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PERCEPTION OF PUERPERAS ON THE VERTICAL POSITION IN CHILDBIRTH

PERCEPÇÃO DE PUÉRPERAS SOBRE A POSIÇÃO VERTICAL NO PARTO

PERCEPCIÓN DE PUERPERAS ACERCA DE LA POSICIÓN VERTICAL EN EL PARTO

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Objective: to describe the perception of puerperae about the vertical position adopted in labor and delivery. Method: this is a descriptive study using a qualitative approach developed in 2014 in a reference maternity hospital in Teresina, Piauí, Brazil. Participants were eight puerperal women with a normal vertical birth. Data were analyzed using the content analysis technique. Results: four categories emerged: women's knowledge in terms of vertical positions; perception of the obstetric nurse's presence in the parturition process as an incentive to vertical positions; memories of the experience of childbirth in other positions; and perceptions of puerperal mothers on birth in the upright position. Conclusions: the puerperae positively evaluated the vertical position of their choice and related it to the greater autonomy of women in childbirth, less professional intervention, faster descent of the fetus, reduction of labor time, decrease of pain and greater comfort.

Descriptors: Labor Stage, Second. Positioning of the Patient. Obstetric Nursing.

Objetivo: descrever a percepção de puérperas acerca da posição vertical adotada no trabalho de parto e parto. Método: estudo descritivo de abordagem qualitativa desenvolvido em 2014, em uma maternidade de referência de Teresina, Piauí, Brasil. As participantes foram oito puérperas com histórico de parto normal na posição vertical. Os dados foram analisados por meio da técnica de análise de conteúdo. Resultados: emergiram quatro categorias: tipo de conhecimento das mulheres sobre as posições verticais; percepção da presença da enfermeira obstetra no processo de parturição como incentivo às posições verticais; recordações da vivência de partos em outras posições; e percepções das puérperas sobre o parto na posição vertical. Conclusões: as puérperas avaliaram positivamente a posição vertical de sua escolha e a relacionaram à maior autonomia da mulher no parto, menor intervenção profissional, descida mais rápida do feto, redução do tempo de trabalho de parto, diminuição da dor e maior conforto.

Descritores: Segunda Fase do Trabalho de Parto. Posicionamento do Paciente. Enfermagem Obstétrica.

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Objetivo: describir percepciones de puérperas acerca de la posición vertical adoptada en el trabajo de parto y parto. Método: estudio descriptivo, cualitativo, desarrollado en 2014, en maternidad de referencia de Teresina, Piauí, Brasil. Las participantes fueron ocho puérperas con historia de parto normal en posición vertical. Datos analizados por medio de la técnica de análisis de contenido. Resultados: surgieron cuatro categorías: tipo de conocimiento de las mujeres sobre posiciones verticales; percepción de la presencia de enfermera obstetra en el proceso de parturición como incentivo a posiciones verticales; recuerdos de la vivencia de partos en otras posiciones; y percepciones de puérperas sobre parto en posición vertical. Conclusiones: las puérperas evaluaron positivamente la posición vertical de su elección y la relacionaron a la mayor autonomía de la mujer en el parto, menor intervención profesional, descenso más rápido del feto, reducción del tiempo de trabajo de parto, disminución del dolor y mayor confort.

Descriptores: Segundo Periodo del Trabajo de Parto. Posicionamiento del Paciente. Enfermería Obstétrica.

Introduction

Since the dawn of civilization, the vertical position has been chosen instinctively by women during childbirth. Cleopatra, Egyptian queen of the Ptolemy dynasty, had her birth portrayed by hieroglyphs, in which she crouched, sitting on two short piles of bricks, and standing. According to Greek mythology, the mother of Apollo, the sun god, embraced the palm tree with both hands, propped her feet against the soft ground, and gave birth. Until the beginning of the modern era, childbirth was the responsibility of women, only. The theory, training, and practice were attributed to midwives, who used to assist the parturient without the help of a physician or surgeon. However, these customs underwent a profound change in the seventeenth century, when surgeons entered the scene in obstetric practice[1].

