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Promoting Alternative and Evidence-Supported Birthing Options in Healthcare Facilities

Ashley Johnson Ross
Gardner-Webb University, ajohnsonross@gardner-webb.edu

Promoting Alternative and Evidence-Supported Birthing Options in Healthcare Facilities

by

Ashley V. Johnson Ross

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Submitted by:	Approved by:
Ashley V. Johnson	
Ashley V. Johnson Ross	Erin Montgomery, DNP, RN, CNE
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Abstract

The project examined the standard birthing process for low-risk, natural labor, and births at healthcare facilities. All deliveries should not be treated the same with the supine-lithotomy birthing position or over-medicalized, obstetric practices, as evidence-based research advises against such practices. The goal of the project intended to deviate from standard birthing practices and implement alternative, evidence-supported birthing options at healthcare facilities. The goal of promoting alternative, evidence-supported birthing options in healthcare facilities by maternity staff, would come after thoroughly educating maternity staff and providers with intel and benefits affiliated with alternative birthing options. Evidence reveals alternative birthing options, such as upright birthing positions, shorten labor duration and facilitate the natural process of vaginal births. Properly educating maternity staff to promote alternative birthing options, supported by evidence-based research, for low-risk, natural births, will improve patient satisfaction scores as evidence suggest mothers preferred a birthing experience with minimal obstetric and medical interventions.

Keywords: birthing positions, alternative birthing options, midwives, obstetricians, supine-lithotomy, maternity education, & patient-reported outcomes

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Table of Contents

List of Figures

List of Tables

CHAPTER I

Introduction

Healthcare is a significant part of pregnancy, especially during labor and delivery. Adequate preparation paired with research and insight allows for a smoother process during the labor and childbirth experience. Birth plans welcome pregnant women to express their wishes and expectations about childbirth and relate to a more natural process of birth with less interventions and offer improvements in the welfare of the mother and newborn (Hidalgo-Lopezosa et al., 2021). During the planning of birth, healthcare providers and the mother should agree on appropriate birthing options suitable for the mother's wishes and achievable by the provider and supporting staff. The use of epidurals, systemic opioids, or grounds for cesarean sections should also be discussed prior to delivery, and during the birth plan. For the intention of this project, the focus population was pregnant women, with low-risk pregnancies, opting for a natural birth.

In regard to childbirth positions, western medicine practices have had a huge influence on other countries. Epidurals and cesarean sections are due to western medicine's influence, women from various countries have shifted away from upright birthing positions, despite evidence supporting upright positions as more beneficial to the woman and the unborn child, than supine-lithotomy position (Mselle & Eustace, 2020). De Jonge et al. (2011) state upright birthing positions are "defined as supine lateral (45 degrees from the horizontal), sitting, birthing stool, standing, squatting, hands and knees, bath, and other" (p.243). Mselle and Eustace (2020) reveal how women used ropes and trees for extra support and strength to push the baby with sufficient force. A study was conducted through a questionnaire composed of two phases asking mothers, midwives,

and obstetricians about their views and experience in Nigeria regarding the use of upright positions during birth and the perineal outcomes. Phase one revealed the supine-lithotomy position was utilized most and selected primarily by the midwife or obstetrician. Phase two discovered mothers felt less in control during their birth and risked obstetric practices being performed. According to Diorgu and Steen (2018), the supine-lithotomy position is the standard practice for childbirth, and has been accepted without consideration for the physiological or psychological consequences of the woman or the baby. Healthcare facilities promote the use of the supine-lithotomy birthing position because it is seen as the best-known and most practiced birthing position. This position is preferred due to the flexibility it provides for continuous monitoring of the mother and baby, the progress in labor, and it assists the midwife or obstetrician in delivering most efficiently (Mselle & Eustace, 2020).

Diorgu and Steen (2018) mention how the experience of childbirth can have profound effects on women due to the permanent, positive, or negative impacts. Even after 15-20 years, women reported having satisfying birthing experiences which contributed to their overall self-esteem and self-confidence (Diorgu & Steen, 2018). According to Melton (2013), the core principle of prenatal and perinatal psychology and health is that we are all conscious, sentient beings when we come into life. With the mother and baby as a priority, healthcare providers can be consciously involved by allowing the mother to select the birthing position or assist her in selecting a position recommended by evidence. These implementations will improve client satisfaction in healthcare, especially as positive, long-term, psychological outcomes are increasingly recognized as important aspects of quality care (Diorgu & Steen, 2018).

Problem Statement

A problem arises when women are not given a choice and are recommended to deliver their baby in a position that is not comfortable or evidence supported. This can be seen as unethical because a women's autonomy is restrained if the birthing position is solely chosen by the healthcare professional, benefiting only that individual. It is essential healthcare facilities welcome alternative birthing positions and incorporate evidence-supporting birthing options to ensure quality care.

Significance

Evidence supports upright birthing positions due to several physiological reasons. An upright position aids the uterus to contract more efficiently which permits a better angle for the baby to pass faster through the pelvis. Healthcare providers must acknowledge gravity-dependent positions allow pelvis flexibility and extend to pelvic outlet (Berta et al., 2019). Gravity assists the mother during labor and birth if she is positioned upright which encourages the baby to descend through the birth canal. Diorgu and Steen (2018) also mentions squatting positions produce an increase in the anterior-posterior and transverse pelvic outlet and how evidence supports women to adopt a hands-and-knees position which allows for better coping with labor pains.

Women are vulnerable during delivery and put their trust in medical professionals. They become less in control of their birthing experience, especially if they are first-time mothers. Healthcare providers should encourage women to have confidence in their birthing choices and explain the benefits of other birthing options. It can be debated whether upright birthing positions empower and facilitate communication between a

woman and the medical professionals at an increased equal level during labor (Diorgu & Steen, 2018).

On the contrary, studies have shown the supine-lithotomy position is associated with numerous negative consequences. Diorgu and Steen (2018) state the following:

> This position promotes loss of control, narrows the pelvis, and makes it difficult for the baby to descend in this position, the angle of the sacrum tilts forward and the pelvic outlet is reduced which can also result in damage to lower extremity nerves. Furthermore, the weight of the fetus compresses the vena cava, thus lowering maternal blood pressure and reducing placental blood flow. Perineal trauma includes a range of injuries, from minor mucosal grazes to third- and fourth-degree tears involving the vaginal wall, perineal muscles, anal sphincter, and rectal muscle. (p. 95)

Another negative consequence associated with the supine-lithotomy birthing position healthcare facilities need to consider is perineal trauma from spontaneous tears and episiotomies. Although perineal tears and episiotomies are inevitable in certain situations, Huber et al. (2021) discovered “approximately 80% of primiparas suffer from perineal lacerations, an estimated 40-50% of lacerations involve the perineal muscles, and up to 7% of these women suffer from severe obstetric anal sphincter injury (OASI)” (p. 1). Women’s quality of life, their motivation to procreate, and their psychological and physical health can all be negatively affected by perineal trauma.

