wary of discussing certain sensitive issues within the peer space especially as men are often part of the groups in some hospitals. The fear of discussing physiological issues in the company of men was expressed by pregnant women in the Novick *et al* (2011) study. In the present study, men were observed during group sessions at Adeoyo, Ring Road Specialist Hospital and Jericho Nursing Home.

Finally, for this section, the findings in this study has shown that though public hospitals are static, its external environment is dynamic and constantly evolving as medical practice is becoming patient-centred, just as there are complexities in patient psychographics with an increase in the aging population and people of complex sexual orientation. Market failure is another reason public hospitals are not amenable to change. In economic terms, market failure implies abnormalities in the forces of demand and supply resulting to a shortfall in merit goods while demerit goods are in high supply. In the context of this study, merit goods are for example, medical supplies, infrastructure and equipment. Demerit goods on the other hand refer to workers' unrest, shortage of health personnel and conflict on health teams. There is evidence in previous studies to suggest that patients consistently experience market failure in the nations' health sector with the reports on poor drug supplies, dearth of infrastructure or equipment and sundry issues (Nnebue, *et al* 2014). Even when medical goods are supplied to public hospitals they are reported missing, stolen or inadequate. All of these issues have compounded the complexity of publicly owned hospitals. To Rouse and Serban (2014), however, transforming health care systems could be gradual, holistic and process driven. Feedback is part of the processes of care that enables behaviour modification and systemic change in hospitals. Results of the

focus group discussion at Apata support the need for suggestion boxes at all public hospitals for clients' perception checking. Patient feedback will drive systemic change if contextual problems in the health sector are addressed and health care providers are empowered to drive change at the unit levels. Feedback implementation will be a mirage where surveys are centrally administered and kept, in which case; such data gather dust in the Chief Medical Director (CMD' s) office. Since the provision of health care is governments' social responsibility, the health sector requires the governmental support and attention.

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

Preamble

This chapter presents a summary of the major findings in this study, its conclusions, recommendations, suggestions for further studies and contribution to knowledge. Each of the sub headings is presented in turn starting with the summary.

5.1 Summary

Nigeria practices a model of group prenatal care that is unnamed and unpopular in literature which explains why donor agencies are sponsoring the trial of foreign but more popular models of group care in the country. With the clamour for patient-centred medicine and care, it becomes imperative to examine if the inner workings of prenatal care groups promote relational communication between pregnant women and the nurses as well as the role of hospital external environment on processes of care. This study also investigated the characteristics of the group prenatal care programme and pregnant women' s perception of nurses' relational skills. A mixed method approach was adopted in proffering responses to the questions raised in this study. For the survey, 365 copies of questionnaires were administered to women of different gestational ages of pregnancy who must have made at least an attendance at the prenatal health education class. Similarly, investigations into the nature of group prenatal care in Ibadan was organised through in-depth and key informant interview guides. An ethnographic study of the sampled facilities was conducted to understand the narratives that depict ' relational dynamics' in group spaces and an observational guide served as a framework for the study.

The findings indicate marked differences in the scope and practices of existing group prenatal care models. For instance, the appellation of the other models (Centring Pregnancy and Parenting Partners) described in literature aims at their focal point whereas the Nigerian model has no means of identification. The absence of a particular name for the latter model explains why it is under-researched and in effect under-developed. This also accounts for why there is an absence of a formal structure in terms of a designed syllabus or guide for the health-talk program in virtually all the public health facilities except for Jericho Nursing Home where nurses are provided with an outline. Also, at Oluyoro, prenatal topics were arranged on a monthly basis. A designed syllabus has implication not only on the quality of education received at prenatal clinics but also on ensuring better coordination of care.

The approach to the biomedical aspect of prenatal care in Nigeria is similar to that of Ghana and South Africa as a routine medical screening of care receivers is usually scheduled, but not limited to urinalysis, PCV (pack cell volume test), foetal height and expectant mother' s body weight/mass index (BMI). In this study, nurses prioritised the technical aspects of care which is while relational care was regimented. Simply put, majority of the nurses adopted the biomedical culture of dispensing care while neglecting the socio-psychological approach to care delivery. The situation is worrisome in large public health facilities, such as Adeoyo Maternity Teaching Hospital, General Hospital Moniya, Jericho Nursing Home and MNCH Apata where nurses are pressured by a teeming population of clients. Expectant mothers in those facilities reported no significant difference in nurses' confirming skills. Consequently, variations in individual psychological behaviour and situational contingencies as enunciated in the attribution theory did not play any significant role in nurses' confirming skills in the aforementioned facilities. Whereas, variations in individual behaviour and situations were found to play a crucial role in nurses' differential approach to rapport building, listening, perception-checking and information-giving skills across the sampled hospitals. Hence, nurse A had significantly better scores in rapport, listening confirming, information giving and checking of perception skills. Meanwhile, the existence of an audit process in private hospitals has diminished care providers' dominance and control, allowing for increased power-sharing between nurses and care receivers.

