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NON-PHARMACOLOGICAL MANAGEMENT OF RELIEF IN DELIVERIES ASSISTED BY AN OBSTETRIC NURSE

MANEJO NÃO FARMACOLÓGICO DE ALÍVIO DA DOR EM PARTOS ASSISTIDOS POR ENFERMEIRA OBSTÉTRICA

MANEJO NO FARMACOLÓGICO DE ALIVIO DEL DOLOR EN PARTOS ASISTIDOS POR UNA ENFERMERA OBSTÉTRICA

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ABSTRACT

Objective: to characterize a delivery assisted by an obstetric nurse regarding non-pharmacological methods of pain relief in the parturition process. **Method:** this is a quantitative, transversal, descriptive, retrospective study with 232 records of parturients with vaginal delivery assisted by an obstetric nurse. Data collection was carried out in patients' records and data analyzed using the SPSS Program version 21.0, presented in figures and tables. **Results:** there were 98.3% of patients using some non-pharmacological method of pain relief, such as: ambulation (79.2%), bath (73.1%), massage (60.0%), position variety (58.8%), aromatherapy (46.9%), ball (42%), among others. **Conclusion:** new studies can be performed focusing on the efficacy of non-pharmacological management of pain in the parturition process. **Descriptors:** Natural Childbirth; Pain; Labor Pain; Obstetric Nursing.

RESUMO

Objetivo: caracterizar os partos assistidos por enfermeira obstétrica quanto aos métodos não farmacológicos de alívio da dor no processo de parturição. **Método:** estudo quantitativo, transversal, descritivo e retrospectivo com 232 prontuários de parturientes com parto vaginal assistido por enfermeira obstétrica. A coleta das informações foi realizada em prontuários de pacientes, e os dados foram analisados usando o programa SPSS, versão 21.0, sendo apresentados em uma figura e quatro tabelas. **Resultados:** 98,3% utilizaram algum método não farmacológico de alívio da dor, a saber: deambulação (79,2%), banho (73,1%), massagem (60,0%), variedade de posição (58,8%), aromaterapia (46,9%), bola (42%), entre outros. **Conclusão:** novos estudos podem ser realizados com enfoque na eficácia do manejo não farmacológico da dor no processo de parturição. **Descritores:** Parto Normal; Dor; Dor do Parto; Enfermagem Obstétrica.

RESUMEN

Objetivo: caracterizar a los partos asistidos por una enfermera obstétrica sobre los métodos no farmacológicos de alivio del dolor, en el proceso de parturición. **Método:** estudio cuantitativo, transversal, descriptivo, retrospectivo con 232 prontuarios de parturientes con parto vaginal asistido por una enfermera obstétrica. La recolección de las informaciones fue realizada en prontuarios de pacientes y los datos analizados usando el Programa SPSS versión 21.0, presentados en figura y tablas. **Resultados:** 98,3% utilizaron algún método no farmacológico de alivio del dolor, entre ellos: deambulaci3n (79,2%), ba3o (73,1%), masaje (60,0%), variedad de posici3n (58,8%), aromaterapia (46,9%), bola (42%), entre otros. **Conclusi3n:** nuevos estudios pueden ser realizados con enfoque en la eficacia del manejo no farmacol3gico del dolor, en el proceso de parturici3n. **Descriptors:** Parto Normal; Dolor; Dolor de Parto; Enfermería Obstétrica.

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INTRODUCTION

The process of childbirth and birth are normal physiological phenomena that can cause significant pain, constituting a unique experience with different answers for each woman. Without harm to the fetus or the parturient, controlling the pain of labor is one of the main goals of women's care in the process of parturition.¹ Pain is a subjective experience involving a complex interaction between the physiology of the body, the spirit, and the environment. It is an emotional, sensitive and unpleasant experience associated with tissue injury.² In labor, the dilation of the cervix is an important component of pain, added to other factors, such as contraction and distension of the uterine fibers; traction of appendages and peritoneum; distension of the vaginal canal; pressure on the pelvic structures, the urethra, the bladder, and the roots of the loin-sacral plexus. Pain discomfort can be alleviated through the use of non-pharmacological methods.³ The reduction of pain sensation allows the parturient to participate actively in childbirth, increasing self-esteem, enabling a better relationship with the newborn (NB) and contributing to the construction postpartum positive memories.⁴

Seeking strategies for equitable, integral and humanized care, the Ministry of Health (MS) published in 2000, through Ordinance/GM number 569, the Prenatal and Birth Humanization Program (PHPN), which aims to ensure the improvement of access, coverage and quality in the monitoring of prenatal care, delivery and puerperium care for pregnant women and the newborn, encouraging comprehensive obstetric care and guaranteeing women's rights of choice. One of the fundamental aspects adopted by PHPN is the use of useful practices to follow birth and birth, avoiding unnecessary interventions.⁵

In this context, complementary or integrative practices have been taking up space and becoming prominent in the current world panorama, both in developed countries and in developing countries.⁶ (In Brazil, complementary or integrative practices in the healthcare model were officially regulated on the national level, with Administrative Rule number 971, of May 3, 2006 - approving the National Policy on Integrative and Complementary Practices in the SUS.⁷ Complementary practices include drug therapies (such as the use of medicinal herbs) and therapies without medicines - such as acupuncture, yoga, aromatherapy, and other physical, mental, and spiritual therapies.

