

Midwives' and Nurses' Views on the Shift from Hierarchical to Clan Culture in Nigerian Public Healthcare Facilities

Rukaiyya Muhammad

r.muhammad@derby.ac.uk

University of Derby

Kim Watts

University of Nottingham

Elsa Montgomery

Kings' College London

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Abstract

Purpose

Midwives/nurses play a pivotal role in maternity care delivery, yet their perspectives on organisational culture remain underexplored. This study aimed to characterise both the existing and preferred organisational culture profiles among midwives/nurses in public healthcare facilities of Osun State, Nigeria, and to identify strategic recommendations for optimising organisational performance.

Methods

A cross-sectional survey design employed the Organisational Culture Assessment Instrument, grounded in the Competing Values Framework. Data were collected online from 352 midwives/nurses representing tertiary, secondary, and primary healthcare tiers. Descriptive and inferential analyses were conducted to compare current and preferred culture dimensions.

Results

Participants reported a predominance of Hierarchy culture (mean = 39.5, SD = 11.4; $p < 0.001$) characterized by centralized decision-making, rigid protocols, and limited autonomy. In contrast, the Clan culture emerged as the preferred model (mean = 36.1, SD = 9.1; $p < 0.001$), emphasizing teamwork, open communication, and shared leadership. These findings reveal a discord between entrenched bureaucratic practices and staff aspirations for participatory, innovation-oriented work environments.

Conclusion

To reconcile this gap, a dual-track change strategy is recommended: retain hierarchical safeguards for accountability while embedding clan-oriented dynamics to foster empowerment, collaboration, and innovative problem-solving. Key interventions include teamwork training, governance reforms with frontline inclusion, performance systems recognising both compliance and innovation, routine multidisciplinary rituals, and real-time feedback mechanisms. This original study is the first to map organisational culture across all three tiers of public maternity services in Osun State. By elucidating midwives/nurses' cultural perceptions and preferences, it provides an empirical foundation for targeted interventions that can enhance team cohesion, accelerate evidence-based practice, and ultimately improve maternal and neonatal outcomes.

Background

Organisational culture has long been invoked by anthropologists and sociologists as both a metaphorical lens and a tangible construct through which to understand what an organisation

essentially is—and what it does (Kaufman & McCaughan, 2013; Schein, 2010; Davies, Nutley, & Mannion, 2000). Understood as an array of identifiable, describable, and malleable elements, culture provides deep insight into the social processes and shared meanings that underpin collective action (Jacobs et al., 2013; Napier et al., 2014; Nutley & Mannion, 2000). Despite its acknowledged importance, organisational culture remains inherently elusive, subject to competing definitions and conceptual tensions. A pragmatic working definition, however, characterises culture as the “taken-for-granted values, underlying assumptions, expectations, collective memories, and definitions of success” that permeate an organisation (Cameron & Quinn, 2006, p. 16).

This definition is operationalised through observable manifestations—what an organisation values, its prevailing leadership styles, the language and symbols in use, and the routines and rituals that guide daily work (Cameron & Quinn, 2006). Importantly, culture is neither monolithic nor static: departments or subunits often cultivate distinct subcultures, and misalignment among these can precipitate coordination breakdowns, interdepartmental conflict, and performance bottlenecks (Cameron & Quinn, 2006; Schein, 2010).

To capture this complexity, a variety of diagnostic tools have been developed. Among the most widely adopted is the Organisational Culture Assessment Instrument (OCAI), which draws on the Competing Values Framework (CVF) to assess an organisation’s core values, shared assumptions, and customary approaches to work (Cameron & Quinn, 2006). The CVF synthesises multiple theoretical perspectives that range from organisational life-cycle models and leadership competencies to information processing and quality management, into a two-dimensional model that maps organisational functioning along axes of internal versus external focus and stability versus flexibility (Cameron, 2009; Morais & Graça, 2013). By situating cultural archetypes within this continuum (Fig. 1), the CVF and OCAI together provide both a rigorous analytic foundation and a practical roadmap for diagnosing, comparing, and ultimately reshaping organisational culture.

One dimension differentiates flexibility from stability and control. The second dimension differentiates the internal environment from external environments, each of which represents alternative approaches to fundamental challenges that must be resolved to function effectively. The two dimensions form four quadrants (clan, adhocracy, market, and hierarchy) in Table 1, each representing a distinct set of organisational effectiveness indicators that employees value about an organisation’s performance.