Purpose

The purpose of this project was for healthcare facilities to become educated on alternative, evidence-supported, birthing positions to effectively promote and educate clients on alternative birthing positions backed with evidence, the client feels most comfortable with; as opposed to allowing the healthcare provider to select, which is commonly the supine-lithotomy position. Research reveals upright birthing positions are more beneficial for the mother and baby. The supine-lithotomy position is not supported by research and shows decreased benefits for the mother and baby; however, it is the most common birthing position practiced in healthcare facilities. The goal of the project was to encourage healthcare facilities and professionals to promote alternative birthing options supported by evidence, by educating healthcare providers about their benefits and how to implement the options during the birthing plan and birthing process.

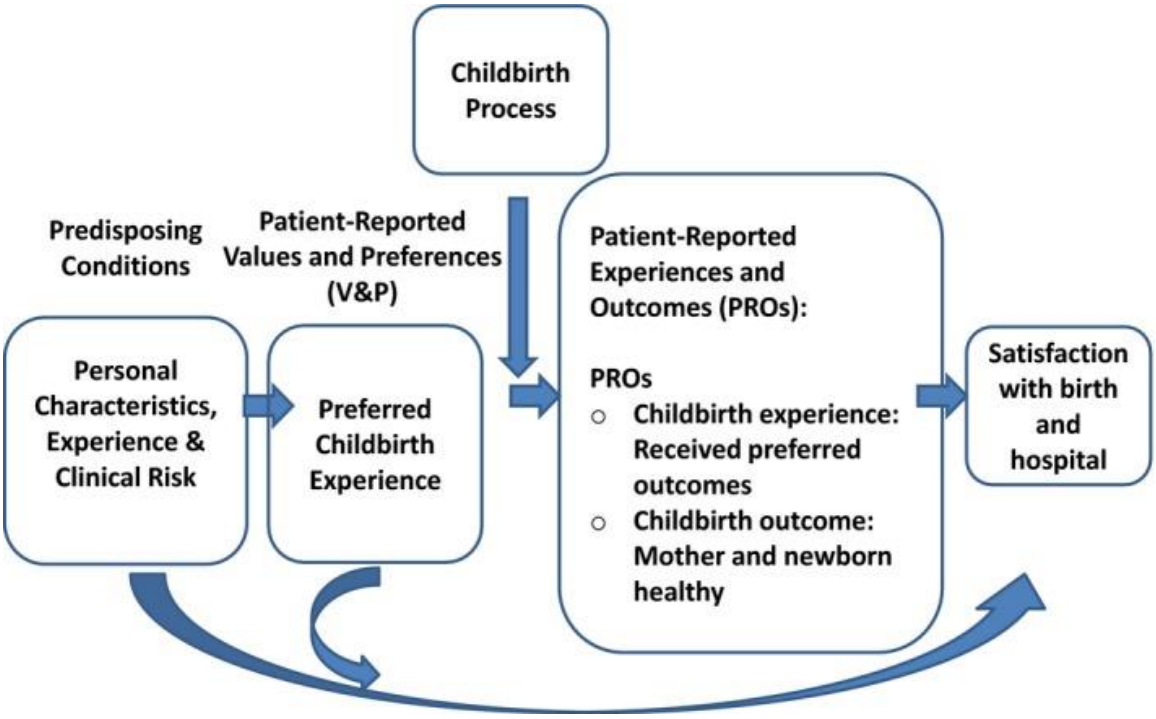
Theoretical or Conceptional Framework

Korst et al. (2018) created the conceptional framework for determining patient-reported outcomes (PROs) in childbirth and is an advanced conceptual framework built on the patient-reported outcomes measurement information system (PROMIS) guidelines and includes various theoretical guidelines regarding health expectations, service preferences, health seeking-information, satisfaction, patient-centered and childbirth outcomes. In addition, Korst et al. (2018) reveal the framework also follows Andersen's Behavioral Model of Health Service Use, which is a conceptual model aimed at demonstrating the factors that lead to the use of health services. The conceptional framework for determining PROs in childbirth relates to this project by considering the pre-disposing conditions such as the client's experience in childbirth and the client's reported values and preferences for their preferred childbirth experience, to achieve

positive PROs. Healthcare facilities can expect these positive outcomes if they promote services that are client-focused, and evidence-supported. This framework implies although PROs have been the focus of quality improvement efforts, values and preferences may be equally or more important in predicting the overall patient experience of childbirth (Korst et al., 2018). Figure 1 illustrates the various components of the conceptual framework for determining PROs in childbirth.

Figure 1

Conceptual Framework for Determining Patient-Reported Outcomes (PROs) in Childbirth



Definition of Terms

- **Assisted vaginal birth**. O'Brien et al. (2018) define an assisted vaginal birth as a vital health intervention with an instrument (forceps or ventouse) that can result in better outcomes for mothers and their babies when complications arise in the second stage of labor.
- **Autonomy.** An autonomous human being is a fully independent, fully realized, self-determining person with internal goals, personal rules, and meaningful choices (Rivera, 2019).
- **Episiotomy.** An episiotomy defined by Jones et al. (2019) is a surgical incision to the perineum during vaginal birth.
- **Supine-lithotomy.** The patient is on their back with the hips and knees flexed and the thighs apart, which was developed and recommended as a birthing position in the 18th century. Ever since then, horizontal positions like lithotomy and recumbent positions have been widely used in the western world (Zhang et al., 2020).

The purpose of this project was for healthcare facilities to become educated on alternative, evidence-supported, birthing positions, deviate from commonly practiced, non-evidence-supported birthing positions, and promote alternative, evidence-supported birthing positions to pregnant clients.

CHAPTER II

Literature Review

A literature review was conducted using various search engines and scholarly databases such as Bulldog One Search, Health Source: Nursing/Academic Edition, Nursing and Allied Database (ProQuest), and Health and Medical Collection (ProQuest). The keywords and phrases explored included: alternative birthing positions/options, waterbirths, natural births, patient-reported outcomes in childbirth, conceptual frameworks in childbirth, routine deliveries in hospitals, and midwives in healthcare facilities.