Admittedly, the advancement of medicine has contributed greatly to the improvement of indicators of maternal and perinatal morbidity and mortality; however, such participation has contributed to the transformation of childbirth and birth into a synonym for disease. In the twentieth century, around the 1940s, the possibilities of intervention were expanded. Thus, the experience of childbirth, once experienced in a private and family environment, lost space and occupied the public and institutionalized sphere, with several actors conducting the parturition process, which made the woman subject to the procedures adopted in the light of science[2-3].

Birth in the hospital environment is characterized by the adoption of various technologies and procedures in order to make it safe. However, the routine use of some of these procedures and technologies over time makes women and newborns exposed to innumerable invasive, sometimes unnecessary, practices such as episiotomy, forceps, amniotomy, caesarean section, the use of oocytes, among others[4]. As a condition for performing some of these practices, women assume lithotomic positions to facilitate professional interventions at the time of childbirth, rendering vertical positions obsolete.

However, changes have occurred in the last decades, in the national and international obstetric scenario, being most noticeable after the publication of the "Good Practices of Attention to Childbirth and Birth" in 1996 by the World Health Organization (WHO)[5]. In the state of Amapá, Brazil, the study shows positive results in favor of good practices in childbirth care, with a significant increase in the presence of the companion and use of upright or squatting positions, reduction of amniotomy rates, use of intravenous oxytocin and of the lithotomic position[6].

Another success provoked in the Brazilian national scenario by the global actions in favor of humanized childbirth, through the National Humanization Policy, was Ordinance No. 1.459, of June 24, 2011, which instituted, within the scope of the Unified Health System (*Sistema* Único *de Saúde* – SUS), the Stork Network, published in the perspective of the humanization of women's care. This strategy brings delivery and birth as a component in a clear and direct way, guides the

use of practices based on scientific evidence and returns to women their role as a subject in the process of parturition[7].

To systematize the use of good practices based on scientific evidence, in Brazil, the Ministry of Health made available the "National Guidelines for Assistance to Normal Birth". Within these guidelines, the orientation of the use of vertical positions for labor and delivery resurfaces, and it is incumbent upon health professionals to encourage them. It is the woman's right to be informed about birth positions and choose the one she finds most comfortable to give birth. Some of the vertical positions oriented are the sitting position (childbirth chair); the semi-lying position (trunk tilted back 30 degrees to vertical); squatting; and four supports (hands-and-knees). The benefits brought about are the reduced duration of the second period of labor, reduction of instrumented and episiotomy deliveries, reduction of fetal heart rate abnormalities and reduction of pain compared to horizontal positions[8].

Vertical positions are still underused, as some studies point out. In a survey carried out in the Northeast of Brazil, in 11 maternity hospitals, with a sample of 456 puerperal women of normal birth, it was evidenced that 95.2% of the deliveries were in the lithotomic position[9]. In another study, with a sample of 238 women, in a survey conducted in the South of the country, there were almost 67% reports of childbirth with women *giving birth on their backs with their legs raised*, making reference to the lithotomic position. Assuming this position may be related to a great cultural value added to the horizontal position by health professionals as well as women. Although the horizontal position is classified as a harmful practice, it is still in the routine of most health services[10].

In view of this reality, and in order to better understand this phenomenon, the following problem question was developed for the development of the research: What is the perception of puerperae about the experience of giving birth in a vertical position? The aim of this study was to describe the perception of puerperae about the vertical position adopted in labor and delivery.

Method

This is a descriptive study of a qualitative approach developed at a reference maternity hospital in Teresina, Piauí, Brazil. Data collection took place from November to December 2014.

Nine puerperal women who had undergone normal birth in the vertical position were identified and they met the adopted inclusion criteria: having undergone the experience of giving birth in the vertical position and having a history of normal birth in the horizontal position in one or more previous deliveries; puerperal women hospitalized in the maternity ward; and being over 18 years of age. Postpartum women with multiple or stillborn fetuses and women who were hearing impaired were excluded.

The interview was the strategy adopted for data collection, using as a tool a semi-structured script to obtain information about demographic data and obstetric history, such as number of pregnancies, parity, number of prenatal consultations and positions used in previous and current deliveries, in addition to the following research questions: "How was your recent birth?", "Did you know that there are different positions for a woman to give birth?", "What do you have to say about the upright position?".