Furthermore, there is no uniformity in the structure of prenatal care in Ibadan as there are obvious disparities in prenatal registration fee, availability of instructional materials, approach to marketing of baby formulas and feedback channels. In fact, while Jericho Nursing Home expressed stiff campaigns against marketing of baby formulas, the same situation did not apply at Maternal and Child Health (MNCH) Apata. Similarly, only Adeoyo Maternity Teaching Hospital was found to have an inbuilt feedback mechanism. The aforementioned systemic irregularities reveal why patients attend prenatal care in distant locations without referrals as people domiciled at Aremo were reported to be attending prenatal care at the Teaching Hospital without being referred by St Peters Hospital Aremo. Other systemic issues that account for variations in care receivers' care are connected to hospital location and ownership structure. These latter factors influence the facility's clientele and care providers' language in dispensing care. Conversely, nurses' language of instruction was a key determinant in pregnant women's judgment of their technical expertise. Incidentally, sign and language interpreters were unavailable at all the sampled facilities.

Finally, the minimum attendance at the prenatal health talk was recorded by women in the third trimester of gestational pregnancy. Eighteen point five (18.5%) of such women attended the classes for less than 36 weeks. This finding mirrors previous reports on Nigerian women's late initiation for prenatal care.

5.2 Conclusion

The ' Ibadan Group Prenatal Care' (IGPC) model was instituted in response to the shortage of skilled manpower compared to hospitals' numerous clients. Apparently, IGPC in the country did not evolve as a result of a particular identified challenge to maternal or infant health; rather it is a care givers' natural way of problem-solving. Though, the system is efficient, its effectiveness is in doubt. Its efficiency stems from the existing ratio of input variables relative to output as one or two care providers dispense care to between 30-60 pregnant women. Consequently, the cost efficiency of the input and output indicators is not at par with the process indicators. Care providers' and care receiver's relational communication is a key process indicator in the model. However, unlike the centring pregnancy model of group prenatal care which was found to have improved provider-patient relationship, the result of this study indicate marked differences in patients' perception of providers.

Communication as a key index in facilitating the group prenatal program is a process matrix in the evaluation of quality healthcare. Therefore, periodic research into care receivers' perception of care providers' communication skills is of paramount importance; especially in assisting the latter negotiate skills appropriately. This study has discussed the various factors influencing relational communication between care providers and care receivers in prenatal clinics. It adopted a holistic approach to examining why previous studies point to the poor communication skills of nurses, investigations point to two broad causative factors. The first are inherent systemic issues affecting care providers' ability to dispense care in an appropriate manner as the spaces for the conduct of prenatal care were explored for further clarity. The second concerns care givers' individual psychological dispositions which are inherent but can be modified over time through training and cognate experience.

5.3 Recommendations

Survey results implied that nurses' poor confirming skills interfered with their ability to dispense therapeutic care. Therefore, it is recommended that aside the organisation of periodic workshops for nurses, recruitment of more hands is expedient. Though it is impossible to completely obliterate noise in hospitals, high noise levels could and does in fact impede learning. Thus, it is suggested that precedence should be given to noise reduction in prenatal clinics. This could be done through the use of " Do not Disturb" signs. Furthermore, the absence of an in built hospital feedback mechanism contributed to deterioration in the care quality of public hospitals. In view of this, feedback intervention programmes should be introduced. Also, lack of standardisation of prenatal care in the state accounted for the disparities in care delivery. Consequently, it is proposed that a brochure spelling out the prenatal health topics, the duration for each topic, study objectives and expected outcomes should be published and circulated across all approved health facilities in the state. This brochure should also incorporate teachings that are germane to women' s mental health as this were clearly lacking during observations.

Furthermore, the lack of a coordinated prenatal care is attributable to improper engagement of both nurses and pregnant women: it is therefore recommended that note taking be encouraged between patients and care providers. This is to allow nurses

prepare notes prior to health classes for incorporation of evidence-based discoveries on taught areas. Conversely, note taking for patients enables them reflect on discussions and ask appropriate questions. In order to mitigate issues relating to participants' complaints on taught areas, information and education received by the women should be documented on their medical records as part of the routine aspects of care. Finally, nurses' perception of the continuous nursing education programme as a license renewal tool portends grave danger to their professional growth. Consequently, the programme should encompass both theoretical and practical aspects.

