British Journal of Mass Communication and Media Research
ISSN: 2997-6030
Volume 4, Issue 2, 2024 (pp. 67-81)
www.abjournals.org

LISTENING AS A PREDICTOR OF HEALTH PROVIDERS' RESPONSE TO EXPECTANT MOTHERS IN SOUTH-EAST NIGERIA

Nancy Nnenna Anaba[1], Walter Ihejirika (Ph.D.)[2],

and Innocent Paschal Ihechu (Ph.D.)[3]

[1]Department of Mass Communication, Clifford University, Owerrinta, Abia State, Nigeria.
Email: anabann@clifford.edu.ng; Tel.: +2348151843009

[2]Faculty of Communication and Media Studies, University of Port Harcourt, Nigeria.
Email: Walter.ihejirika@uniport.edu.ng; Tel.: +2348034903041

[3]Department of Mass Communication, Abia State University, PMB 2000, Uturu, Nigeria.
Email: ipi@abiastateuniversity.edu.ng; Tel.: +2347065138607

Cite this article:

Anaba N. N., Ihejirika W., Ihechu I. P. (2024), Listening as a Predictor of Health Providers' Response to Expectant Mothers in South-East Nigeria. British Journal of Mass Communication and Media Research 4(2), 67-81. DOI: 10.52589/BJMCMR-IH876XZG

Manuscript History

Received: 19 Jun 2024

Accepted: 17 Aug 2024

Published: 23 Aug 2024

ABSTRACT: *This study investigated Listening as a predictor of healthcare providers response to expectant mothers in south-east Nigeria. The Study had two sets of population- the Public Primary Health Centers (PHCs) in the five states of South-East Nigeria (2,110) and all the women in the five states who are between the ages of 18 and 45 (7,159,548). The sample size was in two set, the first was 32 which represented 30% of the total number PHCs in the five L.G.A's sampled from the five states in the South-East Nigeria and the second sample size for the second population was 384. The study adopted survey research design with questionnaire as instrument for data collection. Finally, the data were descriptively analysed and thematically explained. The results from the study revealed that healthcare providers listen and respond, to expectant mothers in South-East Nigeria during antenatal interactions. It was therefore concluded that the ability of healthcare providers to listen to the expectant mothers in South-East Nigeria during antenatal interactions provided the platform for healthcare communication that enabled expectant mothers to share personal information with caregivers for effective outcomes. It was recommended that Policy makers should ensure that the cordiality between healthcare providers and their clients is sustained at all levels of healthcare delivery to promote quality communication for quality healthcare practice.*

KEYWORDS: Communication, antenatal, antenatal information, expectant mothers, healthcare providers.

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

British Journal of Mass Communication and Media Research
ISSN: 2997-6030
Volume 4, Issue 2, 2024 (pp. 67-81)

www.abjournals.org

INTRODUCTION

According to *Healthy People* (2000) health communication "encompasses the study and use of communication strategies to inform and influence individuals and community decisions that enhance health" (p.2). Health communication links the domains of communication and health. It is increasingly recognised as a necessary element of efforts to improve personal and public health.

In his own view, Ratzan (1995) sees health communication as the art and technique of informing, influencing and increasing individual, institutional, and public awareness about important health issues. The scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care as well as enhancement of the quality of life and health of individuals within the community. It is also seen as a central process of health care delivery in the promotion of public health.

Sanda (2010) holds that "health information and communication are powerful tools for the adoption of healthy behaviour necessary to prevent and control communicable and non-communicable diseases" (p.34). Human behaviour is major factor in health outcomes, and health investments, to be successful, must focus on behaviour in addition to providing health services and facilities. People must understand the need to adopt or change health behaviour, and this can come about through effective health communication.

In order to build a positive relationship between healthcare providers and patients, there is a need for the existence of effective communication through interactions between healthcare providers and the patients. This will help to ensure that all parties involved are able to listen to each other and fully understand what is being said (Chadwick, Cooper & Harries, 2014). Effective healthcare provider-patient communication can be facilitated by healthcare provider behaviours such as establishing a positive rapport by avoiding shouting and rudeness, encouraging two-way dialogue, bridging any social gaps between healthcare providers and patients, effectively using both verbal and non-verbal communication, allowing patients ample time to tell their sickness story and exhibiting positive attitudes when talking to patients (McMahon SA, George AS, Chebet JJ, Mosha IH, Mpembeni RNM, 2014).

Lack of effective communication between healthcare providers and patients can result in negative health outcomes (Ojewole & Oludipe, 2017). For instance, a study showed that rudeness, unfriendly and abusive behaviour by nurses discouraged pregnant women from accessing maternal services at a healthy facility, a major contributor to maternal mortality and pregnancy complications (Austad, K., Chary, A., Martinez, B., Juarez, M., Juarez, M. Y., Ixen, C. & Rohloff, P.2017).