Literature Related to Statement Purpose

The first and second stages of labor can be pivotal in the birthing process. Implementations in these stages need to be individually intentional and beneficial to the overall outcome of the birth. Obstetric interventions are becoming routine and standard for normal, low-risk, vaginal births. A descriptive, cross-sectional study was conducted by Zeynep et al. (2020) with the intention to investigate 331 women's birthing experiences and the labor interventions performed during the births. The study revealed routine medical interventions in the birth process cause a disruption of the natural process of birth, a remarkably high rate of obstetric interventions are used during low-risk, natural births, and from this, mothers are experiencing negative, unhappy births (Zeynep et al., 2020). The birth process for low-risk pregnancies in hospitals is becoming facility and provider-driven instead of patient-centered. Zeynep et al. (2020) discusses the issues of the birthing process with obstetric practices; suggesting continuous fetal heart monitoring restricts mobilization of the mother during labor which hinders the passage of

the fetus down the birth canal. Having to stay in limited positions causes an increase in pressure from the fetus and pain in the lumbosacral area. The study mentions how epidurals are usually given to help ease the pain but are associated with supine birthing positions, assisted births, and risk of cesarean sections which are rarely expected outcomes for the mother. Instead of restricting, continuous fetal monitoring, the study suggests routine evaluation of the baby's wellbeing can be assessed with dopplers and fetoscopes. As for analgesia, progressive muscle relaxation, breathing techniques, therapeutic music, perineal massage, warm compresses, utilizing the hands to protect the perineum, and other relaxation techniques in accordance can be recommended to the laboring mother (Zeynep et al., 2020). In conclusion, Zeynep et al. (2020) recommends women assume the position they are most comfortable with during labor; they should be supported to move freely in upright birthing positions as evidence suggest. Thus, navigating from routine, obstetric interventions in normal, low-risk births will increase positive maternal experiences and satisfaction. If maternal hospital staff and providers are educated to adequately promote alternative, evidence-supported birthing options, women will begin to achieve and maintain satisfaction with their birthing experience.

Upright birthing positions are well known in literature and evidence of their benefits to the mother and baby, however, it often comes second to supine-lithotomy birthing positions. A study aimed to explore, through an integrative review, women's capacity to assume upright birthing positions in healthcare facilities and the effects on natural birth. A woman's physical instinct to assume upright birthing positions during labor is challenged in hospital settings (Irvin et al., 2022). Birthing in upright positions is an evidence-based practice known to positively affect maternal and fetal outcomes,

although laboring women are often encouraged into gravity-resistant birthing positions which are known to increase the use of epidurals and obstetric interventions (Irvin et al., 2022). Medical interventions are inevitable at times, yet these practices are often used on a routine basis instead of only when medically necessary. This suggests an influence on the normal and natural processes of birth. The methods used involved a well-developed, five-step, approach to conducting an integrative literature review. From the thematic analysis, three major themes were produced; “the biomedical model of care and workplace culture impact the positions women adopt during labor and birth, midwives' philosophy and views support physiological birth, and clinical settings are not conducive to physiological birth” (Irvin et al., 2022, p.1). Midwives in hospital settings fall under the institution’s policies and hierarchical system which impact the culture of the birthing environments. Midwives may struggle to be compliant and are afraid of consequences if they act autonomously. Irvin et al. (2022) gave insight into the hierarchical system in hospitals revealing obstetricians are at the top, the midwives are next, and the mother and baby are last. The mother and baby should reside at the top if hospitals are providing patient-centered care and ensuring the mother’s wishes and expectations are prioritized. The study concluded that midwives are losing the skills and confidence to support women in upright birthing positions (Irvin et al., 2022). Improvements in upright birthing positions and education and training are needed to see an increase in women adopting alternative birthing options, supported with evidence, in healthcare environments.

A study aimed to compare childbirth duration using the BC-MK15 birth chair, in an upright position, to childbirth duration laying down using a conventional bed. The research sample consisted of 30 multiparous women during their active phases of labor.

The sampling method utilized random permuted blocks. The results showed shorter childbirth durations with the BC-MK15 birth chair as opposed to the conventional bed. The BC-MK15 birth chair displayed a shorter childbirth time of 269.42 minutes (about 4 1/2 hours) compared to 299.09 minutes (about 5 hours) from delivering in the bed (Fitriani et al., 2018). In conclusion, the study demonstrated shorter childbirth durations with the birth chair compared to the conventional bed in multiparous women. The decrease in labor time found with utilizing the BC-MK15 birth chair is a significant benefit and reason healthcare facilities should promote alternative and evidence-supported birthing options.

Prior to colonization and western influence, women in South Africa were known to give birth in upright positions according to Musie et al. (2019). A study was conducted exploring factors hindering midwives from incorporating alternative birthing positions. Research found guidelines for maternity care in South Africa endorse the birthing position women in labor select, including alternative birthing positions to supine-lithotomy. The maternity guidelines also state the supine-lithotomy birthing position should be avoided during stages one and two of labor. With the supine-lithotomy position, the woman is flat on her back, trying to bear down against the force of gravity, fetal head descent is inhibited, which exposes the woman to prolonged labor and increases the chance of emergency cesarean section or instrumental delivery (Musie et al., 2019). In contrast, Musie et al. (2019) discovered alternative birthing positions are shown to “facilitate labor through normal physiological functioning that utilizes the force of nature and gravity and are associated with optimal maternal and neonatal outcomes” (p. 2). In addition, Musie et al. (2019) identified “ x-ray results showing the actual

increase in pelvic diameters (antero-posterior and transverse pelvic outlet diameters) when a woman [assumes] alternative birthing positions such as upright, squatting, and kneeling during childbirth, compared to the lithotomy position" (p.2). Only a few midwives in the study encouraged giving women a choice in birthing position due to a lack of proper education and skills to confidently utilize alternative birthing positions. It is suggested nursing education institutions in South Africa, modify the midwifery program; the curriculum should equip midwives with educational information and insight on the current alternative birthing positions and incorporate theory into practice as the theories relate to alternative birthing positions (Musie et al., 2019). Healthcare institutions should adopt educational training classes to instill the same knowledge recommended for midwifery programs to enforce collaborative efforts between maternity nurses, midwives, and providers in promoting alternative birthing options, as advised by evidence.

A study was conducted to examine the views and experiences of women following water immersion during labor and birth. The study revealed women responded positively to warm water immersion during labor and birth. The findings indicated birthing pools are alternative tools that provide space women can adapt to best suit their needs and preferences. Women who selected warm water immersion for labor and birth had liberating and transformative experiences of welcoming their babies into the world (Feeley et al., 2021). It is suggested maternity professionals offer water immersion as an alternative method for pain relief during labor and birth. In consideration of these findings, healthcare facilities should include and promote warm water immersion as an alternative, evidence-supported birthing option.

The U.S. is a diverse country, filled with various ethnicities and cultures. As citizens or non-citizens, this country is sufficient to provide culturally diverse care and assistance to pregnant and laboring women. A study analyzed how culturally diverse women, who delivered vaginally, and without participation in any birth preparation classes, coped with birth pain using their traditional methods. The sample consisted of 350 women participants, living in Gümüshane, Turkey, who volunteered and delivered vaginally using traditional methods to cope with labor pains. The methods consisted of walking, screaming, crouching, showering, massage, breathing exercises, meditation, providing calming support, warm compresses, eating dates, and drinking zam-zam water (Ozcan et al., 2021). The Muslim women from the study who used traditional methods during labor stated their pain decreased and were able to psychologically relax. With these statements in mind of the relevant benefits of traditional labor methods, Ozcan et al. (2021) recall it is important to investigate different applications and preferences for women's health according to cultural diversity and to support clients with respect. Promotion and incorporation of alternative, evidence-supported birthing options in healthcare facilities can be implemented by simply supporting culturally diverse women to practice their own alternative birthing methods.