5.4 Contribution to knowledge

This study is an addition to knowledge in health communication research particularly in the area of group prenatal care (GPC) as previous researches on the model of care in Nigeria such as those of Lori, Ofosu-Darkwah, Boyd, Banerjee, & Adanu, 2017; Adaji, Jimoh, Bawa, Ibrahim, Olorukooba, Adelaiye, Garba, Lukong Idris & Shittu 2019 focused more on evolving antenatal care practices giving little attention to the implication of systemic issues on the Ibadan Group Care Programme. A novel antenatal care practice that has dominated the research space globally is the Centring Pregnancy Model (CP). There are numerous researches on the CP model, some of which include Novick (2009); Jafari, Efetekhar, Mohammed & Fotouhi (2010) and Carter, (2017) with a plethora of findings. Previous researches on the CP model have dwelt on patient-provider satisfaction, correlation between received care and positive birth outcome among other issues. This present study has extended the frontiers of knowledge by refuting the claim in literature that the CP model is the bedrock of majority of the current models of group prenatal care (Lincetlo, Mothebesoane-Anoh, Gome & Mujanja, 2006; Sharma, O' Connor & Olivet, 2018). In this present study, the similarities and differences between the CP model and the Ibadan Group Care Programme (IGPC) were explicated. As a matter of fact, the IGPC predates the CP model as Nigerians adopted the care programme as a natural response to the perennial problem of a shortfall in health care personnel in the country.

This study has also contributed to knowledge in terms of its examination of systemic issues that affect the Ibadan group prenatal care programme as well as detailing the

nuances and limitations of the group care programme. One of the reasons the IGPC model is under researched in literature is probably attributable to the fact that it is unnamed and this is one of the things achieved in this study. The Ibadan group prenatal care model is hereby named as a Provider-determined care model. One other limitation of this model is its lack of uniformity in scope and practice even within Ibadan metropolis. While some hospitals have teaching outline for expectant mothers, majority of the sampled facilities lacked this very important document which ordinarily, should also detail teaching objectives and expected outcomes. Nonetheless, this study has contributed significantly to knowledge as it has explicated the import of verbal and non verbal language on the relational dynamics between pregnant women and their care givers. In other words, it is an addition to knowledge in the therapeutic effect of language in clinical interaction. The constructs of the Communication Accommodation Theory (CAT) was deployed to understand the relational dynamics among participants in the Ibadan Group Care Programme. This present study has succeeded in filling one of the gaps in literature relating to the failure of previous health communication studies to examine patients' emotional expression in clinical encounter (Farzadina & Giles, 2015). The constructs of the Communication Accommodation Theory were deployed to examine both nurses' and expectant mothers' emotional expression. Typically, the CAT theory has been found to be particularly useful in health communication research. However, studies in literature have shown that the theory has been deployed in geriatrics, psychiatry and pain research to explain patient- provider discourse management strategies (Farzadina & Giles, 2015). The constructs of the CAT theory as employed in this current study has empirically verified the existence of power relations between nurses and their clients.

The propositions of the theory was also found useful in understanding why differences in cultural and group affiliation determine people' s communicative behaviour. For instance, at the Moniya General Hospital, care providers had to devise unique and more culturally sensitive care regimen for their Hausa- speaking clients because of their peculiarities. In contrast, at the Ring Road Specialist Hospital, Yoruba was unwittingly employed by care providers to ostracise non -Yoruba speaking women. The theory also put in proper perspective expectant mothers'

motivation for active participation in the group health- talk programme as women contributed to discussions based on intrinsic motivation, nurses' teaching skills, participation of others or when pointedly called upon. This study is unique as it did not merely investigate nurses' communication behaviour adopting a generic approach as is common to previous studies. It went further to investigate the relationships between individual nurses' psychological disposition and resultant relational communication behaviour. The constructs of the Kelly' s covariational model of causal attribution (consistency, consensus and distinctiveness) were employed to investigate pregnant women' s perception of nurses' communicative behaviour.

Furthermore, the role of large hospital systems such as the Adeoyo Maternity Teaching Hospital and Jericho Specialist Hospital in affecting relational care was brought to the fore in this study. While such referral facilities may have access to resources and corporate sponsorship, the large volume of clients that besiege the facilities for daily care puts unnecessary pressure on caregivers. This systemic issue is a situational factor that explains why nurses at the Adeoyo Maternity Teaching Hospital scored low in their confirming skills. Aside from the fact that service volume in hospitals affects relational care, individual nurses' communicative behaviour is stifled overtime as nurses are socialised into prevailing hospital culture (Sears 2010). Similarly, the general systems theory was deployed to explain how hierarchical structures within the hospital system affect clinical care. In this study, one of the interviewees remarked that at inception the Maternal and Child Hospital (MNCH) Apata was established as a wing of the Jericho Nursing Home (JNH). It has, however, been upgraded to the same status as that of JNH over the course of the years. Notwithstanding this, the state government' s subvention to MNCH has not been reviewed upwards.