Maternal mortality continues to be a major public health challenge in low-income countries with complications of pregnancy and childbirth causing more deaths and disabilities than other reproductive health issues. Maternal mortality refers to any loss of a woman's life resulting from pregnancy complication or death within 42 days after childbirth, notwithstanding the period or site of the pregnancy, emanating from issues that are linked or escalated by the management of the pregnancy but not from accident or incidental factors (Hulton, L., Matthews, Z. & Stones, R.W.2000).

Data from the World Health Organization (WHO) 2015 suggest that globally approximately 830 women die daily from preventable causes related to pregnancy and childbirth, with 99%

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

of the deaths occurring in low income countries (World Health Organization, 2015). Maternal mortality ratio in Nigeria is estimated to be 512 deaths per 100,000 live births (National Population Commission (NPC), International Classification of Functioning, Disability and Health (ICF, 2019), and the World Health Organization reports that Nigeria accounts for 19% of the global maternal deaths (World Health Organization, 2020). As with other low income countries, a higher proportion of these deaths occur among women living in rural areas and in poor communities where access to maternal health care is limited by several barriers including quality of care in health facilities (Azuh D, Azuh A, Iweala E, Adeloye D, Akanbi M, Mordi R. (2017).

Primary health Care (PHC) has been recommended by the WHO to many sub-Saharan African countries and other low resourced countries around the world as the standard of care and the first level of health service for contact with the formal healthcare system. This is because in accordance with the Alma Ata Declaration and as reaffirmed by the World Health Organisation:

Primary health care is an essential health care based on practical, scientifically proven and socially acceptable methods and technologies made scientifically accessible to individuals and families through their full participation and at the cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-determination (World Health Organisation, 1978, p. 47).

To ensure universal health coverage for all Nigerians, the Federal Ministry of Health specifically recommends PHC as the entry point into the healthcare system (National Primary health care development agency; NPHCDA, 2012b, 2012a) in order to address the social inequities that lead to high rates of maternal mortality in the country. PHCs also provide the opportunity for health workers to offer personalised care that address both cultural and social realities of rural women designed to organise health services around the needs and expectations of women (World Health Organisation, 1978).

Statement of the Problem

Maternal and infant deaths are still a public health concern in many nations, particularly the low- and middle-income countries. Globally, maternal mortality rates have reduced. However, developing nations still struggle with this menace, taking on 99% of the burden of maternal and infant deaths. Available record shows that, though Nigeria has the highest rate of maternal mortality in the world, in Nigeria, the Southern states and the South-Eastern states recorded relatively low maternal mortality ratio compared to the Northern states that recorded very high ratio.

Poor communication amongst other factors has been identified to be one of the major factors leading to Maternal Mortality in South-Eastern states of Nigeria. Most studies conducted in the area of healthcare communication involving expectant mothers focus on the information needs during pregnancy as well as information sources. Again, most of these studies were conducted from the perspectives of health and medical professionals. Also, those that delved into quality, looked quality of healthcare service without much attention to communication skills of the healthcare givers which makes quality of healthcare communication.

The problem of this study, therefore, revolves around providing valuable answers to the poser; to what extent does the health communication between healthcare providers and

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

expectant mothers manifest in quality antenatal information exchange? The solution to the above problem would go a long way in substantiating how quality of healthcare communication exchange could contribute to reducing maternal mortality in Nigeria.

Objectives of the Study

The major aim of this study was to assess the quality of health communication between healthcare providers and expectant mothers in South-East Nigeria. However, the specific objectives were to:

i. determine the extent to which healthcare providers listen to the expectant mothers in South-East Nigeria during antenatal interactions;

ii. ascertain the extent to which healthcare providers respond to expectant mothers in South-East Nigeria during antenatal interactions;

Research Questions

The following research questions were posed to guide the conduct of this study. The answers to the research questions determined the extent to which the objectives of the study were achieved.

i. To what extent do healthcare providers listen to the expectant mothers in South-East Nigeria during antenatal interactions?

ii. To what extent do healthcare providers respond to expectant mothers in South-East Nigeria during antenatal interactions?

Research Hypotheses

The following alternate hypothesis was proposed. The outcome determined the relationship between identified variables in the study.

H_1: There is a relationship between healthcare providers' listenership to expectant mothers and their ability to convey clear information during healthcare communication.

