ORIGINAL ARTICLE *DOI: 10.4025/cienccuidsaude.v18i4.45203*

BIRTH IN A NON-SUPINE POSITION: PERCEPTION OF PROFESSIONALS IN HOSPITAL CARE

Camilly Roberta da Silva*
Luciana Barbosa Pereira**
Sibylle Emilie Vogt***
Cristiano Leonardo de Oliveira Dias****

ABSTRACT

Introduction: The supine position predominates in the national context of vaginal delivery care, although there is scientific evidence favoring the adoption of other positions in the expulsive period, with advantages for both mother and newborn. **Objective:** to unveil the perception of health professionals working in an obstetric unit of a University Hospital about non-supine childbirth. **Methods:** qualitative, descriptive study conducted with workers in this sector. Ten medical or nursing professionals were interviewed. Data collection was through semi-structured interviews and submitted to Content Analysis**. Results:** three thematic categories were unveiled: recognizing advantages and stimuli to the use of non-lithotomic positions; noticing obstacles to changing paradigms in giving birth; experiencing non-lithotomic childbirth from the professional's perspective. Data analysis showed divergences between knowledge and practice, highlighting the influence of the biomedical model on the delivery care routine. **Final considerations:** It is suggested that permanent education and sensitization of the parturient care team be carried out, as well as their empowerment through relevant prenatal guidance for the implementation of good practices in childbirth care, including the use of non-supine positions in the expulsive period.

Keywords: Humanized Delivery. Obstetric Nursing. Knowledge. Patient Care Team. Evidence-based Medicine.

INTRODUCTION

The excessive medicalization of the female body and the view of childbirth as a medical event to the detriment of woman-centered care and its autonomy have led to movements towards the humanization of childbirth and the adoption of scientifically based practices. The humanization of childbirth involves changing paradigms in this scenario shifting the focus of attention from the health and service team to the woman who becomes the protagonist of her parturition process[1].

The medicalization of the birth process in some services in the Brazilian context reaches 92.7% of women, considering the presence of at least one of the following interventions: trichotomy, enteroclism, induction/conduction of labor, episiotomy, amniotomy and cesarean section[2].

In this context, the World Health Organization (WHO) proposed, in the 1990s, the classification of obstetric practices based on scientific evidence, according to criteria of efficiency, effectiveness and risk. They were then subdivided into four categories: category A - proven useful practices that should be encouraged; category B - practices that are clearly harmful or ineffective and which must be eliminated; category C - practices on which there is no evidence to support their recommendation and should be used with caution until further research clarifies the issue; category D - practices that are often misused. As an example, the theme in question - routine use of the lithotomic position in the expulsive period, classified as category B[3].

Considering the importance of scientific evidence and female protagonist role related to pregnancy, childbirth and birth, the Ministry of Health (MS) of Brazil launches, in 2016, the National Guidelines on Assistance to Normal Childbirth and recommends encouraging non-supine positions in labor[1].

However, in the Brazilian context, there is a predominance of lithotomic position in the expulsive period of childbirth, being adopted by 91.7% of women at usual risk. This is associated with the technocratic model of care, which considers childbirth as an essentially risk event.

*Nurse. Emergency Care Doutor Alpheu Gonçalves de Quadros. Montes Claros, MG, Brazil. E-mail: camily@yahoo.com.br ORCID iD: 0000-0002-2309-4711.
**Obstetric nurse. Master of Science. State University of Montes Claros. Montes Claros, MG, Brazil. E-mail: lubper@hotmail.com ORCID iD: 0000-0002-0419-0353.
***Obstetric nurse. Doctor of Science. State University of Montes Claros. Montes Claros, MG, Brazil. E-mail: sibyllecampos@hotmail.com ORCID iD: 0000-0001-9553-4096
****Nurse. Master of Science. State University of Montes Claros. Montes Claros, MG, Brazil. E-mail: cristianolodias@yahoo.com.br ORCID iD: 0000-0002-2750-8416.

This principle still anchors the high prevalence of unnecessary interventions and harmful and unscientific practices in most health services[4].

