A Critical Discourse Analysis of Language Dominance and Linguistic Strategies in Midwives-Parturient Women Interactions during Childbirth in Nigeria Zaria, Kaduna State

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Abstract

This study investigates the linguistic interactions between midwives and women in labour in selected labour wards in Zaria, Kaduna State, Nigeria, with particular focus on the dynamics of power and the language strategies employed during childbirth. The problem addressed stems from growing concerns about the dominance of clinical authority in maternity settings, where communication often prioritizes medical efficiency at the expense of emotional and cultural sensitivity. In such contexts, women in labour are frequently positioned as passive recipients of care, raising critical questions about agency, respect, and culturally responsive healthcare delivery. Guided by Fairclough's Critical Discourse Analysis (CDA), the study explores how language functions as a tool of control and negotiation in childbirth-related interactions. The methodology involves a qualitative approach, using audio recordings and non-participant observations to document 18 midwives-parturient women interactions across diverse healthcare settings. From this corpus, three interactions were purposively selected for in-depth discourse analysis based on variations in socio-demographic and institutional contexts. The findings revealed a persistent asymmetry in communicative roles: midwives predominantly use directive and imperative speech acts such as "Push" or "Don't shout," while women in labour often respond through fragmented expressions of pain, prayers, and cries. Although some midwives employ culturally resonant expressions like "Toh" and "Na'am", these do not significantly alter the underlying power imbalance. Religious and spiritual expressions from the women highlight a crucial yet under-recognized aspect of patient experience. The study concludes by advocating for midwifery training programs that emphasize empathetic, culturally competent, and spiritually inclusive communication practices, thereby promoting a more patient-centred approach to maternal care.

Keywords: Childbirth communication, Critical discourse analysis, Linguistic strategies, Midwife-woman interactions, Power dynamics

Introduction

Childbirth is a critical and transformative experience that requires effective communication between healthcare providers and women in labour. In Nigeria, midwives play a pivotal role in guiding women through this process, often using language as a tool to direct, instruct, and manage the delivery process. However, these interactions are frequently characterized by power imbalances, where midwives, as authority figures, may exert dominance over women in labour, leaving them with limited agency. This study conducts a Critical Discourse Analysis (CDA) of interactions between midwives and women in labour in selected private and public healthcare facilities in Zaria, Kaduna State, Nigeria. By examining these interactions, the study uncovered how language reflects and reinforces power dynamics in the labour ward, focusing on the ways midwives and women negotiate authority and agency during childbirth.

The labour ward, a specialized unit within obstetrics and gynecology, is a space where women in labour depend heavily on midwives for care and guidance. Midwives, who are typically women trained to assist during childbirth, hold significant authority in this setting. However, the power dynamics inherent in their interactions with women in labour can sometimes lead to communication that is authoritative or even harsh, particularly in a context where women are vulnerable and reliant on midwives for their safety and well-being. This study recognizes language as a powerful tool that can both reflect and perpetuate social inequalities, particularly in healthcare settings where power relations are pronounced.

Importance of Communication in Childbirth Settings

Effective communication between midwives and women in labour is essential for ensuring positive childbirth outcomes. Midwives' ability to communicate clearly, empathetically, and respectfully can significantly influence the birthing experience. Conversely, poor communication can lead to misunderstandings, increased stress, and even adverse health outcomes. In Nigeria, where healthcare resources are often limited and patient loads are high, the quality of communication in labour wards is particularly critical. Women in labour, regardless of their social or economic status, rely on midwives for guidance and support, making the dynamics of their interactions a key area of study.

Language Dominance and Power Relations in Healthcare

Language is not merely a means of communication but also a tool for exercising power and control. In healthcare settings, power dynamics are often evident in the way medical professionals communicate with patients. Midwives, as authority figures in the labour ward, may use language to assert control, issue directives, or influence decision-making. This dominance can leave women in labour with little room to express their preferences or concerns, particularly in a context where cultural and social norms may already marginalize women. Critical Discourse Analysis (CDA) provides a framework for examining these power relations, revealing how language can both reflect and reinforce social inequalities. To establish the power dynamics and language strategies employed during childbirth, this paper:

1. analyzes language dominance in midwife-woman interactions during delivery, focusing on power imbalances, decision-making, and patient care impact.
2. identifies and examines linguistic strategies used by midwives and women in labour to negotiate authority and agency, and their influence on interactions and outcomes in labour wards.