LITERATURE REVIEW

Healthcare Communication and Health Outcomes

Health communication according to Healthy People (2010) is relevant in several contexts, including:

i. Health professionals-patient relations;

ii. Individuals' exposure to, search for, and use of health information;

iii. Individuals' adherence to clinical recommendations and regimes;

iv. The construction of public health messages and campaigns;

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

v. The dissemination of individual and population health risk information, that is, risk communication;

vi. Images of health in the mass media and the culture at large;

vii. The education of consumers about how to gain access to the public health and health care systems; and

viii. The development of tele-health applications. (www.healthypeople.gov)

Health communication, which consists of interpersonal and mass communication activities, focuses attention on improving the health of individuals and emphasises the need for health literacy skills. Health literacy skills enable members of the public to understand and apply information about health issues to achieve substantial impact on health behaviours and health outcomes.

Effective communication is an essential skill that clinicians need in practice to improve the quality and efficiency of care. Health outcomes in chronic long-term disease management hinge on the quality of information exchange. The quality of therapeutic alliance, described as the collaborative nature, the affective bond, and the goal and task agreement between patients and clinicians, is partly determined by how clinicians and patients communicate. Champ (2017) posits that the safety of the patients, the quality of care they received, as well as the satisfaction they derived from healthcare services is greatly influenced by the communication skills of the health caregivers. Accordingly, communication skills are central to engaging patients in a therapeutic relationship, and particularly putting the patient at the center of the care as an active participant in decision-making (Sullivan, 2005).

The ability to listen and respond is a prerequisite for successful practice. A health caregiver who is not competent in clinical communication may miss important information or may be unable to convey the information to the patient during the course of assessment, thereby leading to a wrong diagnosis and treatment. Therefore, health personnel are expected to communicate effectively over every area in their curriculum to provide effective practice. For healthcare professionals, communication skills need to be taught and learnt in a clinical context, in either clinical practice or clinically relevant simulations (Goke, 2012). To ensure that health professionals are actually competent in communication skills, healthcare programmes need to provide evidence of skill attainment demonstrated through some forms of assessment.

Communication and Antenatal Care

Antenatal care is the care that a woman receives during pregnancy, which helps to ensure healthy outcomes for women and newborn babies, and it is an important opportunity to improve maternal understanding about pregnancy, childbirth, and care of the newborn. Antenatal care also provides a chance for health care provider to interact with a pregnant woman so that the woman can make appropriate choices and decisions that will contribute to optimum pregnancy outcome and care of the newborn (Mulauzi & Daka, 2018). The antenatal care strategies aim to empower women to understand the care they receive, as well as the antenatal care procedures used, enabling informed decision making of pregnant women particularly to prevent maternal to child transmission of HIV/AIDS. The medical approach of

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

the care in general is to identify and minimise risk factors that may influence maternal and foetal health (Agus & Horiuchi, 2013).

To achieve these goals, it is necessary for the professional to have good communication skills. From a medical perspective, good communication is associated with the ability to elicit a history from a patient, in order to make diagnosis accurate and linked with patient satisfaction, adherence to medical recommendation and health outcome. The general health status of pregnant women depends largely on the quality of antenatal services available to them. The provisions of good antenatal services ensure early detection and promote management of any complication or disease that may adversely affect pregnancy outcome (Glenton, 2022).

Theoretical Framework

This research was conducted under theoretical framework of Social Cognitive theory. Social Cognitive Theory (SCT) started as the Social Learning Theory (SLT) in the 1960s by Albert Bandura. It developed into the SCT in 1986 and posits that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behaviour. The unique feature of SCT is the emphasis on social influence and its emphasis on external and internal social reinforcement. SCT considers the unique way in which individuals acquire and maintain behaviour, while also considering the social environment in which individuals perform the behaviour (Schunk, 1995). The theory considers a person's past experiences, which factor into whether behavioural action will occur. These past experiences influence reinforcements, expectations, and expectancies, all of which shape whether a person will engage in a specific behaviour and the reasons why a person engages in that behaviour (Van Dinther, Dochy, Segers & Brae, (2013).

In the context of this study, the behaviour of the care-providers in interacting with the expectant mothers during antenatal visit matters a lot and may determine whether the expectant mothers may learn what is being taught during antenatal visits or not. If the care-providers are strict and mean with in their interactions with the expectant mothers, they may not feel free to communicate with the care-providers and this may cause problems for the expectant mothers in their pregnancy journey.

METHODOLOGY

This study adopted the survey research method. The method was considered appropriate for this study because the study is aimed at ascertaining the opinions of expectant mothers in South-East Nigeria with regards to their perceptions about the quality of health communication that exist during communication exchange between them and the care-providers. There were two sets of population in this study. The first population was 2,110 which was the target population and comprised the Public Primary Health Centres (PHCs) in the five states of South-East Nigeria. They were distributed as follows: Abia, 481; Anambra, 392; Ebonyi, 383; Enugu, 438; and Imo, 416 (www.procurement monitor.org).