The predominance of the lithotomic or horizontal position during childbirth is associated with the influence of Western culture on the models of childbirth care in our country. In the professional environment, its adoption is associated with the easier monitoring of the expulsive period, enabling surgical interventions[4].

However, according to studies of the physiology of parturition, this position, compared to vertical positions, has disadvantages such as reduced pelvic dimensions, aortic compression and lack of gravitational effect[5]. Interestingly, vertical positions are predominant among cultures that have not been influenced by the West and among women who can freely choose the position of giving birth[6].

In addition, the horizontal position impairs the woman's movement and her contact with the professional who performs the delivery, while the vertical position brings the feeling of greater comfort and enables her to participate more actively during the process[7]. Systematic review in women without epidural analgesia shows that the vertical position contributes to reducing the time of the expulsive period and obstetric interventions, such as forceps and episiotomy. Despite a lower risk for abnormalities in the fetal heart rate pattern in vertical positions, there was no significant difference in neonatal unit admission for newborns compared with lithotomic position. As a disadvantage, the review points to an increase in blood loss and 2nd degree lacerations, without, however, increasing the need for blood transfusions[8].

In the context of the implementation of best practices recommended by WHO in the services, there is a distance between knowledge and the reality of care, so that changing the care model is not easy and mobilizes human competencies that go beyond the acquisition of scientific knowledge and technical skills[9]. Thus, it is up to professionals and services, the updating of clinical practices and constant reflection on the model of care at birth and birth, to ensure the quality of care and enable a positive experience of parturition.

Facing the above, the following study question stands out: How do professionals working in the obstetric unit perceive the adoption of non-lithotomic positions in the expulsive period, since they are opinion makers and active in the process of childbirth and birth? For a better understanding of the subject, this study proposes to unveil the perception of health professionals working in an obstetric unit of a University Hospital about non-supine childbirth.

METHODS

The research is a descriptive study of qualitative approach, which had as its scenario the maternity of a University Hospital in the city of Montes Claros/MG, reference in the humanization of maternal and child care in the northern region of Minas Gerais. The hospital holds the titles Child Friendly Hospital Initiative, given in 2000 and Safe Motherhood, given in 2001, and received the title Galba de Araújo in 2006. It has three pre-delivery/delivery/postpartum units (PPP) with the possibility of assisting the parturient during the whole process of parturition in a single environment and with freedom of position. The physical structure was adapted in 2004 to meet the humanization recommendations provided for by the Ministry of Health's National Program for Humanization of Birth and Birth, 2001, and the prerequisites adopted for adherence to the above-mentioned titles. The idea of providing a more welcoming and private environment for women and their families in the experience of childbirth was reinforced in the 2017 National Guidelines for Normal Childbirth Assistance[1] and, in 2018, the institution underwent a new physical adaptation, offering more comfort in the units, including hot water baths in each PPP environment.

Data collection was performed by one of the researchers in October 2014, in the workplace of the research subjects. A semi-structured interview was used, audio-recorded after consent and conducted by the following questions: What is your view on non-supine positions in the expulsive period? What do you consider contributes or hinders the adoption of these positions by the professionals who assist the delivery?

Inclusion criteria were: over two years working in the field, being an obstetrician, resident of gynecology and obstetrics, nursing technician or obstetric nurse. Ten workers participated: one obstetric nurse, two obstetricians, one resident in gynecology and obstetrics and six nursing technicians. The total number of participants was established considering the repetition of information obtained by theoretical saturation.

To favor the characterization of the participants, a field research script was adopted, covering information such as age, occupation and working time in the field. Respondents were identified in the statements by the letter E followed by the Arabic number corresponding to the order in which they were performed.

The findings were analyzed using the Content Analysis technique[10], choosing categories that, based on a common title, gathered elements whose grouping was arranged by their similarities. To explore the testimonies, coding was performed, which consisted of clipping the units of record and context of the participants' speeches and gathering the emerged contents into categories. The treatment of the results was done through its organization according to emerged categories.