Theoretical Framework

Critical Discourse Analysis (CDA), as developed by Fairclough (1995), provides a robust framework for examining the relationship between language, power, and ideology. Fairclough's approach emphasizes the role of discourse in shaping social practices and power relations, particularly in institutional settings. According to Fairclough (1995), discourse is not merely a reflection of social reality but a means through which power is exercised and ideologies are perpetuated. CDA involves a three-dimensional analysis: the text, the discursive practice, and the broader sociocultural context. This framework is particularly suited for analyzing interactions in healthcare settings, where power imbalances are often evident in communication patterns (Wodak, 2001). By applying Fairclough's CDA, this study seeks to uncover how language is used to assert dominance and negotiate authority in labour ward interactions.

Language and Power in Healthcare Interactions

Language plays a central role in healthcare interactions, often reflecting and reinforcing power dynamics between healthcare providers and patients. In medical settings, professionals such as doctors and midwives typically hold authoritative positions, which can lead to asymmetrical communication patterns (Ainsworth-Vaughn, 1998). For instance, studies have shown that medical professionals often use directives and technical jargon, which can marginalize patients and limit their participation in decision-making (Heritage & Maynard, 2006). In the context of childbirth, midwives' language can significantly influence women's experiences, particularly when it is authoritative or dismissive (Eri et al., 2010). This study builds on these insights by examining how language dominance manifests in midwife-woman interactions and its impact on patient care.

This study explores labour ward communication in Zaria through Critical Discourse Analysis, revealing how language reflects power dynamics between midwives and women in labour. It offers valuable insights for linguists, healthcare professionals, and educators, highlighting the need for empathetic, patient-centred care. The findings support improved midwifery training and contribute to Nigeria's underexplored medical discourse literature, aiming to enhance maternal healthcare delivery and address social inequalities through more equitable communication practices.

Gender, Authority, and Agency in Childbirth Settings

Childbirth settings are inherently gendered spaces, where midwives (typically women) interact with women in labour. Despite the shared gender, power imbalances often arise due to the institutional authority vested in midwives (Russell, 2016). Women in labour, particularly in low-resource settings like Nigeria, are often vulnerable and dependent on midwives for their safety and well-being. This dependency can limit their agency and ability to assert their preferences during childbirth (Shallow et al., 2018). Studies have highlighted the need for more empathetic and patient-centered communication in labour wards to empower women and improve childbirth outcomes (Ambady et al., 2002). This

study explores how gender, authority, and agency intersect in labour ward interactions, focusing on the linguistic strategies employed by both midwives and women in labour.

Linguistic Strategies in Negotiation and Decision-Making

Linguistic strategies are crucial in negotiating authority and agency in healthcare interactions. Midwives may use directives, politeness strategies, or persuasive language to guide women in labour, while women may employ resistance or appeals to assert their preferences (Odebunmi, 2006). For example, studies have shown that midwives often use imperative forms to issue instructions, which can reinforce their authority but may also disempower women (Eri et al., 2010). Conversely, women in labour may use indirect language or appeals to personal experience to negotiate their needs (Russell, 2016). This study examines these linguistic strategies in detail, focusing on how they influence decision-making and interaction outcomes in labour wards.

Methodology

This study **adopted** a qualitative research design, utilizing Critical Discourse Analysis (CDA) as its primary analytical framework. The qualitative approach **was chosen** because it **allowed** for an in-depth exploration of the linguistic and social dynamics inherent in midwife-woman interactions during childbirth. CDA, as developed by Fairclough (1995), **was** particularly suited for this study as it **enabled** the examination of language use in relation to power, ideology, and social practices. The study **employed** triangulation, combining multiple data sources and methods to enhance the validity and reliability of the findings. Specifically, it employ**ed** data triangulation (collecting data from diverse participants) and methodological triangulation (combining qualitative and quantitative sampling techniques) to ensure a comprehensive analysis (Jick, 1979; Gillham, 2000).

