Nigerian Mothers’ Perceived Disrespectful Care during Labour and Birth Arising from Lack of Choices for Birthing Position and Episiotomy

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Abstract

Background: Many studies show that women in labour value maternity care, particularly when midwives and obstetricians are open to listening to and caring about women’s needs during labour. However, the majority of women in a recent study undertaken in Nigeria had negative perceptions regarding the treatment they received from their care givers during labour and birth.

Aim: To explore the mother’s perceptions and experiences of birthing positions and perineal trauma.

Methods: A questionnaire survey involving 110 mothers who gave birth at two public hospitals in Port Harcourt. Participants were mothers who had given birth to a live baby vaginally, had perineal injury and were in their six weeks postpartum period. Follow up interviews were undertaken with 12 mothers.

Findings: Majority of the mothers 94 (85%) gave birth in lithotomy position. The positions were as directed by their midwives 59 (54%) and not by the mothers’ choices. However, majority of the mothers, 106 (96%) reported they would be willing to try other positions if given the opportunity. Majority of mothers had an episiotomy 80 (73%) and 76 (69%) reported they did not give their consent and 59 (53%) reported they were not given local anaesthesia prior to the episiotomy. Interview data provided a deeper insight into the mothers’ perceptions and experiences of birth positions and perineal trauma. These mothers were dissatisfied with their birth experience. It was evident that most mother’s perceived that they were coerced and adopted birthing positions as directed by midwives and not given opportunities to make an informed choice and adopt alternative positions for birth. In addition, an episiotomy was performed without anaesthesia and their consent.

Conclusion: This study clearly shows that maternity care was practitioner-led and not woman-led. The findings show that women received disrespectful care and were often a passive participant in their own birth and not listened to. However, there was also evidence that mothers would use different birthing positions if given the opportunity and this may lead to fewer episiotomies.

Keywords: Nigeria; Disrespectful; Birthing position; Episiotomy

Introduction

In evidence-based practice in the delivering of quality health care, users are recognised as a ‘person’ not as an ‘object’, a move from paternalism to responsible autonomy of participants. This shift in paradigm characterises a woman-centred model of care[1,2]. Furthermore, it is believed that good collaboration between midwives and obstetricians promotes partnership working to improve maternity care. To achieve this aim midwives and obstetricians have to identify what women would like and need [3]. Nieuwenhuijze[4] suggests that midwives and obstetricians need to provide the right balance between being responsive to the woman’s wishes and the medical perspective. Several studies show that women in labour and during their birth value respectful care and their choices considered [5,6]. However, the majority of Nigerian women in a recent study reported negative perceptions regarding the treatment they received from their care givers during labour and birth [7].

Several recent studies[8-10], clearly indicate that many women throughout the world experience disrespectful care in health facilities when giving birth. Bowser and Hill [11] have described seven categories of disrespectful care during childbirth: physical abuse, denial of autonomy, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in health facilities. Freedman and Kruk [12] built on the Bowser and Hill’s categories to propose a different definition of disrespectful care during childbirth by articulating criteria for determining when an interaction or condition should be considered disrespectful care. These researchers considered disrespect during childbirth as an interaction or facility conditions that is generally accepted by the local consensus to be humiliating or undignified, or intended to be humiliating or undignified [12]. Disrespect and mistreatment that is deliberate or unintentional by health care providers towards women as well as other health system constraints are negatively contributing to her childbirth experiences and rights to respectful, dignified, and humane care during childbirth. It is, important to note that disrespect and/or conduct by health care providers may not always be intentional, and may coexist with other compassionate and more respectful care practices [13]. However, women’s experiences of disrespectful care must be considered, regardless of intent. Health system factors may provide contextual explanations for negative experiences, but should not be considered as justification for the continued disrespect of women.

Method and Materials

Study design and setting

An exploratory study was undertaken and data collection was by use of a questionnaire and some follow up interviews that explored mothers’ perceptions and experiences of birthing positions and perineal trauma. The study was carried out in two public health facilities (one teaching hospital and one specialist hospital), Port Harcourt, Nigeria, April, 2014.

