Exploring Nigerian obstetricians’ perspectives on maternal birthing positions and perineal trauma

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Abstract

Background. Evidence recommends encouraging expectant mothers to adopt birthing positions that will assist them in having a normal physiological birth. Upright birthing positions have been shown to have good birth outcomes and assist women to give birth normally. However, adopting the lithotomy position with legs flexed and supported with hands has become an entrenched clinical birthing practice in Nigeria and is associated with an increased risk of a routinely performed episiotomy. Hospital protocols have supported this medicalised approach to how women give birth, with little regard to woman-centred care. Nevertheless, Nigerian obstetricians’ perceptions and experiences on birthing position and perineal trauma have received minimal recognition and research.

Aim. To explore perceptions and experiences of Nigerian obstetricians regarding maternal birthing position and perineal trauma following childbirth, and to gain insights as to whether obstetricians’ clinical decisions and practice were influenced by evidence.

Methods. A descriptive qualitative study was conducted involving a purposive sample of eight obstetricians recruited from two referral hospitals in the Niger Delta region of Nigeria during November 2014. Data were collected using an interview schedule and a thematic analysis was undertaken. Data analysis was guided by Braun and Clarke’s (2006) six-stage thematic framework. Interviews were transcribed in full and categorisation of the data achieved with several in-depth readings of the transcripts. Data saturation was reached with the facilitation of the second focus group interview as no more emerging themes were identified. The study obtained ethical approval from the health and social research ethics committee at the University of Chester in the UK, and also from the study hospitals in the Niger Delta region in Nigeria.

Results. Six participants were doctors undertaking obstetric specialist training and two were consultant obstetricians. The following core themes emerged: entrenched practice, lack of insight for evidence, embracing woman-centred care and professional dominance. An overall finding demonstrated a willingness to support mothers in their choices of birthing position and involved reflections on the indications for an episiotomy and incidences of perineal injuries. The findings also indicated that the obstetricians were prepared to consider woman-centred care in relation to birthing position and perineal trauma.

Conclusions. This study has enabled some Nigerian obstetricians to reflect upon their perceptions and experiences of their clinical decisions and practices concerning birthing position and perineal trauma. Their current practice was frequently not supported by evidence. However, it emerged that there was a willingness to listen to women and adopt clinical birthing practices and perineal care that would respect choices based on contemporary evidence. Adopting a woman-centred approach would also enable midwives working in the two study hospitals to support women to give birth in a position of their choosing and reduce the risk of a routinely performed episiotomy.

Key words: Qualitative research, birthing position, perineal trauma, episiotomy, obstetricians, evidence-based midwifery

Background

Normal physiology of labour and birth is driven by the innate human ability of both the woman and fetus (Cheyney et al, 2014). This is enhanced by supportive care and low technology techniques that assist the normal biological process of birth (Romano et al, 2010). Historically, women have recognised and instinctively used the natural laws of gravity and adopted upright positions without the constraints that often accompany the medical model for labour and birth. Obstetricians and midwives can play an important role in supporting women to adopt different birthing positions and also in reducing the incidence of performing a routine episiotomy. A woman-centred approach that enables women to adopt positions they find comfortable can contribute to a positive experience of birth, and, as reported by Nieuwenhuijze et al (2013), a positive experience contributes to a woman’s sense of accomplishment, self-esteem, feelings of competence and wellbeing. Upright birthing positions for labour and birth are safe practices that promote the normal physiological process of birth (Romano and Lothian, 2008). Adopting an upright birthing position takes advantage of gravity to help the fetus descend into the pelvis (Gupta et al, 2012; Steen, 2012; Simkin and Ancheta, 2011). Some researchers have found that the intensity of contractions is greater in an upright position, with a shorter first stage of labour and birthing time and reduction in the need for augmentation (Thies-Lagergren et al, 2013; Gupta et al, 2012). It has been reported that fewer interventions and episiotomies are performed when women adopt upright positions, although the incidence of second-degree perineal lacerations appears to increase (Gupta et al, 2012; de Jonge et al, 2010).

