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Stakeholder-perceived barriers and facilitators to the effective dissemination and implementation of doula support services in Bayelsa State, Nigeria

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Abstract

Background: Doula support services broadly seen as continuous, non-clinical emotional, physical, and informational support during pregnancy, childbirth, and the postpartum period are widely recognized for improving maternal and newborn outcomes and promoting respectful, woman-centered maternity care. Despite strong global advocacy, the dissemination and implementation of doula services in low- and middle-income countries such as Nigeria remain limited. This study emphasizes the importance of understanding stakeholder-perceived barriers and facilitators to inform context-appropriate implementation strategies within existing health systems.

Materials and Methods: Using a descriptive cross-sectional survey design, the study was conducted across selected tertiary health institutions and relevant regulatory and administrative health structures in Bayelsa State, Nigeria. A census sampling approach recruited 101 participants, comprising midwives and nursing directors. Data were collected through a validated and reliable researcher-developed questionnaire rated on a four-point Likert scale, with analysis based on descriptive statistics.

Results: Findings highlight several critical barriers to effective dissemination and implementation of doula support services. These include limited awareness of the doula role and benefits, inadequate and inconsistent funding, absence of standardized training curricula and certified trainers, infrastructural and workforce constraints, lack of clear national policies and regulatory frameworks, and persistent sociocultural beliefs surrounding childbirth. In contrast, key facilitators identified were the presence of experienced midwives, strong community engagement and cultural acceptability, existing dissemination channels, partnerships with governmental and non-governmental organizations, and increasing global evidence and funding prioritization for maternal and newborn health.

Conclusion: Overall, doula support services are perceived as acceptable and potentially feasible within Bayelsa State's maternal health system. However, successful integration and scale-up require deliberate policy endorsement, sustainable financing mechanisms, stakeholder sensitization, and the development of standardized training and regulatory frameworks to ensure long-term sustainability.

Keywords: Perceived Barriers and Facilitators; Dissemination; Implementation; Doula Support Services; Bayelsa State Nigeria

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1. Introduction

Doula support services, defined as the provision of continuous, non-clinical emotional, physical, and informational support to women during pregnancy, childbirth, and the postpartum period—have gained increasing global recognition as an effective strategy for improving maternal and newborn health outcomes. Extensive evidence demonstrates that the presence of doulas during labour and childbirth is associated with reduced rates of caesarean section, shorter labour duration, decreased use of analgesia, improved maternal satisfaction, and enhanced birth experiences [1,2]consequently, doula care has been widely integrated into maternity care systems in several high-income settings and is increasingly advocated for low- and middle-income countries (LMICs) where maternal morbidity and mortality remain unacceptably high.

Despite the growing global emphasis on respectful maternity care and woman-centred childbirth, the dissemination and implementation of doula support services in many LMICs, including Nigeria, remain limited and fragmented. Nigeria accounts for a substantial proportion of global maternal deaths, with structural health system challenges, sociocultural beliefs, and workforce constraints continuing to undermine the quality of intrapartum care [3]. In this context, innovative and community-oriented interventions such as doula support services hold significant potential to complement skilled birth attendance and strengthen maternal health systems, particularly in resource-constrained settings.

However, the successful scale-up of doula services is highly dependent on stakeholder perceptions, institutional readiness, policy environments, and contextual facilitators and barriers. Implementation science literature emphasizes that health interventions are more likely to be adopted and sustained when key actors including nurses, midwives, policymakers, and community stakeholders perceive the intervention as acceptable, feasible, and aligned with existing health system structures [4,5]. Understanding these perceptions is therefore critical for informing context-appropriate dissemination and implementation strategies.

Findings from this study conducted among nursing/midwifery professionals in Bayelsa State highlight several salient barriers to the effective dissemination and implementation of doula support services. These include limited awareness of the role and benefits of doulas, inconsistent funding, lack of standardized training curricula, infrastructural deficits, absence of clear national policies and regulatory frameworks, and deeply rooted sociocultural beliefs surrounding childbirth. Such barriers mirror challenges reported in similar maternal health interventions across sub-Saharan Africa, where policy gaps, professional role conflicts, and weak health communication systems often constrain innovation uptake [6,7].