In Brazil, a study was conducted to compare and report the experience of labor described by nulliparous or never given birth (Miller & Danoy-Monet, 2021), women who participated and who did not participate in a systematic Birth Preparation Program (BPP). During the BPP there are useful opportunities to educate new mothers on what to expect during labor and childbirth and to address any concerns and expectations from the woman. A qualitative study was conducted with 21 women who either participated in a

BPP or attended routine prenatal care. The results from the study revealed women who participated in the educational activities of the BPP reported they maintained self-control during labor, performed breathing exercises, utilized a birthing ball for support, received massages and baths, assumed vertical positions to control pain, and reported satisfaction with their birthing experience (Miquelutti et al., 2013). Women who did not participate in educational activities reported difficulties with maintaining control during labor and were more likely to report dissatisfaction with their birthing experience (Miquelutti et al., 2013). In relation to these results, it can be argued promoting alternative and evidence-supported birthing options during the establishment of the birth plan, in hospital settings, can improve women's pain management during labor and their overall birthing experience.

In Sweden, a study explored how the birthing room impacts the work of the midwife to promote natural births. The study utilized individual interviews from 15 midwives working at four different hospitals in western Sweden. The design of the birthing room, can either support a natural birth or support a risk approach in childbirth (Andrén et al., 2021). Regarding the room promoting activity or passivity, midwives confessed the mothers had better success with movement and position selection than remaining confined to one spot during labor. In the study, midwives discovered they could stimulate the birth room with pictures on the wall of illustrated birthing positions that could facilitate childbirth as inspiration to the mother. The study states with passive birth rooms, medical equipment surrounds the birth bed, there are few options for movement, and the mother can become passive and inactive, and more dependent on the midwife (Andrén et al., 2021). The interview study concluded with the proposal of birth

environments promoting the deliverance of a healthy, natural childbirth when midwives are present, making the room private and home-like, and supporting the mothers to be active. The physiological and psychological benefits listed in the study from activity and movement of laboring mothers are significant enough for healthcare facilities to implement the promotion of alternative, evidence-supported birthing options that stimulate activity and movement.

A literature review performed in London aimed to summarize current evidence regarding how midwives' knowledge, values, and attitudes support their practice in relation to women's birthing positions. From the review's findings, upright birthing positions are promoted by providing information and practical support through education. It was observed that communication styles used by midwives encourage women to trust their bodies to assume upright birthing positions and midwives who prioritize women's preferences over their own also facilitate upright birthing positions and establish a trusted midwife-client relationship (Green, 2015). The literature review stated recumbent positions are associated with midwives who lack training, experience, and/or prioritize their own comfort. The review implicates midwives could narrow the research-practice gap by incorporating what they know about alternative birthing position to pregnant and laboring women. Green (2015) felt midwifery educators could help bring change through promotion and training to normalize alternative options such as upright birthing positions. Healthcare facilities and providers can also bring change in birthing outcomes and experiences if they are properly educated and learn to embrace and promote alternative and evidence-supported birthing options.

In an experiment, Hemmerich et al. (2019) hypothesized loading conditions during squatting and increased ligament laxity during pregnancy would expand the pelvis. The squatting position and mobility effects on the diameter of the female pelvis in pregnant and non-pregnant clients were surveyed. The reason for the experiment rests on the impact of birthing positions and mobility on pelvic alignment during labor, not being explored. From the outcomes of the simulation, Hemmerich et al. (2029) suggest "maternal joint loading in an upright birthing position, such as squatting, could open the outlet of the birth canal and dynamic activities may generate greater pelvic mobility" (p.64), to potentially facilitate delivery than the comparable static posture such as the supine-lithotomy birthing position. With this knowledge, obstetricians, nurse-midwives, labor and delivery nurses, and other relatable hospital staff can be thoroughly educated on how to discuss, inform, and implement into practice the benefits of alternative and evidence-supported birthing options, such as squatting.

The squatting position is a popular position for natural births, in countries where childbirth occurs in non-medical facilities, and with noninvasive technology. A study wished to compare the impact of foot posture during a squatting birthing position either on tiptoes or with feet planted flat. The study composed of 13 women, 32 weeks pregnant and beyond, and not actively in labor, being assessed during the squatting birthing position. In conclusion, Desseauve et al. (2019) suggest with the squatting birthing position, "foot posture had a biomechanical impact on the lumbar curve and pelvic orientation. . . and when comparing squatting positions, on tiptoes versus feet flat, feet flat on the ground are closer to optimal birthing conditions than on tiptoes" (p. 6). These

results can all be factored into the education guidelines needed in hospital facilities to promote alternative and evidence-supported-birthing options.

A study performed in Sweden set out to explore retrospective descriptions of benefits, negative experiences, and preparatory information related to waterbirths. A qualitative study included a design and method composed of women who gave birth in water with low-risk, healthy pregnancies. One hundred and eleven women responded to the survey, out of the one hundred and fifty-five women recruited, that was sent out through email, 6 weeks postpartum. The results of the study identified four themes, two positive benefits, and two negative experiences. Physical benefits came from the ease of labor progression, relief of severe pain from the warm water, and the comfort emitted from buoyancy. Carlsson and Ulfsdottir (2020) concluded the study by proposing women who give birth in water experience systematic benefits but adequate information and finer equipment is needed. In addition to Carlsson and Ulfsdottir's (2020) proposal, obstetricians, midwives, and nurses should continue advocating waterbirths in low-risk pregnancies with adequate education and through the promotion of alternative birthing options supported by evidence-based practices.

Literature Related to Conceptual Frameworks

Part 1 of a childbirth experience survey study wished to develop a conceptual framework and preliminary item bank for specific, patient-reported outcomes in childbirth. The data source of the study contained women who were U.S. citizens, 18 or older, and 20 or more weeks pregnant. The women submitted surveys, using online panels, regarding their childbirth values and preferences (V&P). Korst et al. (2018) "conducted a cross-sectional observational study and fitted a multivariable logistic

regression model to each V&P item to describe [who] wanted each item" (p. 3383). In conclusion, Korst et al. (2018) indicated the conceptual framework and preliminary PROMIS item bank in the study provide a foundation for the development of childbirth-specific V&P/PROs, which will be overall utilized to improve patient satisfaction in childbirth. Using the conceptual framework of PROs in childbirth can help pinpoint expectations and goals. This framework can also incorporate agreed-upon alternative and evidence-supported birthing options between the mother and healthcare facility.

