Exploring Maternity Healthcare Providers' Perspectiveson Maternal Upright Positions during Second Stage of Labor: Qualitative Study

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Abstract

Background: The birth of the baby is an exceptional experience for the mother and the whole family. It is crucial that the women's opinions during maternity care are valued, especially during labor or childbirth, is a crucial factor inproviding respectful maternity care. **Aims:** This study aims to identify barriers to adapting an upright position during the second stage of labor in Madinah and what are the strategies necessary to overcome these barriers. **Methods:** A qualitative study was performed at Maternity and Children Hospital, Madinah (MMCH), Saudi Aribia, The study sample consisted of a non- probability convenience sampling of 18 health care clinicians. Data collection was done through face-to-face semi-structured interviews with the consenting healthcare providers. **Results:** The following core themes emerged: policy, safest way, doctors setthe rules, midwives' hesitancy to assume responsibility, uncooperative, uninformed women, and the way forward. **Conclusion:** This study concludes that irrespective of all the evidence supporting the upright position in the second stage of labor, many healthcare providers continue to practice the lithotomy position in accordance with the cultural and routine norms. Many healthcare providers prefer the lithotomy position for their own convenience, disregarding other birth positions as well as the women's preferences and desires.

Keywords: Upright position; Health care providers; Second stage oflabor; Qualitative

Introduction:

The birth of the baby is an exceptional experience for the mother and the whole family. The literature shows that women have positive childbirth experiences when they feel supported, valued, protected, and willing to engage in shared decision-making with their maternity health professionals **(Bohren, Tunçalp, & Miller, 2020).** Positive childbirth experiences consist of women's involvement as active agents who are fully capable of making their own informed decisions during childbirth **(Mselle & Eustace, 2020).** The World Health Organization (WHO) has provided essential disciplines, valuable discussion, and communications between women and health care providers in terms of birth positions and other relevant issues **(WHO, 2018).**

Valuing women's opinions during maternity care, especially during labor or childbirth, is a crucial factor in respectful maternity care **(Tunçalp et al., 2015).**Respect incorporates women make their own decisions **(Mirzakhani, Karimi, Mohamadzadeh Vatanchi, Feroz Zaidi, & Mirzaei Najmabadi, 2020).** Women should be encouraged and helped to adopt whatever birthing positions they find most comfortable throughout delivery **(NICE, 2014).** This has significant effects on women well-being and plays a vital role in ensuring that they are treated in a hospitality manner **(Bohren et al., 2020).** Women should be free and encouraged to choose their preferred position for themselves duringlabor and birth.

The birthing positions are affected by different factors like setting, caregiver preference, mother's choice, or medical intervention. All these birthing positions have got their advantages and disadvantages **(Singh, 2019).** However, there is a considerable body of scientific evidence on the effectiveness of adopting upright positions during labor such as sitting, using birthing stools, chairs, squatting, and kneeling (for example, Cochrane Library, ICM, and NICE guidelines, WHO database). Evidence is also emerging that many countries, including Saudi Arabia (SA), do not adopt essential beneficial practices and retain or adopt a lithotomy position, which is considered ineffective and harmful **(WHO, 2018).** Strengthening practice rests on applying an evidence-based approach, with the best available evidence stemming from research providing the basis for policies that guide practice.

Saudi Maternal Health Care

According to SA's Ministry of Health **(MOH, 2018)** there were a total 265,000 deliveries in MOH hospitals in 2018; which was a 2.6% increase from previous years. Normal deliveries constituted **70%** of the total number of deliveries and roughly 30% were cesarean deliveries. The last two decades in Saudi Arabia has seen a dramatic increase in the rate of cesarean section (CS) births and a higher maternal morbidity and mortality rate **(Alsulami, Ashmawi, Jarwan, Malli, & Albar, 2020).**

Maternal mortality ratio (MMR) refers to the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births. The MMR in SA in 2018 was 11.9 per 100000 live births. The neonatal mortality ratio (NMR) defined as the number of infants who die from birth to 28 days of life, was 5 in 1000 live births **(MOH, 2018).**

Current midwifery practices in SA

In SA, antenatal and postnatal care are mostly conducted in Primary Health Care (PHC) centers. Their management is in isolation from labor care and is not considered part of the woman and baby's total management. In labor care, midwives usually assist obstetricians, participate in labor procedures (e.g., pelvic exams, episiotomies), and assume sole responsibilities for the births of women categorized as low risk. However, obstetricians are the primary decision-makers and judge the need to use any drugs, including analgesia **(Altaweli, 2015).**

There are no home births across SA; women have been required to give birth within a hospital due to the advancement of technology and expansion of the number of hospitals. Currently, the midwifery workforce is vulnerable and under pressure nationally due to a shortage of midwives in SA **(Altaweli., Shaban, & Paine, 2020).**Consequently, many women were not received one to one support during labor and birth. Furthermore, a large proportion of these hospitals perform routine procedures and interventions, which either have no demonstrable medical benefit or may carry a risk or be harmful to women and their infants. A woman's individual health needs and preference have often been ignored. For example, most hospitals restrict mobility during labor, and nearly all hospitals adopted the lithotomy position for birth.

