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Research Article

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Perception of Women Toward Childbirth Positions Among Women on Postnatal Unit at Jimma Medical Center, South West Ethiopia: A Phenomenological Qualitative Study

Bikila Jiregna[1*], Tigist Demeke[2] and Enatfenta Sewmehone[2]

[1]Department of Midwifery, College of Health Science, Mattu University, Mettu town, Ethiopia
[2]School of Nursing, Institute of health sciene, Jimma University, Jimma town, Ethiopia

[*]Corresponding author
Bikila Jiregna, Department of Midwifery, College of Health Science, Mattu University, Mettu town, Ethiopia.

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ABSTRACT

Objective: To explore the perceptions of women toward child birthing positions among women on the postnatal unit at Jimma Medical Center, Jimma town, Ethiopia, in 2020.

Design: A descriptive phenomenological approach was employed among women from the postnatal unit and maternity care providers from the labor and delivery unit.

Setting: Jimma Medical Center, south-west Ethiopia

Participants: 40 study participants were selected purposively. 30 postnatal women were recruited for both an in-depth interview and a focus group discussion. From maternity health care providers, 10 health professionals were interviewed.

Results: This study involved 30 study participants for in-depth interviews and one focus group discussion with 10 participants. Regarding the variables influencing the use of alternative birth positions in the medical facility, responses were obtained from both women and medical professionals. The women were placed in common supine positions because they were ignorant of other birth positions, because they were passive in allowing themselves to be in the position that they preferred, and because medical professionals lacked the necessary knowledge and expertise to provide alternative birth positions.

Conclusion and Recommendations: The women were coerced to take birth positions against their will by healthcare providers. Thus, evidence-based alternative birth positions should be made available and implemented in order to enhance the practice of healthcare providers.

List of Abbreviations

ANC	:	Antenatal Care
ATLAS.ti	:	Archive for Technology, Life-World, and Everyday Language. text interpretation
BSc	:	Bachelor of Science
COREQ	:	Consolidated criteria for reporting qualitative research
EMDHS	:	Ethiopia Mini-Report Demographic Health Survey
GA	:	Gestational Age
G/P	:	Gravity and/or parity
HCP	:	Health Care Provider
IRB	:	The Institutional Review Board
JMC	:	Jimma Medical Center
OB/GYN	:	Obstetrics and Gynecology
Mdw	:	Midwifery
MSc	:	Master Science
PI	:	Principal Investigator
Prof	:	Professor
TBA	:	Traditional Birth Attendants
WHO	:	World Health Organization

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Keywords: Perception, Birthing Position, Woman, Jimma, Medical Center

Introduction

The maternal birthing position refers to the physical positions a pregnant woman may adopt during childbirth or the arrangement of her body parts in relation to the horizontal plane to give birth to a child during the second stage of labor [1,2]. It falls into two categories: horizontal (angle less than 45°) or vertical (angle greater than 45°) between the horizontal plane and the line connecting the midpoints of the third and fourth lumbar vertebrae [1]. Based on the work of François Mauriceauan, a French obstetrician from the 17th century, the position that is currently most commonly used in maternity units [3]. A primitive woman (uninfluenced by western civilizations) would attempt to avoid the supine position and assume various upright positions, such as standing, sitting, kneeling, and squatting. The positions naturally adopted by women in England during childbirth were described [4].

In order to facilitate maneuvers during delivery and to provide a view of the perineum, birth attendants often employ a half-supine position with the woman's leg supported by a support, rather than doing so for the woman's comfort or preference [5]. The left lateral birth position, sitting, squatting, and kneeling with hands and knees are among the alternative birth positions that women in Africa were clearly using prior to colonization. Pregnancy was frequently performed in these positions, usually at home [6]. As a result, the World Health Organization supported the adoption of different birth positions because they are linked to better outcomes for mothers and babies. However, a recent study found that women's preferred birth positions are not respected [7,8].

Numerous research works have demonstrated the benefits of one delivery position over another. Consequently, most women had a positive perception of different birth positions [9]. In contrast to a supine position, the Dutch women perceived that they experienced more intense labor pain when they were upright; however, two of them felt otherwise. Like this, two of the women in this study experienced labor pain that was more intense when they were supine as opposed to lateral [10]. The women in this study also claimed that their adoption of certain birthing positions during the second stage of labor in the medical facility contributed to their emotional wellbeing, fatigue, and difficulties with daily tasks [10].