As childbirth has become more medicalised, in middle- to high-income countries, it is common for women to be...
constrained during labour and give birth in the lithotomy position (when a woman during childbirth is on their back, with hips and knees flexed and thighs apart). At present, the lithotomy position is a routinely accepted birth position in many African hospitals (Mwanzia, 2014). In Nigeria, obstetric and midwifery care is regimented and institutionalised, obstetricians and midwives are educated and trained to facilitate women giving birth in the lithotomy position and this, along with the routine use of episiotomy, is commonly practised, which is clearly not based on contemporary evidence. The influence of obstetricians is crucial when decisions about what is accepted as safe practice for childbirth are made in a hospital setting. However, there is a lack of research available that has explored obstetricians’ views and experiences relating to maternal birthing positions and perineal injuries (Hodnett et al., 2012; Hanson, 1998). This research was undertaken to address this deficit and was included in a component of a mixed-methods study (Diorgu et al., 2016).

Aims
The aims of this study were firstly, to explore the perceptions and experiences of some Nigerian obstetricians regarding maternal birthing position and perineal trauma following childbirth. Secondly, to gain insights as to whether obstetricians’ clinical decisions and practice were influenced by research evidence.

Method
This study used a descriptive qualitative approach as one component of a mixed-methods study. Undertaking qualitative research enabled the researchers to gain an understanding of obstetricians’ views and experiences of maternal birthing position and perineal trauma, which cannot be captured through a quantitative approach (Smith et al., 2013; Rennie, 2012).

The study involved eight obstetricians who were selected through purposive sampling. A total of 10 obstetricians were approached by the first author (FD) and agreed to participate in the study. However, only eight of these obstetricians were available to participate in either of the two focus group interviews. Data were collected via focus group interviews during November 2014 using a semi-structured interview schedule which included some socio-demographic questions and open-ended questions relating to the study aims. Key questions included:

- What are your views about lithotomy (the lying on the back) position women often use during childbirth?
- How does this position help or not help women with birth?
- What are your views about women having a choice and using upright positions during labour and birth?
- Can you describe what it is like to facilitate a birth with the aid of an episiotomy?
- What is the evidence to support the benefits of performing an episiotomy during childbirth?
- What are your views about women having a choice and using upright positions during labour and birth? The focus group interviews were facilitated by FD and recorded via a digital tape recorder. Participants were identified by the use of codes. Data analysis was guided by Braun and Clarke’s (2006) six-stage thematic framework. Interviews were transcribed in full and categorisation of the data achieved with several in-depth readings of the transcripts. Data saturation was reached with the facilitation of the second focus group interview as no more emerging themes were identified (see Figure 1 and Figure 2, overleaf).

Ethical considerations and research governance requirements were met. The study obtained ethical approval from the health and social research ethics committee at the University of Chester in the UK, and also from the study hospitals in the Niger Delta region in Nigeria. All participants signed an informed consent form following a detailed explanation about the study. The focus group would be recorded but individuals’ identifications would be protected by the use of coding numbers. Also, they had the right to withdraw from the study at any time (Steen and Roberts, 2011).

Results
Among the eight study participants, six were resident doctors undergoing specialist training in obstetrics/gynaecology and two were obstetric consultants. Two participants confirmed that they had more than 10 years of experience in obstetrics and gynaecology, four had more than five years and two had less than five years. Equal numbers of participants represented study hospital one and two. The analysis of the transcripts resulted in the following core themes relating to birthing position emerging: ‘entrenched practice’, ‘lack of insight for evidence’, ‘embracing woman-centred care’ and, for perineal trauma, ‘professional dominance’.

Entrenched practice
Exploring obstetricians’ knowledge and understanding of birthing positions and perineal trauma is important as this gives insights into current clinical practice and whether maternity care is supported by evidence. Interestingly, when participants were questioned about their views regarding birthing position, all stated that the lithotomy position was the only birth position practised in the two study hospitals and that it had become accepted as routine practice. Six of the participants discussed and agreed that the lithotomy (sometimes referred to as dorsal) position was the most suitable birth position as it was convenient for both women and their birth attendants:

“Dorsal position is our standard practice here, more so in this environment, lying down position is like what we are used to. This is the practice our senior colleagues here handed over to us” (D4).