Conversely, the study also identified substantial strengths that could facilitate the successful integration of doula services in Bayelsa State. These include the availability of experienced midwives, strong community engagement, existing dissemination channels such as community radio, established partnerships with non-governmental and civil society organizations, and growing global evidence supporting the effectiveness of doula care. Additionally, the prioritization of maternal and newborn health within global funding agendas presents a strategic opportunity for leveraging external resources to support doula service implementation [8].

By systematically examining stakeholder-perceived barriers and facilitators, this study provides critical empirical insight into the contextual factors influencing the dissemination and implementation of doula support services in Bayelsa State. Such evidence is essential for informing policy development, guiding program design, and strengthening implementation strategies aimed at improving maternal and newborn health outcomes in Nigeria and similar LMIC settings.

Objectives

This study aimed to quantitatively describe stakeholders perceived barriers and strengths to the dissemination and implementation of doula support service in Bayelsa State.

2. Methods

This study adopted a descriptive cross-sectional survey design to generate quantitative evidence on stakeholder-perceived barriers and facilitators to the effective dissemination and implementation doula support services within Bayelsa State's maternity care system. A cross-sectional approach was considered appropriate because it enables the systematic capture of perceptions, preferences, and institutional readiness indicators at a single point in time across

multiple stakeholder groups and settings, thereby supporting priority-setting for implementation planning. This research design has been used by other researchers to explore similar areas in line with the phenomenon under study.

The study was conducted in Bayelsa State, Nigeria, within selected tertiary health institutions (Federal Medical Centre, Yenagoa, and Niger Delta University Teaching Hospital, Okolobiri) and relevant regulatory/administrative health structures such as the Bayelsa State Ministry of Health and the Bayelsa State Hospital Management Board as involved in maternal and newborn care governance and service delivery. These settings were selected because they represent the major decision-making and service delivery nodes through which doula support services would be disseminated, adopted, supervised, and sustained if integrated into routine care. Selection bias was assessed by examining whether the chosen study settings and recruitment procedures could produce a sample whose views differ from the broader stakeholder population for doula dissemination and implementation in Bayelsa State. The study purposively selected two tertiary hospitals and two key governance/regulatory bodies to maximize policy and implementation relevance, but this may limit external representativeness because primary care, private, and community maternity stakeholders were not included, potentially skewing strategy preferences toward what is feasible in tertiary/administrative contexts. At the participant level, a census approach with predefined eligibility criteria, a four-week weekday data-collection period, immediate questionnaire retrieval, and a 100% return rate reduced non-response and improved coverage within the selected institutions. Nonetheless, some residual bias could arise if eligible staff were missed due to workload, shifts, postings, gatekeeping, or if eligibility rules excluded relevant stakeholder categories. Overall, the risk of selection bias is judged low within the defined institutional sampling frame but moderate for generalizability to the wider Bayelsa maternal and newborn care system.

In this study, the researchers made inferences of all midwives in the maternity units of Federal Medical Center (FMC) Yenagoa, and Niger Delta University Teaching Hospital (NDUTH) Okolobiri. Also, Directors of Nursing/Midwifery services in Ministry of Health (MoH), FMC, NDUTH, and Hospitals Management Board (HMB) Bayelsa state, regardless of sex, religious affiliation and age on account of their current positions.

The total participants of this study were 101, comprising key maternal and newborn health stakeholders drawn from selected tertiary institutions and relevant regulatory and administrative health structures in Bayelsa State, Nigeria. Specifically, midwives working in maternity wards at the Federal Medical Centre (FMC), Yenagoa (68 midwives) and Niger Delta University Teaching Hospital (NDUTH), Okolobiri (25 midwives) were included. In addition, 8 nursing directors were recruited, including one each from the Bayelsa State Ministry of Health and the Bayelsa State Hospital Management Board, as well as three nursing directors each from FMC Yenagoa and NDUTH Okolobiri.