Maternity health providers request that a woman open one leg to the side and the other leg to the other side while lying supinely on the stretcher, which further undermines her self-control and dignity [11]. This is in spite of offering alternative positions and respecting women's perceptions during the second stage of labor. Because the women felt their opinions about positions in terms of norms and culture were being disrespected, they chose to give birth at home in upright birthing positions with the assistance of traditional birth attendants [12,13].

Despite recommendations for alternative birth positions during delivery from national guidelines for maternal and child health and maternity care guidelines, it appears that Ethiopian women continue to give birth in the lithotomy birth position, regardless of their preference for positions and evidence-based medical precautions [14]. Thus, this study aimed to investigate women's conceptions of various birth positions as well as the reasons behind healthcare providers' refusal to offer delivery services at alternative birth positions.

Theoretical Framework

The need theory of Virginia Henderson lends support to this study. It demonstrated that the main function of nursing is to support the patient whether well or ill in carrying out those tasks that promote health, healing, or a peaceful end of life and that the patient would complete on his own given the requisite strength, determination, or knowledge [15]. The theory focuses on how important it is to guarantee the patient's autonomy in order to expedite their recuperation in the medical facility, as well as how nurses can assist patients in meeting their most basic needs. To fulfill the fourteen functions outlined in the theory, the client needs assistance from the community, culture, healthcare provider, and facility [15].

During labor and delivery, a woman's need to shift positions and hold them is directly related to this need. When it comes to choosing how to respond to pain, most women will move; this helps the baby find the best passageway through the pelvis and significantly reduces pain [16]. In order to shorten the length of labor, women should alternate between sitting, squatting, walking, standing, and lying down during and after labor. Because it necessitates fewer painkillers and surgical interventions to facilitate childbirth, this also lessens discomfort. When the mother assumes upright positions for childbirth, it primarily aids in the baby's descent, especially when viewed from the angle of gravity [17].

The theory emphasizes the fourteen elements that make up patients' and clients' fundamental needs. These elements demonstrate a comprehensive nursing approach that addresses the social, psychological, spiritual, and physiological elements that may conflict with labor positions [15]. The first nine are physiological needs, which include maintaining a normal body temperature, being safe from environmental hazards, breathing safely in a suit, eating and drinking in moderation, eliminating bodily waste, helping with mobility and maintaining desirable positions, and having unrestricted communication with others. The psychological capacities for worship, independent of religious beliefs, are the tenth and fourteenth, along with health and the utilization of easily accessible medical facilities. Working in a way that creates a sense of accomplishment is the eleventh component, which is moral and spiritual. The sociological elements, which specifically address occupation and recreation, comprise the twelfth and thirteenth components [15].

Methods and Materials

Study Area and Period

The study was carried out at Jimma Medical Center (JMC) from March 20 to May 20, 2020. The location of JMC is in Jimma town, 352 kilometers away from Ethiopia's capital, Addis Ababa. The world population prospects for the 2019 revision states that there are 128,306 people living in Jimma Town, while the population projection for 2014–15 stated that there are 3,090,112 people living in Jimma Zone overall. Southwest Ethiopia's only referral hospital is JMC. It offers a variety of services, including emergency, gynecological and obstetric,

physiotherapy, ophthalmology, and medical, surgical, and more. It also recently opened a reproductive health center that serves 15 million people.

Study Design

A descriptive phenomenological approach was employed to explore the perceptions of the women about childbirth positions at Jimma Medical Center.

Eligibility Criteria

A woman on a postnatal unit with the vaginal birth of an alive baby. The maternity health care providers who are in charge of the maternity unit and have at least six months' work experience in the hospital were eligible for this study. However, a woman of primigravida who had an instrumental delivery or suffered serious medical conditions and required obstetrician-led care was excluded. Additionally, a woman who was severely ill and unable to give responses during data collection was excluded.

Sample Size Determination

The adequacy of the sample size was attained when sufficient data had been collected so that saturation occurred and variation was both accounted for and understood. According to Polkinghorne (1989), for phenomenological studies, saturation means that no new or relevant data seems to emerge regarding a category, the category development is dense, and the relationships between the categories are well established [18]. The informants were selected purposefully. Among the 45 recruited participants, 40 of them were sampled when saturation was achieved. The saturation of data was identified because both the data collection and analysis were done simultaneously. After each data collection, there was transcription, reading, and re-reading to extract significant statements. Therefore, this process enabled data saturation easily.