Consequently, the mother-friendly principle to care is compromised at the facility owing to inadequate resources. As at the time this study was conducted, expectant mothers sat on wooden pews during prenatal care while modern relaxing chairs were available at other facilities such as Jericho Specialist Hospital and Jericho Nursing Home. This result reinforces the propositions of the systems theory on open systems.

A hospital as an example of open systems functions in relation to its environment as it depends on environmental energy only not to survive but thrive (Cordon 2013). One other limitation of the IGPC model as it is practiced in Ibadan is the absence of feedback structures. The absence of feedback structures in hospital systems makes it practically impossible for such facilities to allow energy such as information to flow from its environment. This, to Tamas (2000), makes such systems operate more or less as closed systems. A closed system is apt to experience burn out readily than open systems that allow energy transfer.

5.5 Suggestions for further studies

In this study, the interview of care providers was combined with an ethnographic approach to examine how structural components of care influenced nurses' relational communication behaviour. Further studies should compare the differences in the responses of caregivers and patients on how structural components of care affect relational communication behaviour. In addition, this study is limited in the sense that relational dynamics in group prenatal care were described from the researcher' s perspective. Future researches should examine pregnant women' s perception of accommodation and non accommodation behaviours of care providers in the group spaces.

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APPENDIX I
INFORMED CONSENT FORM

My name is Bukola Christiana Ajala. I am a student of the Department of Communication and Language Arts University of Ibadan. I am interested in measuring the perception of pregnant women on the quality of antenatal care in this health facility. I will need to ask you some questions about what you have observed during the course of the health- talks. Please, note that your responses will be kept confidential. Please, also note that your identity will not be revealed as your name and address are not required at all. The information you and others give will assist government and policy makers in improving the quality of antenatal care in the country.

- You are free to refuse to take part in this programme. You have a right to withdraw at any given point in time, if you choose to. I will greatly appreciate your help in responding to the survey and taking part in the study**.**

- Consent: Now that the study has been well explained to me and I fully understand the content of the process, I will be willing to take part in the programme.

_____ _____

Signature/Thumbprint of participant **Interview date**
Signature/Thumbprint of witness (Date)

APPENDIX II
QUESTIONNAIRE FOR PREGNANT WOMEN

Dear Respondent,

I am a researcher from the Department of Communication and Language Arts, University of Ibadan currently conducting a research in the area of " relational communication in clinical settings" . This questionnaire is a field instrument meant to elicit useful data for this study. I will therefore be most obliged for your cooperation in providing candid responses to the questions posed in the questionnaire. Please, note that this is a purely academic exercise and you can be rest assured that your responses will be given utmost confidentiality. Thank you for your anticipated cooperation.

Bukola Ajala
08032197265

SECTION A

QUESTIONNAIRE ITEMS TO ELICIT RESPONSES ON DEMOGRAPHIC VARIABLES

Instruction: Kindly provide appropriate responses to the questions below by ticking in the appropriate boxes. Please note that you are not required to write your name.

1. Age: 20-25 ( ), 26-30 ( ) 31- 35 ( ) 36-40 ( ) 41- 45 ( )
2. Occupation:
   _____
3. Educational level: No form of formal education ( ) primary ( ) secondary ( ) tertiary ( ) Others, please (specify) _____
4. Tribe:
   _____

SECTION B

Instructions: The questions in this section are meant to measure pregnant women' s perception of the relational communication behaviour of their care givers within a group health talk of a typical antenatal session. Please be as truthful as possible in your responses.

ITEMS ON RAPPORT BUILDING SKILLS OF NURSES

5. How long have you been attending the health-talk programme for antenatal care in this hospital?
6. Is it a particular nurse that delivers the health talk? If No
7. Do other nurses also deliver the health – talk? Yes or No
8. Since you have been attending the health-talk this year, how many nurses have handled the delivery?
9. Please identify the characteristics in the box below that describes the nurse(s). You can choose more than an option.