SA is trying to improve health care, where non-evidence-based practices are still used. The Saudi Ministry of Health launched the Mother and Baby- Friendly Hospitals Initiative in 2018 **(MOH, 2019).** The initiative aims to strengthen the role of a healthy maternity care model that respects a woman's health needs and choices, such as birthing positions that are most comfortable to her and recommending upright positions unless there are problems.

Problem Statement and Significance of Study

There is a scarcity of literature in SA about healthcare providers' perspectives toward upright position benefits. So, the findings from this study may add worthy information to the literature regarding adopting an upright position during the second stage of labor, attitudes toward the position, the skills required, the resources needed, the policies and the preference of midwives and physicians, social influences, and cultural influences will also be revealed.

The findings of this study may also increase policy makers' awareness towards enhancing and integrating the upright position and lead to sharing responsibility among community groups, healthcare providers, and health service institutions. This may **contribute** the development of a national policy to promote Saudi women's health and decrease maternal morbidity and mortality.

Research Question

There are numerous studies highlighting the evidence for adopting an upright position during childbirth and analyzing the perspectives of healthcare providers in Middle Eastern countries. This project investigates the status of midwifery care in SA, the adopting of birth positions during the second stage of labor; advocating for improved maternal health and calling for evidenced-based interventions. The specific research question was:

What are healthcare providers' perceptions about upright position during the second stage of labor?

Aim of the study

This study were to identify the barriers **of** adapting an upright position during the second stage of labor in SA, and the strategies necessary to overcome these barriers.

Methodology

Research design

A qualitative descriptive study face -to-face in-depth interviews was used to explore healthcare providers' perception towards adopting upright positions during labor. Qualitative studies use an emergent design that takes shape as researchers make ongoing decisions reflecting what they have already learned and desire to have the inquiry based on the realities and viewpoints of participants **(Polit. & Beck., 2017).**

Participants

A non-probability convenience sampling was used to explore perceptions of health care providers (obstetricians and midwives) regarding the use of upright positions during labor. The sample was consisted of midwives and obstetricians working in the maternity unit in a MMCH. To ensure that a broad range of health staff participated in the study; experienced staff with over 10 years' experience in the maternity ward, along with less experienced staff were recruited. The inclusion criteria were obstetricians and midwives who are:

- Qualified and registered in the Saudi health commission
- Working in the labor ward at least one year in their field, and

Setting

The study was carried out at Maternity and Children Hospital, Madinah (MMCH), Saudi Arabia. The MMCH hospital carries out about 15000 deliveries per year with 67% normal vaginal deliveries and 33% caesarean deliveries. The total number of midwives working in the labor word were 82; around half of them (no=40) have more than 10 years of experience (personal communication).

Data collection procedure

Data collection was done through face-to-face semi-structured interviews with the consenting healthcare providers. Interviewing is a well-known qualitative research technique, and can be structured, unstructured or semi-structured**(Polit. & Beck., 2017).**Interviews can be used to obtain data about people as well as to measure their opinions, attitudes, and beliefs about certain topics. A structured interview consists of asking the specific questions in the same order and in the same manner by a trained researcher. In contrast, a semi-structured interview is conducted as a standard conversation, with the interviewer/researcher directing the interviews until no new data emerges **(Polit. & Beck., 2017).**In this study, semi-structured face-to-face in-depth interviews with midwives and other health professionals were conducted to provide new knowledge of the perceptions and beliefs of health professionals caring for women during labor in Saudi Arabia**.** A qualitative approach encouraged the participating professionals to freely express their thoughts, beliefs, and perceptions around the use of upright positioning and to identify factors they believed influenced the context of current practice. A set of open-ended questions were developed to ensure that the participants would talk both broadly and more specifically about their practice and discuss the facilitators and barriers to the use of evidence-based positioning in the maternity unit. The following questions asked during the interviews: (1) Can you describe the policy for performing positioning during second stage in the hospital? (2) What is your opinion regarding the supine position? (3) What is your experience of assisting deliveries in alternative birthing position? (4) Can you please explain any obstacles encounter you when using alternative birthing positions? (5) What do you think should be done to promote alternative birthing positions? Other relevant information collected on participants were age; gender; professional; marital status, and educational level.