The research began after the authorization of the institution and the Research Ethics Committee of the State University of Montes Claros (UNIMONTES) with Opinion n. 816.309, September 19th, 2014. The ethical and legal aspects recommended by Resolution n. 466 of December 12th, 2012 of the National Health Council were followed. Workers were invited to participate voluntarily and informed about the proposed objectives and those who accepted the invitation signed the Informed Consent Form.

RESULTS AND DISCUSSION

The age range of the participants was 27 to 59 years old, with an average of 40.2 years old. Regarding gender, two were males and eight females. Regarding time working at the institution, it ranged from 6 to 31 years, with an average of 11.5 years.

Content analysis allowed us to unveil the following three categories:

Recognizing advantages and encouragements to use non-lithotomic positions

This category reveals the participants' positive perceptions about the use of non-lithotomic positions in childbirth and the favoring aspects to the adoption of this practice. Among these advantages, Obstetric Unit workers recognized in vertical childbirth a more comfortable and faster way of giving birth to women and more favorable to the fetus, as reported below:

> It is more comfortable for women, she is in a position that is more pleasant for her and for the baby. (E1)

> For women, it helps to improve the pattern of contraction. (E3)

> The delivery is also faster because she is already there, in that position for the baby to really go down, then she pushes, she is squatting, and the baby is forcing. (E9)

The workers' perceptions corroborate with findings in the literature showing that childbirth in an upright position, on knees or in a chair, is more comfortable for the parturient woman in the expulsive period, as she has gravity in her favor. In addition to reducing the time of the expulsive period, the non-supine position favors the regularity of contractions in relation to her shape and rhythm, allows better fetal oxygenation and contributes to a lower prevalence of episiotomy[5,7,8].

The shift from the technicist paradigm to humanized care, using scientific evidence, is slowly occurring in services and vocational training, pointing to the complexity of this process[9,11]. In this study, some professionals recognized that, in the institution, there is a still incipient tendency to adopt different positions, according to the following statements:

> Oh! Yes "[...]" is starting to have a change. But still, slowly. Vertical delivery is not the most used yet, but it is appearing more. (E1)

> But it is a process, right, a paradigm shift that is slowly going. (E4)

Among the factors that favor or contribute to adherence to childbirth in non-supine positions, respondents highlighted aspects involved in two major areas: the guidance provided to pregnant

women and the awareness/humanization of professionals involved in childbirth care, highlighted below:

> What contributes, I think is mostly the guidance, in welcoming the pregnant woman here in the maternity ward. "[...]". Since early labor starts, begin talking about positions that are helpful to the mother. Sometimes, even during prenatal, talk about labor, normal childbirth positions. (E5)

> Because she needs to be advised that she can deliver child anywhere she wants. (E7)

The importance of guidance on childbirth, from prenatal care and the reinforcement of this information to admission for childbirth care, were highlighted in the statements above. The more information is made available to the woman, the more chance she will have to assume as a protagonist in the birth scenario. The preparation of the pregnant woman should be started early and include information on good practice, possible positions in the expulsion period and the advantages and disadvantages of each. Information can support and strengthen it in their choices, enabling them to actively participate in the parturition process[6,12].

A study that evaluated the impact of intervention measures, such as professional training, for adherence to good practices in childbirth care showed that, after training, the frequency of delivery in the lithotomic position went from 28% to zero, while the use of squatting position increased from zero to 16% [9]. This study pointed to similar perceptions:

> What contributes to this is the awareness of the professional; the professional who is sensitized to work, to use this position at the time of delivery, he/she will certainly use it. (E2)

> As they [doctors] learn, they see others do as well and it ends up motivating and encouraging to start doing. We see this here with a resident who wants to do it, who will do with an obstetric nurse, the doctors who are more sensitive are also following [...] so, I think that what favors is seeing others doing in practice and seeing that it really evolves well. (E3)

> After I entered the residence, it totally changed, I tell everyone who asks me that I am a defender of vertical childbirth. (E5)

The statements above highlight the central role of vocational training in changing the technical assistance model and the crystallized institutional routines. However, the transmission of obsolete and harmful practices is often found in educational institutions in Brazil[9,11,13] and is a major challenge in changing the care paradigm. There is a tendency in the South and Southeast regions to introduce humanized care practices which includes choosing the position to give birth. However, according to the authors, for the effective implementation of the humanized model, the incorporation of new attitudes by professionals is essential as a focus on teamwork and guaranteeing the rights of women and their newborns[13].

