IPS Journal of Basic and Clinical Medicine
IPS J Basic & Clin Med, 2(2): 73-82 (2025)
DOI: https://doi.org/10.54117/ijbcm.v2i2.14

Perception, Enablers and Barriers to the Practice of Physiologic Birth among Midwives in Birthing Facilities in Bayelsa State, Nigeria

Ishember Tabitha Kutim[1], Kinikanwo Green[1], Faith Chinemerem Diorgu[2] and Chinemere Onyema[2]

[1]Africa Centre of Excellence in Public Health and Toxicological Research, University of Port Harcourt. Federal Medical Centre, Yenagoa, Bayelsa State.
[2]Department of Nursing Science, Rivers State University, Port Harcourt, Nigeria.

*Corresponding author email: tabitha2k2@yahoo.com

Abstract

Despite global advocacy for physiologic birth as a safe and empowering alternative to routine medicalized childbirth, its implementation remains limited across many regions, including Nigeria. In Bayelsa State, where maternal health indicators remain suboptimal, the rising tension between ideal midwifery practices and institutional realities warrants critical attention. The problem lies in the inconsistent application of physiologic birth, largely due to midwives' perceptions, inadequate institutional support, and hierarchical decision-making structures. This study explored the perceptions, enablers, and barriers to the practice of physiologic birth among midwives in public birthing facilities across Bayelsa State, Nigeria. A qualitative cross-sectional design was employed, utilizing a 32-item unstructured interview guide to conduct focus group discussions with 27 licensed midwives across tertiary, secondary, and primary health facilities. The data were analyzed using Hsieh and Shannon's five-step content analysis method. Findings revealed that while midwives held strong positive perceptions of physiologic birth as spontaneous, empowering, and woman-centered, their ability to implement it was hindered by restrictive hospital policies, inadequate antenatal education, medicalized training, and physician-dominated leadership. Conversely, midwives' confidence, women's birth preferences, and supportive birthing teams were identified as key enablers. The study concludes that the gap between belief and practice is shaped by both systemic and psychosocial factors. Applying the Health Belief Model clarified how midwives' behavior is shaped by perceived benefits, barriers, self-efficacy, and institutional cues. Hence, it is essential for the Ministry of Health to institutionalize midwife-led care models by enacting policies that promote autonomy, equip facilities, and reframe midwifery as central to safe, respectful maternal healthcare.

Keywords: Physiologic birth, Perceptions, Enablers, Barriers, Midwives

Article History

Received: 15 May 2025
Accepted: 16 Jun 2025
Published: 19 Jun 2025

Scan QR Code to view[1]

How to cite this paper: Kutim, I. T., Green, K., Diorgu, F. C., & Onyema, C. (2025). Perception, Enablers and Barriers to the Practice of Physiologic Birth among Midwives in Birthing Facilities in Bayelsa State, Nigeria. *IPS Journal of Basic and Clinical Medicine*, *2*(2), 73–82. https://doi.org/10.54117/ijbcm.v2i2.14.

1. Introduction

Physiologic birth refers to the spontaneous, unhindered process of labor and delivery that occurs without routine medical intervention, allowing the body's natural mechanisms to function optimally (McCourt, 2022). It encompasses a range of low-intervention practices including spontaneous onset of labor, freedom of movement, non-supine birth positions, continuous emotional support, and delayed cord clamping (Leap & Hunter, 2022). Physiologic birth prioritizes maternal autonomy and minimal technological interference, aligning with the World Health Organization's recommendations for respectful maternity care. Globally, physiologic birth is associated with enhanced maternal satisfaction, reduced perineal trauma, improved neonatal outcomes, and quicker recovery post-delivery (Hodnett et al., 2013; Henshall et al., 2023). Despite these benefits, its uptake remains inconsistent. According to Betrán et al. (2021), global cesarean section (CS) rates rose from 7% in 1990 to over 21% in 2021—far exceeding the WHO's optimal threshold of 10–15%. In Nigeria, the national CS rate is 2.1%, but regional disparities are stark—ranging from over 4.7% in the South-West to below 2% in parts of the North (Adewuyi et al., 2019). These figures reveal not only underuse in rural areas but also overmedicalization in urban centers, pointing to deep systemic imbalances that hinder the practice of physiologic birth.

Enablers of physiologic birth refer to factors that promote, support, or reinforce midwives' ability to implement natural birth practices. These can be cognitive (such as knowledge and confidence), institutional (like supportive policies), or

structural (such as infrastructure or autonomy). For instance, midwives with advanced training, clinical competence, and exposure to evidence-based guidelines are more likely to support non-interventionist approaches (Leap & Hunter, 2022). Supportive leadership, inter-professional collaboration, and access to midwife-led birth units further enhance midwives' capacity to uphold physiologic birth principles (Bohren et al., 2017; Henshall et al., 2023). Additionally, organizational culture plays a crucial role: facilities that empower midwives to make autonomous decisions, provide ongoing professional development, and promote individualized care tend to have higher physiologic birth rates (Reed et al., 2016). In this context, cues to action—such as workshops, clinical guidelines, and peer mentorship—are essential in activating behavioral change. Enablers, therefore, not only support clinical competence but also shape midwives' positive perceptions and beliefs about the feasibility and value of physiologic birth.

