WOMAN'S PERCEPTION ON CHILDBIRTH CARE

PERCEPCIÓN DE LA MUJER QUANTO À ASSISTÊNCIA AO PARTO

RESUMEN

Objetivos: analizar la percepción de la mujer relacionada a la asistencia al parto e identificar las dificultades ocurridas durante este proceso. Método: estudio de enfoque cualitativo, con 10 puérperas, desarrollado durante el mes de febrero de 2015, en el hospital universitario de Alagoas, Nordeste de Brasil. Los datos fueron producidos mediante entrevista semiestructurada y analizados por la Técnica de Análisis de Contenido en la modalidad Categorial. Resultados: se obtuvo la construcción de dos categorías: Las expectativas de la gestante para el momento del parto y Heteronomía en la asistencia prestada durante el parto. Conclusión: la experiencia del parto normal para la mayoría de las puérperas entrevistadas fue señalada por el dolor y sufrimiento, además de existir un déficit de la percepción de estas mujeres en el ejercicio de su autonomía durante el parto.

Abogado

ABSTRACT

Objectives: to analyze the perception of women related to childbirth care and identify the difficulties encountered during this process. Method: qualitative study with 10 mothers, developed in February 2015, at the university hospital of Alagoas, northeast Brazil. The data was produced through semi-structured interviews and analyzed using categorical content analysis. Results: two categories emerged: The pregnant woman's expectations to the time of delivery and Heteronomy in the care provided during childbirth. Conclusion: the experience of normal delivery for most mothers interviewed was marked by pain and suffering, moreover, there is a lack of awareness of these on the exercise of their autonomy during childbirth.

Descritores: Enfermagem; Humanização; Assistência ao Parto.

RESUMEN

Objetivos: analizar la percepción de la mujer relacionada a la asistencia al parto e identificar las dificultades ocurridas durante este proceso. Método: estudio de abordagem qualitativa, com 10 puérperas, desenvolvido durante o mês de fevereiro de 2015, no hospital universitário de Alagoas, Nordeste do Brasil. Os dados foram produzidos mediante entrevista semiestruturada e analisados pela Técnica de Análise de Conteúdo na modalidade Categorial. Resultados: obteve-se a construção de duas categorias: As expectativas da gestante para o momento do parto e Heteronomia na assistência prestada durante o parto. Conclusão: a experiência do parto normal para a maioria das puérperas entrevistadas foi assinalada pela dor e sofrimento, além disso, há a falta de percepção destas quanto ao exercício de sua autonomia durante o parto.

Descritores: Enfermagem; Humanização; Assistência ao Parto.
INTRODUCTION

Until the twentieth century, the birth was carried out at home and constituted an intimate and restricted moment, shared with other women - midwives, who were reliable for the mother and for the community due to their experience in delivering babies and for the monitoring of labor and postpartum, since the doctors at that time did not have much practical knowledge about the completion of deliveries due to the absence of mothers in hospitals, they were only called when complications that midwives could not solve alone arose.1

However, with the development of studies on surgical procedures and the emergence of instruments for this practice, rules were established for the regulation of midwifery profession and so the male figure gradually started to gain ground in childbirth care, marking the presence of that gender at that time.2

In addition, the development of anesthesia begins in the nineteenth century, in 1847, when the Scottish James Young Simpson unveiled the anesthetic characteristics of chloroform and this came to be used aiming at minimizing the painful discomfort of childbirth, but it was not widely accepted because this action was perceived as contrary to the physiological and divine.3

Thus, this physiological, healthy event was transformed into a pathological event, worthy of the role reversal in which the woman is no longer the protagonist and does not conduct this moment anymore. Instead, the doctor takes her place, performing procedures during childbirth when believes to be necessary, despising individual women's needs and rights at this important time of their lives.4

In Brazil, the protection of women's health aimed to the onset of institutionalization of childbirth was mentioned by government policies from the late 1920s through Carlos Chagas' health reform.5

The experience of pregnancy and motherhood allows, by the way women face this time, a psychic development in which there is connection, maturity and the extent of personality, since it constitutes challenges for women and will guide their relationship with their child later.6