Another favorable aspect to the paradigm shift recognized by the interviewees was the participation of the obstetric nurse in childbirth. For them, the availability and willingness to perform the delivery in alternative positions are higher among obstetric nurses and their presence is recognized as a key for changing paradigms. However, most of the deliveries in the institution are assisted by doctors, which was considered a hindering factor in the expansion of non-supine delivery in the institution, as observed in the following statements:

> Here we do not have many obstetric nurses. Obstetric nurses opt for this type of delivery: squatting, childbirth in bed and the doctor does not, the doctor prefers traditional childbirth. (E7)

> But here at the hospital, most births are conducted by doctors, at least on my shift. Hardly a nurse conducts a birth here. (E2)

Nurses' training for obstetric practice stimulates female protagonist role and the physiology of childbirth[14,15] and their role in the care of habitual risk delivery is related to higher satisfaction of women, lower rates of interventions such as episiotomy and assisted childbirth by forceps or vacuum extraction and greater chances of spontaneous vaginal delivery, especially when they can act autonomously[16].

A study that analyzed 2,914 deliveries assisted by obstetric nurses in two maternity hospitals in Rio de Janeiro showed a high prevalence of the use of vertical positions for the expulsive period (81.45%), considering that 59.73% of deliveries were assisted by obstetric nurses[15]. In another study with 23,894 postpartum women between 2011 and 2012, a significant association was observed between

midwifery care and good practices, including non-vertical positions[17].

Contradictorily, a study conducted in Belo Horizonte, MG, reported prevalence of lithotomic position in 66.8% of births, although 71.6% of them were assisted by obstetric nurses[3]. The ambivalence in the study results may be related to the nurses' low professional autonomy in the hospital setting of childbirth care, a space where medical hegemony prevails.

Realizing obstacles to changing paradigms in birth position

In this category, speeches that express the perception of obstacles or challenges to the adoption of non-lithotomic positions in childbirth in that institution were gathered. In this field, cultural aspects related to the professional role, especially doctors, women and the physical structure of the institution were pointed out, as showed below:

> So, we get used to the routine right? The traditional position has long been the gynecological position. (E8)

> Here what happens most is the conventional birth I do not know why, [...] We do not know very well why the professionals do not believe in this, since all the evidence shows the advantages. (E10)

Even after two decades of World Health Organization recommendations for assisting vaginal delivery, adherence of professionals to good practices is still limited[4,13,18]. A determining factor for the maintenance of culturally rooted practices is the overvaluation of professional and personal experiences to the detriment of scientific evidence and behaviors conditioned by cultural, political, economic and religious beliefs[11,12]. In this scenario, the culture/medical education itself based on traditional care assumes a prominent role:

> Vertical delivery for the professional is more uncomfortable [...] and is also very cultural, right. He/she's too used to doing in the gynecological position so, for them, there is some resistance to changing that. (E1)

> And it is something that is less comfortable for the professional [...] and by training, the medical professional is trained to be comfortable in the first place, right? And do not prioritize the patient. (E3)

For some authors, this resistance by the physicians is due to the fact that they have been taught and used to control childbirth and to position the parturient in lithotomy[6,13,18]. This reinforces the importance of continuing education for professionals involved in childbirth care, particularly physicians, about scientific evidence and how to assist childbirth in different maternal positions. There was an increase in the use of the lithotomic position by about 5% after educational intervention on childbirth care, highlighting good practices in a public maternity hospital in Amapá. But it was not clear in the study whether the increase is due to the impact of the educational measure or the expansion of the performance of obstetric nurses[19].