Table 1
The Four Types of Organisational Cultures

Organisational culture	Description
The clan culture	This is seen in the upper left quadrant in Fig. 1. It represents alternative 'A' in the OCAI tool (see supplementary data) and is grounded in collaboration. Members here feel actively involved and organisations are bound by commitments, and leadership takes the form of mentorship. The central values here are rooted in teamwork, communication and consensus.
The adhocracy culture	Is the upper right quadrant in Fig. 1 and alternative 'B' on the tool which is based on creativity. Employees are encouraged to take risks where the leaders are seen to be innovative. This organisation is held together by experimentation while emphasising individual freedom and ingenuity. The core value is based on transformation and change.
The market culture	The lower right quadrant and alternative 'C' on the tool is grounded on competition and achieving concrete results. Leaders here are demanding, challenging, and goal oriented. The goal of this organisation is to beat rivals where the principal drivers are share and profitability.
The hierarchy culture	The lower left quadrant and alternative 'D' on the tool, which is grounded on structure and control. The environment here is formal, with strict institutional procedures. Leadership is based on strict monitoring and organised coordination, where the culture generally emphasises efficiency and predictability. The central values are consistency, conformity, and uniformity.

Organisational Culture Assessment Instrument (OCAI) provides a structured means of diagnosing the prevailing assumptions and value systems that shape an organisation's internal dynamics and external strategies. Drawing on the Competing Values Framework, the OCAI evaluates six core dimensions—dominant characteristics, organisational leadership, management of employees, organisational glue, strategic emphases, and criteria for success—to map a given entity onto one of four archetypal culture types (clan, adhocracy, hierarchy, or market). By capturing both the current and preferred states along these dimensions, the OCAI yields a concise yet multifaceted portrait of the forces that underpin decision-making, behavioural norms, and performance expectations within an organisation.

A systematic review of the literature reveals that the OCAI has been successfully applied across diverse healthcare contexts, including maternity units, general hospitals, and specialised clinics. Noteworthy examples include its deployment in Brazilian tertiary hospitals (Silva et al., 2018), specialist maternity facilities in Jeddah (Alsoulami et al., 2018), Egyptian public health centres (Mahran, 2016), Irish regional hospitals (O'Neill et al., 2021), Vietnamese district health offices (Nguyen et al., 2018), Palestinian maternal-child health services (Alsaqqa, 2021), and Nigerian teaching hospitals (Ojogiwa & Qwabe, 2023). In each instance, researchers have leveraged the instrument to pinpoint cultural strengths, identify areas of misalignment between leadership vision and frontline practice, and generate targeted recommendations for enhancing collaborative workflows and patient-centred care.

In Osun State, Nigeria, maternity services operate within a tripartite public health structure comprising tertiary, secondary, and primary tiers. At the apex, the federal Ministry of Health sets national maternal

health policy, standardises clinical protocols, oversees professional training, and conducts disease surveillance. Two urban tertiary hospitals are situated in Ile-Ife and Osogbo, delivering specialised obstetric and gynaecological care and providing technical support to the lower tiers (Ajala et al., 2005; Izugbara et al., 2016). The State Hospital Management Board, acting on behalf of the state government, administers training programmes for midwives and nurses, coordinates maternal health initiatives across sixty predominantly rural secondary health facilities, and enforces adherence to evidence-based guidelines. At the grassroots level, the National Primary Health Care Development Agency, in partnership with state authorities, supports nearly seven hundred primary healthcare centres, which focus on antenatal care, community health education, and basic sanitation measures (NPHCDA, 2015; Izugbara et al., 2016).

Midwives/nurses serve as the linchpin of maternity care within this multilayered system, yet little is known about the organisational cultures that frame their day-to-day practice. Given the OCAI's proven efficacy in analysing subunit cultures—such as departmental teams or service lines—this study employs the instrument to examine the prevailing cultural paradigms across Osun's three levels of maternity care (Cameron & Quinn, 2011). Specifically, we seek to (1) characterise the existing and aspirational culture profiles as perceived by midwives and nurses, (2) identify dominant cultural attributes that influence teamwork, leadership, and patient outcomes, and (3) suggest evidence-based recommendations for strengthening organisational performance and improving maternal health care. By elucidating the cultural contours of maternity services in Osun State, this research aims to inform targeted interventions that align professional practices with strategic objectives and foster a more cohesive, high-performing care environment.

Methods

This study forms part of an explanatory sequential mixed-methods research involving a cross-sectional questionnaire and interviews. Future publications will report findings from the interviews (Muhammad et al., 2024) and potentially explore follow-up research. This publication, however, focuses solely on the findings of the questionnaire.

All 525 practising midwives/nurses holding a current Nursing and Midwifery Council of Nigeria licence and employed in public health facilities were invited to participate via their facility WhatsApp groups. In accordance with ethical procedures, the recruitment materials and the survey link were disseminated with the endorsement of the Osun State Nursing and Midwifery Association's chair and secretary, as well as principal midwifery and nursing officers within tertiary healthcare centres; these gatekeepers facilitated access to the participants but did not influence survey responses. Data collection took place entirely online from October to November 2020, in accordance with COVID-19 restrictions on in-person contact.