In 1996, the WHO published a document in a report about the safe motherhood entitled Care in Normal Birth: A Practical Guide, aiming to examine the evidences in favor or against some of the most common practices and to make recommendations based on the best evidence as to its role in normal delivery care.7

This study aimed to evaluate the perception of women as the care received during delivery. It is relevant due to the reflection provided regarding the need for comprehensiveness in the care given to women in childbirth, since there is a great emotional fragility of these women throughout this process, given that, in recent decades, scientific and technological advances focused on childbirth care have contributed to hospitalization thereof, leading to a failure in the natural process of such an event.8

This study is justified by the existence of many shortcomings in the practice of care for women during childbirth, since there is still an overvaluation of the biomedical model, with many interventionist actions, mostly unnecessary.

OBJECTIVES

- To analyze the perception of women related to childbirth care.
- To identify the difficulties encountered during this process.

METHOD

This is a qualitative study9 conducted with 10 mothers. Authors chose this universe due to the saturation of the data collected, as well as the response to the study object. Inclusion criterion was women who experienced normal delivery in immediate / mediate postpartum; exclusion criteria were: mothers who experienced the birth of dead fetus or with diagnosis or symptoms that suggested postpartum depression, thus hindering the effectiveness of communication and, thereby, achieving the objectives proposed by the research.

Semi-structured interview was used as an instrument for data production. To develop this study, researchers gave the mothers the opportunity to participate in it, after explaining the objectives and reading and subsequent signing of the Informed Consent Form (ICF).

The analysis of this study was carried out from a qualitative approach referenced by Minayo with the development of the categorization of data. The categorization is considered a task to classify elements of a group, through differentiation and, consecutively, regrouping by following previously established criteria. This can arise from a range of criteria: semantic, syntactic, lexical and / or expressive.10
The ethical aspects of this study were drawn by Resolution 466 of December 12, 2012, after approval of the research project by the Ethics Committee of the Federal University of Alagoas (UFAL), through protocol number 37889212.2.0000.5013 and subsequent authorization by the teaching and research direction of the institution where the research was developed.

The ethical feature of the qualitative research is understood by the humanistic, inter-relational and empathetic aspect. In healthcare, it provides means for proper interpretation and understanding of the point of view of patients / clients as well as professionals and managers on a variety of angles: the quality of services, opinions in certain decision-making and in the provision of services; besides representations about health, illness, death, among other topics.¹

RESULTS

Participants included in this study comprise the age group from 19 to 40 years old.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Age</th>
<th>Schooling</th>
<th>Obstetric dataG / P / A</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>28 years old</td>
<td>Incomplete Elementary School</td>
<td>G5 / P3 / A2</td>
<td>3</td>
</tr>
<tr>
<td>P2</td>
<td>25 years old</td>
<td>Incomplete Elementary School</td>
<td>G6 / P6 / A0</td>
<td>6</td>
</tr>
<tr>
<td>P3</td>
<td>25 years old</td>
<td>Incomplete Elementary School</td>
<td>G4 / P3 / A1</td>
<td>3</td>
</tr>
<tr>
<td>P4</td>
<td>38 years old</td>
<td>Incomplete Elementary School</td>
<td>G10 / P10/ A0</td>
<td>10</td>
</tr>
<tr>
<td>P5</td>
<td>27 years old</td>
<td>Completed high school</td>
<td>G2 / P2 / A0</td>
<td>2</td>
</tr>
<tr>
<td>P6</td>
<td>40 years old</td>
<td>Incomplete Elementary School</td>
<td>G8 / P8 / A0</td>
<td>7</td>
</tr>
<tr>
<td>P7</td>
<td>39 years old</td>
<td>Incomplete Elementary School</td>
<td>G3 / P3 / A0</td>
<td>3</td>
</tr>
<tr>
<td>P8</td>
<td>25 years old</td>
<td>Incomplete Elementary School</td>
<td>G3 / P3 / A0</td>
<td>3</td>
</tr>
<tr>
<td>P9</td>
<td>33 years old</td>
<td>Completed high school</td>
<td>G1 / P1 / A0</td>
<td>1</td>
</tr>
<tr>
<td>P10</td>
<td>19 years old</td>
<td>Incomplete higher education</td>
<td>G1 / P1 / A0</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 1. Profile of postpartum women in the study.