Data Collection Instruments

The open-ended questions were preferred because they will provide a frame of reference for the participants' answers. Based on the research questions, probes and follow-up questions were used to gain an in-depth understanding and facilitate a focus group discussion on the topic of the study. Streubert Speziale and Carpenter stated that a descriptive method in the data collection of qualitative research is central to open-ended, unstructured interview investigations [19]. Accordingly, the interview guides were used to explore the views of a woman toward childbirth positions that were categorized under certain schematized areas, including: 1) factors affecting the use of alternative birthing positions; 2) the influence of birthing positions on labor, the health of mothers, and newborns; and 3) preparation with regard to different positions.

Data Collection Procedures

The data collection process was done using an in-depth interview and FGD guide with open-ended questions by principal investigator. The investigator was engaged with participants, posing questions in a neutral manner, listening attentively to participants' responses, and asking follow-up and probing questions based on the participants' responses. The interview was conducted face-to face and involved one interview with one participant at a time [20]. For each participant, the interviews were conducted in the range of 15 to 30 minutes, and FGD took 45 minutes with one moderator (PI) and one tape recorder. The interviews were conducted by researcher in translation to the local language, using the English version of the open-ended interview guide. Permission was obtained from participants for the audio recording of the interview guide.

All interviews were digitally recorded and transcribed verbatim by the investigators. In addition, short field notes were used for non-verbal (facial, head nodding, etc.) expressions as a means of data collection through active interaction with researcher-participants. The investigator held a debriefing session each day during the entire fieldwork, and the newly emerging probes were included in the emerging themes and guide for the next data collection [20, 21].

Operational Definitions

View/perspective is the way a woman perceives the effects of birth positions on labor, mother, and newborn [22, 23]. Birth position: is the position of the woman resumed at the time of birth (regardless of position during the first stage of labor) [2].

Data Processing and Analysis

The recorded data were transcribed and reviewed with audiotapes, and notes were taken on fieldwork. The verbatim data was translated from local languages to English and checked to maintain consistency. The data was imported from the Word document into ATLAS.ti Development GmbH software for analysis. The investigator used a thematic data analysis approach that looked across all the data to identify the common issues that recurred and the main themes that summarized all the views collected. It is based on prior categories, and the categories become clear to the investigator as the analysis proceeds.

Accordingly, the data analysis passed through the following different steps: The first step was organizing the data, in which the investigator became familiar with the data by reading the transcripts through literal reading (concerning the structure of the documents) and interpretive readings (in which the investigator synthesized and inferred the documents from their own words and meanings). The second step was generating the subcategories, categories, and themes by noting the patterns in the data. Then, the coding of data was followed to apply the categories to the documents as well as to enable examples of the data to be used in the write-up of the qualitative analysis. The fourth-step data analysis passed through was in which the investigator tested the emergent of the data and applied established theory. The final steps were to search for alternative explanations of the data and write reports. Lastly, the narrative texts, followed by participants' quotations, were applied around the themes. In addition, it is discussed within the triangulation of quantitative findings [24].

Data Quality Management

The interview guides were used based on information gained from the literature review and included open-ended questions and probes. It was prepared in the English language, translated to the local languages, and back-translated to English to maintain consistency. The interview guides were pretested on two women on the postnatal unit to ensure their relevance and appropriateness. The entire interview was recorded, transcribed, and translated into the English language. The consolidated

criteria for reporting qualitative research (COREQ) checklist, which includes three domains: research reflexivity, study design, and data analysis and finding, was used to guide the reporting of this study [25].

The various steps had been taken to ensure the trustworthiness of the data. To ensure the credibility of the data, the members of the study checked the interview responses to ensure truth-value from the participants' point of view. All participants were seen equally by using similar guides and approaches. Additionally, peer researchers were also engaged to reduce biases. The advisors and investigator had examined the documents and interview notes, as well as the products (findings and interpretations), and attested that these were supported by raw data to ensure the dependability of the data. Similarly, the transferability of the data was trusted by selecting the study participants purposefully from adequate and different types of respondents to assess the consistency and divergent responses that usually reflect individual differences, including women on the postnatal unit and maternity health care providers. In addition, the respondents were assured that the interviews were conducted purely for research purposes. The other is the conformability of the data, in preference to objectivity. Therefore, the oral recorded and the transcribed texts were compared to ensure their consistency and that the way and their interpretation were actual, similar, and not fabricated. In addition, the researchers bracketed consciously previous concepts and understandings in order to understand, in terms of the perspectives of the participants interviewed regarding the topic of interest in this study.