The Organisational Culture Assessment Instrument (OCAI) was administered as a self-report questionnaire comprising two sections. Section A gathered demographic and professional background

information. Section B evaluated organisational culture across six dimensions, which include dominant characteristics, leadership style, employee management, organisational glue, strategic emphasis, and success criteria using paired “current” and “preferred” columns. Respondents allocated 100 points among four culture-type statements per dimension (ipsative scaling), assigning higher totals to statements most representative of their organisation’s present and desired culture (Cameron & Quinn, 2011).

The survey link received 381 clicks, yielding a 67% completion rate for Section A (352/525) and 42.1% for Section B (221/525). Although a 60% (315 respondents) return was anticipated to ensure representativeness (Draugalis & Plaza, 2009; Fincham, 2008), the slightly lower response on Section B aligns with evidence that online surveys often underperform by approximately 10% relative to other modalities (Deutskens et al., 2004; Fan & Yan, 2010). The International Business Machines (IBM) Statistical Package for Social Sciences (SPSS) version 26 for Windows was used for data analysis. Descriptive statistics in section A and Inferential statistics were used to determine the relationship between variables by applying a *t-test*, chi-square, and analysis of variance (ANOVA) in section B.

The scale reliability for the OCAI in this study, as measured by Cronbach's alpha, ranged from 0.77 for Clan to 0.77 for Adhocracy, 0.65 for Market, and 0.76 for Hierarchy across the four categories. Cameron & Quinn (2006) reported similar statistically significant scores for Clan (0.74), Adhocracy (0.79), Market (0.71), and Hierarchy (0.73). Studies conducted in healthcare settings have reported the OCAI as robust and valid (Alsoulami, 2018; Choi et al., 2010; Jacobs et al., 2013; Morais & Graça, 2013; Nguyen Van et al., 2018; Sensuse et al., 2014; Van Huy et al., 2020).

Results

Of the 381 entries, only 352 were valid, meeting the criteria for the study. All respondents completed Section A; however, only 221 respondents completed all of Sections A and B of the questionnaire. Table 2 presents the basic demographic and professional information collected from the midwives/nurses, including gender, educational qualifications, duration of practice, and current place of practice. The majority of the midwives/nurses, 319/352 (90.6%), were female. Over half of the respondents (n = 208/352, 59.1%) held a dual midwife and nurse qualification, i.e., RM/RN diploma. Other staff (n = 130/352, 36.9%) had a direct entry midwifery or nursing degree, with a master’s degree (n = 14/352, 4.0%) recorded as the highest qualification. There was an even representation (n = PHC: 125/352 (35.5%); SH: 110/352 (31.3%); THC: 117/352 (33.2%)) of midwives/nurses from the three tiers of healthcare in Osun State.

Table 2
Demographic characteristics of respondents

Characteristics of midwives/nurses (n = 352)	Frequency (%)
Sex	
Female	319(90.6)
Male	33(9.4)
Highest Educational Qualification	
RM/RN	208(59.1)
BNSc	130(36.9)
MSc	14(4.0)
Duration of Practice	
Less than two years	31(8.8)
Two to four years	88(25.0)
More than five years	233(66.2)
Current Place of Practice	
Primary Health Care (PHC)	125(35.5)
Secondary (SH)	110(31.3)
Tertiary (THC)	117(33.2)

Table 3
The current and preferred organisational culture types (n = 221)

Types of culture (n = 221)	Now	Preferred	Difference	t (t-test)
	(Mean ± SD)	(Mean ± SD)		
Clan	20.0 ± 9.3	36.1 ± 9.1	16.1	***
Adhocracy	18.6 ± 3.9	23.7 ± 4.4	5.1	***
Market	21.9 ± 5.4	20.6 ± 4.4	-1.3	**
Hierarchy	39.5 ± 11.4	19.6 ± 7.6	-19.9	***
* * p < 0.01; * * * p < 0.001				

Table 3 shows that the current dominant culture across Osun State's healthcare facilities is the Hierarchy culture, with a relative mean score of 39.5. There is a wide margin between the mean scores of the current dominant culture, with a difference of 17.6 for Market, 20.9 for Adhocracy, and 19.5 for Clan

cultures, respectively. On the other hand, the preferred organisational culture was Clan, with a mean score of 36.1. Compared to the preferred Clan culture, there is a difference of 12.4 for Adhocracy, 15.5 for Market, and 16.5 for hierarchy.