Part 2 of the Childbirth Experiences Survey study supported an objective to identify key predictors of hospital childbirth satisfaction through the results of Part 2. Gregory et al. (2019) re-contacted the women from Part 1 and were welcome to join in a postpartum follow-up survey to gather data pertaining to their patient-reported childbirth experiences. With the utilization of bivariate analyses, they tested whether predisposing conditions, values and preferences, patient-reported outcomes (V&P/PROs), experiences, and the "gaps" between V&P/PROs, and experiences were predictors of women's satisfaction with the care of the hospital's childbirth services. From the 500 women who anticipated a vaginal delivery during the time of survey Part 1, who also labored before delivery, and who answered Part 2 of the survey, the study discovered the strongest predictors of women's satisfaction in childbirth at the hospital were staff-patient communication during labor and delivery, compassion, inclusion in decision making regarding pain management, practical support with infant feeding, respect, and empathy (Gregory et al., 2019) . In conclusion, the study identified 23 childbirth-specific PROs and experiences that were predictors of hospital satisfaction in childbirth. Implementations from the Childbirth Experience Survey Part 1 and 2 may lead to

improve hospital performance and development regarding patient-preferred, childbirth experiences. Preferred PROs in childbirth have been shown to be a successful method when deciding if satisfaction of birthing experiences was achieved and may help welcome the inclusion and establishment of alternative and evidence-supported birthing options.

A study felt to evaluate the effectiveness of interventions in perineal trauma, patient-reported outcomes (PROs) should be prioritized as perineal trauma is the most common complication of childbirth (Doumouchtsis et al., 2021). The objective of the study analyzed the selection, reporting, and geographical variations of PROs and patient-reported outcome measures (PROMs), in randomized controlled trials (RCTs) on perineal trauma. In total, the study resulted in 51 identified PROs, however, consistency in outcome reporting was low, with only 27 PROs reported once. The most frequent PROs were perineal pain. Despite the inconsistency, Doumouchtsis et al. (2021) felt PROs are the most prevalent outcome in perineal trauma research. Due to the use of PROs in determining the effectiveness and safety of interventions, makes their incorporation important in perineal trauma research. This conceptual framework can seek solutions to resolve the issues associated with perineal trauma through the promotion of alternative and evidence-supported birthing options that are found to prevent severities in perineal trauma.

Patient-reported outcomes (PROs) and patient-reported experience measures (PREMs) can enable the potential to improve healthcare quality and decision making. Depla et al. (2020) studied the feasibility to use these PROs/ PREMs to address both women's and professionals' perspectives in Dutch perinatal care. The methods used in the

study deployed women patients and professionals' participation in perinatal hospital care. Women were emailed questionnaires and discussed their answers with their obstetric provider at the following visit. A little less than 26 women completed and discussed their PROs/PREMs questionnaire. More than half of the women agreed PROs/PREMs contributed to collaborative decision making, the ability to address concerns, and client-provider relationships. Six maternal providers participated. The providers agreed PROs/PREMs supported symptom identification and individualized care. The study concluded with the suggestion clients and maternal providers adjudge the PCB set a practical instrument for PRO/PREM assessment (Depla et al., 2020). As shown in the study, conceptual frameworks in childbirth can facilitate a platform to promote alternative birthing options supported with evidence by healthcare facilities, to ensure and maintain patient satisfaction.

Generally speaking, "patient-reported outcomes (PROs) provide self-reported patient assessments of their quality of life, daily functioning, and symptom severity after experiencing an illness" (Hancock et al., 2020, p.1), or procedure which resulted in needing services from the healthcare system. It can be proposed, sharing data from PROs with healthcare professionals, may inform clinicians and quality improvement efforts (Hancock et al., 2020). The objective of the review sought to summarize PRO data as feedback to healthcare professionals, due to the lack of knowledge on the best method to utilize when presenting data to the appropriate healthcare professionals. Hancock et al. (2020) discovered "while a single best format or approach to feedback PRO data to healthcare professionals was not identified, numerous guiding principles emerged to inform the field" (p.1). PROs cannot reach their full potential of helping improve quality

in healthcare if providers are not properly informed of these reports; however, with conceptual frameworks in place, alternative, evidence-supported measures can evolve and aid in improvement with PROs.

A study wished “to examine the COVID-19 pandemic birth experience satisfaction, healthcare discrimination during childbirth,. . . and the influence of these birth experiences on postpartum health” (Janevic et al., 2021, p. 860) . A cross-sectional, bilingual web survey was conducted and given to 237 women who delivered at hospitals in New York. The survey assessed patient-reported outcomes (PROs) and experiences in childbirth after the initial outbreak of SARS-COV-2 infections in the state of New York. Janevic et al. (2021) compared birth outcomes and experiences during the COVID-19 pandemic (March 15, 2020–May 11, 2020) to a pre-pandemic response period (January 1, 2020–March 14, 2020). The results uncovered women who delivered during the peak of covid-19 were found to be positive for the virus, and either Black or Latina. In addition, these women had lower birth satisfaction scores with higher discerned healthcare discrimination. It was also stated by Janevic et al. (2021) “experiencing one or more PROs of healthcare discrimination was associated with higher levels of postpartum stress and birth-related PTSD” (p.860). The study concluded with the report of decreased childbirth satisfaction and increased perceived healthcare bias during the COVID-19 pandemic for Black and Latina women, which worsened postpartum health satisfaction. Janevic et al. (2021) recommend hospitals incorporate measures based on these PROs, to guard against any negative birthing experiences, specifically among birthing women of color. With any pandemic in healthcare, standardized methods are susceptible to change to guarantee safety, however, perceived discrimination is never a positive outcome to

expect when faced with a healthcare emergency. Practicing and promoting alternative, evidence-supported outcomes during pandemics, through conceptual frameworks, can corroborate patient respect and equality from healthcare professionals in childbirth.

In Kenya, a study for a data collection tool, using mobile technology to collect patient-reported outcomes (PROs) was selected from the International Consortium of Health Outcomes Measurements Pregnancy and Childbirth Standard Set in Nairobi, Kenya (Al-Shammari et al., 2019). The method recruited women in their third trimester, from three maternal care facilities in Nairobi, and followed the women during delivery, and until 6 weeks postpartum. PROs were collected through mobile surveys at three antenatal and two postnatal time points. The results revealed in 6 months, 204 women were recruited and completion rates for the five PRO "surveys were highest at the first antenatal care visit (92%) and lowest at the postnatal care visit (38%)" (Al-Shammari et al., 2019, p. 2). The collection tool indicated the feasibility of utilizing mobile technology to follow women throughout pregnancy, track their attendance at maternal care visits, and obtain PROs (Al-Shammari et al., 2019). This study reveals the significance of using the conceptual framework of PROs in childbirth by needing to create a method to obtain data through mobile technology to collect PROs in low-resource settings, to become knowledgeable of women's values, preferences, and satisfaction regarding their childbirth experience. The data provides "insight into the quality of maternal care services provided and will be used to identify and address gaps in access and provision of high-quality care to pregnant women" (Al-Shammari et al., 2019, p.2).