Results

30 women and 10 health care providers participated in an in-depth interview and focus group discussion. The results were presented under subheadings as follows:

Socio-Demographic Characteristics

20 women had in-depth interviews when 10 women had focus group discussions, and their ages were between 25 and 45 years. 10 women were literate, while the remaining 20 were illiterate. The women were mostly Muslim and orthodox followers (Table 1).

From health care providers, 5 professionals were interviewed from the labor, delivery, and prenatal wards: 4 BSc midwives, 3 diploma midwives, and 3 OB/GYN specialists. They were 6 males and 4 females, with ages ranging from 25 to 45 years. Their work experience ranged from 2 to 6 years (Table 2).

Table 1: The distribution of women's socio-demographic characteristics for in-depth interviews and focus group discussions at Jimma Medical Center 2020 (N = 30)

Parameter	Categories	Frequency	Percent (100%)
Age	25-30	10	33.3
	31-35	8	26.7
	36-40	6	20
	41-45	4	13.3
Educational status	Illiterate	20	66.7
	Literate	10	33.3
Religion	Muslim	10	30
	Orthodox	14	46.7
	Others	6	20
Gravidity and parity	<2 children	6	20
	3-5 children	20	66.7
	>5 children	4	13.3

Table 2: The distribution of health care providers' socio-demographic characteristics for in-depth interviews and a focus discussion group at Jimma Medical Center 2020 (N = 30).

Parameter	Categories	Frequency	Percent (100%)
Age	25-30	4	40
	31-35	3	30
	36-40	2	20
	³41	1	10
Sex	Male	6	60
	Female	4	40
Educational status	Diploma Midwifery	3	30
	BSc Midwifery	4	40
	OB/GYN specialist	3	30
Experience	<2yrs	3	30
	3-5yrs	5	50
	>5yrs	2	20

Women's Views Toward Childbirth Positions

As shown in the thematic index below, three major themes, including factors affecting the use of alternative birth positions, the effect of birth positions on labor, mothers, and newborns, as well as the required preparedness to use positions at the health facility, were identified. Respective to the identified themes, there were related subthemes, categories, and codes with a direct quotation from both participants, women and health care providers (Table 3).

Table 3: The construction of codes, categories, subthemes, and themes from the thematic analysis of women's views on childbirth positions at Jimma Medical Center in 2020

Codes	Sub-Categories	Categories	Themes
I don't know the disadvantages of the lithotomy position I have never seen or heard of alternative positions. I don't have a hint on the pros and cons of alternative positions. I rely on doctors decisions.	Mothers lack awareness. Women rely on HCP decisions	1.1 Factors for Women Who Visit the Maternity Ward	1. Factors affecting the use of alternative birthing positions
HCPs rejected our choice. I didn't have counseling on birthing positions. Women autonomy of birth positions	HCP abuses women's choice of positions No health information at ANC on positions	1.2 Factors from Health Care Providers at the Maternity Ward	
No chair or bed for sitting position I didn't practice alternative birthing positions. Not enough space in the ward	Lack of necessary skills and training Lack of equipment and facilities	1.3 Factors from Teaching Institutions	
Lithotomy delays labor Lithotomy loss effort of pushing down Lithotomy is comfortable to control the labor process. Lithotomy fasten labor Sitting shortens the duration of labor. Alternatives are not safe for labor.	Effect of lithotomy on labor Effect of alternative positions on labor	2.1 Effect of birth positions on labor	2. Effects of birth positions on labor and delivery
Lithotomy is painful, difficult to breathe, and depressive for the mother. Lithotomy hurt women's privacy and psychology. Squatting relief from the difficulty of breathing Alternative (sitting) lessens back pain. Sitting position is worse for women.	Effect of lithotomy on women Effect of alternative positions on women	2.2 Effect of birth positions on women	
Alternative positions decrease fetal distress. Standing injury baby Alternate positions safe for babies Lithotomy pose newborn for distress	Effects of lithotomy on neonates Effects of alternative positions neonate	2.3 Effects of birth positions on newborns	
Health information on positions Maintaining women's autonomy in birth positions choice HCPs should be trained and practiced in positions The hospital should provide all necessary equipment and materials for positions.	from health care providers from a health institution	3.1 As a teaching institution and health facility	3. Required preparedness to be improved for the future (HCPs and health facilities)