The second population was 7,159, 548 and was made up all the women in the five states of South-East Nigeria who were between the ages of 18 and 45. The distribution of this

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

population, according to National Bureau of Statistics (2022), was as follows: Abia: 1,231,002; Anambra: 1,811,178; Ebonyi: 1,082,141; Enugu: 1,300,0254; and Imo: 1,735,203.

The sample size for the first population was 32, which represented 30% of the total number of PHCs in the five LGAs sampled from the five states in South-East Nigeria that were studied. Then, the sample size for the second population was 384 calculated with online sample size calculator at surveysystem.com under 95% confidence level and confidence interval of 5.0.

However, the researcher adopted the multi-stage cluster sampling technique to group the population into states and into the LGAs in each state. Thereafter, the simple random sampling technique was used to select one LGA from each state.

Therefore, to select 32 PHCs, the simple random method was used in line with the proportionate population in each sampled LGA. The sample size for the second population was proportionately allocated according to the population of expectant mothers in the LGAs under study.

To access the sample units, the cluster sampling technique enabled the researcher to locate expectant mothers at sampled PHCs. Thus, the women that visited the PHCs either for antenatal or postnatal and who had been in contact with the healthcare providers in the health facilities under study at least within the last five years. Finally, the simple random sampling technique was used to pick the women.

DATA PRESENTATION AND ANALYSIS

Out of the 384 copies of questionnaire administered, 372 were found valid and were used for the analysis of the study. This made up 97% of the total sample size hence was representative enough to be used for documentation.

RQ1: To what extent do healthcare providers listen to the expectant mothers in South-East Nigeria during antenatal interactions?

The respondents were subjected to rate indices of Healthcare providers listening level to expectant mothers. The distribution of the data generated for the first research question is as presented in Table 4.below.

Table 4: Healthcare providers' level of listening to expectant mothers during antenatal interaction.

Indices	Rating	SA	A	FA/FD	D	SD	Total	*Xi*
The caregivers pay	*x*	5	4	3	2	1		
attention to me during	*f*	97	186	45	22	22	372	**3.84 >3.0**
interactions.	*fx*	485	744	135	44	22	1430	**Accepted**
	%	26	50	12	6	6	100	**77%**

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

Caregivers show understanding of my expression and complaints	*f* *fx* *%*	74 370 20	179 716 48	67 201 18	30 60 8	22 22 6	372 1369 100	**3.68>3,0 Accepted 73%**
Caregivers take record of my submissions during interaction	*f* *fx* *%*	71 355 19	208 832 56	59 177 16	19 38 5	15 15 4	372 1417 100	**3.80>3.0 Accepted 76%**
Healthcare communication enabled me to share personal antenatal information and it helped me	*f* *Fx* *%*	156 780 42	82 328 22	82 246 22	45 90 12	7 7 2	372 1451 100	**3.90>3.0 Accepted 78%**

xii = 3.80; Accepted @ 76%

The rating for the first index resulted in a mean score, *xi* of 3.84 > 3.0 (sig @ 77%). This showed that the healthcare providers pay attention to the respondents during interaction whenever they attended antenatal sessions. The result was accepted because it indicated 77% level of listening attention by healthcare providers to expectant mothers during antenatal interaction.

The second index sought to determine the level of understanding of respondents' complaints and expressions by healthcare providers. The mean score, *xi,* of 3.68>3.0 (sig@73%) was accepted as it indicated that the healthcare providers showed a high level of understanding of the complaints and expressions made by the respondents at the rate of 73%.

The third index sought to know the level at which the healthcare providers took records of the submissions of the respondents during their interaction sessions. The data clearly revealed a high mean score of *xi* = 3.80 > 3.0; sig.@76%. This result was accepted and implied that 76% of the respondents accepted that their various submissions during the course of their interactions with healthcare providers during their antenatal sessions were recorded by the caregivers.

The fourth index sought to ascertain the extent healthcare communication enabled the respondents to share personal antenatal information. The findings from the presented data analysed showed that the mean score, *xi;* of 3.90>3.0 (sig@73%) was accepted as it indicated that the healthcare providers provided a communication flow that enabled the respondents to share vital antenatal information which in turn helped them in their pregnancy journey at a high rate of 78%.

The results from the Table showed that the respondents accepted that the healthcare providers to a great extent listened to the expectant mothers during antenatal interactions.

RQ2: To what extent do healthcare providers respond to expectant mothers in South-East Nigeria during antenatal interactions?