Conversely, barriers to physiologic birth involve obstacles that impede its consistent and effective practice. These barriers can be internal, such as fear of adverse outcomes or lack of confidence, or external, such as rigid institutional policies, high patient loads, or hierarchical decision-making dominated by physicians (Toohill et al., 2017; Martin-Arribas et al., 2022). In many low-resource settings, midwives report limited training in non-pharmacological pain relief, insufficient privacy for laboring women, and inadequate facilities that do not accommodate upright birthing positions (Chen & Tan, 2019; Matta et al., 2019). The medicalization of childbirth, especially in tertiary hospitals, fosters a culture where CS and labor augmentation are routinely used, even in the absence of clear clinical indications. These barriers not only limit the autonomy of midwives but also alter their perception of what constitutes 'safe' childbirth. The cumulative effect of these constraints often leads to underutilization of physiologic birth, despite midwives' awareness of its benefits.

Midwives' perceptions—shaped by their training, personal experiences, and institutional environment—are central to understanding the implementation of physiologic birth. Perception refers to how midwives interpret the risks, benefits, and feasibility of practicing physiologic birth in their specific settings. Positive perceptions are often linked to prior success with physiologic methods, supportive work environments, and professional recognition (Sadeghzadeh et al., 2019). On the contrary, negative perceptions stem from past complications, unsupportive leadership, and lack of legal protection in the event of adverse outcomes. Existing empirical studies emphasize these perceptual dynamics. For example, Darling et al. (2021) found that midwives with high self-efficacy were more likely to practice physiologic birth, especially when cues to action—like mentorship and policy support—were present. Reed et al. (2016) revealed that midwives practicing in environments that valued woman-centered care were more inclined to view physiologic birth as safe and empowering. However, these findings also reveal contradictions: even well-trained midwives may resist physiologic practices due to institutional rigidity or fear of professional reprisal (Walker et al., 2018; Chen & Tan, 2019).

Despite the global attention to physiologic birth, a critical gap remains in understanding the nuanced perceptions of midwives and the interplay of enablers and barriers within sub-Saharan African contexts. While several studies have explored facilitators and constraints in high-income countries, few have investigated these dynamics in Nigerian public health systems, particularly in Bayelsa State where maternal health outcomes remain suboptimal. Little is known about how midwives in this region conceptualize physiologic birth, what motivates or discourages its practice, and how demographic, structural, and cultural factors intersect to shape midwifery behavior. This study, therefore, aims to explore midwives' perceptions, as well as the enablers and barriers influencing the practice of physiologic birth in birthing facilities in Bayelsa State, Nigeria.

The significance of this study lies in its ability to generate context-specific insights that inform interventions to promote physiologic birth. By examining the cognitive, organizational, and systemic factors that shape midwives' beliefs and practices, the study contributes to the broader discourse on respectful maternity care and maternal health equity. Moreover, the application of the Health Belief Model (HBM) offers a structured lens to evaluate midwives' motivations and constraints, identifying actionable levers for behavioral change. Findings will be instrumental in shaping evidence-based training curricula, influencing policy reforms, and strengthening institutional support for midwives. Ultimately, the study aims to enhance maternal outcomes by fostering a healthcare environment where physiologic birth is respected, supported, and sustainably practiced.

Aim and Objectives

This study investigated the perceptions, enablers and barriers to practice of physiologic birth among midwives in birthing facilities across Bayelsa State. In specific terms, the study explored the following:

1. The Midwives perceptions of physiologic birth in birthing facilities in Bayelsa State, Nigeria.
2. the enablers of the practice of physiologic birth in birthing facilities in Bayelsa State, Nigeria.
3. the barriers to the practice of physiologic birth in birthing facilities in Bayelsa State, Nigeria.

Research Questions

Two critical questions were answered in this study

1. How do Midwives perceive physiologic birth in birthing facilities in Bayelsa State, Nigeria?
2. What are the enablers of the practice of physiologic birth in birthing facilities in Bayelsa State, Nigeria.
3. What are the barriers to the practice of physiologic birth in birthing facilities in Bayelsa State, Nigeria.

Literature Review

Physiologic birth refers to the spontaneous, non-interventionist process of labor and childbirth that supports the body's innate ability to deliver without routine medical interference (McCourt, 2022). Core components include natural onset of labor, continuous emotional and physical

support, freedom of movement, upright birthing positions, and delayed cord clamping or natural placental expulsion (Leap & Hunter, 2022). Central to this process is the midwife, whose perception of birth—whether as a natural, empowering event or a clinical risk to be managed—can profoundly influence practice. Hence, exploring midwives' perceptions, as well as the enablers and barriers they encounter in implementing physiologic birth, is essential for scaling its adoption in maternity care. Physiologic birth is not just a clinical outcome but a behavior shaped by psychological, educational, and institutional factors.

The Health Belief Model (HBM), developed by Rosenstock and refined by Becker, provides a strong theoretical lens for examining midwives' perceptions and behavioral choices regarding physiologic birth (Rosenstock, 1974; Becker, 1974). The model posits that six constructs influence health behavior decisions: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Glanz et al., 2015). Midwives' perceptions of physiologic birth are shaped by these constructs. For instance, perceived benefits—such as safer outcomes, shorter recovery periods, enhanced maternal satisfaction, and reduced intervention-related complications—positively influence midwives' intention to support physiologic birth (Hodnett et al., 2013; Sandall et al., 2016). Conversely, perceived barriers—including institutional norms that favor medicalized birth, lack of equipment or privacy, fear of legal repercussions, or limited autonomy—discourage midwives from embracing these practices (Toohill et al., 2017; Bohren et al., 2017).