Nurse A	Tense	Relaxed	Causal	Patient	Unconcerned	Alert	Friendly	Unfriendly	Aloof
	Makes eye contact	Do not make eye contact	Relieves tension	Increases tension	Uses gestures to explain	Hardly uses gestures			
Nurse B	Tense	Relaxed	Causal	Patient	Unconcerned	Alert	friendly	Unfriendly	Aloof
	Makes eye contact	Do not make eye contact	Relieves tension	Increases tension	Uses gestures to explain	Hardly uses gestures			
Nurse C	Tense	Relaxed	Causal	Patient	Unconcerned	Alert	friendly	Unfriendly	Aloof
	Makes eye contact	Do not make eye contact	Relieves tension	Increases tension	Uses gestures to explain	Hardly uses gestures			
Nurse D	Tense	Relaxed	Causal	Patient	Unconcerned	Alert	friendly	Unfriendly	Aloof
	Makes eye contact	Do not make eye contact	Relieves tension	Increases tension	Uses gestures to explain	Hardly uses gestures			

10. What informed the above perception on Nurse A above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

11. What informed the above perception on Nurse B above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

12. What informed the above perception on Nurse C above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

13. What informed the above perception on Nurse D above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

14. SECTION C: ITEMS ON LISTENING SKILLS OF NURSES

Nurse A	Listens well to patients	Unwilling to listen	Encourages patient to talk	Gives no opportunity to talk	Ignores patient body language	Picks up patient body language	Neutral
Nurse B	Listens well to patients	Unwilling to listen	Encourages patient to talk	Gives no opportunity to talk	Ignores patient body language	Picks up patient body language	Neutral
Nurse C	Listens well to patients	Unwilling to listen	Encourages patient to talk	Gives no opportunity to talk	Ignores patient body language	Picks up patient body language	Neutral
Nurse D	Listens well to patients	Unwilling to listen	Encourages patient to talk	Gives no opportunity to talk	Ignores patient body language	Picks up patient body language	Neutral

15. What informed the above perception on Nurse A above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

16. What informed the above perception on Nurse B above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

17. What informed the above perception on Nurse C above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

18. What informed the above perception on Nurse D above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

19. **SECTION D**: **ITEMS ON CONFIRMING SKILLS OF NURSES**

Nurse A	Talks down to patients	Threatens patient	Ridicules patient	Reassures patient	Supports patient point of view	Does not judge patient	Neutral
Nurse B	Talks down to patients	Threatens patient	Ridicules patient	Reassures patient	Supports patient point of view	Does not judge patient	Neutral
Nurse C	Talks down to patients	Threatens patient	Ridicules patient	Reassures patient	Supports patient point of view	Does not judge patient	Neutral
Nurse D	Talks down to patients	Threatens patient	Ridicules patient	Reassures patient	Supports patient point of view	Does not judge patient	Neutral

20. What informed the above perception on Nurse A above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

21. What informed the above perception on Nurse B above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

22. What informed the above perception on Nurse C above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

23. What informed the above perception on Nurse D above?

    (a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

24. **ITEMS ON INFORMATION GIVING SKILLS OF NURSES**

Nurse A	Speech is clear	Speech is not clear	Gives enough information	Gives insufficient information	Knowledgeable on subject matter	Not knowledgeable on subject	Neutral
Nurse B	Speech is clear	Speech is not clear	Gives enough information	Gives insufficient information	Knowledgeable on subject matter	Not knowledgeable on subject	Neutral
Nurse C	Speech is clear	Speech is not clear	Gives enough information	Gives insufficient information	Knowledgeable on subject matter	Not knowledgeable on subject	Neutral
Nurse D	Speech is clear	Speech is not clear	Gives enough information	Gives insufficient information	Knowledgeable on subject matter	Not knowledgeable on subject	Neutral

25. What informed the above perception on Nurse A above?

(a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

26. What informed the above perception on Nurse B above?

(a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

27. What informed the above perception on Nurse C above?

(a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

28. What informed the above perception on Nurse D above?

(a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

29. **ITEMS ON ABILITY OF NURSES TO CHECK PERCEPTION FROM CLIENTS**

Nurse A	Aware of what patients think of her	Unaware of what patients think of her	Allows feedback from patients	Does not allow feedback from patients	Neutral
Nurse B	Aware of what patients think of her	Unaware of what patients think of her	Allows feedback from patients	Does not allow feedback from patients	Neutral
Nurse C	Aware of what patients think of her	Unaware of what patients think of her	Allows feedback from patients	Does not allow feedback from patients	Neutral
Nurse D	Aware of what patients think of her	Unaware of what patients think of her	Allows feedback from patients	Does not allow feedback from patients	Neutral

30. What informed the above perception on Nurse A above?

(a)The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

31. What informed the above perception on Nurse B above?

(a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

32. What informed the above perception on Nurse C above?

(a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

33. What informed the above perception on Nurse D above?

(a) The nurse always behaves in that way (b) The nurse behaved like that only once (c) I do not think that particular nurse behaved any differently from other nurses. (d) Others (Please) specify……

34. What motivates you to participate in the health-talk?

(a) When other women respond to questions (b) When the midwife teaches the topic well (c) When the midwife pointedly ask me questions (d) When I am in a good mood (e) When the midwife is friendly

35. What things distract your attention during the health talk? (You can tick more than an option)

(a) Women seated beside me (b) noises from vehicles on the street (c) interruptions from other nurses (d) noises from the crowd (e) others (specify)----------