Only eight postpartum women were interviewed, since one of them was discharged before the interview, after being accepted to participate. The interviews were conducted by a trained and skilled nurse, who was active in the research scenario during the collection period. The questions were conducted in the presence of the companion, and the factors in the environment that could cause embarrassment or interfere in the speech of the participants at the time of the interviews, which lasted on average 15 minutes, were observed and avoided.

The testimonies were recorded and later transcribed in full. The transcripts were not shown to the participants due to the brief period of hospitalization after natural delivery.

The starting point for the content analysis was the organization of the data, which turned to three poles, as it guides publication on this methodology[11]: the pre-analysis, the exploration of the material and, finally, the treatment of the results (inference and interpretation). The last pole was the one that allowed establishing results, with respect to the intended objectives, or that they related to other unexpected discoveries.

The research protocol was approved by the Research Ethics Committee of the Federal University of Piauí, through Opinion number 880.602. Participants were clarified about the objectives and the development of the research, and expressed desire to participate in writing, signing the Informed Consent Term. The ethical aspects are in accordance with Resolution No. 466/2012 of the National Health Council.

Results

The eight mothers who participated in the research were aged between 18 and 33 years. Of these, two were married, four had a stable union and two claimed to be single. As for schooling, three had completed high school, one had completed elementary school and four had incomplete elementary school. Most of the women were from the countryside region of Piauí. As to family income, six declared to earn a minimum wage; one earns more than two minimum wages; and another is dependent on her parents. In the item occupation, four were housewives, one was a farmer, one was a saleswoman, one was a school coordinator, and one was unemployed.

Regarding the obstetric characteristics, five mothers in their second delivery and three multiparous participated. All of them underwent prenatal care. The vertical positions adopted by the puerperas were two standing, one sitting on the horse and five sitting on a stool.

From the data collection, four categories emerged: women's knowledge in terms of vertical positions; perception of the presence of the obstetrician in the process of parturition as an incentive for vertical positions; memories of experiences of childbirth in other positions; and perceptions of puerperal mothers on birth in the upright position.

Women's Knowledge in terms of Vertical Positions

In this category, gaps in the information process for pregnant women regarding labor and delivery since prenatal care were identified. All of them reported having performed prenatal care; however, the study revealed that pregnant women did not know the delivery positions in primary care, and some showed that even in the maternity ward. It was noted that knowledge on childbirth was empirically acquired and was based on previous pregnancies, according to testimonials:

> *I only knew that there was that lying position. I said that I wanted to give birth in a standing position, but it was a joke, the first time.* (E1).

> *No, none other than lying down with the legs open.* (E3).

> *No, I had not yet been introduced to them* [birthing positions] [...] *it's new for me.* (E4).

> *I didn't know. I only knew now, my God! I thought it was good, you know?* (E5).

> *I didn't know. I thought I was just lying down.* (E8).

Perception of obstetrical nurse presence in the parturition process as an incentive to vertical positions

The interviewees made reference to the obstetrician nurse in several testimonials. Women reported being welcomed in the parturition process, receiving help for pain relief, emotional support, and general guidelines throughout the parturition process. There were mentions regarding the accomplishment of squatting, ambulation, massage, exercise in the support bar and the right of choice in relation to the position that would offer greater comfort at the time of the childbirth:

> *I went up to give birth, but when I arrived there, I could swear I was going to be received by a doctor, but I was greeted by five nurses, you know?* [Reference to the nurse obstetrician, nursing trainees, and nursing residents in

obstetrics] *But they all went very well, because they gave me several options on how to give birth*. (E3).

There was a nurse, who helped me yesterday [...] *talking to me to see if I could relax* [...] *I exercised on the ball, I squatted with the nurse holding my hand as I crouched, then they took me to another squat, in which I had to hold the bars. I was doing the exercise on the horse yesterday* [...] *I chose the stool, but I did not have time*. (E4).

The nurses put some songs so I could walk and exercise, and I did it [...] *I kept walking and dancing* [...] *they showed me the birth positions. There was a sign on the wall that showed a person in a sitting position with a person behind, squatting. There were several positions. Mine was like this, lying down, but almost sitting down* [half seated] [...]. (E5).