Table 4
Primary characteristics between the Now and Preferred organisational culture types

Organisational culture by primary characteristics	Now (Mean $\pm$ SD)	Preferred (Mean $\pm$ SD)	Difference	χ^2 (t-test)
Dominant characteristics				
Clan	17.6 $\pm$ 13.0	35.0 $\pm$ 15.1	17.4	***
Adhocracy	17.7 $\pm$ 6.2	23.7 $\pm$ 8.0	6	***
Market	20.8 $\pm$ 9.6	22.0 $\pm$ 10.0	1.2	NS
Hierarchy	43.9 $\pm$ 16.1	19.3 $\pm$ 12.1	-24.6	***
Organisational Leadership				
Clan	19.4 $\pm$ 11.0	37.0 $\pm$ 12.3	17.6	***
Adhocracy	18.1 $\pm$ 6.4	23.8 $\pm$ 7.8	5.7	***
Market	23.3 $\pm$ 11.9	19.4 $\pm$ 8.2	-3.9	***
Hierarchy	39.2 $\pm$ 15.1	19.8 $\pm$ 11.9	-19.3	***
Management of Employees				
Clan	22.2 $\pm$ 12.8	38.3 $\pm$ 12.4	16.1	***
Adhocracy	18.6 $\pm$ 7.2	23.0 $\pm$ 8.7	4.4	***
Market	20.9 $\pm$ 8.1	19.6 $\pm$ 7.6	-1.3	NS
Hierarchy	38.3 $\pm$ 15.0	19.1 $\pm$ 9.6	-19.2	***
Organisational Glue				
Clan	19.5 $\pm$ 11.3	36.0 $\pm$ 12.2	16.5	***
Adhocracy	18.6 $\pm$ 7.2	23.3 $\pm$ 7.5	4.7	***
Market	22.6 $\pm$ 8.6	21.4 $\pm$ 7.5	-1.2	NS
Hierarchy	39.3 $\pm$ 14.7	19.3 $\pm$ 9.9	-20	***
Strategic Emphasis				
Clan	20.5 $\pm$ 10.8	35.0 $\pm$ 11.3	14.5	***
Adhocracy	19.4 $\pm$ 8.4	25.2 $\pm$ 6.7	5.8	***
Market	22.4 $\pm$ 8.7	20.2 $\pm$ 6.9	-2.2	**
Hierarchy	37.7 $\pm$ 14.5	19.6 $\pm$ 9.4	-18.1	***
Criteria of Success				

Organisational culture by primary characteristics	Now (Mean $\pm$ SD)	Preferred (Mean $\pm$ SD)	Difference	χ^2 (t-test)
Clan	20.9 $\pm$ 12.0	35.5 $\pm$ 11.7	14.6	***
Adhocracy	19.0 $\pm$ 7.0	23.4 $\pm$ 7.3	4.4	***
Market	21.6 $\pm$ 9.4	20.7 $\pm$ 7.0	-0.9	NS
Hierarchy	38.5 $\pm$ 15.9	20.4 $\pm$ 9.7	-18.1	***
* $\chi^2 < 0.05$; * * $\chi^2 < 0.01$; * * * $\chi^2 < 0.001$; NS = not significant.				

Table 4 illustrates pronounced differences between the current (“Now”) and desired (“Preferred”) culture profiles across all six OCAI dimensions: dominant characteristics, organisational leadership, employee management, organisational glue, strategic emphasis, and success criteria. Notably, the market culture exhibited no statistically significant change in four dimensions ($p > .05$), consistent with its entrenched focus on transactions, competitive positioning, profitability, and efficiency.

In contrast, the adhocracy dimension registered significant shifts across the board ($p < .05$), but it was the clan and hierarchy archetypes that demonstrated the most dramatic movement. Both experienced highly significant alterations between their Now and Preferred scores ($p < .001$). These shifts pinpoint the levers for cultural realignment: for each domain, Table 4 identifies how points must be reallocated to attain the midwives/nurses’ aspirational profile.

For example, within the organisational leadership domain, the clan culture score increased from a mean of 19.4 (± 11.0) in the current state to 37.0 (± 12.3) in the preferred state ($p < .001$). Conversely, the hierarchy culture rating fell from 39.2 (± 15.1) “Now” to 19.8 (± 11.9) “Preferred” ($p < .001$). This inversion highlights the need to shift away from a traditional controller/organiser model toward a facilitator, mentor, and team-builder leadership style.

Discussion

In our study, midwives/nurses consistently described the existing culture in Nigerian public maternity services as a classic “Hierarchy” profile characterized by formalized procedures, centralized decision-making, and strict adherence to rules and protocols (Cameron & Quinn, 2011).

Across tertiary, secondary, and primary tiers, participants reported that authority flows top-down, with clinical decisions often gated by managerial sign-off and rigid documentation requirements. Stability and predictability are valued above innovation, and individual autonomy is subordinated to institutional policies—an arrangement that respondents felt constrained their ability to apply evidence-based practice in real-time (Ominyi et al., 2019). Similar hierarchical norms have been documented in West African contexts beyond Nigeria, for example, in Ghanaian public hospitals where entrenched bureaucracy impedes frontline staff from piloting quality-improvement initiatives (Amoakoh-Coleman., 2022) and in Kenya, where staff cited administrative delays as barriers to timely care (Masaba et al., 2022).