Interviews were conducted in a private area in the nursing development unit and short duration (no more than 30 minutes). Participants were contacted during business hours. The healthcare providers who responded were provided with information about the study and were given a copy of the information sheet (See **Appendix A).** Written permission was obtained from participants to be interviewed and audio-recorded (see **Appendix B).** All data were transcribed in the language they were spoken to and then translated into English by the researcher. The data was collected and then revised to allow new emerging issues to be included during transcription. Participants were added until saturation was reached, and no new essential meaning could be derived from participants' statements.

Ethical consideration

This study proposal was approved by the College of Nursing Research Ethics Committee at Taibah University TUCN-REC **(Appendix C)** and by the Institutional Review Board (IRB), General Directorate of Health Affairs in Madinah **(Appendix D).** The issue of confirming anonymity was addressed prior to the request to participate, Confidentiality and privacy were maintained by encoding data and eliminating identifiable information. Participants were also informed that if they had the right to leave from the research at any time.

The researcher had a laptop computer for data collection and all data was stored on the password-protected laptop. The electronic voice recordingsof interviews were transferred to the laptop computer and erased from the portable voice recorder. Any hard paper-based copies of data were stored in a locked filing cabinet in the researcher's office. The data will be stored for five years after data collection.

Data analysis

The qualitative data from the one-to-one interview was analyzed using thematic analysis. Thematic analysis is a repetitive process where concepts, categories, or themes are constantly refined through analysis. This process included many steps to analyze the data. First, the researcher organized and prepared data for analysis; this involved transcribing interviews (the form used for transcribed data is present in **Appendix-E**). The researcher read the whole interview transcript to obtain an overview and a general sense of the data. This reading process and listening to the recorder to understand was repeated for each interview. In this way, data was coded, grouped into concepts and preliminary themes, and labeled using terms based on the participants' language. Following the development of preliminary themes, the data was further coded in each theme, and links and relationships between themes were identified (Diekelmann, Allen, & Tanner, 1989). The process of theme identification was carried out independently by the researcher and her adviser. When discrepancies occurred, the researcher discussed and resolved them by consensus to ensure that the categories and subcategories were derived from the data and not imposed by personal beliefs or prejudgments. In reporting the results, direct quotations by respondents were used to illustrate the issues they expressed.

Rigor in qualitative research

This study was a qualitative study, and it is important to consider how rigor was maintained in all phases of data collection and analysis. Researchers may deal with the data in a variety of ways. Triangulations of data obtained by using of open-ended interviewing techniques; audio recording; and verbatim transcriptions to increase the accuracy of data collection **(Polit. & Beck., 2017).**The goal of rigor in qualitative research is to accurately represent the nature of participants' experiences. The theory of Guba and Lincoln (1989) wereused as a guide to address the issue of rigor in this study. According to Guba and Lincoln, there are four general criteria in judging scientific rigor for qualitative research, namely: credibility, transferability, dependability, and confirmability **(Guba & Lincoln, 1989).**

Credibility relates to the truthfulness of the findings judged by participants and others involved in the research. In this study, key findings were validated through transcriptions following each interview and used reflexively in the analysis to gain further insights and interpretations of the practice experience of midwives and others. In addition, opportunities to confer with my supervisor and other higher degree research candidates allowed me to refine my thoughts and convey experiences and insights gained through the process of inquiry.

Confirmability relates to 'the way in which the findings and conclusions achieve their aim and are not the result of the researcher's prior assumptions and preconceptions'**(Polit. & Beck., 2017).**This is achieved by revealing details of the research, including raw data (participant quotations), to demonstrate how the process of data analysis and synthesis has taken place.

Transferability refers to the faithfulness of participants' constructions of their world, and whether the findings can be applied to other contexts. In this study, transferability was achieved primarily by taking the preliminary findings back to participants in the feedback session, and secondly, by relating the findings to other studies conducted in the Middle East for example**(Altaweli, 2015; Hatamleh, Shaban, & Homer, 2013; Shaban, Barclay, Lock, & Homer, 2012; Shaban, Hatamleh, Khresheh, & Homer, 2011).**

Dependability refers to how well the researcher has developed and explained the research process. If this is achieved to a high standard, then another researcher or reader can follow the conclusions of the research. Dependability has been achieved in this research by providing the reader with adetailed description of all aspects of the research process, and clearly describing the methods taken to collect and analyze the data.