Study Setting

The study was conducted in selected labour wards within Zaria, Kaduna State, Nigeria. Zaria is home to a mix of public and private healthcare facilities, including tertiary, secondary, and primary healthcare centres. These settings were chosen to capture a wide range of socio-demographic and institutional contexts, ensuring the diversity of the data. Public hospitals in Zaria are managed by federal, state, and local governments, while private hospitals are owned by individuals. The labour wards in these facilities serve as the primary sites for data collection, as they are spaces where midwives and women in labour interact intensively during childbirth.

Data Collection Methods

The study employed two primary methods of data collection: audio recordings of midwife-woman interactions and non-participant observations with field notes.

iv. **Audio Recordings**: Audio recordings are used to capture the verbal and paralinguistic aspects of interactions, such as tone, pitch, and pauses. These elements are crucial for understanding the power dynamics and implicit meanings in the discourse. Informed consent is obtained from all participants before recording, and strict measures are taken to ensure privacy and confidentiality.

v. **Observations and Field Notes**: non-participant observation is employed to complement the audio recordings. This method allows the researcher to observe interactions without directly influencing them, ensuring that participants behave naturally. Field notes are taken to document contextual details, such as the physical environment, non-verbal cues, and the overall atmosphere of the labour ward.

Sampling Technique and Participant Selection

The study used a purposive sampling technique within a contingency framework to select participants. Purposive sampling was chosen because it allowed the researcher to select participants based on specific criteria relevant to the research objectives (Patton, 1990; Creswell & Creswell, 2017). The sample included midwives and women in labour from both public and private healthcare facilities in Zaria. The public hospitals were categorized into tertiary, secondary, and primary healthcare centres, while private hospitals were selected based on their accessibility and patient demographics.

A total of 18 labour ward interactions were recorded, with a proportionate purposive sample of 3 interactions selected for detailed analysis. This sampling strategy ensured diversity in terms of participant age, experience, and socio-economic background, enhancing the representativeness of the findings.

Ethical Considerations

This study upholds strict ethical guidelines to safeguard the rights and well-being of all participants. Prior to data collection, informed consent is obtained, ensuring that participants understand the purpose of the study and their voluntary involvement. Anonymity and confidentiality are strictly maintained, with all names in the transcriptions being fictional to protect identities. Ethical approval has been granted by the appropriate institutional review board. Furthermore, the researcher remains highly sensitive to the vulnerabilities of women in labor, ensuring that their participation does not compromise their safety, comfort, or dignity.

Data Analysis

The data analysis was based on Fairclough's three-dimensional model of CDA, which includes:
Text Analysis: This involves examining the linguistic features of the interactions, such as vocabulary, syntax, and tone. The focus is on identifying how language is used to assert authority, negotiate agency, and reflect power imbalances.
Discursive Practice Analysis:
This dimension explores the production and interpretation of the discourse. It examines how midwives and women in labour use language to achieve specific communicative goals, such as issuing directives or expressing resistance.
Sociocultural Practice Analysis:
This level of analysis situates the discourse within its broader social and cultural context. It investigates how institutional norms, cultural values, and power relations shape the interactions between midwives and women in labour.