Factors Affecting the Use of Alternative Birthing Positions

Women in this study lack awareness about alternative positions, their advantages, and disadvantages during the second stage of labor to give birth. For example, there is a point forwarded by one woman that she gave birth in this hospital in a lithotomy position because she saw women giving birth in this position here in the hospital and had never seen or heard of alternative positions before being admitted to the delivery room.

"I haven't ever seen or heard of alternative birthing positions to give childbirth; what I saw was giving birth lying at supine by opening the legs apart on stirrups." (From Participant G1P1)

"As my concern, I don't know about alternative birthing positions rather than lithotomy." (From Participant G3P1)

"Now I have known nothing about other alternative birthing positions advantages and disadvantages." (From Participant G2P2)

Interestingly, the respondents from maternity health care providers confirm that women's lack of awareness about alternative positions leads them to stay passive about their preference and choice of birthing positions.

"Most of the time, we guide them in common positions (lithotomy). Because women lack awareness about alternative positions and are too shy and simple to accept our request, whether they like it or not."(from the participant OB/GYN specialist)

Another factor women forwarded was health care providers' ignorance of their feelings or needs toward resuming the positions of their preference. This happened to a few of them when they tried to use alternative birth positions while pushing down the baby. Especially, they had stressed the negative response from maternity health care providers to birthing positions that was mistreatment and disrespectful when they were on the delivery coach.

"I tried to attain another position (sitting), but the health care providers rejected me to resume back to supine positions (lithotomy), but the health care providers pushed me to the position they preferred." (From Participant G3P3)

"During my previous delivery, I used to give birth in other positions, but the HCP didn't give me the chance to use..." (From Participant G2P2)

"For example, I had tried to use a squatting position by getting off the delivery coach, but the doctor neglected to tell me to go back to bed." And the health care providers advise me only to give in the lithotomy position." (From Participant G3P2)

Maternity health care providers added another barrier to why they positioned women in a lithotomy position. They had thought alternative birthing positions were uncomfortable for both mothers and babies. Since lithotomy is common, they had practiced it, and they had never seen women giving birth in different positions in the health facility.

"As my thought positions out of lithotomy are not comfortable for health care providers and women..." (from a participant in BSc Midwifery)

"I had learned at school about alternative birth positions, but I had never seen on the ground (in a health facility) when women gave birth by their choice of positions, and similarly, I, as an HCP, didn't provide information." (from a participant in BSc Midwifery)

"In this hospital, women give birth in the lithotomy position as a common. This does not mean women don't need or prefer other positions. Standing from this here in our hospital, nobody is trained in alternative positions; it is not from women's needs but rather from health care providers' concerns. So we conduct the lithotomy position routinely." (From participant OB/GYN Resident)

Lack of preparedness of hospital set up, including chairs or beds, and enough space were other factors forwarded from health professionals for not giving birth in different positions. As it was responded from them, women need homelike care, which means free of any coercion and ensures their privacy toward birth positions.

"Here in our hospital, the problem of why we don't facilitate delivery at alternative positions was no prepared set up (delivery bed). The preparedness for even lithotomy is not home-like care (free of any dangers and privacy)." (from participant BSc Midwifery)

"There is nothing prepared for such positions, and... because without preparedness, the risk outweighs the benefit." (from participant OB/GYN Resident).

"As to my suggestion, the preparedness of the delivery coach in this hospital lacks the issue of privacy. It is good if the service of labor and delivery in this hospital should be home-like care, and if so, women will give birth to whatever positions they want." (from a participant in BSc Midwifery)

Effects of Birth Positions on Labor, Mother and Newborn

Women complain about the positioning (lithotomy) at the hospital for childbirth, which causes delaying labor and losing the effort to push when she feels pushing down. Similarly, health care professionals said that the lithotomy position has the risk of prolonging labor and weakening the pushing effort of mothers.

