



Who decides the position for birth? A follow-up study of a randomised controlled trial



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ABSTRACT

Background: Physical benefits are suggested for women and their babies when women adopt an upright position of their choice at birth. Available care options during labour influence women's impressions of what intrapartum care is. This indicates that choice of birth positions may be determined more by midwives than by women's preferences.

Question: The aims of this study were to investigate factors associated with adherence to allocated birth position and also to investigate factors associated with decision-making for birth position.

Method: An invitation to answer an on-line questionnaire was mailed.

Findings: Despite being randomised, women who gave birth on the seat were statistically significantly more likely to report that they participated in decision-making and that they took the opportunity to choose their preferred birth position. They also reported statistically significantly more often than non-adherers that they felt powerful, protected and self-confident.

Conclusions: Midwives should be conscious of the potential impact that birth positions have on women's birth experiences and on maternal outcomes. Midwives should encourage women's autonomy by giving unbiased information about the birth seat. An upright birth position may lead to greater childbirth satisfaction. Women's experience of and preferences for birth positions are consistent with current evidence for best practice.

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1. Introduction

A growing body of evidence reports physical benefits for birthing women and their babies when women adopt an upright position of their choice at birth.^{1,2} Upright positions are associated with shorter second stage of labour, less medical interventions, no increased risk for anal sphincter rupture, but increased blood loss, though without any clinical significance for healthy women.^{2,3} Despite the evidence, semi-recumbent or lithotomy positions at birth are currently still the norm in high-income countries and in some low-income countries.² A Swedish cohort study including 12 782 women, reported that 16.1% gave birth in some upright position leaving 83.9% in a non-upright position at birth.⁴

It has been suggested that the care options available to women influence their preferences for intrapartum care, indicating that the choice of birthing positions in the second stage of labour may be determined more by midwives' advice than by women's personal preferences.^{5–7} In a recent Cochrane review it was suggested that the influence of midwives on the positions adopted by women during labour and birth can be regarded as inconsiderate of women's comfort and disempowering.² It is well documented that women who have choices and are involved in decision making during labour and birth have an increased sense of control, which optimises their birth experiences.^{8–10} Two factors shown to provide increased control for birthing women are assuming an upright position and being able to get into the position that was most comfortable.^{9,11} In a study to assess women's preferences in intrapartum care Hundley and Ryan⁶ concluded that for 40% of the women the most important attribute was involvement in decision-making. Very little scientific investigation has considered women's decision-making and preferences for birth positions in the second stage of labour.⁷

Two older randomised controlled trials (RCTs) reported that participants allocated to an upright birthing group experienced

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significantly less pain and that women who gave birth on a birth seat more often expressed a positive birth experience compared to women in horizontal positions at birth.^{12,13} An American national survey found that maternal preference was associated with the use of the non-lithotomy positions.¹⁴ However a recent survey from the Netherlands answered by 1154 women reported that 58.9% preferred supine positions, 19.6% preferred non-supine positions and 21.5% had no distinct preference.¹⁵ Midwives' personal attitudes and own physical capacity were shown, to some extent, to have an impact on the adherence-rate in an RCT by Thies-Lagergren et al.,¹⁶ and other researchers have also suggested that midwives have an impact on women's birth position.^{1,7} Non-adherence in intrapartum studies is a problem that has been discussed in a study by Hundley and Cheyne.¹⁷ Since little is known about the complex process of negotiation between the midwife and the birthing woman¹² it was considered important to investigate who made the decision about adherence to allocated birth position. The aims of this study were to investigate factors associated with adherence to allocated birth position in an RCT and also to investigate factors associated with decision-making for birth position.

2. Methods and materials

2.1. Design

A follow-up questionnaire exploring women's experiences with allocated birth positions was undertaken between 2010 and 2011 and included women who had previously participated in an RCT. The RCT was initially carried out to compare levels of instrumental vaginal birth in healthy nulliparous women who gave birth on a birth seat or in any other position for vaginal birth. Women allocated to the control group were free to choose whatever preferred position except for using the birth seat. Eligible women were randomised when assessed as being in active labour. Active labour was defined as painful, regular contractions (3–4/10 min), cervix dilated 3–4 cm, and/or rupture of the membranes. Further details of the recruitment have been reported previously.^{3,16} The committee for research ethics in Lund, Sweden gave approval for the study (protocol 2009/739). A completed questionnaire was interpreted as informed consent.

2.2. Subjects in the present study

Altogether 527 (52.6%) women responded to a questionnaire: 289 (54.8%) of responders had been allocated to the experimental group and 238 (45.2%) to the control group. For the purpose of the present study we have included only the 289 women who had been allocated to the experimental group and had answered the follow-up questionnaire. These comprised 177 (62%) women who gave birth on the birth seat (adherence group) and 112 (38%) women who did not give birth on the birth seat (non-adherence group). Answers from the 238 respondents who were allocated to the control group will be analysed and reported later.

2.3. Procedure and data collection

All women who had participated in the RCT received a letter by post, which included information about the follow-up study and an invitation to answer an on-line questionnaire.

Included in the invitation letter was also comprehensive information about how collected materials would be processed under current confidentiality regulations. Participation in the study was voluntary and the prospective participant was informed that she at any time, without any particular explanation, could terminate participation. Two reminders were sent and altogether

527 (52.5% of the total RCT population) women answered the on-line questionnaire.

2.4. The on-line questionnaire

The on-line questionnaire was constructed for the purposes of the follow-up study. Before invitation for participation in the present study was distributed, seven first time mothers, not participants in the RCT, pre-tested the questionnaire to ensure that the questions were comprehensible. This resulted in some linguistic corrections.

The questionnaire contained socio-demographic variables, items regarding expectations and experiences of birth and birth position. Questions regarding pain intensity, pain experience and experience of labour duration have been used earlier in a Swedish national survey relating to women's experiences of childbirth.¹⁸ Questions about expectations of birth position, the midwife's encouragement to take a certain position, the mother's opportunity to take her own preferred position, experiences of safety and trust in the midwife, and the occurrence of birth complications could be answered "yes", "no" or "do not know". A question regarding decision making about birth position could be answered either; by herself, by the midwife or tried different positions. A question about the overall experience of the birth could be answered positive, both positive and negative or negative. Five questions regarding maternal experience of birth position, labour pain and length of labour were measured on scales ranging from 0 to 10. Respondents were asked to check boxes next to expressions of emotions (seven positive and six negative expressions) that they may have felt in relation to their birth position. They were free to check any number of emotions that were relevant to their experience.

2.5. Outcome measurements

Outcome measurements were possible explanatory factors for adherence to allocation to the birth seat and decision-making for birth position. These were: preference for birth position, women's expectations and experiences of birth and the attending midwife, experience of birth position, labour pain, length of labour, self-reported complications and emotions aroused in relation to birth positions.

2.6. Statistical analyses

Descriptive statistics and *t*-tests were used. Crude and adjusted odds ratios with a 95% confidence interval¹⁹ were calculated for the different explanatory variables between women who complied and women who did not comply with allocation. All analyses were performed using PASW version 20.0.²⁰

3. Findings

Findings reported here are derived from responses from women who were allocated to give birth on a birth seat. A total of 177 gave birth as allocated (adherence group) and 112 did not give birth as allocated (non-adherence group). Reasons reported in the questionnaire for non-adherence were medical (54%) maternal (28%) and midwife (18%).

3.1. Birth positions

Women in the adherence group all gave birth sitting on a birth seat without instrumental assistance. Birth positions used in the non-adherence group were semi-recumbent (30%), lithotomy (60%) lateral (8%) and kneeling (2%).

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