36. What are the things you discuss with other pregnant women at the end of the health-talk?

(a) Personal issues (b) challenges of pregnant women (c) attitude of nurses/midwives to work (d) diet and nutrition (e) others (Please) specify

37. How would you describe the ways nurses relate with you? (You can choose more than one option)

    (a) The nurses can view things from my perspective b) the nurses ask what is happening in my daily life c) the nurses seem concerned about me and my family d) the nurses are understanding e) I would recommend this hospital to my family and friends because of the nurses here

38. What other ways describe how nurses relate with you?

    (a) The nurses explain things in a way that is easy for me to understand(b)I am confident of the nurses' knowledge and skills(c)The nurses encourage me to talk about my health concerns(d)The nurses spend enough time with me.(e)The nurses show respect for what I say

39. Do you have friends who have been delivered of their babies outside a health facility? Yes or No

40. Do you have family members who have been delivered of their babies outside a health facility before? Yes or No

41. Have you also delivered a baby outside a health facility before? If yes, how would you describe the experience you had then? .....

42. In your opinion, what other benefits have you derived from the health talk programme? ……

APPENDIX III
IN-DEPTH INTERVIEW QUESTIONS MEANT FOR NURSES/MIDWIVES ONLY

1. How long have you been delivering health talk to pregnant women in the group antenatal care sessions?
2. How many pregnant women are usually in a group at a time?
3. How do you conduct discussion within the group?
4. How do you as a nurse relate interpersonally with each of these pregnant women?
5. How would you rate the effectiveness of the group health talk in terms of providing emotional support to pregnant women?
6. How do you help shy members to participate in the group?
7. How do you regulate people' s contribution during health talk so as to ensure that some people do not dominate the discussion at the expense of others within the group?
8. I am aware that one of the recommendations of the World Health Organization as regards antenatal care globally is that provision of care should include the following: assessment, education, skills building and social support. To what extent in your view, has the group antenatal care programme been able to achieve these objectives?
9. What, if any, are the perceived organisational factors affecting the accomplishment of these objectives?
10. How has the federal government' s policy of giving ₦5,000 incentives to pregnant women who attend antenatal care, affected enrolment/attendance at your health facility?
11. Do you have a guide for delivering health talk in this hospital? Are you aware of where the guide originated from
12. How often are these materials updated
13. How do manage the discussion in the event that some participants wish to supply answers to questions raised by their colleagues?
14. What kind of feedback have you received from the women overtime as regards specifically the conduct of the prenatal care?
15. Can you recollect a particular feedback that you received from the community on the quality of maternity care in your hospital?
16. In what way have you adjusted your operations based on the feedback you received?

APPENDIX IV
OBSERVATION GUIDE CHECK LIST

Name of Health-Facility ……

Number of participants in a group……

Date of observation……

Length of observation……

Characteristics of Participants in the Group				
Distribution by Age	Adults ☐	Teenagers ☐		
Distribution by Ethnicity	Hausa ☐	Igbo ☐	Yoruba ☐	Others (Specify) ☐
Appearance of Participants	Women in Purdah ☐	Neatly clad in traditional attire ☐	Neatly clad in western wears ☐	Shabbily dressed ☐
Description of Environment within which Interaction is taking place	Open area ☐	Enclosed area ☐	Comfortable ☐	Suitable ☐
Seating Arrangement	Circular ☐	Rectangular ☐	Triangular ☐	Others (Specify) ☐
Attitude towards subject of discussion	Indifferent ☐ Dozing ☐	Keen interest ☐	Bored ☐	Scornful ☐ Others (Specify) ☐
Interactions within the group				
Level of Participation of Pregnant women	Moderate ☐	High ☐	Low ☐	Others (Specify) ☐
Power Relationships	Rigid complementarity ☐	Complementarity ☐	Dominance ☐	Submissive ☐
General Climate for Learning	Highly conducive ☐	Moderately conducive ☐	Not conducive ☐	Others (Specify) ☐
Levels of Support received by Pregnant Women	High level ☐	Moderate level ☐	Low level ☐	No support ☐
Non -verbal behaviour				
Facial Expressions of Nurses	Smiles/ laughter ☐	Bland look ☐	Indifferent ☐	Condescending ☐
Facial Expressions of Pregnant Women	Smiles/ laughter ☐	Bland look ☐	Indifferent ☐	Diffident ☐
Body Movement of Nurses	Eye contact ☐	Use of gestures ☐	Stationary position ☐	Sitting ☐
Body Movements of Pregnant Women	Nodding ☐	Uneasy/ shifting movements ☐	Eye contact ☐	Others (Specify) ☐
Facilitators' Skills				
Clarity of Communication	High ☐	Moderate ☐	Low ☐	Others (Specify) ☐
Group leadership skills i.e. encouraging full Participation	High ☐	Moderate ☐	low ☐	Others (Specify) ☐
Sensitivity to Group Climate	High ☐	Moderate ☐	Low ☐	Others (Specify ☐
Knowledge of subject/use of teaching aids	High ☐	Moderate ☐	Low ☐	Others (Specify) ☐