Understanding enablers through the HBM further elucidates why some midwives are more inclined to adopt physiologic birth practices. Midwives with higher academic qualifications and greater professional experience often exhibit stronger self-efficacy, believing in their competence to manage physiologic births safely and independently (Sadeghzadeh et al., 2019; Henshall et al., 2023). Access to supportive environments—such as midwife-led units—further reduces perceived barriers and enhances self-confidence. Cues to action, including workshops, updated practice guidelines, peer role modelling, and institutional recognition, play a vital role in activating the decision to implement physiologic birth techniques (Reed et al., 2016; Darling et al., 2021). When these cues are present, they reinforce midwives' belief in the importance and feasibility of natural birthing practices.

On the other hand, understanding the barriers within the HBM framework highlights opportunities for intervention. For instance, midwives who work under physician-led teams or in high-pressure facilities may perceive increased severity of complications or reduced control, thus avoiding physiologic practices (Matta et al., 2019; Chen & Tan, 2019). Additionally, where training in physiologic birth is limited, or institutional protocols strongly favor intervention, midwives' motivation and perceived benefit are diminished. These psychosocial and systemic dynamics ultimately determine practice behavior.

In summary, the HBM provides a structured approach for examining midwives' perceptions, motivations, and challenges in practicing physiologic birth. It not only captures individual belief systems but also accounts for institutional and environmental cues that can shape behavior. By identifying and targeting these modifiable constructs—particularly self-efficacy, perceived barriers, and cues to action—the study can inform capacity-building efforts, policy shifts, and organizational change strategies aimed at improving midwifery practice in Bayelsa State, Nigeria.

2. Materials and Methods

This study employed an exploratory cross-sectional research design with an embedded qualitative component. This mixed-methods approach was suitable for comprehensively exploring both the enablers and barriers influencing the practice of physiologic birth among midwives in birthing facilities in Bayelsa State, Nigeria. The quantitative component aimed to assess associations between midwives' demographic profiles and their self-reported physiologic birth practices, while the qualitative component sought in-depth insights into contextual, institutional, and attitudinal factors facilitating or hindering these practices.

Bayelsa State, located in the Niger Delta region of Nigeria, lies between Latitude 4°15′ North and 5°23′ South, and Longitude 5°22′ West and 6°45′ East. It shares boundaries with Delta and Rivers States and is predominantly served by one tertiary facility (Federal Medical Centre, Yenagoa), one secondary hospital (Diete-Koki Memorial Hospital), and seven comprehensive primary-level health centres spread across eight local government areas.

This study employed a qualitative data collection approach using an unstructured 32-item interview guide developed by the researcher to explore midwives' perceptions, enablers, barriers, and practices of physiologic birth. The data were collected through focus group discussions involving 32 midwives per session, conducted in facility common rooms. Each session lasted approximately 90 minutes and followed Sim and Waterfield's (2019) five-stage process: preparation, introduction, discussion, closing, and debriefing. During the discussion phase, open-ended questions were used, allowing participants to provide rich narrative responses, while the researcher took detailed notes, probed for clarity, and observed non-verbal cues. Participants were informed of the study purpose, assured of confidentiality, and signed consent forms prior to the interviews. The sessions concluded with a summary and opportunity for participants to add final thoughts, followed by a debriefing to ensure participant comfort. Facility birth and postnatal records were also reviewed as secondary sources of qualitative data.

The qualitative data analysis for this study followed a systematic content analysis method based on Hsieh and Shannon's (2005) five-step approach. The process began with organizing and transcribing audio recordings and notes to ensure data accuracy. This was followed by a careful review and exploration of the transcripts to confirm completeness and clarity. Next, coding rules were developed to consistently categorize the non-numerical data. These codes were then methodically grouped to identify overarching themes and subthemes, allowing the discovery of meaningful patterns and insights. Finally, the themes were

presented in a structured and coherent format, enabling clear interpretation of the findings. This rigorous approach ensured that key perceptions, enablers, and barriers related to the practice of physiologic birth among midwives were effectively captured, analyzed, and reported, thereby addressing the study's research objectives with depth and credibility.

Ethical approval was secured from the University of Port Harcourt Institutional Review Board, and all procedures aligned with the ethical standards outlined in the Declaration of Helsinki (2013 revision). Participation was voluntary, and all respondents gave informed consent. Confidentiality was maintained through anonymous coding, and all data were stored securely in a password-protected database and a locked cabinet accessible only to the researcher.

3. Results

The study involved 27 midwife participants. Most were aged 40–49 years (51.9%), followed by those aged 30–39 (29.6%) and 50–59 (18.5%). The majority were female (92.6%), with only 7.4% being male. In terms of professional experience, 33.3% had 6–10 years of experience, 29.6% had 1–5 years, 26.0% had 11–15 years, and 11.1% had 16–20 years. Most participants held a RM, BNSc qualification (70.4%), while 22.2% held RN, RM, and 7.4% had a master's degree; none held a PhD. Most worked in primary level facilities (77.8%), and 77.8% were in midwife-led teams, while 22.2% worked in obstetrician-led settings.

Research Question 1: What is the perception of midwives concerning physiologic birth in birthing facilities in Bayelsa State, Nigeria?