Inclusion criteria are critical for defining the study's scope, enhancing validity, and ensuring reproducibility. Inclusion criteria for the selection of respondents for this study were as follows: respondents must be between 25 and 60 years of age, must have a minimum of three (3) years' experience post-qualification, and must be willing to participate in the study. The exclusion criteria were midwives not working in the maternity units of the hospitals in this study, and those who were terminally sick.

A census sampling method (total population sampling) was employed, with the entire target population included in the study. Consequently, the total sample size was one hundred and one (101) respondents. This approach was selected to ensure full population inclusion, reduce sampling error, and enhance completeness of data collection as well as policy relevance within the study context.

The measurement tool for this study was a researcher-developed structured questionnaire designed to quantitatively assess stakeholder-perceived barriers and facilitators to the effective dissemination and implementation of doula support services in Bayelsa State. The questionnaire was organized into three sections. Section A assessed respondents' socio-demographic characteristics and contained four (4) items. Section B measured stakeholder-perceived barriers to using eight (8) items Section C measured stakeholder-perceived facilitators to the effective dissemination strategies for doula support services using eleven (11) items. All questions were closed-ended and rated on a four-point Likert scale (Strongly Agree, Agree, Disagree, and Strongly Disagree) to ensure standardized responses and support quantitative analysis. To ensure the tool measured what it was intended to measure, the questionnaire was subjected to face and content validity procedures. Reliability was assessed using a test-retest method with 38 participants, in which the same instrument was administered twice to the same group. Internal consistency reliability was further established using Cronbach's alpha, yielding a coefficient of 0.93, which indicates that the questionnaire was highly reliable for the measurement of the study constructs. Following the receipt of a letter of introduction from the Dean, Faculty of Nursing Sciences, Niger Delta University, Wilberforce Island, Bayelsa State, and ethical approvals from the research and ethics committees of the Federal Medical Centre, Yenagoa; Niger Delta University Teaching Hospital, Okolobiri; the Bayelsa State Ministry of Health; and the Bayelsa State Hospitals Management Board, the researcher proceeded to the study

sites to commence data collection. The researcher formally approached the head nurses of the participating facilities and conducted appropriate introductions to facilitate access and coordination within each setting.

Two research assistants were trained to support the data collection exercise. Their training covered the purpose and objectives of the study, the procedures for engaging respondents appropriately, and the correct approach to administering and retrieving responses. The assistants were selected based on their ability to communicate effectively in English. The researcher and trained assistants explained the purpose of the study to eligible respondents and obtained information only from those who voluntarily consented to participate.

Data collection was conducted on weekdays (Mondays to Fridays) during official working hours and scheduled before the commencement of nursing and medical rounds to minimize interruptions and distractions. The data collection period spanned four weeks to ensure that all eligible respondents, including those who were on annual leave, had sufficient opportunity to participate. All administered forms were retrieved immediately after completion, resulting in a complete return rate of 100%.

For this study, the researchers utilized descriptive statistics, including frequency and percentage.

3. Results

This study was conducted among 101 nursing professionals, among whom the largest proportion of them were aged between 43 and 51 years, were female 94 (93.1%), most had obtained a Bachelor of Nursing degree, and as much as 42 (41.6%) had obtained between 1 and 9 years of working experience in maternal and child health services.

Table 1 Socio-demographic characteristics of respondents

Variable	**Frequency (n=101)**	**Percentage (%)**
Age (years)		
25-33	27	26.7
34-42	26	25.7
43-51	34	33.7
52-60	14	13.9
Sex		
Male	7	6.9
Female	94	93.1
Educational qualification		
Diploma	14	13.9
BNSc	73	72.3
M.Sc.	12	11.9
Ph.D.	2	2.0
Years of experience in maternal and child health services (years)		
1-9	42	41.6
10-18	27	26.7
19-27	21	20.8
28-35	11	10.9

The barriers perceived by the study respondents as being capable of limiting the dissemination and implementation of Doula support services were also assessed in this study. Notable barriers which most of the respondents strongly agreed to, included the general lack of awareness about specific benefits of these services 71 (70.3%), limited and inconsistent funding for the service 68 (67.3%), as well as the unavailability of media engagements 64 (63.4%). Others included infrastructural deficits 65 (64.4%), lack of certified trainers and curricula 65 (64.4%), as well as the lack of clear national

guidelines, integration policies/regulatory frameworks 64 (63.4%), and the problem of deeply-rooted beliefs about childbirth 60 (59.4%).