Results

In total, 18 healthcare providers were interviewed, including seven nurses\ midwives and 11 physicians. Participants were aged between 30 and 60 years, with a mean age of 37.6 years. Four of the participants were registered midwives and three double qualified with a range from 3 to 35 years of experience. Two out of the 11 physicians were consultants in the maternity unit, with the remainder (nine) being residents. This mix allowed for a sample with a variety of ages, experiences, and positions in the maternity unit to be interviewed. Details of the participants who were interviewed are provided in **Table 1.**

Six major themes emerged from the thematic analysis including: 'policy' (sub-divided into 'written but invisible' and 'the unwritten and assumed policy'), 'the safest way', 'doctors set the rules', 'midwives' hesitancy to assume responsibility', 'uncooperative and uninformed women' and 'the way forward.

The major theme is 'policy: written but invisible and unwritten and assumed' which describes the participants' perspectives on the development of the policies, and their beliefs about how the policies influence or direct current practice regulating the use of the upright position in the hospital. The following group of themes is related to factors that facilitate the adoption of lithotomy position as routine in the process of care. These were categorized as :

1. The safest way
2. Doctors set the rules
3. Midwives' hesitancy to assumed responsibility.
4. Uncooperative uninformed women
5. 'The way forward'

The last theme, 'the way forward' discusses the key strategies that midwives and other staff see as important in effecting change around adopting upright positioning during the second stage of labor .

The emergent themes are illustrated with quotations from participants. The actual words spoken by participants are identified using italics (or inverted commas). Each of the main themes is composed of several associated sub-themes that are described. The themes and sub-themes are presented in **Table-2.**

At the start of each interview all participants - midwives and physicians - were asked whether they were aware if the hospital had a policy related to type of position that must be adopted during delivery and if so, what that policy stated. What emerged from the analysis, however, was that there were in fact two policies – 'the written but invisible policy' and 'the unwritten and assumed policy'.

Written but invisible policy.

Some participants explained that a written policy was available to guide practice related to positioning; however, this policy was not easily sourced or even known to most midwives. The written policy focuses on the upright position as recommended by best practice principles or the evidence. However, this written policy did not provide any directions about how or when to use the upright position. A copy of this policy was kept on a shelf in the Nursing Development Unit and not disseminated to staff. Few participants in the study knew of its presence– hence the label, 'the invisible policy'.

"It is just a set of guidelines to deal with a mother's preference during birth; it is just like following steps to reach desirable outcomes". (Interview No 7, physician)

Several other participants indicated that they had heard about the policy but had never seen it.

"I remember that I heard about it once when one physician talked to another about the recommendations needed for the guidelines and guide workshop about that ". (Interview No 12, physician)

During the interviews, it became apparent that most participants were completely uninformed to this written policy that guide practice related to positioning; not only had they never seen it, but they were not even aware of its existence.

"I have no idea about this policy, and this is the first time I have heard about it". (Interview No 9, Midwife)

Unwritten and assumed policy.

The analysis revealed that the dominant policy that related to positioning was an unwritten one. This 'unwritten policy' dictated that all primiparous women require supine position without even assessing the preference of the mother. The same policy applied to women having their second baby but who had a caesarean section for their first birth. Participants appeared to rely almost exclusively on the 'unwritten and assumed policy' to guide their practice. This unwritten policy was viewed by participants as the 'real' policy, and it was evident that midwives and other healthcare providers viewed the unwrittenpolicy as though it were the approved policy to be implemented even in emergency cases.

"It has become a fixed attitude regarding each woman, and health staff consider it a formal policy that we should follow when working in the maternity unit". (Interview No 10, Midwife)

From the analysis, it was evident that more senior or experienced staff members played an important role in ensuring that new midwives and other staff were aware of this unwritten policy regarding lithotomy position.

"When I started working in the hospital, I was told that I should follow this policy and do what others do in the maternity care". (Interview No 3, Midwife)

Some of the participants interviewed explained that this 'unwritten policy' is a general policy that affects the practice in all hospitals throughout Saudi Arabia. It is widely believed that this practice offers optimal care for women during birth.