Another cultural issue, which prevents the use of vertical positions, is the social representation of the lithotomic position. Condemning women to passivity is a way of denying their autonomy and reinforcing the authority of the health professional and their power to control the parturition process and the female body[12]. The verticalization of hierarchical relations between professional and parturient is another determining factor in the paradigm shift.

Regarding the role of women in the childbirth and birth scenario, the team believes that their lack of knowledge about the positions that favor labor makes her insecure to assume different positions from the traditional, that is, the horizontal position, which explains her refusal:

> There are patients who, when they say, 'it is squatting,' they don't want it, I have seen it. They say: 'oh, the birth is squatting', 'oh no, I won't go'. (E9)

> Who must decide this is the woman during this her process! In what position do you think your baby should be born in? Do you want to try a squatting or half-lying position or sitting on the floor or on the obstetric bench? Or in the bathtub? (E10)

It is essential that relevant information is provided to women at the right time, which will allow them to make their own decisions[12].

One of the interviewees also considered that women should be physically prepared to deliver

in non-lithotomic positions, as reported below:

> Because in order to have a vertical birth, the woman also must have a better physical preparation, she needs to be psychologically prepared for that type of delivery, so it is very changeable. (E6)

Such a claim may, in fact, signify professional resistance to offer this possibility to women and to guide them about the advantages of this position. No studies were found that prove the need for physical exercise or specific psychological preparation for the delivery in an upright position, as stated by the interviewed professional.

Another aspect mentioned by one of the interviewees as a disadvantage of the upright position during the expulsive period of delivery was increased bleeding, as follows:

> The only disadvantage is that in squatting, the vertical position, one loses more blood than in conventional birth. (E10)

Studies show the association between vertical delivery and increased risk of uterine bleeding above 500 ml. However, there was no increase in the need for blood transfusion, relativizing the clinical impact of this finding[5,8]. The allegation of increased blood loss as a hindering factor for upright position suggests the interpretation of scientific evidence according to Professional staff point of view. In this case, it seems that the professional is aware of the blood increase evidenced in the studies but does not recognize the lack of clinical impact of this disadvantage.

Finally, the hospital structure was a point of divergent perception among respondents. For some, the service does not provide the necessary resources and for others the structure is not a determining issue for the paradigm shift, as follow:

> There is only one squatting chair. You understand? (E4)

> I think that makes it more difficult is the structural issue as well. [...] but, it is a matter of structure. We have an alternative delivery room, but the structure is, honestly, precarious. (E8)

> Because we have all the conditions to have a vertical birth here (...) our PPs are all equipped with a vertical or semi-vertical delivery table, [...] in the vertical or semi-vertical position, somewhat inclined. (E10)

Although the hospital environment is an important factor, the hospital structure for childbirth care in the context of humanization does not require major changes in its physical structure. In the expulsive period, verticalization can be achieved in many ways, without necessarily requiring significant resources, although there are technologies for this purpose, such as vertical delivery chairs, bathtubs, etc.

The ambivalence of the answers reveals that the hospital infrastructure is not used by all professionals, which reinforces that delivery in vertical positions is strongly linked to the disposition of the professional and thus depends on their training/awareness.

Experiencing non-lithotomic childbirth from the professional's perspective

This category expresses the professionals' experiences and perceptions about vertical childbirth. Although childbirth care in non-lithotomic positions, especially vertical childbirth, is advocated by some of the team members, there have been contradictions between what is said and effective action. In the exercise of their practice, professionals, as subjects, express their way of understanding childbirth, influenced by cultural, social aspects and the training model, as previously discussed. The following statements confirm the dichotomy between discourse and professional practice:

> From the experiences I've had, some were positive, some were not. [...] I, if it were me, would not choose to have. [...]. I would not want to give birth in upright position man, I would rather do it in the traditional position, right? (E8)

> Squatting, I personally find it a discomfort for the patient because she stays in that position there, it's too much exposure, right? It gets very exposed then. It's my point of view, right? [...]everyone watching, you know? There are times when I feel they get embarrassed sometimes. (E9)

Therefore, the perception and opinion about the practices adopted in the service and which disclose an internal aspect of the individual/professional, may overlap with their knowledge, as the statements above. In the daily practice of services, it is observed the use of both practices without scientific basis and good practices[20]. It seems that childbirth care and

changes in the paradigm are linked to the availability and sensitivity of the professional to adopt scientific evidence, superimposing it on their opinion. This is a central aspect of stopping technical assistance[20].