Table 2 Stakeholders perceived barriers to the dissemination and implementation of Doula Support Service in Bayelsa State

Variable	**Frequency (n=101)**	**Percentage (%)**
General lack of awareness about role, benefits etc.		
Strongly Agree	71	70.3
Agree	26	25.7
Disagree	4	4.0
Strongly Disagree	0	0.0
Limited and inconsistent funding		
Strongly Agree	68	67.3
Agree	33	32.7
Unavailability of media engagement		
Strongly Agree	64	63.4
Agree	35	34.7
Disagree	2	2.0
Strongly Disagree	0	0.0
Perception of Doulas as role encroachers by midwives and other staff		
Strongly Agree	57	56.4
Agree	36	35.6
Disagree	8	7.9
Strongly Disagree	0	0.0
Deeply rooted beliefs about childbirth		
Strongly Agree	60	59.4
Agree	38	37.6
Disagree	2	2.0
Strongly Disagree	1	1.0
Infrastructure deficits, limited workforce, etc.		
Strongly Agree	65	64.4
Agree	34	33.7
Disagree	2	2.0
Strongly Disagree	0	0.0
Lack of certified trainers, standardized curricula and practical training sites		
Strongly Agree	65	64.4
Agree	32	31.7
Disagree	4	4.0

Strongly Disagree	0	0.0
Lack of clear national guidelines, integration policies and regulatory frameworks		
Strongly Agree	64	63.4
Agree	36	35.6
Disagree	1	1.0
Strongly Disagree	0	0.0

The strengths perceived by the study respondents as being capable of enhancing the dissemination and implementation of Doula support services were also assessed in this study. Notable strengths which most of the respondents strongly agreed to, included the possession of proven skills by midwives, local NGOs among others, 61 (60.4%), the availability of stakeholder partnerships 58 (57.4%), as well as the availability of community women to serve as Doulas 58 (57.4%). Others included the availability of experienced midwives 66 (65.3%), strong community engagements and cultural acceptability 63 (62.4%) as well as the availability of dissemination channels 65 (64.4%). The priority given to global health funding for maternal and newborn health was also reported as a perceived strength for enhancing the dissemination and implementation of Doula support services 66 (65.3%).

Table 3 Stakeholders perceived strengths to the dissemination and implementation of Doula Support Service in Bayelsa State

Variable	**Frequency (n=101)**	**Percentage (%)**
Possession of proven skills by midwives, local NGOs, women groups and faith-based organizations		
Strongly Agree	61	60.4
Agree	38	37.6
Disagree	2	2.0
Strongly Disagree	0	0.0
Existing partnerships among government agencies, NGOs and CSOs		
Strongly Agree	58	57.4
Agree	39	38.6
Disagree	4	4.0
Strongly Disagree	0	0.0
Availability of community women to serve as doulas		
Strongly Agree	58	57.4
Agree	39	38.6
Disagree	4	4.0
Strongly Disagree	0	0.0
Availability of experienced midwives		
Strongly Agree	66	65.3
Agree	34	33.7
Disagree	1	1.0
Strongly Disagree	0	0.0
Strong community engagement and cultural acceptability		
Strongly Agree	63	62.4

Agree	38	37.6
Disagree	0	0.0
Dissemination channels e.g., community radio, peer educators etc., are well established		
Strongly Agree	65	64.4
Agree	35	34.7
Disagree	0	0.0
Strongly Disagree	1	1.0
Global health funding prioritizes maternal and newborn health		
Strongly Agree	66	65.3
Agree	34	33.7
Disagree	1	1.0
Strongly Disagree	0	0.0

Other notable strengths which most of the respondents strongly agreed to, included the growing global evidence of the effectiveness of Doula support services 65 (64.4%), the use of existing health care infrastructure for integrating Doulas without the creation of parallel systems 61 (60.4%). Others included the availability of space and care teams in health facilities 56 (55.4%), and the increasing media focus on respectful maternity care and maternal health rights among others 66 (65.3%).