The second research question sought to know the extent healthcare providers respond to expectant mothers during antenatal interactions. The data generated are presented in Table 5 below.

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

British Journal of Mass Communication and Media Research
ISSN: 2997-6030
Volume 4, Issue 2, 2024 (pp. 67-81)

www.abjournals.org

Table 5: Healthcare providers' level of responding to expectant mothers during antenatal interactions.

Indices	Rating	SA	A	FA/FD	D	SD	Total	*Xi*
	x	5	4	3	2	1		
Caregivers give adequate answers to questions.	*f*	93	149	112	11	7	372	**3.83 >3.0**
	fx	465	596	336	22	7	1426	**Accepted**
	%	25	40	30	3	2	100	**77%**
Caregivers make appropriate gestures to explain their points during interactions.	*f*	67	186	67	33	19	372	**3.50>3.0**
	fx	335	744	201	18	5	1303	**Accepted**
	%	18	50	18	9	5	100	**70%**
Caregivers' carryout appropriate examination of my body during interaction.	*f*	85	179	74	19	15	372	**3.80>3.0**
	fx	425	716	222	38	15	1416	**Accepted**
	%	23	48	20	5	4	100	**76%**
Caregivers adequately explain antenatal issues timely.	*f*	71	177	67	15	48	372	**3.54>3.0**
	fx	355	684	201	30	48	1318	**Accepted**
	%	19	46	18	4	13	100	**70%**

xii = 3.66; Accepted @ 73%

From the table above, the first index aimed at ascertaining the level at which caregivers gave adequate answers to respondents' questions. The data showed a mean score, *xi* = 3.83 > 3.0 (sig@ 77%). The result indicated that the healthcare providers gave adequate answers to the questions of expectant mothers during their antenatal sessions up to 77% rate.

The second index sought to determine the level at which caregivers make appropriate gestures during antenatal sessions to explain their points to expectant mothers during interactions. The mean score, *xi* = 3.50 > 3.0 (sig.@ 70%), was accepted because it showed that there was a high rate of acceptance by the respondents that healthcare providers' made appropriate gestures to explain their points during antenatal interactions.

The third index was aimed at determining the level at which caregivers' carried out appropriate examination of the body of the expectant mothers during interactions. The data indicated that the level at which healthcare providers carried out appropriate body examination of the respondents was high (*xi* = 3.80 >3.0; sig. @ 76%). This result was accepted and implied that 77% of the respondents accepted that their bodies were examined during antenatal interactions by the healthcare providers.

The fourth index sought to ascertain the extent healthcare givers adequately explained antenatal issues to the expectant mothers on timely basis. The findings from the presented data analysed showed that the mean score, *xi;* of 3.54>3.0 (sig@70%) was accepted as it indicated that the healthcare providers adequately explained antenatal issues timely to the expectant mothers at a high rate of 70%.

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

British Journal of Mass Communication and Media Research
ISSN: 2997-6030
Volume 4, Issue 2, 2024 (pp. 67-81)
www.abjournals.org