By contrast, when asked to envision their ideal future, midwives/nurses overwhelmingly chose a “Clan” culture—an internally focused environment that prizes teamwork, open communication, and shared values (Cameron & Quinn, 2011). In a clan model, line managers function as coaches rather than controllers, inviting staff input into protocol reviews, training programs, and even job-rotation schemes. Participants in our study felt that such an environment would foster greater ownership of patient safety initiatives, encourage peer-to-peer learning, and strengthen morale in otherwise over-stretched units. This aspiration aligns with findings from a recent mixed-methods study in a tertiary hospital, where pharmacists identified clan attributes, such as strong teamwork and solid working relationships, as significant enhancers to service delivery and patient outcomes (Mohammed et al., 2022).

In many countries, mixed “Hierarchy–Clan” cultures appear to prevail in maternal health settings. In Kwara State, Nigeria, Ojogiwa and Qwabe (2023) reported that 33.5% of respondents perceived a clan orientation, alongside 31% who saw hierarchy as dominant. Likewise, in Vietnam’s public general hospitals, Nguyen Van et al. (2018) recorded nearly identical scores for clan (26.7%) and hierarchy (26.6%) cultures. In the multi-country project, conducted in community and hospital midwifery services across Greece, the Netherlands and the UK, midwives reportedly valued clearly defined processes (a hierarchy trait) and rated team-based continuity of care, shared decision-making and mentorship (clan elements) as most impactful on maternal outcomes (Fair et al., 2021). Similar dual-modal profiles have been described in studies from Jeddah (Alsoulami et al., 2018), Cairo (Mahran, 2016), and Dublin (O’Neill et al., 2021), suggesting that bureaucracy and collegiality often coexist, even if one dominates.

Dominant attributes of hierarchical cultures, such as stringent rule enforcement, siloed subunits, and limited upward communication, tend to hamper rapid problem-solving and cross-disciplinary team coordination. Midwives have reported routine delays in escalating clinical alerts due to mandatory chain-of-command approvals and have expressed frustration that innovative ideas for streamlining labour ward workflows were routinely tabled or discarded (Ominyi et al., 2019). Conversely, clan-oriented teams, where leaders facilitate rather than police interactions, show stronger cohesion, higher trust, and faster collective responses to emergencies (Jacobs et al., 2013). Irish maternity units that have deliberately cultivated clan attributes report, for instance, a 20% reduction in intrapartum complications after implementing daily multidisciplinary safety briefings and joint reflection sessions (O’Neill et al. 2021). This position was also supported by Al-Dhafiri (2024).

Effective leadership in a clan culture is characterised by empowerment, psychological safety, and collaborative role-modelling (O’Neill et al. 2021). Our participants specifically called for more frequent peer-led meetings, structured forums to co-design patient-education materials, and locally tailored leadership training that emphasises emotional intelligence, conflict resolution, and shared governance. European peers echo this sentiment: a Danish study showed how staff who perceived leaders as inclusive and supportive of frontline-led change initiatives reported higher change efficacy and greater commitment to improvement efforts (Storkholm et al., 2019).

Nonetheless, any cultural shift must balance the stability afforded by hierarchy—essential for accountability in large, public-sector systems—with the agility and staff-engagement strengths of clan environments. Davies, Nutley, and Mannion (2000) argue that sustainable improvement in healthcare requires integrated efforts across organisational structure, finance, strategic planning, and human resources. In practice, this might involve preserving clear escalation pathways and rigorous clinical audit cycles while decentralising decision-making on care pathway refinements and operational protocols. Our midwives/nurses emphasised that in smaller or stand-alone maternity units, particularly at local government and PHC levels, the clan model is both feasible and desirable, as tighter social bonds and a shared mission fuel rapid innovation and sustained morale (Jacobs et al. 2013).

Ultimately, realizing an aspirational clan culture within Nigeria's public maternity services and in similar settings worldwide demands coordinated change management that addresses the motivations and constraints of staff at every level. Leadership education should combine group facilitation skills with process improvement methodologies. Performance metrics must reward collaborative problem-solving alongside compliance. Governance frameworks should include frontline voices in policy reviews. By weaving together the control mechanisms of hierarchy with the inclusive spirit of clan culture, health systems can foster environments where teamwork, adaptive leadership, and patient-centred innovation thrive in equal measure.