Table 4 Stakeholders perceived strengths to the dissemination and implementation of Doula Support Service in Bayelsa State

Variable	**Frequency (n=101)**	**Percentage (%)**
Growing global evidence of the effectiveness of Doula support		
Strongly Agree	65	64.4
Agree	36	35.6
Disagree	0	0.0
Using existing health care infrastructure for integration of Doulas without creating parallel systems		
Strongly Agree	61	60.4
Agree	37	36.6
Disagree	2	2.0
Strongly Disagree	1	1.0
Availability of space and care teams in health facilities		
Strongly Agree	56	55.4
Agree	43	42.6
Disagree	1	1.0
Strongly Disagree	1	1.0
Increasing media focus on respectful maternity care, maternal rights among others.		
Strongly Agree	66	65.3
Agree	34	33.7

Disagree	1	1.0
Strongly Disagree	0	0.0

4. Discussion

4.1. Profile of respondents and implications for interpretation

The study involved 101 nursing stakeholders, predominantly female, mostly educated to BNSc level, and with moderate years of maternal–child health experience. This profile reflects the gendered and professional composition of the nursing and midwifery workforce in many low- and middle-income countries. The dominance of facility-based nurses and midwives suggests that the findings primarily reflect perceptions shaped by routine clinical practice, professional accountability, and institutional constraints. Similar observations have been made [4], who argue that implementers' professional background and organizational positioning strongly influence how innovations are interpreted and judged for feasibility.

From an implementation science perspective, the respondents' characteristics suggest strong representation of the "inner setting" and "characteristics of individuals" domains, which are known to shape adoption decisions [4]. Consequently, barriers related to workflow disruption, professional boundaries, and staffing pressures were expected to feature prominently.

4.2. Salient barriers to Doula Service Dissemination and Implementation

4.2.1. Limited awareness and understanding of the doula role

The most prominent barrier identified was poor awareness and limited understanding of doula roles and benefits. This finding aligns closely with evidence reported by [1], who demonstrated that when maternity care providers lack clarity about the non-clinical, supportive nature of doulas, they are more likely to resist their inclusion in care teams. Similarly, [9] reported that inadequate knowledge about doula scope of practice contributes to skepticism and delayed adoption in facility-based settings. The implication is that dissemination strategies must move beyond public awareness alone to include provider-focused sensitization**,** clarifying that doulas offer non-clinical emotional, physical, and informational support rather than clinical decision-making. Without this clarity, even well-designed doula programs risk rejection at the point of care. This aligns with diffusion theory [12], which posits that innovations perceived as ambiguous or incompatible with existing roles are less likely to be adopted.

4.2.2. Financial constraints and sustainability concerns

Funding emerged as a major perceived barrier, reflecting concerns about sustainability beyond pilot phases. This concern emphasizes the importance of embedding doula services within existing financing structures**,** such as state maternal health budgets, performance-based financing schemes, or community-based health insurance. Without such integration, doula services risk remaining informal or volunteer-based, limiting scalability and long-term impact. The findings therefore point to financing not merely as a resource issue, but as a determinant of institutional legitimacy. This finding mirrors the observations of [10], who noted that even highly acceptable community doula models struggle to scale without defined financing mechanisms. [11] further emphasized that lack of reimbursement pathways and unclear budgetary ownership often undermine long-term integration of doula services within public health systems.