Source: Adapted from Cloutier *et al* (1987) as cited in Taylor-Powell and Steele (1996)

APPENDIX V
FOCUS GROUP DISCUSSION GUIDE

Opening Remarks: 5minutes

You are all welcome to today' s forum. I believe you are all in good health. The purpose of this meeting is to discuss freely our perceptions of the quality of antenatal care health talk in hospitals in Nigeria. The following are the rules that will guide the conduct of our discussions.

- Everything that will be discussed today should not to be discussed outside of this forum. This is to protect the anonymity of all participants.
- There are no right or wrong answers.

Introductions: 5minutes

Before we start, I' ll like to go around the room and have everyone introduce themselves and state briefly how long they have been attending the antenatal care health-talk.

Interactive Exercise: 10 minutes

Can you recollect the different things you have learnt from the ANC health-talk?

APPENDIX VI
A SUMMARY OF THE OBSERVATIONAL SUBTHEMES IN THE GROUP PRENATAL SESSIONS

Confirming Behaviour of Nurses	**Disconfirming Behaviour of Nurses**
The ability of nurses to adopt fluid movement in actively teaching content to client	Nurses adopts a sedentary position in teaching content
The ability of nurses to create an interactive learning environment	Inability of nurses to create an interactive learning environment
The ability of nurses to utilize teaching aids	Inability of nurses to utilize teaching aids
The ability of nurses to communicate learning outcome and how the session will be run	Inability of nurses to communicate learning outcome and how the session will be run
The Ability of nurses to support a patient' s point of view	Nurses talks down to patients
The ability of nurses to reassure patients	Nurses ridicule patients
The ability of nurses not to judge patients	Nurses threaten patients
Rapport Building Skills	**Clarity in Communication**
The ability of nurses to actively engage patients by making eye contact	Ability of nurses to communicate without ambiguity
The ability of nurses to demonstrate practical aspects of subjects of discussion	**Environment of Facility** Conducive/ non- conducive
The ability of nurses to be at alert and control group discussion appropriately	
Levels of Social influence	
Variations in delivery style	
Attentive/inattentive audience	