Practical implications

This study provides critical insights into multiple levels of the Nigerian healthcare system by documenting how midwives/nurses have historically interacted with entrenched hierarchical norms. Recognising that organisational culture profoundly influences job satisfaction, staff commitment, and the success of quality improvement efforts (Chalmers & Brannan, 2020), our findings underscore the need for targeted reforms to foster inclusive workplaces where midwives/nurses can thrive. As care models increasingly emphasise partnership between patients and healthcare professionals, the persistence of rigid, rule-bound structures in specialised services such as midwifery and maternity demands urgent attention from hospital managers and policy-makers within Nigeria's State and Federal Ministries of Health. Equally, the Nursing and Midwifery Council of Nigeria is well-positioned to champion policy and guideline reforms that empower frontline staff across all tiers of care.

To translate these cultural insights into measurable improvements in maternity services, we advocate a dual-track strategy that balances essential hierarchical safeguards with clan-oriented dynamics. First, leadership development curricula should equip managers with skills in collaborative decision-making, emotional intelligence, and facilitation, enabling a shift from command-and-control toward collective leadership and co-creation with frontline teams. Second, governance structures must be recalibrated to ensure that standardised audit cycles and clear escalation pathways operate in conjunction with localised committees that include midwives/nurses in protocol reviews, resource allocation, and quality-improvement initiatives. Third, human resources frameworks should reward both compliance and innovation by embedding teamwork and peer-mentorship contributions into performance appraisals,

promotion criteria, and recognition schemes. Fourth, daily operational practices such as safety huddles, multidisciplinary debriefings should be institutionalised to reinforce shared ownership of patient outcomes and expedite problem-solving. Finally, continuous feedback loops, leveraging real-time staff surveys and focus groups, will be indispensable for monitoring cultural shifts and addressing emergent barriers. By weaving the stability of hierarchical practices, engagement, and adaptability of clan culture, Nigerian public maternity services can strengthen team cohesion, accelerate the adoption of evidence-based practices, and ultimately improve maternal and neonatal outcomes.

Limitations, strengths, and further study

A key strength lies in the representative cross-section of providers from tertiary (33.2%), secondary (31.3%), and primary healthcare (35.5%) settings in Osun State, enabling us to characterise both existing hierarchy and aspirational clan culture profiles with confidence. This investigation is the first to explore organisational culture specifically within Nigerian maternity services, mapping how cultural attributes shape teamwork, leadership practices, and patient outcomes.

Despite achieving a modest total sample size ($n = 352$), the study's shift from planned pen-and-paper to exclusively online questionnaire delivery, necessitated by COVID-19 travel restrictions, may have constrained participation and potentially underrepresented midwives and nurses who are less comfortable with digital platforms. It remains unclear whether face-to-face administration would have improved response rates and data completeness.

Future research should broaden the professional lens by including medical doctors, laboratory scientists, and other allied health practitioners who collaborate with midwives/nurses in maternity care. Such multidisciplinary perspectives would enrich our understanding of how hierarchical controls influence core clinical decision-making and whether clan-oriented interventions can be effectively piloted within distinct subunits across all tiers of care.

Moreover, qualitative enquiry—already initiated as part of the larger study design—will deepen insight into the mechanisms by which culture drives or hinders evidence-based practice, staff engagement, and innovation. Subsequent studies might employ longitudinal designs to evaluate the impact of dual-track change strategies (integrating hierarchical safeguards with collaborative, clan-style dynamics) on maternal and neonatal outcomes. By addressing these limitations and extending the scope of inquiry, future work can provide more robust information for policy reforms and targeted leadership development that aligns organisational culture with high-quality maternity care.

Conclusions

This study offers an in-depth evaluation of organisational culture within public maternity services across primary, secondary, and tertiary facilities in Osun State, Nigeria. It delineates current and desired culture profiles among midwives/nurses—we revealed a predominant hierarchy characterised by centralised authority, stringent procedural compliance, and minimal discretion at the frontline. In stark contrast,

participants uniformly identified a clan culture, emphasising collaboration, transparent communication, shared leadership, and staff empowerment, as their preferred model for improving workplace dynamics and patient care.

This study has reported the cultural attributes that most substantially affect teamwork, leadership practices, and clinical outcomes. We found that rigid adherence to protocols and compartmentalised structures hampers rapid decision-making, stifles evidence-based innovations, and undermines morale. Conversely, attributes associated with clan culture, such as empowering leadership, collective ownership, and peer collaboration, were correlated with enhanced team cohesion, quicker clinical responses, and favourable maternal and neonatal outcomes. The representative sampling across all tiers bolsters the transferability of these insights to other public healthcare contexts.