To proceed with the data analysis, it was performed a categorization, which resulted in two thematic categories, discussed below.

◆ The pregnant woman’s expectations to the time of delivery

To establish contact with the research mothers, the authors observed that all women felt anxiety during pregnancy in relation to the time of delivery, which generated this thematic category, which will address the following topics: preparation for childbirth during the prenatal care, the importance of developing / participation of groups of pregnant women and fear of childbirth.

Prenatal care should be seen as a multidisciplinary care that aims to promote the realization of basic care through guidelines on the stages of pregnancy, as well as of preparation of pregnant women for childbirth, since this can be marked by trauma, to both the mother and to the baby, when women are unprepared for this experience.¹²

Childbirth is far more expected by the pregnant woman and her family, and this expectation is marked by meanings already built according to family culture and also by others that will be built during pregnancy. But one cannot deny that it is also a very dreaded moment by the woman, since she has to deal with a range of feelings and determining factors for this time of her life, which is a transition in her role as a social being. Such prospects are also underpinned by her prior experiences and / or shared with other women. The existence of heightened anxiety during pregnancy may contribute to a negative experience of childbirth. However, positive expectations about the birth time can trigger a positive experience of this event.¹³
When the respondents were asked about their expectations for the delivery, the following responses were obtained:

- **I had negative images, you know?** (P4).
- **I thought he would be born well (positive images)** (P10).
- **I thought it was going to be bad, because in the beginning I was feeling a lot of shortness of breath [...]** (P1).

The Ministry of Health, in its manual, recommends the following educational measures to prevent and control the anxiety during pregnancy:

- Welcoming the pregnant woman and her companion, listening, being respectful and supportive, seeking ways to understand their expectations, which implies the accountability of professionals for the realization of care, as well as the co-responsibility of people for their health;
- Promoting knowledge on the part of the pregnant woman and her companion about their legal rights during the delivery process, such as the presence of a companion and the visitation in advance to the maternity to demystify and minimize the stress of the hospitalization process during childbirth;
- Clarifying, simply and clearly, the stages of labor and delivery and possible changes: contraction, expansion, loss of mucus plug, rupture of the amniotic sac.

An effective way to accomplish the interaction between pregnant women and all primary care professionals and other pregnant women is through the development groups for the proper exchange of knowledge and experiences, since it is through moments like these that women will be enticed to question their doubts, and there will be a proper approach on various topics surrounding pregnancy and childbirth.

However, it can be seen through the interviews that in practice this activity is seen in a trivialized way through the responses from respondents about participation in a group of pregnant women in their health facilities during pregnancy:

- **No. I attended those pregnancy fairs, but that meetings I did not participate** (P1).
- **Only that thing [...] the course for making layette** (P6).

The practice of health education is one of the elements that make up the basic health interventions, aiming to promote the adoption of practices for improvement and / or maintenance of participants' health. It also enables understanding the process of normal changes resulting from pregnancy, information on childbirth and on the care for the newborn.

The lack of these causes stress in the pregnant woman, negatively contributes to the delivery process and may cause several troubles during postpartum.

The fear of the delivery time is not is only due to the pain but also due to the care to be provided. There is the fear of being alone, of not being duly comforted, because many research results found that the care by the health team has been increasingly impersonal and distant.

- **No, I thought that, if only I had someone with me at the time (birth), right? A doctor, but I had no one but me, alone, only God and me** (P6).

  **We enter with that negative image to find ignorant people inside it, you know?** (P8).

- Heteronomy in the care provided during childbirth.

In the field research, it was found failure and triviality related to women's rights by many factors that influence and lead to this professional practice, which made it possible to approach this theme category, which will mention the following themes: the importance of the exercise of women's autonomy over their labor / delivery, therapeutic communication between health staff and the laboring woman and the presence of the companion chosen by the woman during her labor / delivery as a right guaranteed by law No. 11,108, 2005.