The transfer of knowledge about the use of scientific evidence in clinical practice and its implementation are actions of a complex and dynamic process, which requires proper studies and methodologies for its accomplishment[9,19]. Thus, the paradigm shift in childbirth care transcends the implementation of new evidence-based routines and permeates the relationships involving the subjects involved in this context, which may explain the slowness of the process.

The need for a broader approach to the subject in the undergraduate curriculum of medical and nursing courses and its introduction in the training of nursing technicians is evident. It is also essential to train all health care staff involved in childbirth care and pregnant women for the informed choice of positions that can be adopted during the expulsive period of birth, as well as the issues pertinent to their parturition process.

Finally, knowing the perception of professionals who assist women during childbirth was important to outline intervention proposals, but, as the paradigm shift involves prenatal care, it is also important to know the perception of professionals working in this field. Thus, further studies with this approach are suggested.

FINAL CONSIDERATIONS

Professionals working in the Obstetric unit realize the advantages of non-lithotomic delivery and the need for a paradigm shift in childbirth care, which has already been incipient in the scenario institution. However, the obstacles identified for adhering to the new approaches denote, in fact, the predominance of the biomedical model and its influence on childbirth care culture. Therefore, every effort should be made to return the woman to the role of childbirth, including choosing the most appropriate position for childbirth. Obstetric nurses can contribute to this transition.

PARTO EM POSIÇÃO NÃO SUPINA: PERCEPÇÃO DE PROFISSIONAIS NA ASSISTÊNCIA HOSPITALAR

RESUMO

Introdução: a posição supina predomina no contexto nacional de assistência ao parto vaginal, embora haja evidências científicas favoráveis à adoção de outras posições no período expulsivo, com vantagens para mãe e recém-nascido. **Objetivo:** desvelar a percepção de profissionais de saúde que trabalham em bloco obstétrico de Hospital Universitário acerca do parto em posição não supina**. Métodos:** estudo qualitativo, descritivo, realizado com trabalhadores desse setor. Foram entrevistados 10 profissionais das áreas médica ou de enfermagem. Dados coletados por entrevistas semiestruturadas e submetidos à Análise de Conteúdo**. Resultados:** foram desveladas três categorias temáticas: reconhecendo vantagens e estímulos ao uso de posições não litotômicas; percebendo obstáculos à mudança de paradigmas na posição de parir; vivenciando o parto não litotômico na perspectiva do profissional. A análise dos dados revelou divergências entre o conhecimento e a prática, destacando-se a influência do modelo biomédico na rotina de assistência ao parto. **Considerações finais**: sugere-se a realização de educação permanente e sensibilização da equipe de assistência à parturiente além de seu empoderamento por meio de orientação pré-natal pertinente para a efetivação das boas práticas na atenção ao parto incluindo o uso de posições não supinas no período expulsivo.

Palavras-chave: Parto Humanizado. Enfermagem Obstétrica. Conhecimento. Equipe de Assistência ao Paciente. Medicina Baseada em Evidência.

PARTO EN POSICIÓN NO SUPINA: PERCEPCIÓN DE PROFESIONALES EN LA ATENCIÓN HOSPITALARIA

RESUMEN

Introducción: la posición supina predomina en el contexto nacional de atención al parto vaginal, aunque haya evidencias científicas favorables a la adopción de otras posiciones en el período expulsivo, con ventajas para madre y recién nacido. **Objetivo:** desvelar la percepción de profesionales de salud que trabajan en el departamento obstétrico de Hospital Universitario respecto al parto en posición no supina**. Métodos:** estudio cualitativo, descriptivo, realizado con trabajadores de este sector. Fueron entrevistados 10 profesionales del área médica o de enfermería. Datos recolectados por entrevistas semiestructuradas y sometidos al Análisis de Contenido**. Resultados:** fueron desveladas tres categorías temáticas: reconociendo ventajas y estímulos al uso de posiciones no litotómicas; percibiendo barreras