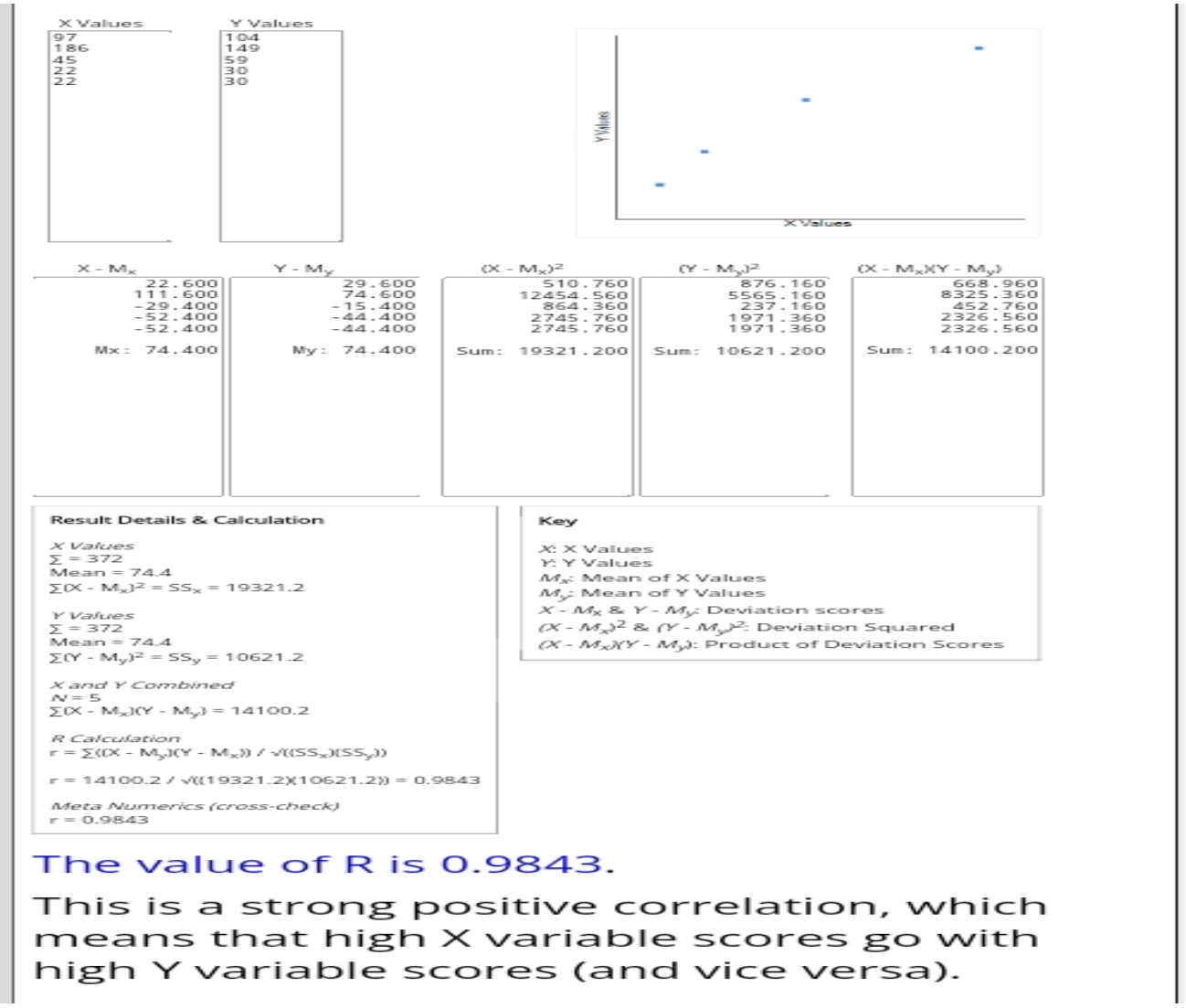
The result was accepted because it indicated that the healthcare providers to a great extent responded to expectant mothers during antenatal interactions. From the results in Table 5..it was summed that healthcare providers respond to expectant mothers in South-East Nigeria during antenatal interactions and they give adequate answers to the questions of expectant mothers during their antenatal sessions.

TESTING OF HYPOTHESIS

To test the hypothesis, it was stated in the null hypothesis, thus:

H_{O1}: There is no relationship between healthcare providers' listenership to expectant mothers and their ability to convey clear information during healthcare communication.

Correlation of Healthcare Providers' listenership (X) and their Conveyance of Information (Y)



Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

From the result, the correlation coefficient, r, was 0.98. This indicated near perfect relationship with high impact linearity. In other words, there was a very high positive relationship between the variables correlated. With this result, the null hypothesis was rejected while the alternate hypothesis was accepted, thus: *There was a positive relationship between healthcare providers' listenership to expectant mothers and their ability to convey clear information during healthcare communication.*

This result implied that listening to expectant mothers was proportional to healthcare providers' conveyance of information. That is to say that the more healthcare providers listened to the expectant mothers, the more they were able to convey clear information during antenatal interactions. Such situations enable effective communication; and this result confirmed the existence of quality healthcare communication between caregivers and expectant mothers in South-East Nigeria.

DISCUSSION OF FINDINGS

RQ1: To what extent do healthcare providers listen to the expectant mothers in South-East Nigeria during antenatal interactions?

The data in Table 4 showed that healthcare providers pay listening attention to the expectant mothers during antenatal interactions (77%); showed understanding of the expressions and complaints of the expectant mothers (73%); took record of their submissions during antenatal interactions (76%); and the healthcare communication enabled them to share personal antenatal information that helped them (78%). These were indices of healthcare providers' level of listening and implied to a great extent, healthcare providers listened and pay attention to expectant mothers during antenatal interactions. Based on the results, it would be apt to answer the first research question by stating as followed: *healthcare providers listened to the expectant mothers in South-East Nigeria during antenatal interactions through activities such as:*

i. *Paying attention to expectant mothers during antenatal interactions*
ii. *Showing understanding of the complaints and expressions of the expectant mothers during antenatal interactions*
iii. *Taking records of the submissions of the expectant mothers during antenatal interactions.*
iv. *Providing healthcare communication that enables expectant mothers to share personal antenatal information that helped them.*