Table 1: Textual and Discourse Analysis of Interaction 1 (MW and WL in Labour Ward Islamic Context)

Dimension	**Analysis**
Textual Analysis	
Lexical Choices	- MW uses imperative language: "Hold," "Push," "Don't lift," "Stop," "Drop." These commands reflect authority and urgency.
	- WL uses religious invocations: "La ilaha illallah," "Innalillahi wa inna ilayhi rajiun," "Alhamdulillahi kathiran." These reflect her reliance on faith and spirituality during the pain and stress of labor.
	- MW mixes English with local language (e.g., "Oya," "Toh, kinga abunda na gaya miki?"), showing cultural and linguistic adaptation.
Grammar	- MW's sentences are short, direct, and often imperative, reflecting control and urgency.
	- WL's sentences are fragmented, emotional, and repetitive, reflecting her physical and emotional state.
Modality	- MW uses high modality: "You must," "Don't," "Stop," indicating authority and insistence.
	- WL uses low modality in her prayers and cries, showing vulnerability and dependence on divine intervention.
Turn-taking	- MW dominates the conversation, giving instructions and reprimands. WL's responses are mostly reactive (prayers, cries, and attempts to comply).
Discursive Practice	
Production	- The interaction is produced in a high-stress, clinical setting where the MW is focused on ensuring a safe delivery, while the WL is focused on coping with pain and seeking divine help.
Interpretation	- The MW interprets the WL's actions (e.g., lifting buttocks, holding hands) as non-compliance, while the WL interprets her own actions as coping mechanisms (praying, crying).
Interaction	- The interaction is asymmetrical, with the MW holding power and authority over the WL. The WL's agency is limited to her prayers and cries.
Social Practice	
Power Relations	- The MW holds institutional and professional power, directing the WL's actions. The WL, in a vulnerable position, has limited power and relies on faith and compliance.
Cultural Context	- The WL's use of Islamic prayers reflects her cultural and religious background, which provides her with emotional and spiritual support.
	- The MW's use of local language and cultural expressions (e.g., "Oya") shows an attempt to connect with the WL on a cultural level.
Ideology	- The interaction reflects ideologies of medical authority and patient compliance. The MW's focus is on the physical process of childbirth, while the WL's focus is on spiritual and emotional survival.

Dimension	Analysis
	- The WL's reliance on prayer highlights the intersection of faith and healthcare in her cultural context.

Table 2: Textual and Discourse Analysis of Interaction 2 (MW and WL in Labour Ward – Christian Context)

Dimension	Analysis
Textual Analysis	
Lexical Choices	- MWs use imperative language: "Stop," "Push," "Don't," "Calm down," "Open your legs." These commands reflect authority and urgency.
	- WL uses religious invocations: "Jesu o! Oluwa gba mi o!" "Oluwa, help me o!" These reflect her reliance on faith and spirituality during the pain and stress of labor.
	- MWs mix English with local language (e.g., "Oya," "jor"), showing cultural and linguistic adaptation.
Grammar	- MWs' sentences are short, direct, and often imperative, reflecting control and urgency.
	- WL's sentences are fragmented, emotional, and repetitive, reflecting her physical and emotional state.
Modality	- MWs use high modality: "You must," "Don't," "Stop," indicating authority and insistence.
	- WL uses low modality in her prayers and cries, showing vulnerability and dependence on divine intervention.
Turn-taking	- MWs dominate the conversation, giving instructions and reprimands. WL's responses are mostly reactive (prayers, cries, and attempts to comply).
Discursive Practice	
Production	- The interaction is produced in a high-stress, clinical setting where the MWs are focused on ensuring a safe delivery, while the WL is focused on coping with pain and seeking divine help.
Interpretation	- The MWs interpret the WL's actions (e.g., shouting, lifting buttocks) as non-compliance, while the WL interprets her own actions as coping mechanisms (praying, crying).
Interaction	- The interaction is asymmetrical, with the MWs holding power and authority over the WL. The WL's agency is limited to her prayers and cries.
Social Practice	
Power Relations	- The MWs hold institutional and professional power, directing the WL's actions. The WL, in a vulnerable position, has limited power and relies on faith and compliance.
Cultural Context	- The WL's use of Christian prayers reflects her cultural and religious background, which provides her with emotional and spiritual support.