“Lithotomy position is the commonest position women use in our centre. It has become so entrenched. It is usual to assume that the patient is going to adopt it and when they are also giving birth without being told, they already know, so they adopt it” (D1).

“...then if the membranes have been ruptured also and the fetal presenting part is still high, the lying position keeps your mind at rest to ensure the patient may not have cord prolapsed. Lying on the back is a convenient position for us” (D6).

Figure 1. Initial thematic map (themes and sub themes within)

**BIRTHING POSITIONS**

- Established practice
  - Expert opinion
  - Position long in use

- Practitioner focused
  - Work for us
  - Mothers not complaining
  - Professional justification

- Embedded practice
  - Embedding of research context
  - Poor knowledge of evidence-based practice
  - Limited awareness of evidence

- Clinical knowledge base
  - Clinical skills
  - Only position allowed
  - Not up to date with current evidence
  - Position taught

**OBSTETRICIANS’ NARRATIVES**

- Acceptance of ongoing practice
  - Believing in good practice
  - Have insight
  - Not at all skills
  - Willingness for change
  - Good professional network
  - Only position allowed
  - Position taught
  - Routine practice
  - Shared clinical experience

**PERINEAL TRAUMA**

- Lack of continuity of care
  - Medicalised practice
  - Repair difficulty
  - Failed anaesthesia

- Lack of standards
  - Episiotomy use
  - Misconception
  - Insufficient awareness
  - Feeling confident

- Fragmented care
  - Promote skill development
  - Professional dominance
  - Perceive good clinical practice
  - Feeling in control
  - Need no help

- Midwifery or nurses perform, doctors repair
  - Respecting and acknowledging expertise
  - Promote skill development
  - Position of authority
  - Episiotomy use
  - Others need help
  - Need no help

- Professional dominance
  - Professional oversight
  - Position of authority
  - Perceived good clinical practice
  - Need no help

- Feeling confident
  - Perceived good clinical practice
  - Need no help
  - Feeling in control
  - Position of authority

- Perceived good clinical practice
  - Need no help
  - Feeling in control
  - Position of authority
The acceptance of the lithotomy position for birth as standard practice was clearly articulated and, until now, the participants had not reflected upon or challenged this. While the participants acknowledged the importance of evidence-based practice to assist them in making clinical decisions to provide best care, their responses indicated that decisions and care undertaken in the two study hospitals were based on a ‘practice norm’. It was evident that the participants’ clinical practice was in alignment with a medicalised model of care, but it was not based on contemporary evidence. However, it became apparent during the focus group discussions that most of the participants viewed birthing position and routine use of episiotomy from the perspective of hospital standards, as well as being influenced by their own personal philosophies and preferences.

**Lack of insight for evidence**
Knowledge and awareness of evidence in support of birthing positions and perineal outcome is vital when highlighting ‘best practice’. Studies have associated supine position during childbirth with negative consequences and increased risk of perineal injuries (Hodnett et al, 2012; Albers and Borders, 2007; Hastings-Tolsma et al, 2007). This theme relates to perceptions of both birthing position and perineal trauma. When participants were asked about their perspectives concerning perineal trauma when supporting women during childbirth, the majority (six) assumed that an episiotomy prevents a perineal tear. With regards to the birthing position, five participants expressed uncertainty on the effectiveness of an upright birthing position. One participant reported that by taking part in this study enabled her and other participants to know that other birthing positions existed and are supported by evidence:

“...but it is better to give episiotomy than for you to allow the patient to have a perineal tear” (D5).

“...when you are giving episiotomy most times because they are already in so much pain you do not have problem giving it. Usually it is easy giving it. Basically episiotomy is [...] it is a very good practice, very good practice instead of allowing the woman to have a perineal tear we give episiotomy. It is even very easier to repair” (D2).