The idea of autonomy refers to freedom, free choice of individuals about their actions and the ability to build their own life paths. This way of deciding is a responsible and informed manner and thus constitutes personal citizenship.

Autonomy as a right value on health suggests an active search of democracy in relations between professionals and clients through knowledge sharing, as well as the recognition, respect and appreciation of diversity, uniqueness and subjectivity by the ethics of solidarity and responsibility.

According to these statements, it appears that women do not have knowledge of the exercise of their autonomy in relation to their major role in childbirth, when they were asked to evaluate the care received by the health staff during labor / delivery. For this reason, the lines do not report to the established by the Public Policy for the practice of humanized care for women during childbirth, though these are not consistent with what is defined in the Practical Guide on Care to Normal Childbirth, of the WHO.

**Good, because they did not leave me alone, not only for a minute, from moment to moment**
moment they were looking over me, checking me (P2).

Very good. I liked the nurse, she was very friendly, nice (P3).

Great, because I was well cared for (P5).

It was good, because they did not treat me rudely, they treated me very well; they kept talking to me. When I entered the room they kept saying: easy, mom, your baby will be born, do not worry [...] (P8).

Communication is a therapeutic action that constitutes an action of continuous competence of health professionals, and is a starting point of great importance to establish a helping relationship, as well as to evaluate the services provided. Thus, the health team should make use of this tool in order to humanize care, using this intrinsic instrument of the human being to answer questions of customers and of their families as the evolution of labor / delivery, the received medications, by the existence of some impediment to the use of these, and to the baby's health during all stages of childbirth.17

They did digital vaginal examination on me, but did not tell me how much it was, I heard him tell the nurse, so I knew how many centimeters I was. [...] His heart, they always heard [...] I did not take any medicine, they only put something to blow, I think it was the rest of the bag (P1).

They did the digital vaginal examination, but did not tell me, no [...] They heard his heart all the time [...] I did not take any medication, they only put some pills in my vagina and told me it was for the boy to born, only this. I was there alone until the child was born (P6).

According to the communication features mentioned above, it could be seen in this study that there was not proper professional / client interaction in the process of delivery care. It is perceivable that there is failure in therapeutic communication during the course of a few calls, which triggers a feeling of anguish in the assisted person.

According to the provisions in the Good Obstetric Practice, there was emphasis on the issue of the companion chosen by the woman to accompany her throughout the labor / delivery, so much so that, in 2005, the Law No. 11,108, of April 07, 2005 was published. Since this law, the health services of the Unified health System (SUS) and the private health network or a partner network were required to permit the presence of a companion of her choice during labor, delivery and immediate postpartum period.17

In research interviews conducted in this study, women were asked about the presence of the companion during labor and delivery period and the following answers were obtained:

My husband and my mother remained out there, right? Not inside the room, because it was fast (P1).

No one. I was alone. Only God and I (P6).

No, because by the time I was entering, my sister-in-law wanted to go, but she was alone, she and the doctor, then she said that if she came in, because she never saw it, right? So if she came in and she felt sick, then she could not care for her and care for me at the same time. So she did not leave, she told her not to enter (P8).

No, I was alone because he could not enter, right? Only if the doctor had authorized. Because when we arrive, we have to have a doctor's authorization for someone to see the birth, you know? (PP1).

Scientific studies conducted with pregnant women that have been properly monitored during this time of their lives showed that support to women during labor / delivery has four dimensions: emotional - through encouragement, praise and peace waivered; physical comfort - through aid to the woman to change position, to bathe, conducting massages, supply of liquids and soft foods, thus there is a reduction of discomfort; informational - when the necessary information / guidance on the evolution of the process are provided; and intermediation - when there is proper interpretation of women's desires by the companion and conveyed to the health team.18

CONCLUSION

By the results of this study, authors present the perception of mothers about the health care provided during their labor process, in which it is described a practice still focused in the biomedical model of care during childbirth.

Thus, it is clear that some health institutions still fail and lack of a professional practice focused on respect for the individuality of each woman, their fears, their expectations, which favors a less traumatic experience during childbirth.

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