4.2.3. Weak dissemination and media engagement

Respondents highlighted limited media engagement and public sensitization as key barriers. In this context, weak dissemination contributes to both low public demand and limited provider buy-in. The implication is that implementation strategies should deliberately leverage existing communication platforms already trusted by communities and health workers, rather than relying solely on facility-based introduction. According to Rogers [12], diffusion of innovations requires repeated exposure through trusted communication channels. Empirical work by [11] similarly showed that community-based doula programs are more successful when deliberate dissemination strategies are used to normalize the intervention among both providers and service users.

4.2.4. Perceived role encroachment and professional resistance

A substantial proportion of respondents perceived doulas as potential role encroachers. This finding is particularly important because it indicates that resistance is not rooted in opposition to supportive care per se, but in uncertainty about role delineation. Without clear scopes of practice, supervision structures, and accountability mechanisms, doulas

may be viewed as disruptive rather than complementary. Addressing this barrier therefore requires formal role definitions, protocols for collaboration, and leadership endorsement. This aligns with findings [9], who documented professional resistance rooted in fears of role dilution, authority loss, and accountability confusion. [13] also reported similar resistance among midwives in Nigeria when new supportive roles are introduced without clear role delineation and supervisory structures.

4.2.5. Sociocultural norms and childbirth beliefs

Deeply rooted sociocultural beliefs were identified as barriers to doula acceptance. This finding underscores the necessity of culturally congruent doula models**.** Programs that fail to align with local values may face resistance from women, families, and community gatekeepers. Conversely, culturally embedded doulas particularly community women can act as cultural brokers, enhancing trust and acceptability. This finding is consistent with empirical finding [1], who noted that cultural norms regarding privacy, gender roles, and traditional birth practices can influence women's acceptance of continuous labour support. [10] further emphasized that culturally discordant doula models face greater resistance unless community engagement and cultural adaptation are prioritized.

4.2.6. Infrastructure, staffing, and training limitations

Respondents also identified inadequate infrastructure, workforce shortages, and lack of standardized training curricula as major constraints. The absence of certified trainers and standardized curricula further raises concerns about quality assurance and professional credibility. This highlights the need for structured training programs linked to nursing and midwifery institutions, ensuring that doulas are prepared, supervised, and evaluated within recognized systems. Similar system-level barriers have been documented by [14], who observed that respectful maternity care interventions often fail in overstretched facilities without concurrent investments in workforce capacity and training systems.

4.2.7. Policy and regulatory gaps

The absence of clear national or subnational policy frameworks was strongly endorsed as a barrier. Without policy recognition, doula services remain vulnerable to inconsistency, informal practice, and discontinuation. This finding reinforces the argument that successful implementation requires alignment with macro-level governance structures**,** not merely facility-level enthusiasm. This aligns with the arguments of [4], who emphasize that formal policy endorsement legitimizes innovations and facilitates accountability, funding, and standardization. [11] similarly found that doula services lacking regulatory recognition remain informal and vulnerable to discontinuation.

4.3. Facilitators and enabling factors

4.3.1. Skilled midwifery workforce and team capacity

The availability of experienced midwives was identified as a key facilitator, suggesting that doulas are viewed as complementary rather than substitutive. The availability of experienced midwives was identified as a key facilitator, suggesting openness to collaborative care models. Rather than viewing doulas as substitutes, respondents recognized their potential to complement skilled clinical care by addressing emotional and psychosocial needs. This finding aligns with [1], who demonstrated that continuous labour support is most effective when integrated alongside skilled clinical care rather than positioned as an alternative.

4.3.2. Community readiness and cultural acceptability

Strong community engagement and the availability of community women to serve as doulas were perceived as facilitators. Strong community engagement and the availability of community women to serve as doulas were perceived as powerful facilitators. Community-based doulas who share linguistic, cultural, and social backgrounds with clients can enhance trust, reduce fear, and improve care-seeking behaviors. Researchers have [10] reported that community-based doulas who share cultural, linguistic, and social ties with clients enhance trust, acceptability, and program uptake. This supports the notion that sociocultural alignment can offset cultural resistance identified as a barrier.