"The major problems of giving birth in lying to supine positions are labor, delays, and losing the effort to push the baby." (From FGD)

"But when they give birth at the lithotomy position, the complication is the weakness of the push-down effort." (from participant BSc Midwifery)

"Lithotomy position prolongs the duration of labor; it is also painful." (from participant OB/GYN specialist)

Seven women felt severe back pain when they gave birth in a lithotomy position. There were also other problems in which women didn't want to give birth in supine positions, including difficulty breathing, and exposed their genitalia to everybody's white-dressed personnel.

"When I was pushing the baby lying in the lithotomy position, there was a difficult backache; my breathing was in trouble, and it was my pleasure if someone supported me by raising my entire back to the sitting position." (From participant G2P2)

"Oho, it is my pleasure if you didn't ask me what happened to me. It was very painful and depressive, and I thought that would never come again, but it's forgettable. Ah, it was very difficult and painful." (From Participant G3P2)

"Hum, very difficult. There was no way in which I became confidential about my privacy when I was in the situation of pushing the baby by opening my legs. A lot of health care providers saw me naked. In addition to being in terrible pain, I felt discomfort at the situation that happened being naked." (From participant G3P3)

Similarly, maternity care providers shared the problems women encountered that their lithotomy position threatened them, causing lower limb numbness, severe back pain, and fatigue (loss of effort to push) when they lied to the delivery coach.

"It is also painful, worse than giving birth in a sitting position." (from the participant OB/GYN specialist)

"But when they give birth in the lithotomy position, complications—numbness of their entire legs—will happen. Again, most of the time, women complain about the difficulty of getting on the coach." (From Participant BSc Midwifery)

As the majority of women weren't satisfied with the lithotomy birthing position, there were also women and health professionals who wanted the lithotomy position for different reasons, including comforting the baby and health professionals, controlling labor, and fastening delivery.

"So giving birth in the lithotomy position is beautiful, even though it has a bit of stress. It is comfortable for health care providers; it also fastens the labor while others don't take comfort." (From FGD)

"I gave birth in supine (lithotomy) positions. It is better than other positions; it is safe for me as well as for a baby." (from participant G2P1)

"The advantages of the lithotomy position are obvious; it is comfortable for both mothers and health professionals, and especially to control the labor process." (From Participant BSc Midwifery)

From women respondents, though more than half of them didn't know the presence of alternative birth positions, surprisingly some women prefer other positions to give birth due to multiple reasons, including being easy to give birth, lessening backache, and fastening labor.

"It was better to give birth in a sitting position since it relieves me from back pain and the child will deliver soon, but the health care providers pushed me to resume." (From Participant G3P3)

"It is not so bad to give birth in alternative positions; the point is to give birth in a way that is comfortable and easy for the mother." (From Participants G2P1)

Maternity health professionals also suggested that the advantages of alternative birthing positions outweigh the lithotomy position in terms of fastening the second stage of labor and minimizing the rate of episiotomy.

"...Giving birth in a sitting position that fastens the duration of labor as well as relieves back pain." (From FGD)

"In my suggestion, childbirth in the sitting position might shorten labor in terms of gravity and reduce genital trauma... So it is better if sitting positions are put to practice." (From Participant BSc Midwifery)

Nevertheless, there were health care professionals who claimed alternative birth positions that compromised the newborn breathing system and led to fetal distress. Three women also reflected that different birthing positions cause more negative outcomes for a newborn than a common childbirth position (lithotomy) at the hospital, including injury to the baby and changing fetal presentation.

"If a woman gives birth in a sitting position, it will compromise her breathing system and result in newborn bradycardia." (From Participant BSc Midwifery)

"For example, most of the time there was a situation in which women challenged HCP to get off the bed (coach) to give birth in a squatting position that was difficult to control the further complications (extension, genital laceration)." (from the participant OB/GYN specialist)

"But others like the sitting position, which looks worse at changing fetal presentation and compromises the fetal breathing system." (from participant G2P1)

The Preparation with Regard to Birthing Positions

Women of more than eight responded by stressing the need to have a clear understanding of alternative birth positions. Especially when a woman comes to visit a health institution, she should have been informed either during antenatal care or during labor and delivery of birth positions.