Theme 1: Midwives' Perceptions of Physiologic Birth

The analysis of interviews revealed a central theme: Midwives' perceptions of physiologic birth. Within this theme, four distinct subthemes emerged, shedding light on how midwives conceptualize normal birth encompassing the ideals, interventions, unpredictability, and the purpose of pain experience.

Subtheme 1: Physiologic Birth is Spontaneous

The informants expressed a shared ideal of normal birth as spontaneous, vaginal, free from medical interventions, and allowing women the autonomy to respond to their bodies' natural processes. However, they acknowledged a disconnection between this ideal and the reality of current birthing practices, with one midwife noting,

> "While we wish for births to be natural and without any medical help, the way things actually happen during childbirth may not always match this ideal." - (Midwife 2)

The discourse emphasized the challenge of aligning conceptual ideals with real-world birthing experiences.

Subtheme 2: Physiologic Birth Requires No Medical Intervention

The informants perceived induction of labour as a notable intervention, disrupting the natural course of normal birth. However, debates arose concerning the definition of intervention, with informants varying in their perspectives. Induction of labour was widely regarded as an intervention.

> "If doctors decide to bring in a first-time mom and induce labour early, you shouldn't expect a normal birth to happen" - (Midwife 5)

There was disagreement on whether augmentation of labour and epidural analgesia should also be classified as interventions. The discussion unveiled a nuanced understanding of the intervention, with some informants seeing epidurals as a means of control and expressing concerns about the skills of certain staff in supporting non-medicated births.

> "It's like letting go of control and allowing someone else to take charge, in a way." - (Midwife 23)

A notable divergence was observed, as a few informants considered episiotomy as part of physiologic birth, illustrating the variability in defining normalcy within midwifery practice.

> "A typical vaginal birth, without the need for interventions like vacuum or forceps delivery, without using epidural, but including the option of giving an episiotomy, would be what I consider a physiologic birth." - (Midwife 14)

Subtheme 3: Physiologic Birth Can Be Unpredictable

The informants unanimously acknowledged the spontaneity of labour in physiologic birth, but they stressed the importance of managing women's expectations during antenatal education, preparing them for unforeseen circumstances that may necessitate interventions such as episiotomy.

> "Even though we aim to maintain the birth as natural as we can, if the patient struggles to push effectively, and there's a risk to the baby's heart rate, then we have to consider doing an episiotomy." - (Midwife 24)

Subtheme 4: There is a Purpose for Pain Experience in Physiologic Birth

Debates centred on the use of epidural analgesia, revealing diverse opinions on the purpose of labour pain. The informants concurred that pain serves a physiological purpose by encouraging movement and facilitating the progress of labour.

> "The pain serves a purpose; it helps you understand what to do with your body." - (Midwife 9)

Personal reflections on childbirth experiences further underscored the belief that enduring labour pain contributes to a profound sense of achievement and satisfaction.

> "Experiencing childbirth without pain relief is entirely normal. I've had an epidural myself, and I can attest to the difference. There's a purpose to the pain—a sense of achievement and satisfaction that your body can go through that process." - (Midwife 17)

Research Question 2: What are the enablers of the practice of physiologic birth in birthing facilities in Bayelsa State, Nigeria?

Theme 2: Perceived enablers of the practice of physiologic birth

The analysis generated three subthemes under this theme. The subthemes highlighted the significance of women's preferences, midwives' confidence, and institutional support as enablers of physiologic birth and promoting positive birth experiences.

Subtheme 1: Preference of the labouring woman

Preference of the labouring woman was mentioned across the interviews as an enabler of physiologic birth.

> "It's important to recognize that the woman in labour has a say in how she wants to give birth. Sometimes, despite our efforts to encourage natural birth, the woman may choose a different approach, and we have to respect that. We don't want to be held responsible, so we sometimes agree to their preferred method." - (Midwife 17)

The informants emphasized the importance of offering informative support to women in labour, enabling them to participate in decision-making processes. They also recognized that providing psychological support, such as reassurance and encouragement, played a crucial role in facilitating physiologic birth.

> "I once attended to a woman who, near the end of labour, requested a caudal block. I encouraged her, saying, 'This is just the transition phase; you can do it, just hold on a little longer,' and she successfully delivered vaginally." - (Midwife 1)

The informants acknowledged that when a woman in labour decides to transition from a natural birth to a medicalized one without a clear indication, they employ strategies to uphold the woman's initial choice for physiologic birth. They reported that such strategies pivot on their birth preference to enable physiologic birth.

> "If I believe they're capable, I usually try to postpone if they're asking for a caudal block. They've come so far already; they'll likely give birth naturally." - (Midwife 14)

***Subtheme 2*:** Midwives' self-confidence

The informants noted that gaining more knowledge through education and increased exposure to physiologic births played a key role in boosting confidence. Midwives who witnessed successful physiologic births and observed the benefits for women going through the process felt motivated to support and encourage physiologic births.

> "When midwives witness natural births, they notice they're often calm and involve less foetal distress compared to births with interventions like intravenous syntocinon (Oxytocin) and cervical priming. This observation empowers them to strongly advocate for natural births without any interventions, almost with a confident, hands-on-hips akimbo style." - (Midwife 19)

Some of the informants acknowledged that their self-confidence from experience is an enabler for the reason that it allowed them to effectively distinguish between what was deemed normal and abnormal, enabling them to prevent unnecessary episiotomies and recognize the physiological signs of labour.