Dimension	Analysis
	- The MWs' use of local language and cultural expressions (e.g., "Oya," "jor") shows an attempt to connect with the WL on a cultural level.
Ideology	- The interaction reflects ideologies of medical authority and patient compliance. The MWs' focus is on the physical process of childbirth, while the WL's focus is on spiritual and emotional survival.
	- The WL's reliance on prayer highlights the intersection of faith and healthcare in her cultural context.

Table 3: Textual and Discourse Analysis of Interaction 3 (MW and WL in Labour Ward – Hausa Muslim Context)

Dimension	Analysis
Textual Analysis	
Lexical Choices	- MWs use imperative language: "Lie down," "Stop," "Push," "Don't," "Relax." These commands reflect authority and urgency.
	- WL uses religious invocations: "Innalillahi wa inna ilayhi raji'un," "Ya Allah," "Subhanallah." These reflect her reliance on faith and spirituality during the pain and stress of labor.
	- MWs mix English with local language (e.g., "Toh," "Na'am," "Yanzu"), showing cultural and linguistic adaptation.
Grammar	- MWs' sentences are short, direct, and often imperative, reflecting control and urgency.
	- WL's sentences are fragmented, emotional, and repetitive, reflecting her physical and emotional state.
Modality	- MWs use high modality: "You must," "Don't," "Stop," indicating authority and insistence.
	- WL uses low modality in her prayers and cries, showing vulnerability and dependence on divine intervention.
Turn-taking	- MWs dominate the conversation, giving instructions and reprimands. WL's responses are mostly reactive (prayers, cries, and attempts to comply).
Discursive Practice	
Production	- The interaction is produced in a high-stress, clinical setting where the MWs are focused on ensuring a safe delivery, while the WL is focused on coping with pain and seeking divine help.
Interpretation	- The MWs interpret the WL's actions (e.g., shouting, lifting buttocks) as non-compliance, while the WL interprets her own actions as coping mechanisms (praying, crying).
Interaction	- The interaction is asymmetrical, with the MWs holding power and authority over the WL. The WL's agency is limited to her prayers and cries.
Social Practice	

Dimension	Analysis
Power Relations	- The MWs hold institutional and professional power, directing the WL's actions. The WL, in a vulnerable position, has limited power and relies on faith and compliance.
Cultural Context	- The WL's use of Islamic prayers reflects her cultural and religious background, which provides her with emotional and spiritual support.
	- The MWs' use of local language and cultural expressions (e.g., "Toh," "Na'am") shows an attempt to connect with the WL on a cultural level.
Ideology	- The interaction reflects ideologies of medical authority and patient compliance. The MWs' focus is on the physical process of childbirth, while the WL's focus is on spiritual and emotional survival.
	- The WL's reliance on prayer highlights the intersection of faith and healthcare in her cultural context.

Discussion of Findings

The conversations between midwives (MWs) and women in labour (WLs) reveal notable patterns in language use, power dynamics, and cultural contexts, reflecting broader trends in healthcare communication, particularly in childbirth settings. These interactions demonstrate a consistent asymmetry in power, where midwives assume authoritative roles, while women in labour, experiencing physical and emotional vulnerability, often respond with prayers, cries, or fragmented speech. This discussion examines these findings in detail, linking them to existing research and highlighting their implications.

A key observation is the dominance of midwives in controlling the discourse. Across all interactions, midwives use directive language such as "Push," "Stop," and "Don't lift" to exert authority and guide the labour process. This establishes an asymmetrical power relationship in which the WLs are passive recipients of care, responding primarily through emotional expressions. This pattern aligns with findings in medical discourse studies, which indicate that healthcare professionals often lead interactions with patients through imperatives and commands, positioning them in a subordinate role. In childbirth settings, this power imbalance is heightened due to the inherent vulnerability of women in labour, who are dependent on medical expertise for a safe delivery. However, while the authoritative approach remains consistent across all conversations, variations in the level of empathy and cultural sensitivity are observed. For example, in one interaction, midwives incorporate local expressions such as "Toh" and "Na'am," suggesting an attempt to connect with the patient culturally. Nevertheless, this minor adaptation does not significantly alter the overall hierarchical dynamic.