en el cambio de paradigmas en la posición de parir; viviendo el parto no litotómico en la perspectiva del profesional. El análisis de los datos reveló divergencias entre el conocimiento y la práctica, destacándose la influencia del modelo biomédico en la rutina de atención al parto. **Consideraciones finales**: se sugiere la realización de educación permanente y sensibilización del equipo de atención a la parturienta además de su empoderamiento por medio de orientación prenatal pertinente para la efectividad de las buenas prácticas en la atención al parto, incluyendo el uso de posiciones no supinas en el período expulsivo.

Palabras clave: Parto Humanizado. Enfermería Obstétrica. Conocimiento. Equipo de Atención al Paciente. Medicina Basada en Evidencia.

REFERENCES

1. Ministério da Saúde (BR). Secretaria de Ciência, Tecnologia e Insumos Estratégicos. Departamento de Gestão e Incorporação de Tecnologias em Saúde. Diretrizes nacionais de assistência ao parto normal: versão resumida [recurso eletrônico]. Brasília (DF): Ministério da Saúde [on-line]. 2017. [citado em 2017 Nov]; 51. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf.

2. Monteschio LVC, Sgobero JCGS, Oliveira RR, Deise Serafim D, Mathias TAF. Prevalence of medicalization of labor and delivery in the public health network. Cienc Cuid Saude [on-line]. 2016. [citado em 2019 Jul]; 15(4):591-598. doi: http://dx.doi.org/10.4025/cienccuidsaude.v15i4.33420.

3. Sousa AMM, Souza KV, Rezende EM, Martins EF, Campos D, Lansky S. Practices in childbirth care in maternity with inclusion of obstetric nurses in Belo Horizonte, Minas Gerais. Esc Anna Nery [on-line]. 2016 [citado em 2017 Nov]; 20(2):324-331. doi: http://dx.doi.org/10.5935/1414-8145.20160044.

4. Leal MC, Pereira APE, Domingues RMSM, Filha MMT, Dias MAB, Pereira MN, Bastos MH, Gama SGN. Obstetric interventions during labor and childbirth in Brazilian low-risk women. Cad. Saúde Pública [on-line]. 2014 [citado em 2017 Nov]; 1(30):17-47. doi: http://dx.doi.org/10.1590/0102-311X00151513.

5. Desseauvea D, Fradet L, Lacouture P, Pierre F. Position for labor and birth: State of knowledge and biomechanical perspectives. Eur J Obstet Gynecol Reprod Biol [on-line]. 2017 [cited 2017 Nov]; 208:46-54. doi: http://dx.doi.org/10.1016/j.ejogrb.2016.11.006.

6. Odent M. Pode a humanidade sobreviver à medicina? Instituto Michel Odent, Rio de Janeiro, 2016. 201p

7. Silva LS, Leão DCMR, Cruz AFN, Alves VH, Rodrigues DP, Pinto CB. Os saberes das mulheres acerca das diferentes posições de parir: uma contribuição para o cuidar. Rev enferm UFPE [on-line]. 2016 [citado em 2017 Nov]; 10(Supl.4):3531-6. doi: http://dx.doi.org/10.5205/reuol.9681-89824-1-ED.1004sup201604.

8. Grupta JK, Hofmeyr GJ, Shehmar M. Position in the second stage of labour for women without epidural anaesthesia. Cochrane Database Syst Rev. [on-line]. 2017 [citado em 2017 Nov]; doi: https://doi.org/10.1002/14651858.CD002006.pub3.

9. Côrtes CT, Santos RCS, Caroci AS, Oliveira SG, Oliveira SMJV, Riesco, MLG. Implementation methodology of practices based on scientific evidence for assistance in natural delivery: a pilot study. Rev Esc Enferm USP [on-line]. 2015 [citado em 2017 Nov]; 49(5):716-725. doi: http://dx.doi.org/10.1590/s0080-623420150000500002.