> "After gaining a lot of experience in midwifery, I've learned that many women can deliver without needing an episiotomy. This builds my confidence in their ability to birth naturally, that way it enables me to always suggest natural birth and take medicalization of the table." - (Midwife 12)

Subtheme 3: Supportive birth team in the facility

The interviews indicated that a supportive birthing team greatly enables midwives to practice physiologic birth.

> "In situations where the medical consultant prioritizes physiologic birth, none of my fellow professionals would oppose it; they would actually offer support. If a woman expresses her desire for a physiologic birth, nobody would object— in fact, the midwife would be pleased to provide her natural birthing services." - (Midwife 6)

The informants believed that having wireless electronic foetal monitoring machines, gym mats for birthing on all fours, squatting chairs, and birth balls in the birthing facility would enhance antenatal education on alternative birthing positions, hence enabling physiologic birth.

> "…i know that having wireless electronic foetal monitors, gym mats for birthing on all fours, squatting chairs, and birth balls in the birthing facility helps the us (the midwife) teach the mothers about different alternative birthing positions...this motivates the mothers to choose natural birth over medicalized birth, and it also makes the practice of natural birth easier." – (Midwife 25)

Research Question 3: What are the barriers to the practice of physiologic birth in birthing facilities in Bayelsa State, Nigeria?

Theme 3: Perceived barriers to the practice of physiologic birth

The analyses generated four subthemes covering hospital policies restricting midwife autonomy, inadequate antenatal education, doctors' control over the birth process, the impact of medicalized midwifery training and past negative birth incidents.

Subtheme 1: Hospital policies restricting midwife autonomy

During the interviews, some informants highlighted the influence of hospital policies that constrain the autonomy of midwifery practice, discouraging midwives from fully supporting women seeking physiologic birth experiences.

> "...Yeah, like, there's this policy that restricts the use of alternative pain relief methods, such as reflexology and use of birthing balls, which I think many women can find helpful in

managing labour pain. It's disappointing when we [Midwives] can't offer these options due to hospital regulations. In fact, it's like our hands are tied by these policies sometimes, you know? We want to give women the best care, but the rules can make it tricky." - (Midwife 14)

It was buttressed by another informant who voice further concern.

"Absolutely, hospital policies hinder my ability to provide personalized care. It's frustrating when we can't fully support a woman's birthing preferences because of administrative constraints such as the policy of calling the doctor once a pregnant woman begins to labour." - (Midwife 18)

Subtheme 2: Inadequate antenatal education

The informants expressed concerns that some women, who were planning for a natural physiologic birth but did not attend antenatal classes, lacked sufficient prenatal education. These women often relied on internet sources or lay advice for labour information, resulting in the development of unrealistic and complex birth plans. This situation presented challenges for the midwives in providing care.

"Some women have these big ideas about how they want their birth to go, but it's not always safe or possible. They expect everything to happen exactly as they want, even if it's not the best idea. Another problem is that if they don't learn the right stuff before the birth, they get really scared. Then, they might decide way before labour even starts what pain medicine they want." – (Midwife 4)

***Subtheme 3*:** Doctors' control of the birth process

The informants stated that the birthing outcomes of women were heavily influenced by the preferences or decisions of obstetricians. Women placed unwavering trust in and adhered faithfully to the guidance provided by their obstetricians, thereby presenting a challenging barrier for midwives in advocating for physiologic birth.

"The obstetricians inform the women that they need to be induced. Personally, I don't agree with them, but if the patients consent, we are not in a position to voice strong objections." - (Midwife 22)

In the interviews, informants who favoured supporting women through natural childbirth mentioned encountering resistance and negative attitudes from obstetricians when advocating for physiologic birth.

"At times, you might feel that the woman doesn't require syntocinon or a caudal block, but the doctor might have a different opinion and believe that she does need it. Since the doctor is often the head of the healthcare team, every midwife will certainly follow his lead" – (Midwife 5)

Subtheme 4: Medicalized midwifery training

During the interviews, the discussion delved into the impact of medicalized midwifery training and past experiences with negative birth incidents.

". . . Back in the day, nobody seemed to be interested in physiologic birth, about 20 years ago when I embarked on midwifery training. It was a different landscape then. We have this lingering memory of a heartbreaking incident, of a baby's life lost during a normal delivery." - (Midwife 13)

Research question 4: How do the midwives practice physiologic birth in birthing facilities in Bayelsa State, Nigeria?

Theme 4: Midwives practice physiologic birth

During the interviews, most of the informants acknowledged that midwives practice physiologic birth by adopting a woman-centred approach that prioritizes the natural physiological process of childbirth, minimizes unnecessary interventions, and promotes a positive and empowering birth experience for women and their families. Six subthemes emanated from the analyses encompassing supporting informed decision-making, creating a supportive environment, providing continuous support, encouraging freedom of movement, utilizing non-pharmacological pain relief, and monitoring labour progress with minimal intervention.

Subtheme 1: Supporting informed decision-making

Informants stated that they engage women in shared decision-making, providing them with evidence-based information about their options for labour and birth. They respect women's autonomy and preferences while ensuring they have the information they need to make informed choices about their care.