"So, HCPs should have informed us of alternative birthing positions from which one has a greater benefit than others because we (women) may have a different need for the positions to give birth, so it should be according to our choice in addition to what the health care provider recommends." (From FGD)

"...so that it is good if we have a better understanding of the present options for the position that could be safe for mother and newborn." (From Participant G3P1)

Similarly, health care providers supported the thought that women should have a better understanding of birth positions, including their advantages and disadvantages for mother, labor, and newborn.

"Ohoo...from the beginning, information about birth preparedness could be addressed to the clients in addition to alternative birth positions." (From FGD)

"If possible…women should have all necessary information about birth positions and their consequences." (from participant OB/GYN Specialist)

The preparation of health facilities set up for women giving birth in alternative positions was also another point forwarded from women and maternity health care providers: that it could be homelike care and ensure the privacy and autonomy of clients and patients.

"There is no problem so far, but if health facilities and health care providers prepare for other positions because a woman needs home-like care," (from participant G2P1)

"As to me, it is better if the delivery bed could be enough support for a woman to assume a sitting position." (From Participant G2P2)

"As to my suggestion, the preparedness of the delivery coach in this hospital lacks the issue of privacy. It is good if the service of labor and delivery in this hospital should be home-like care, and if so, women will give birth in whatever positions they want." (From Participant BSc Midwifery)

As there were women who needed health facilities and should be prepared enough for alternative birthing positions, nevertheless, there were also women who needed everything to be continued as it is.

"As to me, this position is safe; let it continue as it is." (From participant G4P3)

"What I'm going to leave a message is that it is enough to give birth at home since the government makes everything available and suitable and lets it continue as such." (From Participant G3P3)

Lastly, health care professionals need to scale up their knowledge and skills through training on how to conduct childbirth in alternative birthing positions.

"Training for health care providers on how to give birth in an alternative birth position should be my suggestion." (From Participant BSc Midwifery)

"I had learned about different childbirthing positions, but since then I have never seen women deliver in alternative positions. Why it doesn't work in practice is also a question for me. So it is good if health care providers receive training. (From Participant BSc Midwifery.

Discussion

The quality of maternal and newborn care guidelines demonstrated three useful categories for all women who are expecting a child: the first is the midwives' provision of health education (information); the second is the midwives' promotion of normal labor processes to prevent complications [26]. However, in this study, most women reported that they had not discussed childbirth positions with their healthcare providers, either during prenatal care or during labor and delivery. This finding is in line with a study conducted in Tanzania, wherein information regarding birthing positions was not routinely included in antenatal health education, even though some postnatal mothers were aware of it [27].

In the second stage of labor, however, the maternity health care providers at the Michigan labor and delivery unit once mentioned (discussed) birthing positions. Frequently, when the second stage of labor extended, they talked about birthing positions and provided various alternative positions [28]. This disparity might result from medical facilities' lack of readiness and their staff members' deficiencies in terms of knowledge about different delivery positions.

According to this study, medical professionals believed that the alternative birthing positions would not be safe for the mother, the fetus, or the labor process itself. Furthermore, they believed that since they had never had any experience managing women in the alternative birth position, they lacked the necessary skills at the hospitals or educational facilities where they were employed. This study bears similarities to one conducted in Tanzania, wherein midwives failed to support women's autonomy in choosing their birthing positions and lacked the necessary skills to enable them to occupy positions that would be appropriate for them [29]. This is also in line with a Tanzanian study where nurse-midwives did not encourage or help women to use different birthing positions because they were unaware of them themselves [27].

In this study, women acknowledged the advice of health professionals even when they were aware of other options and their own preferences for giving birth. In the same way, a majority of the female participants expressed confidence that medical professionals understand them and don't harm them. This is comparable to a Dutch study that found women value health professionals' recommendations over their personal preferences [10].

The women are positive about health care professionals who are supportive, friendly, polite, and who stay close to their needs [30]. In this study, however, women asked to be positioned in the positions of their choice because they were dissatisfied with the responses they received from medical professionals when they were in the delivery coach or bed. One woman reported, for example, that she asked to be left alone by the healthcare provider so she could give birth while squatting, but the provider disregarded her request. This is comparable to a study conducted in Nigeria where medical professionals ignored her wishes and collaborated with her spouse to implement the positions against her will [29].