Memories of the experience of childbirth in other positions

In the reports, the interviewees had a history of childbirth in other positions, which led them to compare their memories. In describing their births, they showed evidence that brought the horizontal positions as facilitators for a greater number of professional interventions during childbirth. Some women also reported practices characterized as obstetric violence at birth in the horizontal position, among them the following procedures: Kristeller's maneuver, routine episiotomy during the expulsive period, and too many touches in the perineum during labor[12]. In addition, perineal lacerations were reported in the horizontal positions, according to:

In my first and second delivery, the beds were the same as this reclining bed [...] *there was a place to put my feet* [...] *In the delivery room* [...] *they pressed my belly in the same way, a woman on one side and another on the other. That's why I had a person press here [reference to recent birth], then the boy tore me and I had stitches* [referring to the second childbirth]. (E1).

In the previous birth, I thought it was bad because there was no one to help me. I was alone in bed in pain. The doctors poked me, different people; I thought it was good that they pressed my belly so the boy could leave soon and end the pain. I thought it was bad that I was cut [...] (E2).

[...] *The experience was different from the current* [...] *really bad, because the doctor didn't have much patience. He* [the doctor] *told me to remain lying down, and asked me to push. Since I wasn't that strong, he lay on top of me; Instead of putting his arm on my belly to press down, he put his elbow, and then it got really sore. It was sore for two weeks. He also had to cut me down there, and I had some stitches* [...] *I had all those problems with the stitches*. (E3).

The previous birth was more uncomfortable, because in the lying position, it is more complicated for us to help, and this is because our legs are up [...] *Once the water broke, they did that little cut down there, and soon she was born. It didn't take as long as this*. (E4).

In bed, it was lacerated. I had some stitches. (E7).

In the perception of some puerperal women, procedures such as episiotomy, Kristeller and excessive vaginal touches seem to be considered as part of normal delivery, with reports of the same experience in different deliveries.

Perceptions of postpartum women on upright delivery

As to the vertical position, overall, women rated it as a positive experience. In analyzing the reports, it is possible to see impressions and sensations, such as the rapidity of descent of the fetus, less professional interference, greater comfort in the pulls, and also the fear of the child falling. In addition, they reported the occurrence of lacerations, when talking about the stitches:

The position [vertical] was the best, because it was quick. The lying position takes much longer, and they have to keep pressing us [Kristeller maneuver] *and with that position here I just sat down and the boy came down*. (E1).

I thought it was good that people helped me to have the baby faster. The delivery was fast, the position comfortable, but strange. I had never had a boy like that before. I thought it was better to push in the sitting position. I had some stitches later. (E2).

On the stool I was afraid the boy would fall to the ground. [...] *I didn't need to be cut and stitched* [...] *It was different from now, because they asked me not to push*. (E3).

The sitting position was better than lying down because I had to push him to get out faster. I had some stitches and I have normal bleeding. (E4).

The boy falls faster. I had the first, second, and fourth pregnancies [referring to childbirth] *sitting* [...] (E6).

It was a unique experience. I got no stich. I felt a lot of pain though. (E7).

The painful perception appears in the statements through the word pain, which appears repeatedly in the transcriptions related to women position, both during the active phase and during delivery and postpartum. According to the women, when they were standing or sitting, the pains (referring to the contractions)

were less intense. In the expulsive period, women reported less vertical pain, less pain in the horizontal position and others reported pain, but did not compare with the position of labor. In general, the vertical positions were associated with the reduction of pain by the majority of the women, according to testimonials:

> *When we lie down, it's more painful than sitting.* [Referring to the expulsion period] [...] *When I lied down for a while, the pain was twice stronger than it was in the standing position. Then I stood up again and squatted, and the pain of contraction eased.* (E3).
>
> *Much pain. I felt more pain when I was lying down. When I got up, it eased. Then I started to walk* [...] *I got sore!* [Regarding postpartum] (E4).
>
> *It wasn't painful; I didn't feel pain afterwards, nothing, nothing!* (E5).
>
> *We notice that we feel way less pain. I don't know if it is, but at least it feels like there is much less pain. Back pain increases when you are lying down.* (E6).
>
> *I felt more pain now* [...] *I was lying down before delivery* [...] (E7).
>
> *In this* [recent birth] *I felt more pain. I almost died! I screamed in the whole hospital* [laughs]. (E8).