The purpose of a study conducted in Australia wished to achieve maternity-care outcomes that align with women's needs, preferences, and expectations through the

development of an instrument to assess women's perception of their entire maternity-care experience (Clark et al., 2016). A survey was given to 195 women who had recent birthing experiences to establish valid and reliable scales pertaining to dissimilar stages of maternity care. The study found the development of "nine theoretically informed, reliable, and valid stand-alone scales, measuring the achievement of [various levels] of women's expectancies of maternity care" (Clark et al., 2016, p. 89). The scales also identified areas for quality improvements in the deliverance of maternity care. In relation to the scales discovered in the study, the conceptual framework of patient-reported outcomes (PROs) in childbirth would be an appropriate method to utilize to assess women's perceptions, values, preferences, birth satisfaction, and quality improvement areas of their experience in maternity-care, from healthcare facilities.

CHAPTER III

Needs Assessment

Healthcare facilities are deviating from the natural process of birth and seem to be conforming to standardized obstetric practices. Women with low-risk pregnancies who want to labor and deliver naturally should be given the choice to perform alternative evidence-supported birthing options. Healthcare facilities need to educate labor and delivery staff on the dynamics and benefits of alternative birthing options reinforced with evidence. Furthermore, the promotion of evidence-supported, alternative birthing options should be enacted by educated and competent labor and delivery staff.

Target Population and Setting

The target population for the project will consist of healthcare providers who care for low-risk, pregnant women opting for a natural labor and birthing experience. Specifically, obstetricians, midwives, and labor and delivery nurses will make up the target population. The setting will include the antepartum (occurring or existing before delivery) and intrapartum phases (time period spanning childbirth from the onset of labor through the delivery of the placenta) of maternity units within select healthcare facilities, located in the southeast region of the country. Maternity units are composed of life-changing experiences, and care processes to protect, promote, and support physiological childbirth, ensure evidence-based care, and supportive care for client decision-making. The objective of the project aims to explore, identify, and inform clients with the benefits of alternative and evidence-based birthing options. Thus, with proper education, healthcare professionals will know how to adequately promote alternative, evidence-supported birthing options in healthcare facilities.

Sponsors and Stakeholders

The overseer of the project will be partnered with an experienced midwife, obstetrician, and the nurse director of the maternity unit. In order for pregnant clients to experience a great birth, Majumdar and Majumdar (2021) recommend the birth should include options to choose from and plan, mothers should receive emotional support from care providers, and the least amount of medical interventions should be utilized. Nurse-midwives can aid with education on alternative birthing options by discussing and demonstrating the benefits when women select evidence-based birthing positions or how to incorporate coping methods for clients who want to labor and deliver naturally. Although the natural physiological process of childbirth seems to have changed into a pathological state under dominant obstetric practices due to medical training (Majumdar & Majumdar, 2021), obstetricians are still a significant component of the birthing process. The nurse director will facilitate teaching seminars, which will be instructed by nurse educators. Labor and delivery nurses will be responsible to attend the seminar, as they are the primary staff for the duration of the birthing process.

Desired Outcomes

With the implementation of this project, healthcare facilities will adopt a medical, and maternity culture that promote alternative birthing options supported by evidence-based knowledge and practices. Diverse and collaborative insight from appropriate maternity staff can strengthen and adequately prepare staff to support and care for pregnant mothers during labor and delivery. The benefits of alternative birthing options are becoming increasingly appealing to pregnant clients who wish to labor and deliver naturally. Experiencing shorter labor times, possessing the freedom to eat and drink, or

having the ability to move freely and transition into various positions during labor are only some of the benefits associated with alternative birthing options.

The desired outcome of the project focused on eliminating the standard, obstetric birth process and promoting alternatives for natural, low-risk pregnancies in healthcare facilities. The achievement to meet the desired outcome can be measured through patient-reported outcomes (PROs) in childbirth. PROs in childbirth provide valid and reliable data directly from mothers who encountered the birthing experience.

SWOT Analysis

An analysis of strengths, weaknesses, opportunities, and threats were done to help plan project implementation. The internal factors include the strengths and the weaknesses. Strengths identified in these facilities are the maternity unit's focused objective statements for client-desired birthing experiences and the availability of maternal staff and resources. Most labor and delivery (L&D) units contain protocols enforcing the mission statement and obligation to excel at meeting clients' birthing preferences. Maternal staff and resources are adequately equipped within these units to support natural, low-risk, pregnancies. The weaknesses included stagnancy to implement evidence-based practices for alternative birthing options and establishing functioning dynamics to manage birth plan preferences. Despite data supporting and favoring upright birthing positions, pregnant clients are commonly instructed to assume the supine-lithotomy position. With the limited implementation of alternative birthing options in healthcare facilities, there are few guidelines enacted to assist or direct these birthing processes.

The external factors include opportunities and threats. The opportunities consist of an increase in patient satisfaction scores through patient-reported outcomes (PROs) and improvements in staff morale. Positive feedback from PROs has the potential to cause desired effects in the attitudes and environments of L&D staff. In addition, increased patient satisfaction scores set the foundation for the facility to explore options for grants and funding to ensure the necessary resources and education are available when offering alternative birthing services. The potential threats are lack of identification in superiority when obstetricians and nurse midwives work alongside maternal/fetal complications during labor or delivery. Depending on the client's birth plan, an obstetrician or midwife will lead the birth. However, if unexpected complications arise, making a low-risk, natural birth now a high-risk birth, the obstetrician and midwife may face issues in decision making. Table 1 provides a visual representation of the projected SWOT analysis.

Table 1

SWOT Analysis

SWOT Analysis	
Strengths	Weaknesses
• Maternity unit objective statements • Available staff/resources	• Stagnancy implementing alternative birth options • Lack of functioning dynamics
Opportunities	Threats

SWOT Analysis	
• Increase in patient satisfaction reports	• Discrepancies in role identification
• Improved staff morale	• Maternal/Fetal complications

Resources

The project leader identified the necessary resources to ensure the project concluded with the desired outcome. Maternal staff and providers were thoroughly educated on alternative birthing options by nurse leaders and educators, over a series of courses. Nurse directors, managers, and administrators facilitated the schedule for the education courses. During the courses, nurse educators explained the benefits and practices associated with alternative birthing options. Once courses were completed, maternal staff was encouraged to promote and welcome alternative birthing options, both during the birth plan and at the time of the delivery. Before mothers were discharged home, they were presented with a survey to rate overall satisfaction with their birthing experience. From the survey's results, the project expected to see a rise in patient satisfaction reports following the implementation of promoting alternative birthing options from healthcare facilities.

Team Members

In order to execute the project, the project leader needed to establish an effective team equipped with competence and years of experience in maternity units. The project leader asked nurse directors and nurse administrators for permission to orchestrate the series of educational courses. A senior midwife, chief obstetrician, nurse educators, and project leader mandated the evidence-based information and established proper

utilization of available resources for the courses. Simultaneously, the project leader reviewed the budget requirements and communicated any necessary changes made in order to protect budget limits with the team members. The L&D nurses, including nurse-midwives and obstetricians, were required to attend the educational courses but were also encouraged to insert any concerns, issues, or ideas to welcome diverse perspectives on alternative birthing options. L&D nurses were the individuals responsible for providing clients with a patient-reported outcome (PRO) survey to verify satisfaction with the birthing experience at the healthcare facility.