Prior to participating in this study, none of the participants promoted the use of upright birthing positions during labour and birth, despite good evidence of the benefits to women. What resonates in these quotes is that some obstetricians appeared not to be up to date with current available evidence in relation to birthing positions and perineal outcomes and that they had strong beliefs. Poor knowledge of evidence was identified as a theme, as it emerged clearly during the discussions around birthing position and perineal trauma.

**Embracing woman-centred care**
This theme emerged when there was discussion about providing women with choices that would help them to give birth. It was noted that participants were now considering ways to enable women to make choices regarding birthing positions. Six participants remarked that they would “allow” or “oblige” women to choose their birthing positions. Four participants indicated that they would provide women with choices that would help them to give birth. It was noted that participants were now considering ways to enable women to make choices regarding birthing positions. Six participants remarked that they would “allow” or “oblige” women to choose their birthing positions. Four participants indicated that they would provide women with choices that would help them to give birth. It was noted that participants were now considering ways to enable women to make choices regarding birthing positions. Six participants remarked that they would “allow” or “oblige” women to choose their birthing positions.
benefit. By the time the people who are using the methods give testimonies of their success, the traditional method of lying down will die a natural death. Or somebody will try this method in one birth and may wish to try another in another pregnancy. So there is variety. I am not sure that we will lump everybody into a particular method. People will now have an opportunity to make a choice” (D2).

Some participants commented on women who had fixed expectations about birth and the positions in which they wanted to give birth. Six participants stressed the importance of preparing women during the antenatal period to consider the use of upright birthing positions and provision of special training of health professionals in the use of upright birthing positions. In addition, these participants expressed that increasing awareness and preparing both women and health professionals are vital for a change in clinical practice to take place:

“The new birthing positions as proposed offer clear advantage than the dorsal position that we use. Why not after due counselling of the patients, if they opt for it, we will oblige them” (D6).

“There is something I will suggest to you, we have thought about having some facilities that will enable the position to be sustained, it will be better to provide them. If there are some of those things that they have over there [overseas], they can be provided for us here, all those things if we have them, some women if not for any other thing but a curiosity, they might use […] [all laughed], but they are not here. That is the problem” (D4).

“What we need is awareness, the awareness has to be created and the enabling environment provided, so we can start using the new method […] I am sure everybody would want to try something new as it is better, more convenient and easy for women” (D7).

This theme refers to the notion that some participants were considering the “old fashioned” way to give birth as expressed during the focus group discussions and, therefore, support women to innately adopt alternative birthing positions. Most of the obstetricians clearly showed a willingness to support women in their choices of birthing positions near completion of the focus group discussions. The most frequently mentioned challenges reported were lack of experience in supporting women to give birth in upright positions and the need for a good knowledge base to support a change in their clinical practice. It was noted that participants were now considering ways to enable women to make choices regarding birthing positions and how to create an “enabling environment”.

Professional dominance

From the interview data, it is apparent that the obstetricians instilled a professional dominance relating to the clinical care of episiotomies. It was acknowledged that midwives had the clinical skills to perform an episiotomy, but did not repair the episiotomy incision. Perineal repair was viewed as within the role of the obstetricians and not the midwives:

“The repair of the episiotomy depends on the indication for the episiotomy and the nature of the episiotomy. If it is a simple episiotomy that is not wide, the house officer that is the least doctor can repair, but if it is a condition where there are things like sickle cell disease, heart failure, very high-risk patients, may be a registrar can repair it. But generally [midwives] do not usually repair episiotomy in our centre here, they don’t repair yes. But they can give but they do not repair” (D2).

“The midwives give, but they don’t repair. We [doctors] can give and can repair… and we use the opportunity to train the younger doctors to acquire the skill of repair of episiotomy, so that is what we do here” (D3).

This theme clearly shows that there was a clear demarcation of the role of obstetricians and midwives concerning who can perform and repair an episiotomy.