Cultural and religious factors are central to the interactions, with WLs relying on faith as a coping mechanism. Throughout the conversations, expressions such as "Jesu o!," "Innalillahi wa inna ilayhi raji'un," and "Ya Allah" frequently appear, illustrating the profound role of spirituality in childbirth experiences. This finding resonates with research indicating that religious and cultural beliefs significantly influence women's perceptions of labour. In many African and Islamic societies, childbirth is not only a medical event but also a deeply spiritual journey, where faith provides solace and strength. The responses of midwives to these religious expressions vary. In some cases, they acknowledge and encourage prayer, reinforcing the WLs' faith as a source of resilience. However, in other instances, midwives either overlook or dismiss religious utterances, prioritising medical directives over spiritual considerations. This inconsistency highlights a tension between the WLs' spiritual needs and the midwives' clinical responsibilities, suggesting that greater integration of spiritual awareness in maternity care may enhance patient support.

The communication strategies employed by midwives reflect a task-oriented approach prioritising efficiency and safety. They predominantly use direct and imperative language to control the labour process, focusing on delivering concise, actionable instructions. Conversely, WLs communicate primarily through emotional and repetitive expressions, often articulating pain, fear, and distress. This contrast aligns with studies on medical discourse, which indicate that healthcare professionals typically prioritise procedural efficiency, sometimes at the expense of emotional engagement. The emotional intensity of childbirth, as demonstrated by the WLs' repeated cries for help and expressions of frustration, underscores the necessity of empathetic communication in maternity care. While some midwives attempt to bridge cultural gaps through familiar language such as "Oya" and "Toh," this strategy is not consistently applied, and authoritative, dismissive tones often prevail.

The emotional and physical vulnerability of WLs is evident across all interactions. They frequently express distress through crying, shouting, and pleading for assistance, highlighting the overwhelming nature of labour. Their reliance on both medical guidance and spiritual invocations reflects the dual sources of support they seek in a challenging experience. This aligns with previous studies suggesting that childbirth is not only physically demanding but also an emotionally intense event requiring both clinical expertise and psychological reassurance. The midwives' responses to these expressions of vulnerability vary significantly. In some cases, they offer encouragement and reassurance, using phrases such as "You are almost there" to motivate the WLs. However, in other instances, they react with impatience or reprimands, instructing WLs to "keep quiet" or comply with orders without addressing their emotional state. This inconsistency highlights the ongoing challenge of balancing clinical efficiency with compassionate care in maternity settings.

A significant theme emerging from these conversations is the intersection of faith and healthcare. WLs consistently turn to religious expressions alongside medical interventions, indicating that spiritual beliefs are integral to their childbirth experience. Research supports the importance of integrating spiritual care into healthcare, particularly in contexts where religion is a central aspect of life. Despite this, midwives primarily focus on the clinical aspects of childbirth, with only occasional acknowledgment of the WLs' spiritual expressions. This suggests that while religious coping mechanisms are widely recognised by patients, they are not always adequately accommodated within medical practice. The marginalisation of spiritual considerations in healthcare reflects a broader trend, where biomedical priorities often overshadow holistic patient needs.

In conclusion, the three conversations reveal persistent patterns in language use, power dynamics, and cultural influences, reinforcing broader findings on healthcare communication. The authoritative role of midwives and their task-driven approach align with established medical discourse practices, while the WLs' reliance on faith underscores the importance of culturally sensitive care. Variations in midwives' responses to WLs' emotional and spiritual expressions highlight the need for more consistent, patient-centred communication in maternity settings.

Based on these findings, it is recommended that midwives receive training in culturally competent and empathetic communication strategies to better support WLs during labour. This includes recognising and accommodating spiritual expressions as a legitimate aspect of patient care, providing reassurance alongside medical directives, and adopting a more patient-focused approach that balances clinical efficiency with emotional support. By fostering a more holistic and compassionate communication style, maternity care providers can enhance the overall childbirth experience, ensuring that WLs feel respected, supported, and empowered throughout the process.

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