Cost-Benefit Analysis

A cost-benefit analysis was conducted to ensure the outcomes of executing the project were worth the costs. According to research, women benefit more emotionally and physically from a natural birth and midwifery care than from highly medicalized births. Because midwives are involved in a wide range of alternative birthing choices across all birth settings, they are able to develop mutually trusting relationships with clients and support and facilitate client-preferred births (Feeley et al., 2020). With the inclusion of obstetricians and their significance, Morr et al. (2021) suggest “a midwife-led birth [can be] a safe alternative to a primarily obstetrician-led birth, provided that selection criteria are being followed and prompt obstetrician involvement is available in case of abnormal course of labor and birth, or postpartum complications” (p.1).

Decreased educational course costs can originate from employees conducting the courses as opposed to a non-employed instructor who would require additional payments for the duration of courses. An abundance of evidence-based information and practices are readily available and free from reputable resources and individual experiences. The

development of facility guidelines to incorporate alternative birthing options may acquire a cost. However, the client's experience of care is measured by hospital consumer assessment of healthcare provider systems (HCAHPS) surveys which are used to determine hospital reimbursement (Levin et al., 2017), therefore, the cost may be accounted for, if clients report satisfaction with rendered care.

When analyzing in-direct and actual costs, the utilities, internet service, and printed handouts were calculated. The utility calculations were based on a 1,024-square-foot classroom, which according to average commercial property cost, was approximately $2.10 per square (IotaComm, 2020), for a monthly cost of $2,150. Internet service cost consumers on average approximately $60.00 per month. Printing cost $0.10 per sheet, therefore $40.00 was spent on the two-paged handout to accommodate the 200 employees from the select facilities in the southeast region. The overall cost of birth in a hospital setting ranges from $13,000- $19,000, whereas home birth with a midwife ranges from $3,000-$9,000 (Morr et al., 2021). Once these benefits are disseminated in states where home births are legal, and processed globally, healthcare facilities may face an undesired shift decrease in maternal services. Being proactive in promoting alternative birthing options, supported by evidence for low-risk, natural births in healthcare facilities, may assist with this potential shift.

CHAPTER IV

Project Design

Goals and Objectives

The projected plan of the project was to promote alternative, evidence-supported birthing options in healthcare facilities. The goal of the project was for healthcare facilities to transform the standardized birthing process for low-risk, natural births, into individualized, client-centered birth at healthcare facilities from the evidence of increased patient satisfaction scores. The project intended for maternity units to promote and welcome alternative birthing options for these clients through proper education, guidelines, and evidence-based practices. In addition to thorough education and implementation of evidence-based birthing practices, patient-reported outcome (PRO) surveys were distributed and reviewed for increased patient satisfaction. The use of PRO surveys offered the opportunity for women and healthcare providers, to identify and review significant areas of unmet needs to improve outcomes (Kelly et al., 2021). The desired outcomes of the project were intended for patient satisfaction scores to improve with the establishment of promoting alternative evidence-supported birthing options in healthcare facilities. Adopting a standardized measure such as PRO surveys can provide evidence of health outcomes and well-being from the woman's perspective (Kelly et al. 2021). The objectives of the project were:

1. Create and implement guidelines to promote and encourage alternative birthing options, supported by evidence, per client preference 2 weeks prior to the initiation of the education courses.

2. Within 6 weeks educate maternity staff and providers on alternative, evidence-based birthing options.
3. Utilize patient-reported outcome (PRO) surveys 3 months after implementing alternative birthing options in the select healthcare facilities, to improve client satisfaction scores and birthing experiences.

Plan and Material Development

Before the implementation of the project, the project leader discussed the intentions and plan of the project in three points. The team leader began with a meeting, that included all team members of the project, to inform the maternity staff why alternative, evidence-supported birthing options should be promoted in hospital facilities. According to evidence discovered during the literature review, there was a deviation from natural, physiological births to over-medicalized births. The World Health Organization, (WHO) defines normal physiological births as spontaneous in on-set, low-risk at the start of labor and throughout labor and delivery (Healy et al., 2020). With over-medicalized births, there were trends of longer labor, increases in obstetric interventions, and risk for cesarean sections. Normal physiological births omit the usage of epidurals or other pharmaceutical pain relief agents, as these medications may negatively impact the natural process of labor. Furthermore, the induction and augmentation of labor requires synthetic oxytocin which may cause increased, painful contractions when compared to natural labor (Healy et al., 2020). The team leader also mentioned the desire for women to experience patient-controlled births as the WHO highlights, most women value natural labor and birth.

The second portion of the project plan included the development of education courses needed to properly train maternal staff and providers on implementing and promoting alternative, evidence-supported birthing options in the facility. The project leader gained permission from the nursing director to address the scheduling and establishment of the educational courses with the nurse administrator and manager. Nursing educators were in charge of informing and training the maternal staff, along with nurse-midwives and obstetricians. The information discussed and provided originated from researched evidence-based practices and experience from the project leader. In a study, Dzomeku et al. (2021) revealed maternal staff reported a 4-day training seminar had a positive impact on their maternity caregiving in the hospital regarding respectful maternity care, (RMC) strategies. The educational courses were held in a classroom setting, for 6-weeks. The education courses were the most important component of the project as they included training to encourage the primary outcome for all pregnant women, as stated by the WHO, “to have a positive childbirth experience [which] includes giving birth to a healthy baby in a conducive, safe environment with continuity of care provided by kind, competent, maternity care professionals” (Healy et al., 2020, p. 2).

The final point of the project plan focused on the actual implementation of alternative birthing options, supported by evidence. One month after completion of the courses, maternal staff were authorized to begin promoting alternative birthing options during the birth plan or at the time of delivery. Guidelines were created and measured to ensure quality service and care were rendered by staff and patient satisfaction was achieved. A patient-reported outcome (PRO) survey was designed by the team members

of the project and dispersed by L&D nurses prior to discharge. Childbirth is a significant life event; healthcare facilities should always consider and prioritize.

Timeline

The preparation and duration of the project took place over 6-weeks. Two weeks included content preparation for the educational courses by the project leader and later reviewed by the senior nurse-midwife and chief obstetrician. During this time, the budget was also addressed and examined to guarantee finances were sufficient. The project leader reviewed the content with the nurse educators to ensure feasibility in teaching the material. Once the nurse-midwife and obstetrician reviewed a substantial amount of evidence-based content and the nursing educators created lesson plans and teaching methods to begin sharing the material with staff, the courses were mandated. Weeks 3-5 initiated and finalized the educational courses. L&D staff from each facility attended the courses and completed a final examination online to determine competency in alternative birthing options, at healthcare facilities. Week 6 included reviewing evaluations of the course and offered staff who did not pass, a second attempt to successfully pass the examination. At the conclusion of week 6, all L&D staff should have been adequately educated to start promoting alternative and evidence-supported birthing options at their facilities.