Study population

Mothers who had a vaginal birth of a live baby and were in their six weeks postpartum period were recruited to the study. Mothers who had an instrumental delivery, or suffered serious medical condition and required obstetrician-led care were excluded to maintain similarity of study subjects.

Sample size and sampling

A purposive sample of 110 mothers participated in the quantitative survey and completed a structured questionnaire. Approximately, in both study hospitals, 1,099 perineal injuries occurred between the year 2012 and 2013 (Hospital register). The sample size of a 110 was a 10% proxy estimate for sample size as the study was an exploratory study.

Follow up interviews were undertaken with a sample of 12 mothers at 6 weeks postnatal, as part of a bigger qualitative study exploring both mothers’ and maternity care providers’ perceptions and experiences of mothers’ birthing position and perineal trauma.
Data collection

The questionnaire explored the reporting rate of different birthing positions and the experiences of mothers regarding birthing position and perineal trauma. Participants completed self-administered questionnaire during the six weeks following their first postnatal visit. The completed questionnaires were dropped in the collection box provided in the postnatal clinic at both hospitals. Other socio-demographic variables, such as mother’s age, number of births, antenatal care duration, levels of education attainment, marital status, birthing position, and whether the perineal trauma was spontaneous or surgically induced were added to the data collection tool as additional information. Some of the information were checked and verified against medical records.

Data quality assurance

Data collection tool was adjusted after pre-testing to improve clarity, understanding and simplicity of the questionnaire items. Completeness and accuracy of the questionnaire were checked during the period of data collection.

Ethical Consideration

The study proposal received ethical clearance from the Institutional Ethical Review Boards of UPTH & BMSH. Written permissions were obtained. Informed written consent was obtained from all clients who participated in the study.

Results

A total of 110 questionnaires were administered and 110 were correctly filled, given a response rate of 100%. The majority of the respondents’ age was between 26-35 years and majority were first time mothers 64 (58%). Almost all were married and more than one third had tertiary education. All respondents attended antenatal clinic during the period of the pregnancy. Majority of mothers 94 (83%) gave birth in lithotomy position. The results show that the positions were as directed by the midwives 59 (54%) not by the mothers’ choices. However, many of the mothers 106 (96%) reported willingness to try other position if given the opportunity. Another mother stated that there had been no agreement prior to giving her the cut:

“It was a horrible experience. Before I knew what was happening to me, and before I could think, e-e-r-m had already been given the cut” (Bliss)

One mother articulated how her midwife disregarded her opinion and joined forces with her spouse to carry out a procedure against her wishes:

“So the midwife told me that she will give me a cut, episiotomy in order to allow my baby to be born. I said ‘NO’, I said ‘NO. Yeah, I do not want that’. She said I must do it. In-fact she pressurized me, she told my husband and my husband talked to me and I said okay. She now gave me the cut without any pain injection. She gave me like that [...] raw. I was not happy with it.” (Sarah)

The women in the study felt overruled coerced into accepting what they felt was not comfortable or in their best interest.

Discussion

Women in this study reflected upon the care they received which they considered made them feel insignificant as they were only able to play a subservient role in their care, and the midwives and obstetricians dominated the birthing care process. It was found that the decision to perform an episiotomy was made by the midwives and was never discussed with some of the women. The birthing position adopted by some women was dictated and enforced by the healthcare providers. It was clear that the women accepted, and did not challenge the decisions made by those whom they saw as professionals and believe to have knowledge and expertise which afforded them the power to overrule and control the birth process. The acceptance of the decisions made on their behalf may have been based on the notion that disapproval from a person delivery, they started to stitch. I said ‘Aaah what is this now?’ They said they gave me cut. I said why?........’ (Lizzy).

Another mother stated that there had been no agreement prior to giving her the cut:

Discrimination / Experience

Perceptions / Experiences of birthing position and perineal trauma from mothers’ perspective.

Table 1: Percentage distribution of mothers’ perceptions and experiences of birthing position and perineal trauma from mothers’ perspective.