"We make sure to sit down with each woman and go through all the options available to her. We discuss the benefits and risks of each choice, and we always encourage questions. It's important for women to feel empowered in their decision-making process." - (Midwife 7)

"I provide women with the knowledge and support they need to make decisions that align with their preferences and values. Whether it's discussing pain management options or birth interventions, i listen, educate, and support women every step of the way." - (Midwife 19)

Subtheme 2: Monitoring labour progress with minimal intervention

The informants stated that they closely monitor labour progress using intermittent auscultation of foetal heart rate and regular assessments of maternal vital signs. They intervene only when necessary, prioritizing the physiological process of labour and minimizing unnecessary medical interventions.

"I make it a point to listen to the foetal heart rate regularly, but i don't rush to intervene unless there's a clear indication of distress. It's important to trust the natural progression of labour." - (Midwife 10)

"I keep a close eye on how labour is progressing but at the same time allow the

woman's body to do what it's designed to do." - (Midwife 11)

"I use intermittent monitoring to keep track of both the mother and infant's well-being, intervening only if there are signs of potential complications." - (Midwife 19)

"My approach is to monitor labour in a way that respects the body's innate ability to give birth." - (Midwife 25)

Subtheme 3: Creating a calm and supportive environment

Informants stated that they create a calm, supportive, and homelike environment in birthing facilities, conducive to promoting physiologic birth. It involved ensuring privacy and confidentiality for women during labour and birth.

"I make sure to keep the environment as serene as possible, with soft lighting and minimal disruptions. It's crucial for women to feel comfortable and relaxed during labour, so we prioritize creating a peaceful atmosphere." - (Midwife 22)

"Privacy is paramount during labour and birth. We ensure that each woman feels secure and undisturbed in her birthing space, respecting her need for confidentiality and providing a sense of safety and security." - (Midwife 25)

Subtheme 4: Providing continuous support

The informants stated that they offer emotional and physical support to women throughout labour and childbirth. This support helps women feel empowered and confident in their ability to birth naturally.

"...I provide hands-on support, like massaging the Rhomboid of Michaelis, counter-pressure, and guide breathing techniques. It's about using touch and words to help women cope with the intensity of labour and feel more in control of their bodies." - (Midwife 15)

"We're there for them...offering reassurance, encouragement, and a comforting presence. It's about creating a safe and supportive environment where women feel empowered to navigate the birthing process." - (Midwife 8)

"Our presence is constant, offering a steady source of comfort throughout labour and childbirth." - (Midwife 21)

Subtheme 5: Encouraging mobility and freedom of movement

Informants stated that they encourage freedom of movement during labour, allowing women to adopt various positions that are comfortable and conducive to the progress of labour such as walking, squatting, kneeling, or using birthing balls where available.

"I actively encourage women to move around during labour. Walking, changing positions, even swaying their hips—these movements can help them cope with contractions and progress labour more effectively." - (Midwife 2)

"Giving women the freedom to move as they wish during labor is crucial. Some women find comfort in standing, while others prefer kneeling or leaning over a birthing ball...it's about empowering them to find what works best for their bodies." - (Midwife 8)

"Using birthing balls and other aids can be incredibly helpful. When possible, i will provide a birthing ball to support and allow women to change positions easily, relieving pressure and promoting relaxation...that enhance their birthing experience." - (Midwife 17)

Subtheme 6: Utilizing non-pharmacological pain relief methods

Informants revealed that they employ a range of non-pharmacological pain relief techniques to help women manage discomfort during labour. These include massage, relaxation techniques, and breathing exercises.

"I often incorporate massage techniques, applying gentle pressure to specific areas to alleviate tension and promote relaxation. Additionally, I guide women through breathing exercises, encouraging slow, deep breaths to help manage contractions and maintain a sense of calmness throughout labour." - (Midwife 6)

"Breathing techniques are fundamental... i teach women rhythmic breathing patterns, such as the slow-paced breathing technique, to help them stay focused and manage pain during contractions. These techniques empower women to actively participate in their labour experience and enhance their sense of well-being." - (Midwife 27)

"I guide women through progressive muscle relaxation exercises, encouraging them to listen to gospel music to help distract them from the intensity of contractions." - (Midwife 13)

4. Discussion

The findings on midwives' perceptions of physiologic birth in Bayelsa State revealed a divergence between ideal beliefs and actual clinical practice. Many midwives conceptualized physiologic birth as spontaneous, vaginal delivery without intervention but acknowledged institutional realities that limit such practices. This perception aligns with studies by Shorey and Ng (2023) and Prosen and Krajnc (2019), which found that midwives often held strong philosophical support for physiologic birth yet struggled with structural constraints. Similarly, Sadeghzadeh et al. (2019) noted that while midwives believe in the benefits of physiologic birth, institutional guidelines and past adverse outcomes often deter its implementation. However, studies like Chen and Tan (2019) observed a more optimistic alignment between perception and practice among younger midwives, suggesting generational differences in adaptability. The divergence in Bayelsa may be due to the persistent dominance of medicalized training and limited exposure to supportive environments for natural birth.

The study also highlighted several enablers of physiologic birth, including women's preferences, midwives' confidence, and a supportive birth team. These findings echo those of Thompson et al. (2016) and Wong et al. (2017), who found that midwives were more inclined to promote physiologic birth when supported by collaborative teams and empowered decision-making structures. Carolan-Olah et al. (2015) similarly identified maternal preferences and teamwork as key facilitators. However, studies from more hierarchical systems, such as Matta et al. (2019), revealed that even when midwives felt confident, lack of institutional authority undermined their ability to act. This contrast suggests that confidence and preference alone are insufficient without organizational backing—an issue particularly salient in the Nigerian context where obstetric dominance persists.