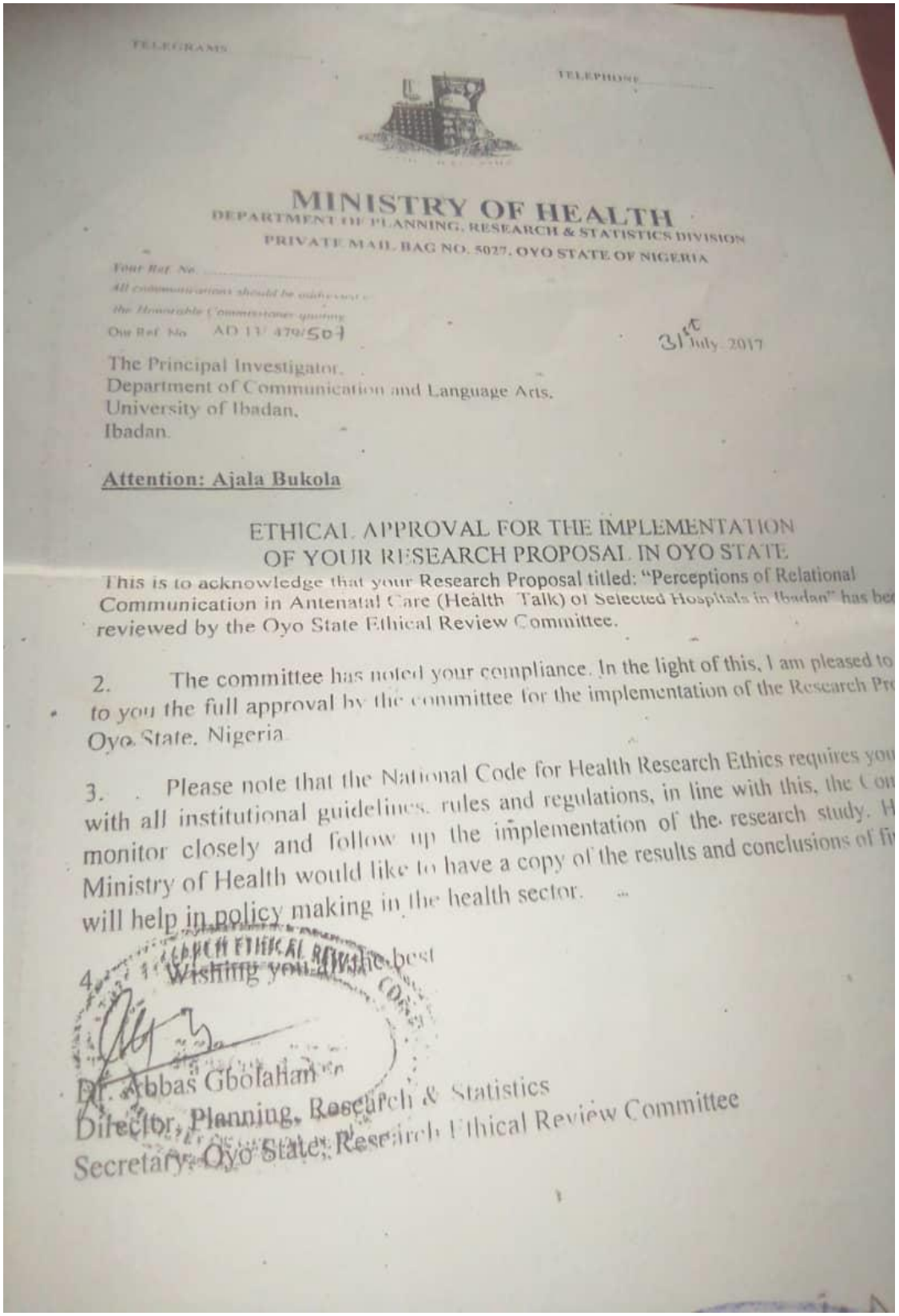
APPENDIX VII

A LIST OF STATE-OWNED HEALTH FACILITIES IN OYO STATE

SN	NAME AND ADDRESS OF HEALTH FACILITY
1	Adeoyo Maternity Hospital, Yemetu, Ibadan.
2	BCOS Staff Clinic, Bashorun Ibadan.
3	Dental Centre, Dugbe, Ibadan.
4	General Hospital, Ayete.
5	General Hospital, Ado Awaye.
6	General Hospital, Ago Are.
7	General Hospital, Ago-Amodu.
8	General Hospital, Eruwa.
9	General Hospital, Fiditi.
10	General Hospital, Iganna.
11	General Hospital, Igbetti.
12	General Hospital, Igboho.
13	General Hospital, Igboora.
14	General Hospital, Ikoyi Ile.
15	General Hospital, Ilora.
16	General Hospital, Iresaadu.
17	General Hospital, Iseyin.
18	General Hospital, Kasunmu Ajia.
19	General Hospital, Kishi.
20	General Hospital, Kutayi.
21	General Hospital, Lagun.
22	General Hospital, Lanlate.
23	General Hospital, Moniya.
24	General Hospital, Okaka.
25	General Hospital, Okeho.
26	General Hospital, Orile Odo.
27	General Hospital, Tede
28	Government Chest Clinic, Jericho, Ibadan.
29	Government House Clinic, Ibadan.
30	Health is Wealth Clinic, Ibadan.
31	Jericho General Hospital, Ibadan.
32	Jericho Nursing Home, Ibadan.
33	Maternal and Child, Apata.
34	Oni Memorial Children Hospital, Ibadan.
35	Ring Road State Hospital, Ibadan.
36	Rural Comprehensive H. Centre, Sepeteri.
37	Samuel Adegbite Cottage Hospital, Igbo Oloyin, Ibadan.
38	Secretariat Staff Clinic, Ibadan.
39	St. Peters Hospital, Aremo.
40	State Hospital, Ogbomoso.
41	State Hospital, Oyo.
42	State Hospital, Saki.

APPENDIX VIII

OYO STATE ETHICAL APPROVAL FORM



TELEGRAMS TELEPHONE

MINISTRY OF HEALTH
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No.
All communications should be addressed to the Honourable Commissioner quoting
Our Ref. No. AD 13/ 479/507

31st July, 2017

The Principal Investigator,
Department of Communication and Language Arts,
University of Ibadan,
Ibadan.

Attention: Ajala Bukola

ETHICAL APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Perceptions of Relational Communication in Antenatal Care (Health Talk) of Selected Hospitals in Ibadan" has be reviewed by the Oyo State Ethical Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to to you the full approval by the committee for the implementation of the Research Pr Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you with all institutional guidelines, rules and regulations, in line with this, the Co monitor closely and follow up the implementation of the research study. H Ministry of Health would like to have a copy of the results and conclusions of fi will help in policy making in the health sector.

4. Wishing you all the best

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State, Research Ethical Review Committee