"It is widely used in all hospitals and all health staff are convinced of this procedure as the best way for a safe birth with few complications". (Interview No 15, physician)

Two kinds of policy that covered the adoption of lithotomy position were discussed in this study: the written policy and the unwritten. Although the formal 'written' policy was available to guide practices, it was not easily obtained or even clear to most midwives, whereas the second or 'unwritten' policy was in fact the one with which staff were familiar. As such, it was viewed as the 'real' policy. Healthcare providers have used these two kinds of policies in different ways. The written policy was used to present a front that the maternity unit was following evidence-based practice. Yet each group of healthcare providers believed the unwritten policy to be the 'safest way' for them to avoid unfavorable consequences.

The safest way

The second theme that emerged from analysis was the 'safest way'. This title is derived from the participants' own words. The theme 'the safest way' reflects the perceptions and beliefs of healthcare providers that adopting lithotomy position as a routine practice for women is the best and safest approach. Participants viewed the lithotomy position as the safest alternative for women. More importantly, however, adoption of supine position was viewed by physicians as the 'safest way' due to its suitability: the easiest option, it required less effort, and thereby reduced their workload. The theme 'the safest way' is reflected in three sub-themes, namely: 'it is better for the patient', 'the known way', and 'the easiest and most efficient way'.

It is better for the patients.

According to the participants, the primary reason for adopting the lithotomy position as a routine practice related to patient safety. That is, they believed it to be in the best interests of the patient. It was evident that most midwives viewed the childbearing woman as a sick person.

"We think that delivering pregnant women on lithotomy position it's better for mothers".(Interviews No 17,18)

Some participants stressed that women were accepting of the option of the supine position, and frequently requested it, since they believed that the position would prevent complications. Healthcare providers also believed that women's perceptions regarding supine position were culturally passed down through generations; the mother taught her daughter to ask for supine position, and so on.

"Women come and ask for supine position as her close friend told her about the benefitof having supine position during birth". (Interview No 5, physician)

The known way

Midwives and other participants used the phrase 'the known way' as a reason that they adopt the lithotomy position as routine practice. 'The known way' demonstrated that health professionals preferred to work in a way that was familiar to them rather than taking a risk by choosing an unknown method or a different practice. Working in a known way can make professionals feel more comfortable and secure.

"We fell into a habit; we feel more comfortable when we adopt lithotomy position rather than dealing with unknown complications". (Interviews No 3,9)

It was also identified that working with a well-known practice that is viewed as routine is more acceptable to staff than struggling with uncommon and unfamiliar practices.

"Undertaking familiar duties and experiences creates a stress-free environment". (Interview No. 6)

Initially, participants were asked to explain the reason for adopting the lithotomy position as a routine practice for primiparous women. In response, participants expressed their fears and concerns about unexpected outcomes during birth, such as perineal tears.

"Many physicians describe their concerns and anxieties about the probability of increasing perineal tears or any other complications during birth as we cannot do good support". (Interview No 13, physician)

The easiest and most efficient way

Some participants indicated that adopting the lithotomy position as a routine practice is also the easiest way to facilitate birth and requires less effort. They explained that time constraints, combined with receiving more than the expected number of women into the birthing unit concurrently, encouraged health professionals to adopt the lithotomy position to mothers as this was a familiar and therefore more efficient practice .

"Physicians may have multiple demands on their time and feel more pressure to accomplish a delivery as soon as possible". (Interview No 18, physician)

In summary, adopting supine position was viewed by all to be the safest way, and was accepted as the easiest thing to do, requiring less effort. It was also believed to result in better outcomes for the woman. It was evident that the less risky and better-known way was the path that was preferred by most healthcare providers.

Doctors set the rules.

In the interviews, I explored in greater depth with the midwives the justifications that were provided for continuing with a non-evidence-based practice. Questions and prompts were used, such as ‘tell me more about who determines that all women are required to maintain the supine position’. This encouraged participants to openly discuss the role of the doctors in the maternity unit. This theme also encompasses the sub-theme of ‘the stage is set’, which describes how the environment is prepared in a way that facilitates and creates the context of practice and promotes the supine position. This theme reflects the dominant role of doctors within the maternity unit. The view that ‘doctors set the rules’ emerged not only from data gathered from the doctors, but also from the participating midwives. These midwives also indicated that physicians have the authority to regulate the rules in maternity care, since ‘doctors know best’ based on their educational status and experience .

“I was told that physicians have high educational levels and are more experienced in dealing with major tasks, so they have the main responsibility in maternity care”. (Interviews No 3,10, midwives)

The stage is set.