4.3.3. Partnerships and intersectoral collaboration

Existing partnerships with government agencies, NGOs, and CSOs were viewed as enabling factors. Such collaborations expand resource pools, strengthen advocacy, and enhance program legitimacy. In resource-limited settings, intersectoral collaboration is often essential for sustaining innovations, particularly those that span clinical and community domains. [10] emphasized that multi-sectoral partnerships enhance program resilience by pooling resources, expertise, and legitimacy. Such collaborations are particularly important in resource-constrained health systems.

4.3.4. Growing global evidence and respectful maternity care discourse

Respondents recognized increasing global evidence supporting doula effectiveness and growing attention to respectful maternity care. The implication is that global evidence can be strategically leveraged to support national advocacy, guideline development, and funding mobilization. This perception is strongly supported by the works of [1,14] who demonstrated that continuous labour support improves maternal satisfaction, reduces unnecessary interventions, and aligns with person-centred care principles.

4.3.5. Integration Within Existing Health Infrastructure

Finally, respondents noted that doula services could be integrated into existing health infrastructure without creating parallel systems. This perception is critical for sustainability, as parallel systems are often donor-dependent and fragile. Integration into existing workflows, supervision structures, and referral systems enhances institutional ownership and long-term viability. [11] identified system integration as a critical determinant of sustainability, noting that parallel volunteer-based models are less likely to endure once external funding ceases.

Taken together, the findings suggest that while doula services are perceived as acceptable and potentially feasible, their implementation is constrained by policy, financing, training, and professional role clarity challenges. This pattern closely mirrors implementation experiences reported by [4,1,9,11]. Addressing these barriers through stakeholder sensitization, standardized training, policy endorsement, and sustainable financing is essential for successful adoption and scale-up.

5. Conclusion

This study demonstrates that while doula support services are widely perceived by key nursing stakeholders in Bayelsa State as acceptable, beneficial, and feasible, their effective dissemination and implementation are significantly constrained by systemic and contextual barriers. Prominent challenges include limited awareness of the doula role, inadequate and inconsistent funding, absence of standardized training and regulatory frameworks, infrastructural and workforce limitations, professional role tensions, and deeply rooted sociocultural beliefs surrounding childbirth. At the same time, the findings reveal substantial facilitators, such as the availability of experienced midwives, strong community engagement, existing partnerships with governmental and non-governmental actors, established dissemination channels, and growing global and local advocacy for respectful maternity care. Overall, the study underscores the need for deliberate policy endorsement, sustainable financing mechanisms, stakeholder sensitization, clear role delineation, and standardized training structures to translate the identified strengths into effective and sustainable integration of doula support services within Bayelsa State's maternal health system.

Compliance with ethical standards

Acknowledgments

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Disclosure of conflict of interest

The authors declare no conflict of interest.

Statement of ethical approval

This study received ethical approval from four relevant institutions in Bayelsa State, Nigeria: the Federal Medical Centre, Yenagoa (protocol number: 1018); the Niger Delta University Teaching Hospital, Okolo Biri (NDUTH/REC/0060/2025); the Bayelsa State Ministry of Health (reference: BY/SMOH/HPRS/HP/VOL.1/2025); and the Bayelsa State Hospitals Management Board (reference: BSHMB/ADM/314/VOL.1/57). The research was conducted in accordance with the ethical principles of respect for persons, beneficence, non-maleficence, and justice. Verbal informed consent was obtained from all participants after explaining the study's purpose, procedures, and their right to withdraw without consequence. Confidentiality and anonymity were maintained throughout the study, and all data were stored securely in compliance with the guidelines of the approving ethics committees.

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Authors' Contribution

- Jimmy Agada J: contributed to conceptualization, methodology, formal analysis, investigation, funding acquisition, data curation, visualization, and writing of the original draft.
- Wakais Adubato H: contributed to supervision, project administration, resources, methodology, validation, and scholarly refinement.
- Teleseme Okoko: contributed to conceptualization, project administration, software-analytical software

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