Budget

The budget was an essential component of the project that required frequent tracking to maintain its stability for the duration of the project. Courses were conducted in a classroom, which cost $2,150 after necessary utilities were factored in. Internet service was provided and cost $60.00 for the 4 weeks of courses. Printing costs were

addressed, as $40.00 was the cost for the handouts provided. For the review of research and educational content by the senior nurse-midwife and chief obstetrician, they received $500 each. The biggest portion of the budget stemmed from the cost of paying L&D staff. The 200 staff received $30 an hour, for the 4-hour course, which amounted to $24,000. In total, the project budget was projected to not exceed $27,250. Table 2 provides a visual representation of the breakdown of the budget.

Table 2

Budget

Item Component	Cost
Classroom Utilities Cost	$2,150.00
Internet Service Cost	$60.00
Handout Print Cost	$40.00
L&D Staff Pay Cost	$24,000.00
Nurse Midwife/Obstetrician Review Pay Cost	$1,000
Total Cost	$27,250

Evaluation Plan

The evaluation process took place 3 months after the project's practices were implemented in the select facilities. L&D nurses were responsible for providing and collecting patient-reported outcome (PRO) surveys, containing questions regarding the mother's overall birthing experience, before they left the hospital. The PRO survey served as the measurable, qualitative tool to collect and measure data. After data interpretation, the project leader identified if the desired outcomes were successfully met.

From the evaluation, the responses should yield an increase in patient satisfaction scores and staff morale, from implementing and promoting alternative, evidence-supported birthing options at the healthcare facility. In addition, responses were also intended to reveal a decrease in standard, obstetric birth processes for low-risk, natural births. If the PRO survey responses resulted in the desired outcomes, the project leader could assume the project's implementations effectively impacted maternal practices, thus deeming the project successful.

Although the project design was a tedious component of the project, it was necessary. The goals and objectives were instilled to keep the project on track and focused on the purpose. The project plan was used to instruct and orchestrate the steps of the project. Material development was intended to keep resources available and maintained for the duration of the project. Creating a timeline and budget ensures the project was organized and arranged to meet the project's goals in an appropriate, cost-effective time period. The evaluation plan revealed reliable and substantial justifications for the purpose of implementing the promotion of alternative, evidence-supported birthing options in healthcare facilities.

CHAPTER V

Dissemination

The intention of the project was to promote alternative, evidence-based birthing options in healthcare facilities for low-risk pregnancies and clients who opt for a natural birthing experience. Hospitals and other healthcare facilities are known for over-medicalizing childbirth, despite the risk level of the pregnancy. Women are commonly instructed to assume the supine-lithotomy birthing position instead of an upright birthing position, which is supported and recommended by evidence. The practice problem of healthcare facilities treating the majority of births with obstetric measures in maternity units is no secret, however, there have not been any remarkable implementations to address or change this phenomenon. An abundance of evidence-based research and practices indicate alternative birthing options are more beneficial for clients with low-risk pregnancies and who want to labor and deliver naturally.

Dissemination Activity

The Alternative Birthing Options presentation was conducted in the presence of a labor and delivery nurse of a local maternity unit at a healthcare facility. During the presentation, background and historical information was discussed, initially regarding alternative birthing options, followed by the benefits discovered from research. There was a segment for questions and answers at the end of the presentation for the nurse to inquire about or seek clarification. Feedback and recommendations were also discussed during the concluding segment of the project. The feedback received recommended healthcare facilities pursue and continue evidence-based research and practices pertaining to alternative birthing options, being that patient satisfaction scores in childbirth

increased since the implementation of the project. The project leader used a PowerPoint presentation to deliver the project's information and provided a handout copy of the PowerPoint slides. The Alternative Birthing Options PowerPoint presentation and the provided handout are listed in the Appendix.

Limitations

The project faced limitations in the locations where the project was conducted and the time constraints to prep and oversee the educational courses, used to prepare the maternity staff and providers. These limitations originated from the available budget and resources the project leader and team could accumulate. Four healthcare facilities in the southeastern region of the United States were selected to participate in the project, however, the practice problem of standardizing the birthing process has a worldwide impact. It would have been favorable if healthcare facilities were selected from various countries worldwide. Fortunately, there is ample research available supporting alternative birthing options, however, the project team members had 2 weeks to gather information and research to prepare content for the educational courses. A longer preparation period could have warranted additional evidence-based knowledge and practices to strengthen the course's content or given deeper insight into the benefits associated with alternative birthing options.

Implications for Nursing

Nurses have direct responsibility and accessibility to promote alternative, evidence-supported birthing options in healthcare facilities due to their time spent with pregnant mothers and the establishment of patient-nurse relationships. From the creation of the birth plan to the actuality and deliverance of the birth plan, nurses can facilitate an

environment that welcomes, supports, and promotes alternative birthing options. Nurses can continue to serve as advocates for pregnant clients by reinforcing the client's birth plan wishes and ensuring the client's needs are being met. By maternity staff implementing the promotion of alternative, evidence-supported birthing options in healthcare facilities, trusting relationships between the staff and patient will emerge which will increase patient satisfaction scores in childbirth.

Recommendations

After a thorough evaluation of the project, it was recommended to seek other facilities investigating the same or similar practice problem regarding the promotion of alternative, evidence-supported birthing options in healthcare facilities. With the unity of the other facilities, further evidence-based research and practices can be discovered and implemented. Discussions of shared knowledge between the facilities can reveal the strengths and weaknesses of implementing specific practices. It was also recommended by Dzomeku et al. (2021) for policies and programs aimed at improving practices in maternity care, to advocate for and include facilities that support alternative birthing options. Collaboration between maternity units focused on deviating from standard, obstetric birthing practices in low-risk, natural births, to alternative birthing options, will invite additional opportunities to improve patient outcomes in childbirth.

Conclusion

Childbirth is a special period for mothers and newborns that should be cherished. Birthing experiences should orbit around the mother's birth plan and the condition of the pregnancy. Each and every birthing experience should be individualized and unique to the patient.

Standard birthing positions, such as supine-lithotomy and obstetric practices are not always beneficial or necessary in low-risk, natural births. There are various options, less medicalized and still effective to accommodate natural labor and birth, such as warm water immersion and upright-birthing positions. Maternity units within healthcare facilities should promote alternative birthing options supported by evidence to ensure patient-centered care is being rendered appropriately. Properly educating maternity staff and providers at healthcare facilities, on alternative birthing options, will help promote and encourage the implementation of alternative, evidence-supported birthing options into practice.

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Appendix

Alternative Birthing Options Presentation and Handout