This sub-theme illustrated the way in which the institution of the maternity unit; midwives’ and physicians’ practices prepared 'the stage' for the supine position. It was apparent during data collection that the way in which the delivery suite was set up was conducive for the supine position. The delivery beds are designed in a way that makes them suitable only for the lithotomy position during birth. Some of the participants interviewed indicated that there was no option to use optimal positions for childbirth in the hospital.

“The delivery beds are designed to suit just the lithotomy position, so if you want to use other birthing positions, you need to change all the beds in the delivery suite”. (Interview No 12, physician)

In summary, doctors influence the context of practice and in many respects, prepare the stage for adopting the supine position as routine practice. They also limit the responsibility that midwives can assume.

Midwives’ hesitancy to assume responsibility.

The theme of ‘midwives’ hesitancy to assume responsibility’ reflected the midwives’ fear of exposure to punitive action if they failed to comply with the rules. Consequently, this led to their hesitancy to assume responsibility for the care of women in labor and birth and reflected their perceived powerlessness. Midwives believed they had no choice; in addition, they were worried and hesitated to practice unfamiliar positions like the upright positions.

"*Midwives were not authorized to change the available policy or switch from lithotomy to an existing one". (Interview 1, Midwife)*

The concept of ‘safety’ was accorded a variety of meanings by different participants. One midwife interviewed used the phrase ‘to be on the safe side’ and stated that this reflected her perception that if she adopts lithotomy position for women, she would be ‘safe’. The theme of safety incorporated two sub- themes: ‘the protective way’ and ‘feeling powerless/ not confidence.

The Protective Way

The sub-theme ‘the protective way’ reflects the perceptions and beliefs held by midwives regarding the adoption of lithotomy position as a routine practice in birth care. Choosing to work with the system and in accordance with the 'unwritten policy' was considered a keyway in which midwives protected themselves against criticism from other healthcare providers as well as from mothers. Working against the system left midwives vulnerable to being blamed and punished for any adverse events; thus, midwives have learned to protect themselves by working within the ‘rules.

“*We must protect ourselves ... no-one will support us if something happens, so it is* *better for us to engage with the rules rather than face problems". (Interviews No 10,17)*

Feeling powerless/ not confidence

In this context, midwives were reluctant to take responsibility for decisions related to positioning. Midwives over many years had preference participating as an assistant in the birthing process, rather than assuming a more active role. Generally, they were either not trained to make decisions, or did not have the confidence to do so. Rather, they were accustomed to passively complying with doctors' orders:

"*I prefer to go away from any problems, I will not expose the patient to any hazards".(Interviews No 8,10,15)*

This theme reflected midwives choose to work in alignment with the system and in accordance with unwritten policy which considered as a way in which midwives could protect themselves against criticism from other.

Uncooperative and uniformed women

Some healthcare providers during interviews expressed that they prefer lithotomy position during birth rather than upright position because of uncooperative and uninformed women. Also, many healthcare providers verbalized that women only know and prefer the supine position.

"I am used to the supine position because all mothers want to be delivered on the backand refuse to change their positions". (Interview No 3)

Some healthcare workers thought that it prevents mothers' complaints because some mothers think that alternative positions are not good. According to interviewers, some healthcare providers said.

" Mothers always want to give births on their back; they do not have any education about other positions, and they would complain". (Interviews No 5,8,10)

Uninformed women

According to the participant, some women refused the upright position due to lack of knowledge as they did not hear about it before from women in their culture. Other women have false myths that if they changed labor positions serious complications may happen to them and their babies .

"Women have not heard before about the upright position and told me that I should not try it may harm me or my child ". (Interview No 1, physician)

Uncooperative women

The sub-theme 'uncooperative women' reflects the perceptions held by women and their cooperation to adopt the upright position during the second stage of labor. Many women refuse to cooperate in this position due to their beliefs and fear of pain or other complications. Healthcare providers reported that women refuse to cooperate in this position when they ask them to do it and may affect their satisfaction and relief of labor.

" Mothers told me I can't do this position it may be painful, and baby will fall down". (Interview No 6)

The way forward

Participants were also asked to identify strategies that could facilitate a change in positioning during childbirth. The way forward title is derived from the healthcare providers' own words. This theme explains the viewpoint and opinion of the healthcare providers about the strategies needed to improve the situation and adopt an upright position during the second stage of labor. These strategies are discussed in three sub-themes: educated staff, educated women, and staff readiness.