This finding is in disagreement with the previous findings of research on communication between healthcare providers and consumers of health care which showed that women did not receive adequate information about their pregnancy. According to Baiye (2019), some of these researchers found that providers of healthcare impose barriers to communication as they do not pay attention to information requests of the client. It is through paying of adequate attention to these expectant mothers during their antenatal interactions that healthcare providers will be able to understand their all expressions and complaints especially when

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

there are potentially negative outcomes (Onuaoha & Amuda, 2013). This was also in line with the assertion of the three phases of "Delay Model" which highlights the importance of quality of communication between clients and healthcare providers in the prevention of maternal death by describing the sequence of events from late recognition of danger signs to maternal death (Kyei, Chansa & Gabrysch, (2012). Health Caregivers understanding of the complaints of the expectants mothers helped them to provide appropriate health information and prescription that can help avert maternal death.

RQ2: To what extent do healthcare providers respond to expectant mothers in South-East Nigeria during antenatal interactions?

The results from the data in Table 5 showed that healthcare providers responded to expectant mothers in South-East Nigeria during antenatal interactions. The result indicated a 77% agreement among the participants that healthcare providers gave adequate answers to the questions of expectant mothers during antenatal interactions. Further, the result showed a 72% level of agreement that healthcare providers went as far as making appropriate gestures to explain their points during antenatal interactions. Also, the result showed 76% level of agreement that the healthcare providers carried out appropriate examination of the body of the expectant mothers during their antenatal interactions. Lastly, findings of the analysis showed 70% level of agreement that the healthcare providers adequately explained antenatal issues timely to the expectant mothers during their antenatal interactions.

The above findings indicated that the healthcare providers to a great extent responded to expectant mothers during antenatal interactions. The results led this researcher to answer the second research questions as followed: *healthcare providers responded to expectant mothers in South-East Nigeria during antenatal interactions by:*

i. *Giving adequate answers to the questions of the expectant mothers.*
ii. *Making appropriate gestures to explain their points during interactions.*
iii. *Carrying out appropriate examination of the body of the expectant mothers.*
iv. *Adequately explaining antenatal issues timely to the expectant mothers.*

The findings above all showed various ways healthcare providers responded to the expectant mothers during their antenatal interactions. In the aspect of healthcare providers giving adequate answers to the questions of expectant mothers, women were prone to seek out information necessary to meet the demand posed during pregnancy (Ojewole & Oludipe, (2017). Thus, it would not be surprising to healthcare providers when they asked a lot of questions, this is because the health knowledge of the expectant women were improved in the area of engaging in preventive health behavior and improving self-care abilities when healthcare providers responded to their questions by providing adequate relevant answers to their questions.

This finding goes contrary to popular assertions that healthcare providers did not answer the questions of expectant mothers. Nwagwu & Ajama (2021) stated that the communication between client-healthcare provider is unidirectional with the provider giving information and the client listening to what the provider said and only half of the clients given chance to ask questions. This study has shown that adequate answers to the questions of expectant mothers

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

is believed to be one of the key components of maternal health hence Uloma and Adedotu (2013) averred that availability, giving access to, and utilization of health information would translate to a safe delivery thereby reducing maternal mortality. The need for an urgent, global coordinated response has prompted several agencies and international organizations to join forces and create partnerships for maternal, new born and child health.

Hence the researcher submits that healthcare providers have a high level of response to expectant mothers' questions and timely explain antenatal issues as well as making use of gestures to explain their points during antenatal interactions.

CONCLUSION AND RECOMMENDATIONS

In furtherance of the communicative engagement, healthcare providers responded adequately and appropriately by rendering answers and gestures that helped to explain antenatal issues. They also engaged in appropriate examinations and prescriptions that were in tandem with the expectations of the expectant mothers, thereby engendering satisfaction of the pregnant women with the outcome of the interactive sessions. Based on the above established situations that existed in the primary healthcare centres in South-East Nigeria, it would be apt to conclude that quality healthcare communication existed between healthcare providers and expectant mothers in South-East Nigeria. Therefore, appropriate listening enhanced the nature of responses by the healthcare providers to the expectant mothers

In order to apply the findings of this study to the society, the following recommendations are made:

i. Policy makers should ensure that the cordiality between healthcare providers and their clients is sustained at all levels of healthcare delivery to promote quality communication for quality healthcare practice.

ii. Caregivers should always ensure that their clients heed to healthcare instructions at all level to enhance the effectiveness of healthcare communication for effective healthcare delivery.

REFERENCES

Agus, Y. & Horiuchi, S. (2013). Factors influencing the use of antenatal care in rural West Sumatna, Indonesia. Retrieved from http://www.antenatal.org

Austad, K., Chary, A., Martinez, B., Juarez, M., Juarez, M. Y., Ixen, C. & Rohloff, P. (2017). Obstetric care navigation: a new approach to promote respectful maternity care and overcome barriers to safe motherhood. *Reprod Health*. 14,148-156.