Importantly, our findings establish an empirical foundation for targeted cultural transformation. Although organisational culture is complex and multifaceted, it remains amenable to intentional change strategies. We advocate a dual-track approach that retains essential hierarchical safeguards, ensuring accountability and standardisation while integrating clan-oriented practices that foster innovation and staff engagement. Leadership development should shift from autocratic to clan paradigms by incorporating collaborative decision-making, emotional intelligence training, and facilitation skills. Governance structures must blend rigorous audit cycles and clear escalation mechanisms with localised, multidisciplinary committees that involve midwives/nurses in protocol design and resource allocation. Human resources frameworks should recognise both compliance and creativity by embedding peer-mentorship and teamwork metrics into performance evaluations and recognition systems. Daily routines, such as interprofessional safety huddles and structured debriefings, should be institutionalised to reinforce shared responsibility and expedite adaptive problem-solving. Finally, real-time feedback mechanisms, such as staff surveys and focus groups, are essential for monitoring progress, addressing emerging obstacles, and sustaining cultural momentum.

By harmonising the stability of hierarchical controls with the engagement and adaptability of clan culture, public maternity services in Osun State, Nigeria, can enhance team performance, accelerate the implementation of best practices, and ultimately elevate the quality of maternal and neonatal care.

Abbreviations

OCAI

Organisational Culture Assessment Framework

CVF

Competing Values Framework

PHC

Primary Health Care

Declarations

Data availability

The datasets generated and analysed for this study are not publicly available due to confidentiality reasons and are not available upon request. It was stored securely on the King's College London OneDrive during analysis and was only accessible by the research team.

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Author Information

Authors and Affiliations

College of Health, Psychology and Social Care, University of Derby - Rukaiyya Muhammad.

Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London - Elsa Montgomery.

Faculty of Medicine and Health Sciences, University of Nottingham - Kim Watts.

Contributions

RM participated in the conceptualisation, investigation, methodology, data analysis, and drafting of the manuscript. KW and EM contributed to the conceptualisation, methodology, and supervision of the study. All authors read, reviewed, and edited the manuscript.

Corresponding Author

Correspondence to Rukaiyya Muhammad

Clinical Trial Number

N/A

Ethics Declarations

Ethical approval for the study was obtained from the Psychiatry Nursing and Midwifery PNM research ethics committee of Kings College London HR-19/20-14734 and the Osun State Primary Health Care Development Board OSPHCDB/042/210, Osun State health research ethics committee

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Consent to participate

All participants provided their informed consent by completing the online questionnaire.

Consent for publication

All participants provided their informed consent by completing the questionnaire and understood that the anonymised data would be published.

Competing interests

The authors declare no conflicts of interest in this work.