Educated staff

Most of the participants indicated that education was an essential requirement for medical staff to accept changing their practice, and to address the deep-rooted resistance to changing non-evidence-based practices. In this subtheme, healthcare providers emphasized the importance of undertaking scientific conferences and medical campaigns to teach the benefits of an upright position during the second stage of labor, and that this is the best way to implement evidence-based practice in relation to positioning during childbirth. Participants also believed that increasing the education of the healthcare staff about upright position might make women more confident of their advice about this position. A healthcare provider said during the interview:

"When healthcare providers are well educated about this position, [this position] can be used frequently with high confidence, without fear from any complication of this position and women will trust them". (Interviews No 3,5, 6,7,8,9, 11,14)

Educated women

Most participants described the need for a greater focus on educating pregnant women by running educational programs to improve their knowledge of pregnancy and the process of birth, and to familiarize them with various positions that may be adopted during the birth process. Some participants stated that current antenatal clinics are lacking in services, and that this adversely affects the quality of care.

"If women had good knowledge about the upright position, they will be more cooperative and will trust healthcare providers when they are asked to do so". (Interviews No,3,5,8)

"It is important to educate women about upright position to make it easier for healthcare providers ". (Interviews No 1,7,15)

In addition, participants also suggested that running educational classes atantenatal units would be a good idea.

Staff readiness

When participants were asked during the interviews about theirreadiness to change, a variety of responses were recorded. Most of the midwives were unwilling to even look at the idea of change. It was also identified during the interviews that motivation and encouragement from the key stakeholders such as managers and modifications on the birthplace can positively affect the change process.

"Staff should be encouraged to adopt the upright position and face potential complications". (Interviews No 6,13,14,17)

In this final theme, 'the way forward', I have discussed the key strategies that midwives and other staff see as important in facilitating change around the use of the upright position during childbirth. Staff education was viewed as a key path to accepting change and reducing the resistance to improvement. The need for a greater focus on educating women around the birth process was alsodiscussed.

Table 1. Participants' Demographic characteristic

		N	%
Gender	Female	14	77.8
	Male	4	22.2
Nationality	Saudi	12	66.7
	Non-Saudi	6	33.3
Age group in years	30-40	14	77.8
	41-50	3	16.7
	51-60	1	5.5
Educational level	Diploma	4	22.2
	BSc	8	44.4
	MSc	3	16.7
	PHD	3	16.7
Marital status	Single	5	27.8
	Married	13	72.2
Experience in years	<5	3	16.7
	5-10	6	33.3
	10-15	5	27.8
	>15	3	16.7
Specialty	Midwife	4	22.2
	Nurse/ Midwife	3	16.7
	Gynecologist	9	50.00
	Consultant	2	11.1

Table 2: Themes and sub-themes

The policy	• Written but invisible policy
	• Unwritten and assumed policy
The safest way	• It is better for the patient
	• The known way
	• The easiest and most efficient way
Doctors set the rules	• Doctors set the rules
	• The stage is set
Midwives' hesitancy toassume responsibility	• The protective way
	• Feeling powerless or not confidence
Uncooperative, uninformed women	• Uninformed women
	• Uncooperative women
	• Disembodied and disconnected women
The way forward	• Educated staff
	• Educated women
	• Staff readiness

Themes and sub-themes

'Policy'- 'written but invisible' and 'the unwritten and assumedpolicy.'

Discussion

The aim of this project was to examine the facilitators and barriers to evidence-based positioning practice in Madinah, including an exploration of healthcare providers' perceptions and beliefs around the use of the upright position during childbirth. This project also described the strategies that may be effective in introducing evidence-based practice in relation to positioning.

The analysis of interviews with staff showed the written policy that did exist was hidden too most. The study showed that a spoken policy dominated, one that had been passed down over the years by obstetricians and reinforced by most staff including midwives and doctors.

Additionally, the qualitative analysis demonstrated that doctors dominated maternity care practices in the hospital and were the ones who directed policy related to upright positioning and other practices in the maternity unit. Doctors' treatment of midwives as their assistants rather than care providers in the birth process was also highlighted in this study. In this highly medical environment, it was also clear that midwives were anxious and hesitant about making change to the existing positioning during childbirth practices.

The study also revealed that healthcare providers appeared to view women in a judgmental way, believing that they lacked specific knowledge and experience regarding the birth process. Women were viewed as weak and needing to be 'managed' by an expert.

Many cultural and social factors that inhibit the acceptance of practicing the upright position were identified in this study. The healthcare providers stated that the number of deliveries in the maternity unit led to a very heavy workload. This influenced both the current practices and the perceived opportunities for practicing change. However, the culture of the maternity unit was the main obstacle to the adoption of evidence-based practices during birth. Even the way in which the maternity unit was designed and how it was managed implied the routine use of the lithotomy position. The delivery beds were designed for the sole use of lithotomy position, and so all women were placed in that position to give birth.