The World Health Organization suggested in the 1990s that obstetric procedures be divided into several groups based on risk, efficacy, and efficiency, as supported by scientific data [7]. As a result, category B health care providers in this study were condemning women to passivity by taking away their autonomy and using their power to enforce a common and traditional birthing position (lithotomy).

The lithotomy position is linked to adverse outcomes for both the mother and the infant, such as asphyxia at birth, maternal hypotension, prolonged labor, decreased fetal oxygenation, and inhibition of fetal descent [31]. Similarly, the lithotomy position is painful, depressing, delays labor, loses the effort of pushing down, and compromises the breathing system, according to some women and most medical professionals surveyed for this study. In a similar vein, a Dutch study revealed that labor pain, exhaustion, and back pain were more severe for women who gave birth supine [10]. According to a previous study conducted in three regional states of Ethiopia, giving birth in a supine position was against the customs and norms of a society where every white person in an institution or hospital would see a woman's reproductive organs in their nude state [32].

However, despite its convenience in controlling the parturition process, some women and medical professionals thought that the lithotomy position was safe for both mothers and babies. Similar findings were found in a South African study where midwives preferred lithotomy for its easy labor monitoring, good view of the perineum, and ability to reduce physical strain on them during childbirth [33]. Likewise, supine positions were considered the safest, most convenient for the accoucheur, provided greater access, and allowed nurse-midwives in Tanzania and Nigeria to effectively control the delivery process during the second stage of labor [27,34].

Some of the women in this study felt that different positions, such as sitting, were safe for a variety of reasons, such as making childbirth easier, relieving back pain, and reducing the need for undue exertion when pushing the baby down. This result is consistent with the research that shows how different birthing positions can facilitate labor by allowing the body to function normally and by taking advantage of natural forces like gravity and the laws of nature, which are linked to the best outcomes for both the mother and the fetus [35-40]. It also resembles a study

conducted in Nijmegen, Netherlands, where women who were in upright positions during the second stage of labor felt more in control of their pushing, were less exhausted, and had relief from back pain [23].

According to this study, women expressed a significant need for health education regarding birthing positions either during their antenatal care follow-up or during their labor and delivery admission [41-45]. This study bears similarities to one conducted in 2002 in Nijmegen, Netherlands, where women felt that midwives' knowledge of birthing positions was crucial during their clinic visit [23]. Finally, by receiving training on how to manage women in various childbirth positions during their second stage of labor, health care professionals involved in this study need to expand their knowledge and abilities [46]. In a similar way, a Nigerian study revealed that every health care provider surveyed indicated a desire for additional training on the application of different birth positions for their clients' futures [34]. Using a baseline for subsequent research was a novel approach taken by this study, making it a strong point. The data was gathered, nevertheless, during the 2019 COVID-19 pandemic, which affected both the country and the world [47].

Conclusion

In general, women and maternity health care providers shared important information about what influences the use of different birthing positions in medical facilities. These included women's ignorance of different birthing positions, women's apathy to respecting their choice of birthing position, and the lack of alternative positions by medical professionals. Several women in this study expressed dissatisfaction with their position (lithotomy) upon returning to the hospital for a variety of reasons, including the fact that it hindered their ability to push the baby, prolonged labor pain, and compromised their breathing system.

Furthermore, medical professionals emphasized that women believe that having a lithotomy puts them at risk for poor outcomes for both mother and child. Some mothers and medical professionals, however, disagreed of alternate birthing positions for a number of reasons, such as harm to the unborn child and inability to regulate the labor process. In addition, the study's healthcare providers denied women's rights to information, autonomy, and their preferences regarding childbirth positions, as well as non-consented services. In this specific study, one example of the disrespectful care and mistreatment women experience today is this, despite the fact that women depend on everything to continue as it is.

Recommendations

We are forwarding the following recommendations in light of the findings; Health care providers should use various teaching resources (posters or pamphlets) to educate expectant mothers about all birth positions and increase their knowledge and proficiency in using alternative birth positions through appropriate training. More research should be done to determine the ideal position for delivery because the birth position is a current issue.

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Ethical Consent

Ethical approval was given by the Mattu University Institutional Review Board. The data collectors explained the purpose of the study to the participants. Information was gathered after verbal consent from each participant was ensured. The study granted its participants the liberty to withdraw from participation at any point in time and the chance to pose any inquiries they might have about the investigation. All other participant information was kept confidential, including their names.

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