Supplementary Information

OCAI tool

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Figures

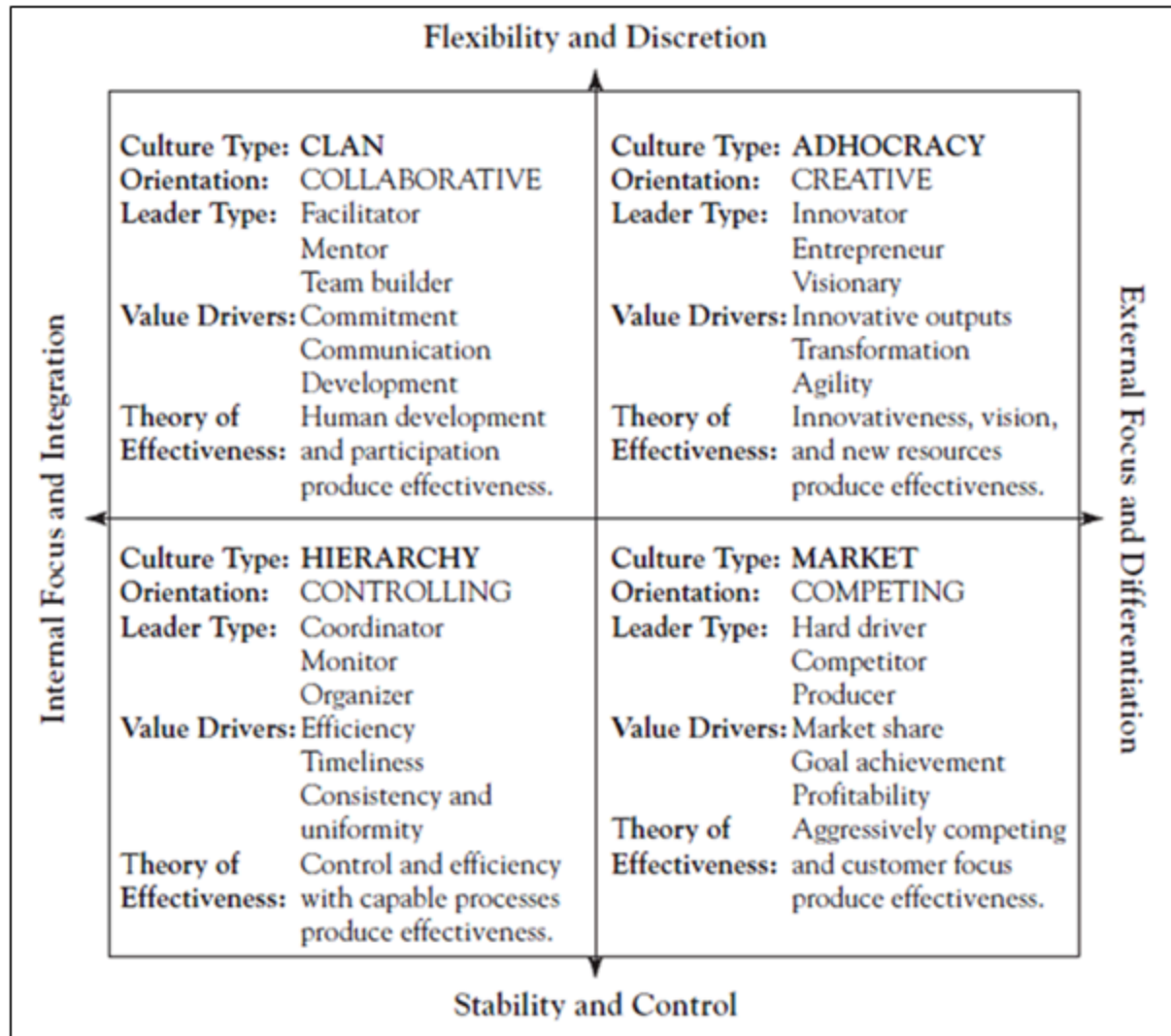


Figure 1

The Organisational Cultures and the Competing Values Framework (Cameron and Quinn, 2011, p.50)

The Now and Preferred culture types

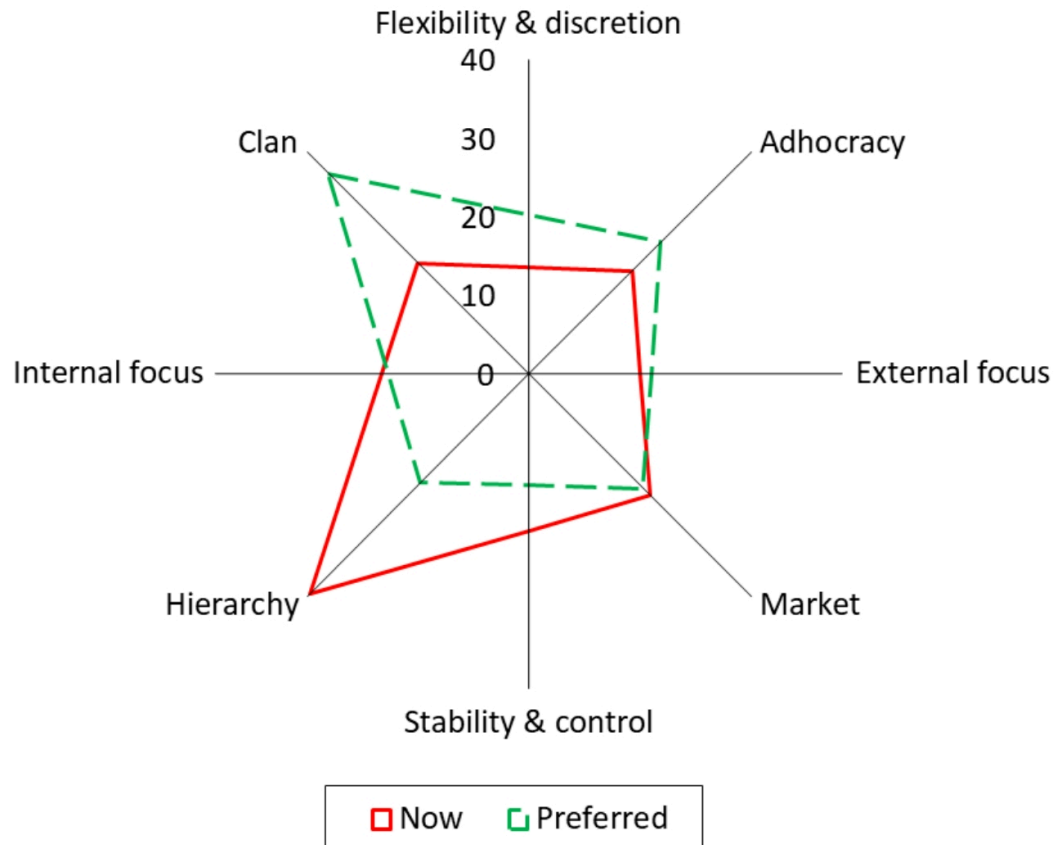


Figure 2

Graphical plot of the midwives/nurses' now and preferred culture types.

Supplementary Files

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