Education was identified as the key factor. The study participants mentioned that the lack of ongoing educational programs for health staff as well and patients meant that many outdated practices and beliefs continued to be practiced. Healthcare providers believed that educational and medical campaigns to emphasize the benefits of the upright position during the second stage of labor would enhance women's confidence in this position.

The findings of this study indicated that the supine position in the hospital were not consistent with evidence-based practices and current international guidelines. International evidence supports the restricted use of the supine position, and this is reflected in policy statements and clinical practice recommendations such as in the ICM and NICE **(ICM, 2017; NICE, 2014)**. The evidence suggests that upright and lateral positions can have some advantages over supine positions. A meta-analysis that compared any upright or lateral position to the lithotomy position reported that non-supine positions had significant associations with fewer assisted births, fewer fetal heart rate (FHR) abnormalities, and fewer episiotomies, yet higher estimated blood loss rates ≥500 cc, and more second-degree lacerations **(Gupta, Sood, Hofmeyr, & Vogel, 2017).** Other researchers have demonstrated that upright positions are related to a shorter second stage of gestation, less surgical births, a healthier neonatal performance, and a more positive labor experience than typical supine or horizontal positions**(de C Williams, Fisher, Hearn, & Eccleston, 2020).**

The WHO **(WHO, 2018)**released guidelines for intrapartum care for a healthy childbirth experience and emphasized that women deserve to give birth in a comfortable and welcoming atmosphere where they are able to mobile and take various roles. A broad body of research suggests that allowing women to rotate and assume an upright position during labor results in a host of physical and psychological benefits for women, including a lower risk of caesarean section, improved agency and sense of control during labor, and increased satisfaction with the birth process **(Gupta et al., 2017).**

The findings of my research indicated that there were many barriers to implementing evidence-based positioning during childbirth, and moreover that these obstacles existed at both the institutional and individual level. Institutional barriers in this maternity unit included the current policy with limited capacity to develop and implement evidenced-based policy. This was impacted by high staff workloads and a lack of training and education in evidenced-based practice. Other researchers have identified that even where there is access to evidenced-based policy, implementation is frequently limited by a lack of resources, inadequate time, staff shortage, workload and being unsupported by key stakeholders **(Iravani, Janghorbani, Zarean, & Bahrami, 2016).** On an individual level, obstacles were a lack of midwifery preparation and acknowledging a lack of expertise. The midwives chose to work with the system (the unwritten policy), protecting themselves from criticism, blame, and punishment. Generally, they were either not trained to make decisions or did nothave the confidence to do so.

Strengths

Our study considered as a new study that open the gate for another studies. Data saturation was reached even though only 18 healthcare providers participated. Personal interviews offered an opportunity to objectively examine attitudes and expressed questions over the practice regarding different birthing positions.

Our study included healthcare providers from Madinah, Saudi Arabia. However, using a more diverse community of obstetricians and midwives, such as those with various ethnic and cultural backgrounds, revealed different viewpoints and strengths of this study. The perspectives and experiences of these participants have helped us get a better understanding of the attitudes and values of healthcare providers', the reasoning behind their clinical practice decisions.

Limitations

There were several limitations to this study. For one, there was a limited ability to analyses, discuss, and interpret the findings due to the qualitative nature of the data. The participants were all from one region of Saudi Arabia. There was the potential for responder's bias since participants were made aware that their interviews would be documented. Furthermore, the presence of the researcher during data collection—a necessity in most the cases of most qualitative research—could also have affected the participants responses. All measures were taken to ensure that the documentation remained anonymous, including how recordings were used and who had access.

Conclusion and Recommendations

This study concludes that despite all the evidence supporting the upright position in the second stage of labor and disfavoring the supine posture for its negative maternal and neonatal outcomes, many healthcare providers continue to practice it. This is due to cultural acceptance of the supine position and the daily routine practice of positioning all women in the lithotomy position. Many healthcare providers prefer the lithotomy position for their own convenience, disregarding the evidence-based practice in other birth positions. Therefore, we recommend the training and preparation systems for healthcare providers to focus on providing them with the expertise and updated evidenced-based teaching required to use alternative birth positions. In addition, healthcare providers are urged to stay up to date on new trends in the provision of alternate birth positions. Furthermore, it is important that obstetricians follow a woman-centered approach and collaborate with midwives to ensure that approach is practiced and followed while supporting women during childbirth.

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