Regarding barriers, midwives in Bayelsa reported limited autonomy due to restrictive hospital policies, inadequate antenatal education for mothers, and lingering effects of negative past experiences. These findings are consistent with Anna et al. (2020) and Darling et al. (2021), who cited centralized, obstetrician-led care and risk-averse hospital cultures as major barriers. Hadjigeorgiou and Coxon (2014) emphasized that gaps in training and institutional support prevented midwives from confidently advocating physiologic practices, aligning closely with this study's observations. In contrast, some studies in midwife-led environments, like those in Scandinavia (Sandall et al., 2016), documented significantly fewer institutional barriers, suggesting that the healthcare system's structure profoundly impacts practice. The disconnect between belief and practice in Bayelsa could thus be attributed to systemic issues rooted in policy, power dynamics, and lack of resources.

Theoretically, these findings validate the Health Belief Model (HBM) as an effective framework for understanding midwifery behavior. Constructs such as perceived barriers (institutional restrictions), perceived benefits (improved outcomes), and self-efficacy (confidence tied to training) were clearly observable. Studies by Glanz et al. (2015), Hodnett et al. (2013), and Reed et al. (2016) have applied HBM in similar contexts to explain healthcare behaviors, reinforcing its relevance. From a practice standpoint, the study underscores the need for comprehensive reforms: institutional policy should shift to support midwife-led models, antenatal education programs must be strengthened, and continuous professional development should target confidence-building in physiologic birth. Empowering midwives through systemic and educational interventions could bridge the gap between ideal and real practices, ultimately improving maternal outcomes across Nigeria.

5. Conclusion

This study explored midwives' perceptions, enablers, and barriers to the practice of physiologic birth in birthing facilities across Bayelsa State, Nigeria. Findings revealed that while midwives generally held positive perceptions of physiologic birth as a natural, empowering, and low-intervention process, their ability to implement it was often constrained by institutional policies, medicalized training, and hierarchical power dynamics. Although midwives demonstrated a strong belief in women-centered care and acknowledged the value of physiologic birth, systemic issues such as restrictive hospital protocols, inadequate antenatal education, and dominance of physician-led decisions created significant obstacles. Nonetheless, key enablers such as midwives' confidence, supportive birth teams, and respect for women's preferences enhanced the potential for physiologic practices when present.

The application of the Health Belief Model offered valuable insight into how constructs like perceived benefits, barriers, self-efficacy, and cues to action shaped midwives' behaviors. The study affirmed that addressing modifiable barriers and strengthening enabling conditions could bridge the gap between midwives' professional ideals and their clinical realities. The findings underscore the importance of context-specific interventions, particularly in regions with high maternal mortality and limited access to respectful maternity care.

By identifying these factors, this study contributes meaningful evidence to inform policy reform, midwifery education, and healthcare system strengthening in Nigeria. Empowering midwives with the tools, autonomy, and institutional support needed to promote physiologic birth can lead to safer, more satisfying birth outcomes for women, ultimately aligning practice with global standards for respectful and evidence-based maternal care.

6. Recommendations

In connection with the study findings, the following recommendations were made:

1. The Ministry of Health should develop and implement policies that empower midwives to lead birth practices and reduce unnecessary medical interventions by promoting midwife-led models of care.
2. The Midwifery Training Institutions should integrate physiologic birth modules into midwifery curricula and offer continuous professional development to build midwives' confidence and clinical skills in natural birth support.

Healthcare centres Facility Administrators should equip birthing units with supportive tools (e.g., birthing balls, foetal monitors) and allow flexible labor protocols to support women's birth preferences and enhance physiologic birth practices.

Conflicts of Interest

Authors declare that there is no conflict of interest

Funding

There was no funding for this research

Ethical approval and consent to participate

Approvals were obtained from the institutions and consent from participants

References

Adewuyi, E. O., Zhao, Y., Lamichhane, R., & Okere, R. A. (2019). Cesarean delivery in Nigeria: prevalence and associated factors—A population-based cross-sectional study. *BMJ Open*, *9*(6), e027273. https://doi.org/10.1136/bmjopen-2018-027273

Anna, P., Lindgren, H. E., & Christensson, K. (2020). Midwives' experiences of medicalised birth and their desire to support natural birth. *Women and Birth*, *33*(2), e129–e137. https://doi.org/10.1016/j.wombi.2019.03.005

Becker, M. H. (1974). The Health Belief Model and personal health behavior. *Health Education Monographs*, *2*(4), 324–473. https://doi.org/10.1177/109019817400200407

Betrán, A. P., Ye, J., Moller, A. B., Zhang, J., Gülmezoglu, A. M., & Torloni, M. R. (2021). The increasing trend in caesarean section rates: Global, regional and national estimates: 1990-2021. *PLOS ONE*, *16*(2), e0247334. https://doi.org/10.1371/journal.pone.0247334

Bohren, M. A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R. K., & Cuthbert, A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, *7*, CD003766. https://doi.org/10.1002/14651858.CD003766.pub6