<table>
<thead>
<tr>
<th>Antenatal care duration</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 8 times</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td>Above 8 times</td>
<td>81</td>
<td>74</td>
</tr>
</tbody>
</table>

Table 2: Percentage distribution of mothers’ perceptions and experiences of birthing position and perineal trauma from mothers’ perspective.

<table>
<thead>
<tr>
<th>Mother’s age</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>26-35</td>
<td>77</td>
<td>70</td>
</tr>
<tr>
<td>36 and above</td>
<td>19</td>
<td>17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of births</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>104</td>
<td>95</td>
</tr>
<tr>
<td>5 and above</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary level</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td>Post-secondary level</td>
<td>80</td>
<td>73</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>108</td>
<td>98</td>
</tr>
<tr>
<td>Single</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

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who is highly valued in their care may be seen as being disobedient and may be detrimental to their care.

Many women reported that they did not give consent for an episiotomy and the episiotomy was performed without a local anaesthetic which the women viewed as dehumanizing care with little or no compassion. It is unethical for health professionals to perform an episiotomy procedure without consent from the woman. Not informing a woman before performing an episiotomy and obtaining consent according to recent international initiatives, is considered as non-consented care and may even be regarded as physical abuse[14]. If this is performed in an open delivery ward without privacy curtains, then it is also non-confidential care[14]. Unfortunately, some of the women in the group had an episiotomy performed on them without consent and sometimes against their wishes. The needless use of episiotomy has been described as another form of obstetric violence, as well as physical abuse and maltreatment during childbirth, and is currently being addressed by the World Health Organization[8].

Furthermore, in this study, midwives with limited clinical skills for suturing or inexperienced medical officers were left to attend to the women’s perineal care needs with no supervision. Variation in assessment and difficulty in repair of perineal tear were reported in this study. This suggest lack of skill by both midwives and doctors who participated in the study. Similarly, other scholars also reported that these inexperienced health workers are often left with the responsibilities for care without adequate supervision[15]. In addition, the women in the study perceived that they were poorly cared for. These women articulated their lack of opportunities to express their views about the treatment and services rendered during childbirth. This observation is endorsed by findings from earlier studies[16,17]. Several reasons for this poor treatment include women not wanting to argue or get into trouble with their care giver, health workers being perceived as unapproachable and women being unaware of their rights as service users. In addition, the lack of observed accountability and the apparent sanctioning of poor practices within the health facility left women feeling powerless.

Seemingly, the passive roles of some mothers were compounded as standards of communication were generally poor and the women were not treated as equal partners in the process of care. Women described communication issues with care providers that left the women feeling ‘in the dark’ about their care. Some women in this study appeared to express dissatisfaction with the explanations given by the midwives regarding the reason for an episiotomy and the lithotomy birthing position that were forced on them. Some felt spoken at rather than communicated with, some women believed that their midwives were more interested in the women’s compliance rather than in providing opportunities to ask questions or clarify the need for certain decisions. Women’s dissatisfaction with the birth experiences has been reported by several other studies which concur with the findings of this study in Nigeria, for example:[18-20,10]. These researchers are of the view that adequate explanations from health providers are imperative for women to fully comprehend the situation, however, for the women in this study, the explanations were often inadequate or were never provided. Therefore the women found no opportunity to make an informed choice.

In conclusion, the findings of this study describe and explain the dissatisfactory experiences of women regarding birthing position and perineal trauma during their childbirth. When giving birth, the mothers’ two main key issues were that they were treated as insignificant participants throughout the birth process and the care they received was disrespectful. The findings identified that women’s decisions and preference about their wishes concerning birthing position and perineal care were not considered. The birthing position dictated by the midwives and the increased use of episiotomy are not based on evidence. Therefore, the findings indicate that further research is required into the experiences of women during birth with the view to ensure that women experience satisfactory maternity care during childbirth. Finally, an evaluation of evidence based practice in the area of perineal care and birthing positions during birth may be required in Nigeria.

References


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