10. Bardin, L. Análise de Conteúdo. Lisboa: Edições 70, 2011.

11. Busanello J, Kerber NPC, Fernandes GFM, Zacarias CC, Cappellaro J, da Silva ME. Humanização do parto e a formação dos profissionais da saúde. Cienc Cuid Saude [on-line]. 2011 [citado em 2017 Nov]; 10(1):169-175. doi: http://dx.doi.org/10.4025/cienccuidsaude.v10i1.8533.

12. Reis TLR, Padoina SMM, Toebe TRP, Quadros CCPJS. Women's autonomy in the process of labour and childbirth: integrative literature review. Rev Gaúcha Enferm. [on-line]. 2017 [citado em 2017 Nov]; 38(1):e64677. doi: http://dx.doi.org/10.1590/1983-1447.2017.01.64677.

13. Pereira RM, Fonseca GO, Pereira ACCC, Gonçalves GA, Mafra RA. Novas práticas de atenção ao parto e os desafios para a humanização da assistência nas regiões sul e sudeste do Brasil. Ciênc. saúde colet [on-line]. 2018 [citado em 2019 Jul] 23(11). doi: http://dx.doi.org/10.1590/1413-812320182311.07832016.

14. Lima MFG, Pequeno AMC, Rodrigues DP, Carneiro C, Morais APP, Negreiros FDS. Developing skills learning in obstetric nursing: approaches between theory and practice. Rev Bras Enferm [on-line]. 2017 [citado em 2017 Nov]; 70(5):1054-60. doi: http://dx.doi.org/10.1590/0034-7167-2016-0665.

15. Vargens OMC, Silva ACV, Progianti JM. The contribution of nurse midwives to consolidating humanized childbirth in maternity hospitals in Rio de Janeiro-Brazil. Esc Anna Nery [on-line]. 2017 [citado em 2017 Nov]; 21(1):e20170015. doi: http://dx.doi.org/10.5935/1414-8145.20170015.

16. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews [on-line]. 2016 [citado 2017 Nov]. doi: https://doi.org/10.1002/14651858.CD004667.pub5.

17. Gama SG, Viellas EF1, Torres JA, Bastos MH, Brüggemann OM, Theme Filha MM, Schilithz AOC, Leal MC. Labor and birth care by nurse with midwifery skills in Brazil. Reproductive Health. [on-line]. 2016 [citado em 2017 Nov]; 13(Supl.1):46-54. doi: https://doi.org/10.1186/s12978-016-0236-7.

18. Andrade PON, Silva, JQP, Diniz CMM, Caminha MFC. Fatores associados à violência obstétrica na assistência ao parto vaginal em uma maternidade de alta complexidade em Recife, Pernambuco. Rev. Bras. Saúde Matern. Infant. [on-line] 2016 [citado em 2017 Nov]; (1):2. doi: http://dx.doi.org/10.1590/1806-93042016000100004.

19. Côrtes CT, Oliveira SMJV, Santos RCS, Francisco AA, Riesco MLG, Shimoda GT. Implementation of evidence-based practices in normal delivery care. Rev. Latino-Am. Enfermagem [on-line]. 2018 [citado em 2019 Jul]; 26:e2988. doi: http://dx.doi.org/10.1590/1518-8345.2177.2988.

20. Melo LPT, Doudou HD, Rodrigues ARM, Silveira MAM, Barbosa EMG, Rodrigues DP. Practices of health professionals in delivery and birth care. Rev Rene. [on-line]. 2017 [citado em 2017 Nov]; 18(1):59-67. doi: http://dx.doi.org/10.15253/2175-6783.2017000100009.

Corresponding author: Camilly Roberta da Silva. Rua Roraima, 231 Ibituruna, Montes Claros, Minas Gerais. Cep: 39401286. E-mail: camilly@yahoo.com.br

Submitted: 02/11/2018
Accepted: 17/07/2019