Carolan-Olah, M., Kruger, G., & Garvey, D. (2015). Midwives' experiences of the factors that facilitate normal birth among low risk women at a public hospital in Australia. *Midwifery*, *31*(10), 1045–1051. https://doi.org/10.1016/j.midw.2015.07.008

Chen, Y., & Tan, K. H. (2019). Midwives' perceptions and experiences of using non-pharmacological pain relief methods for labouring women in a hospital setting: A qualitative study. *BMC Pregnancy and Childbirth*, *19*, 465. https://doi.org/10.1186/s12884-019-2622-0

Darling, E. K., Atanackovic, J., Smith, P., & Murphy, M. S. (2021). Midwives' experiences of barriers and enablers to the promotion of physiologic birth in hospital settings. *Women and Birth*, *34*(2), e121–e128. https://doi.org/10.1016/j.wombi.2020.01.011

Glanz, K., Rimer, B. K., & Viswanath, K. (2015). *Health behavior: Theory, research, and practice* (5th ed.). Jossey-Bass.

Hadjigeorgiou, E., & Coxon, K. (2014). In Cyprus, 'midwifery is dying...'. A qualitative exploration of midwives' perceptions of their role as advocates for normal childbirth. *Midwifery*, *30*(9), 983–990. https://doi.org/10.1016/j.midw.2013.09.004

Henshall, C., Doherty, J., Rawding, B., & Meedya, S. (2023). A qualitative study exploring women's experiences of midwifery care during physiologic birth. *BMC Pregnancy and Childbirth*, *23*, 1–10. https://doi.org/10.1186/s12884-023-05620-7

Hodnett, E. D., Gates, S., Hofmeyr, G. J., Sakala, C., & Weston, J. (2013). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, *7*, CD003766. https://doi.org/10.1002/14651858.CD003766.pub5

Leap, N., & Hunter, B. (2022). *Supporting women for labour and birth: A thoughtful guide*. Routledge.

Martin-Arribas, M. C., García-Mochón, L., & Carmona, R. (2022). Barriers to normal childbirth and facilitators for physiologic birth: A qualitative meta-synthesis. *Women and Birth*, *35*(4), e406–e415. https://doi.org/10.1016/j.wombi.2021.09.007

Matta, G., Braganza, A., & Hanrahan, M. (2019). Medicalization of birth and the crisis in midwifery: Reflections on a qualitative study of midwives in Nigeria. *Midwifery*, *77*, 1–8. https://doi.org/10.1016/j.midw.2019.06.002

McCourt, C. (2022). *Midwives and normal birth: Rediscovering the art of birth*. Routledge.

Prosen, M., & Krajnc, M. T. (2019). Intrapartum care: Knowledge and beliefs of midwives and physicians. *Midwifery*, *76*, 38–45. https://doi.org/10.1016/j.midw.2019.05.004

Reed, R., Garrett, C., & Anderson, S. (2016). Normal birth: Women's voices, midwives' insights. *Midwifery*, *36*, 41–48. https://doi.org/10.1016/j.midw.2016.02.013

Rosenstock, I. M. (1974). Historical origins of the health belief model. *Health Education Monographs*, *2*(4), 328–335. https://doi.org/10.1177/109019817400200403

Sadeghzadeh, A., Hashemi, S. A., & Ghavami, M. (2019). Attitudes and beliefs of Iranian midwives toward physiologic childbirth. *Journal of Obstetrics and Gynaecology Research*, *45*(1), 129–137. https://doi.org/10.1111/jog.13728

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*, *4*, CD004667. https://doi.org/10.1002/14651858.CD004667.pub5

Shorey, S., & Ng, E. D. (2023). Midwives' perspectives on promoting natural birth: A qualitative study. *Midwifery*, *120*, 103571. https://doi.org/10.1016/j.midw.2023.103571

Sim, J., & Waterfield, J. (2019). Focus group methodology: Some ethical challenges. *Quality & Quantity*, *53*(1), 3003–3022. https://doi.org/10.1007/s11135-018-0729-2

Thompson, R., Miller, Y. D., & Watkins, J. A. (2016). Perinatal care and the health of mothers and babies: A review of midwives' perspectives. *BMC Pregnancy and Childbirth*, *16*, 362. https://doi.org/10.1186/s12884-016-1131-7

Toohill, J., Sidebotham, M., Gamble, J., & Fenwick, J. (2017). A qualitative exploration of midwives' perceptions and experiences of providing continuous support during labour and birth. *Midwifery*, *45*, 1–6. https://doi.org/10.1016/j.midw.2016.11.007

Walker, C., Lannen, B., & Rossie, D. (2018). Barriers to physiologic birth: A qualitative study of midwives' experiences. *Journal of Midwifery & Women's Health*, *63*(1), 74–81. https://doi.org/10.1111/jmwh.12701

Wong, M. S., Choi, K. C., & Lee, L. Y. K. (2018). Midwives' perspectives of promoting physiologic birth in obstetric-led units: A qualitative study. *BMC Pregnancy and Childbirth*, *18*, 370. https://doi.org/10.1186/s12884-018-2027-0

Wong, M. S., Chan, Y. C., & Leung, D. Y. P. (2017). Barriers and facilitators to promoting physiologic birth in obstetric-led units: Midwives' perspectives. *Women and Birth*, *30*(1), 1–8. https://doi.org/10.1016/j.wombi.2016.06.005