Discussion

International research has shown that vertical positions are poorly used within maternity wards and unknown to most women. A cross-sectional descriptive study at a maternity hospital in Malawi, East Africa, with a sample of 373 low-risk postnatal women, showed that 99.2% of the participants only knew about the supine position as a delivery position[13]. In Nigeria, a study conducted in institutions in the southwest of the country showed a lack of knowledge of the delivery positions of women; only 0.6% had good knowledge, while 19.7% had reasonable knowledge and the remaining 79.7% had little knowledge[14].

In Brazil, a study carried out with interviews by external evaluators of the Program for Improving Access and Quality in Primary Care (*Programa de Melhoria de Acesso e da Qualidade na Atenção Básica* – PMAQ-AB), with a sample of 6,125 women who had their last prenatal care in family health units, found that only 15% received adequate prenatal care, considering all the actions recommended by the Ministry of Health[15]. Prenatal care is the most opportune moment to inform pregnant women about the diversity of vertical positions that could be chosen; however, it has been revealed that there is still much to be improved for quality care.

In a cross-sectional study of 358 postpartum women in southern Brazil, prenatal care, despite having high coverage (85.5%) and early onset in 71.8% of the women, 81.7% reported not having received guidance for delivery during prenatal care[16]. The deficiency of this educational process from prenatal to labor may be one of the factors that prevent women from exercising their citizenship in labor and delivery, being subject to the decisions of health professionals.

Professionals who attend pregnant women no longer perform actions to carry out humanized delivery, including informing about the positions of labor and allowing women to know and choose the most comfortable for them, even though they recognize walking and free positioning as practices that should be undertaken to improve the care delivered and make it humanized[17]. This resistance, found in some professionals as well as in some women, may be associated with a cultural value and continuity of the supine position difficult to break[10].

In this study, the presence of the obstetrician in the scenarios of vertical birth is mentioned by the women in the testimonies. A study carried out in a teaching hospital in the capital of the state of Mato Grosso, which analyzed the insertion and performance of obstetrical nurses, showed that these professionals contribute to the improvement of care for women in childbirth by reducing the interventions considered more invasive. Some examples are episiotomy and caesarean sections, which encourage the use of techniques that preserve the physiology of the parturition process. One of the practices recorded in the survey results was the increase in the number of vertical births[18].

A study conducted in maternity hospitals of the municipal public network of Rio de Janeiro also showed the assistance of obstetricians in the majority of deliveries in vertical positions.

The records of 4,787 births were evaluated. Of these, 59.73% were followed by them, with the predominance of the adoption of upright positions in 78.95% of the sample, at delivery time. The use of non-invasive nursing care technologies was also evidenced, such as women's free movement, ambulation, and the performance of pelvic exercises during labor, including the use of instruments such as physioball, increased use of the delivery chair, massage, sprinkler baths with warm water and use of aromas, performance that is in line with good practices of attention to childbirth[19].

In addition to the fact that most women have the right to information and choice about the vertical positions, which were denied them in previous births, they also reported in the testimonies situations that may be associated with violence. The manifestations of violence in the obstetric scenario can be practiced in various forms, such as power relations against the female body, through communication, in the form of service (bureaucratization of access, lack of reception and resolution) and violation of rights. The woman is in a state of submission, passivity and obedience in the face of the historical and cultural power of health professionals. Unnecessary interventions and procedures, such as routine episiotomy, supine position at birth, abusive oocyte use, and Kristeller's maneuver; performing vaginal touches without authorization and prior explanation; disrespect for privacy; disrespect for physical pain; communication failure, absence of dialogues between professionals and users; and absence of reception[12].

In the testimonies, reports of participants who considered the delivery in a vertical position faster were found. The National Guideline for Assistance to Normal Labor resulted in a systematic review of 19 randomized controlled trials involving 5,764 women, in which the vertical or lateral position, when compared to the supine position, horizontal dorsal decubitus or lithotomy, during the second phase of labor, results in an average reduction of 4.29 minutes in the duration of the second period of labor. In the review, a reduction in the frequency of instrumented deliveries, episiotomies, severe pain during the second period, less abnormal patterns of fetal heart rate, and a decrease in perineal pain were observed in the first 3 days of postpartum. However, as a disadvantage, there was an increase in second degree lacerations and an estimated increase of blood loss of more than 500 ml when the delivery was performed on the stool or delivery chair[8].