Discussion

Cumulative evidence has associated a lithotomy position during childbirth with negative consequences and increased risk of perineal injuries (Hodnett et al, 2012; Albers and Borders, 2007; Hastings-Tolsma et al, 2007; Gupta and Hofmeyr, 2004). In contrast, studies suggest that upright birthing positions, such as squatting, sitting, standing, kneeling and hands and knees positions, assist in reducing the incidence of perineal trauma and vaginal injuries (da Silva et al, 2012; Gupta et al, 2012; RCM, 2012). In the UK, guidelines suggest that women should be encouraged to give birth in upright positions (NICE, 2007). In addition, studies have looked at the benefits of different birthing position and two meta-analyses studies found that most women preferred upright compared to a supine birthing position (de Jonge et al, 2004; Gupta and Nikodem, 2000). Despite international recommendations and strong evidence of benefits associated with upright positions, the findings in this study demonstrated that participants accepted a lithotomy position as being culturally and institutionally adopted as ‘the norm’ and so standard practice. This finding is in agreement with Okonta (2012) who found a supine position routinely used in Africa. The history and acceptance of different birthing positions varies in low-, middle- and high-income countries. A lithotomy position has never had any scientific evaluation before its introduction and only since the late 1980s has research been undertaken to evaluate different birthing positions (de Jonge, 2007; Reid and Harris, 1988). In some parts of the world, the upright position is still commonly used, especially in areas where Western medicine has not been introduced. Nevertheless, in Western countries, such as Europe and Australia, where the medicalisation of childbirth prevails, a high proportion of women continue to give birth in a supine position (de Jonge et al, 2011; Dahlen et al, 2007).

Routinely giving birth in a lithotomy position and the use of episiotomy to prevent spontaneous perineal tears highlights the cultural medical norms and regulations of the study hospitals. This study demonstrated the influence of workplace culture upon obstetricians’ clinical practices and their decisions were based on a medical model. Similarly, other studies have reported the working environment exerts a significant influence in determining preference of maternal
position in labour (de Jonge et al, 2008; Freeman et al, 2006). Therefore, the impact of the birthing environment, as well as the model of maternity care influenced by the medicalisation of childbirth, is considered to be influential on obstetric clinical practice.

Accepting and not challenging entrenched and practice norms not based on evidence appeared to demonstrate a lack of knowledge of current evidence. In practice, evidence-based knowledge assists in the provision of high-quality care to mothers and babies. Rather than their decisions for care being based on clinical opinions and personal belief that then become standard practice, yet may not be beneficial to a mother or her baby, practitioners need to use evidence to inform the care they offer. To apply evidence-based practice in the provision of maternity care, obstetricians need to keep themselves up to date with current available evidence.

Notably, in this study the obstetricians showed some willingness to be adaptable to change and were considering informing and allowing women to adopt upright positions. This is encouraging, as this acknowledges a woman-centred approach to maternity care which is in line with evidence-based practice as scientific literature justifies the need for a change in birthing practices. A woman-centred approach that incorporates holistic aspects (emotional, social, and cultural) of care promotes quality care that recognises a woman as a subject, not as an object, thus moving from a trapped in a vicious cycle to a virtuous cycle.

Initially, the obstetricians' views and experiences of birthing practices were clearly influenced by their education and training, and an entrenched medical model of maternity care had been adopted and accepted at the two study hospitals. However, in the process of undertaking this study, awareness and practices not based on evidence were challenged, and a change in the views of the obstetricians participating in this study was observed. A change of view that involved critical thinking and an acceptance that some adaptation for birthing practices were being considered, such as enabling women to adopt different positions during labour and birth and that this may result in less routine episiotomies being performed, was a positive outcome.

There was a clear willingness among obstetricians to change and incorporate clinical practices that benefitted women based on contemporary evidence. This resonates with what is commonly referred to as the change that occurs within an appreciative inquiry approach when people move from being trapped in a vicious cycle to a virtuous cycle.

It is vitally important that obstetricians adopt a woman-centred approach and work collaboratively with midwives, in order to ensure that this approach becomes accepted and practised when they are supporting women during their childbirth experiences.
References