Azuh, D., Azuh, A, Iweala, E., Adeloye, D., Akanbi, M. & Mordi, R. (2017). Factors influencing maternal mortality among rural communities in southwestern Nigeria. *International Journal of Women's Health*; 9:179-188.

Baiye, B (2019) Behind the 66%: Pathfinder International initiative helps reduce maternal deaths in Cross River. *Nigeria Healthcare,* 2(3); 23-34.

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

Chadwick RJ, Cooper D, Harries J. Narratives of distress in south African public maternity settings: a qualitative study. *Midwifery.* 2014;30:862–8.

Champ (2017). "Maternal Child health." Available at: http://www.champzambia.org/health_information/maternal_child_health (Accessed on 10th June, 2019)

Glenton, C. (2022). Developing patient - centered information for back pain suffers. *Health Expectations*, 5(4): 319 – 329.

Goke (2012). Reducing maternal, newborn, and childhood deaths. Retrieved from http://www.thisdaylive.com/articles/reducingmaternal-newborn-and-childhood-deaths1-/122513

Healthy People (2000*). Annual report on media and health issues*. https://www.askme.org/healthypeople...

Healthy People (2010*). Annual report on media and health issues*. https://www.askme.org/healthypeople...

Hulton, L., Matthews, Z. & Stones, R.W. (2000) A framework for the evaluation of quality of care in maternity services. University of Southampton.

Kyei, N.N., Chansa, C. & Gabrysch, S. (2012) Quality of antenatal care in Zambia: A national assessment. *BMC Pregnancy and Childbirth*, 12(1): 151.

McMahon, S. A., George, A.S., Chebet, J. J. Mosha, I. H., Mpembeni, R. N. M. & Winch, P. J. Experiences of and response to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. *BMC Pregnancy Childbirth*. 2014;14:268.

Mulauzi, F. & Daka, K. (2018). "A literature review on maternal health information needs of women." *Journal of Lexicography and Terminology*, 2(1), 124 -126.

Ngwagwu, W. E. & Ajama, M. (2021). Women's health information needs and information sources: A study of a rural oil palm business community in South - Western Nigeria. *Annals of Library and Information Studies*, 58, 270-281.

Nigeria Health Watch (2019). The Ultimate Health Meets Tech NG Hack: Funding healthcare with plastic waste. https://nigeriahealthwatch.com/the-ultimate-healthmeetstechng-hack-funding-healthcare-with-plastic-waste/

Ojewole, F. & Oludipe, U. (2017). Pregnancy-related information need and information-seeking pattern among pregnant women attending antenatal clinic at Ikorodu General Hospital, Lagos State, Nigeria. *European Scientific Journal* 13(24). DOI: https://doi.org/10.19044/esj.2017.v13n24p436

Onuoha, U.D., & Amuda, A. A. (2013). Information seeking behaviour of pregnant women in selected hospital of Ibadan Metropolis. *Journal of Information and Knowledge Management*, 4(1), 77-91.

Ratzan, K. (1995). Media and development in emerging societies in Africa. In Gebbs, J. (Ed) . *Issues in media Studies.* New York: Holder.

Sanda, K. (2010). Integrating modern and traditional media for health communication in Nigeria. *The Nigerian Journal of Communication;* 3:45-61.

Schunk, D. H. (1995). Self-efficacy and education and instruction. In J. E. Maddux (Ed.), Selfefficacy, adaptation and adjustment: Theory, research and application (pp. 281–303). New York: Plenum Press.

Sullivan, P. L. (2005). Felt learning needs of pregnant women. Canadian Nurse, 89(1), 42-45.

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG

Uloma, F. G. & Adedotu, C, V. (2013). Information seeking behaviour of pregnant women in selected hospitals of Ibadan Metropolis. Information Impact: *Journal of Information and Knowledge Management*. 4(1)

Van Dinther, M., Dochy, F., Segers, M., & Braeken, J. (2013). The construct validity and predictive validity of a self-efficacy measure for student teachers in competence-based education. *Studies in Educational Evaluation*, 39(3), 169.

World Health Organization (1978). Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

World Health Organization (2015). Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. World Health Organization.

World Health Organization (2020). Sexual and Reproductive Health. Maternal Health in Nigeria: Generating Information for Action. https://www.who.int/reproductivehealth/maternal-health-nigeria/en/. Accessed January 7, 2022.

Article DOI: 10.52589/BJMCMR-IH876XZG
DOI URL: https://doi.org/10.52589/BJMCMR-IH876XZG