Half of the participants reported the occurrence of lacerations; however, the vertical position is not the only risk factor for this occurrence. In a prospective cohort study that collected data on planned home births in Norway, Denmark, Sweden and Iceland between 2008 and 2013, women gave birth in the majority (65.2%) in the flexible positions of the sacrum. The kneeling position was highlighted as the most used birth position, regardless of parity. Although there was a significant occurrence of lacerations, especially in primiparous women, no associations were found between vertical and severe lacerations. Association of vertical positions with less occurrence of episiotomies was also pointed out in the study[20].

The vertical positions do not allow many interventions of the professionals and this fact explains the lower incidence of episiotomies when comparing the vertical and supine positions. Another advantage of vertical positions is its association with a lower incidence of postnatal urinary incontinence[21]. These have also been pointed out as strategies that reduce maternal stress and provide comfort to the mother at the time of delivery, which may result in benefits for her and also for the fetus. It is known that the increase in adrenergic activity caused by maternal stress during labor may be detrimental to the fetus due to hormonal reactions that impair vascularization, reducing utero-placental flow and favoring the occurrence of asphyxia[22].

In general, the vertical position in childbirth has been considered beneficial, due to the physiological advantages on the supine position, such as: effects of gravity; reduction of the risks of compression of the aorta artery and vena cava,

improving blood acid-base balance indicators in newborns; effective uterine contractions; fetus accommodation during its course by the pelvis; and radiological evidence of larger pelvic exit diameters, such as the anteroposterior and transverse[23].

With regard to the pain felt by women in labor and delivery, it is a symptom that is widely variable and subject to influences not only psychic (behavioral) and temperamental (motivation), but also cultural (education) and organic (genetic constitution) and also to the possible deviations of normality (stress), in addition to other factors, such as dystocia that may increase it, and release of endorphins, which may decrease it[24]. Another study revealed that women consolidate pain as a phenomenon of suffering associated with obstetric care gaps and dissatisfaction with the parturition process[25], which confirms the importance of emotional support to the parturient, through orientations in terms of coping with acute pain.

Conclusions

The majority of postpartum women in this study were unaware of different birth positions, which evidences the existence of a gap in the health education process on childbirth and birth that occurs from the prenatal period and prevents women from being subjected to their delivery. Thus, the vertical position was presented only at the time of delivery.

Women perceived the upright position as good to be adopted at delivery and were left with a positive impression of the experience.

The testimonies showed a differentiated assistance, in which the professional gained the confidence of the parturient, making her feel supported and at the same time free to make decisions that were previously unknown. The obstetrician nurse was cited as someone who mentored and helped the study participants to feel like protagonists of childbirth. In describing the exercises, the presence of the music in the environment, and the possibility of choosing the most comfortable position to give birth, demonstrated the recognition for the assistance offered.

In the women's perceptions, the vertical positions were comfortable and different, allowed faster birth, were less painful with greater autonomy of the women, and had less professional intervention.

Thus, the objectives of this research were achieved and the information obtained can be of great value for the training of future professionals of obstetrics and for the current professionals who seek to improve their practice each day. This study may also be a source of information for the improvement of care for women in the puerperal pregnancy period and also contribute to the breakdown of taboos, which involve professionals and women regarding the use of vertical positions, caused by fear of the different.

Collaborations:

1. conception, design, analysis and interpretation of data: Joelma Lacerda de Sousa, Iolanda Pereira da Silva and Lucimar Ramos Ribeiro Gonçalves;

2. writing of the article and relevant critical review of intellectual content: Joelma Lacerda de Sousa, Iolanda Pereira da Silva, Lucimar Ramos Ribeiro Gonçalves, Inez Sampaio Nery, Ivanilda Sepúlveda Gomes and Larissa Ferreira Cavalcante Sousa;

3. final approval of the version to be published: Joelma Lacerda de Sousa, Iolanda Pereira da Silva, Lucimar Ramos Ribeiro Gonçalves, Inez Sampaio Nery, Ivanilda Sepúlveda Gomes and Larissa Ferreira Cavalcante Sousa.

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