In this perspective, the birth and delivery scenario should have humanized practices, as well as pharmacological and non-pharmacological pain relief methods, to minimize the discomfort caused in the parturition process. Non-pharmacological methods can be couple oriented during prenatal care and/or taught/applied by the nurse or multi-professional team during labor and delivery. They include psychoprophylactic method, acupuncture, transcutaneous electrical stimulation (TENS), ambulation, music therapy, body massages, baths (shower or immersion), breathing and relaxation techniques, comforting touches, use of the Swiss ball, aromatherapy and reflexology, among others. Ideally, the multi-professional team should establish a relationship of closeness and empathy with the woman during the delivery event, as well as adequate assistance in the provision and implementation of humanized practices.⁹

In this scenario, the presence of the obstetric nurse in assisting the woman in the process of parturition favors the implementation of humanized care practices as non-pharmacological methods of pain relief. The humanization of childbirth care allows the professional to respect the aspects of the physiology of the woman, offering emotional support and facilitating the affective bond between mother and baby.¹⁰ According to Law number 7,498, dated June 25, 1986, the obstetric nurse is legally able to assist the parturient in normal delivery and to identify obstetric distorts, being able to intervene until the doctor's arrival, perform episiotomy and episioraphy, and apply local anesthesia if necessary.¹¹

It is necessary to raise the awareness of obstetric professionals regarding the assistance to women in the process of parturition in an individualized and integral way, especially regarding the implementation of humanized practices in pain relief. The relevance of this study lies in the importance attributed to the theme of non-pharmacological management of pain relief in childbirth and birth, characterizing obstetric care in a humanized and integral way. This study may contribute to the strengthening and visibility of obstetric nursing work in humanization and delivery and birth care, in the perspective of women's role and autonomy during the birth and delivery process. It is expected that the knowledge generated by this study contributes to the qualification of women's care in the parturition setting and the awareness of the professionals in the obstetric area regarding pain relief practices.

Considering the implementation of non-pharmacological methods of pain relief, in the process of labor and birth, as humanized practices of care, the following research question arises: how are the deliveries assisted by an obstetric nurse in the Normal Delivery Center to the non-pharmacological management of pain relief?

OBJECTIVE

- To characterize deliveries assisted by the obstetric nurse for non-pharmacological methods of pain relief in the parturition process.

METHOD

This is a quantitative, cross-sectional, descriptive, retrospective study conducted in a large public hospital located in Porto Alegre, Brazil.

The sample consisted of the analysis of records of parturients who performed vaginal delivery assisted by an obstetric nurse from January 1, 2015, to December 31, 2015. The medical records of women who had their deliveries attended by a physician, fetus dead and those who were initially attended by the nurse and who began to be attended by the doctor due to the dystocia presented throughout the labor.

For this study, an average of 4,400 births per year was considered, with 62% occurring vaginally. Of them, 20% are assisted by the obstetric nurse. For a confidence level of 95% - and 5% margin of error -, the sample size was calculated by WinPEPI (Programs for Epidemiologists for Windows) version 11.43 in 232 records in the defined temporal cut-off.

The access to medical records was through the computerized system of the “Mother and Baby Care Line” and the birth registration booklet of the delivery room, later accessed through the Medical and Statistical Archive

Service (SAME). The data were collected by the researcher, using a standardized form, and later inserted into a database in the Excel program. The variables were characterized as: maternal age, color, maternal education level, occupation, marital status, number of pregnancies, parity, number of prenatal consultations, gestational age by the baby, water bag conditions, amniotomy, aminorex, clear liquids or food during labor, touch examination, non-pharmacological methods of pain relief used, chaperone, delivery position, episiotomy, laceration, Apgar, newborn weight and skin to mother/baby contact.

Descriptive statistics were used for data analysis, based on absolute and relative frequency for categorical variables and mean, and standard deviation for the quantitative variables. The association between categorical variables was assessed by Pearson's chi-square test. In case of statistical significance, the tests of adjusted residuals were adopted. To support the analysis, SPSS software version 21.0 was used, with a significance level of 5% ($p \leq 0.05$).

For this study, ethical issues were considered, according to Ministerial Resolution 466/2012, which deals with research on human beings.¹² The research was carried out after the approval of this project by the Ethics and Research Committee (CEP) of the University of Vale of Sinos River - UNISINOS - and of the Cooperating Institution, under protocol number 1,588,497.

RESULTS

Of the 232 records of parturients analyzed, the non-pharmacological methods of pain relief used in labor and delivery were: ambulation (79.2%), bath (73.1%), massage (60.0%), range (58.8%), aromatherapy (46.9%), Swiss ball (42.0%), shawl (12.7%), foot-scrubbing (2.4%) and music therapy (2%) as shown in figure 1.

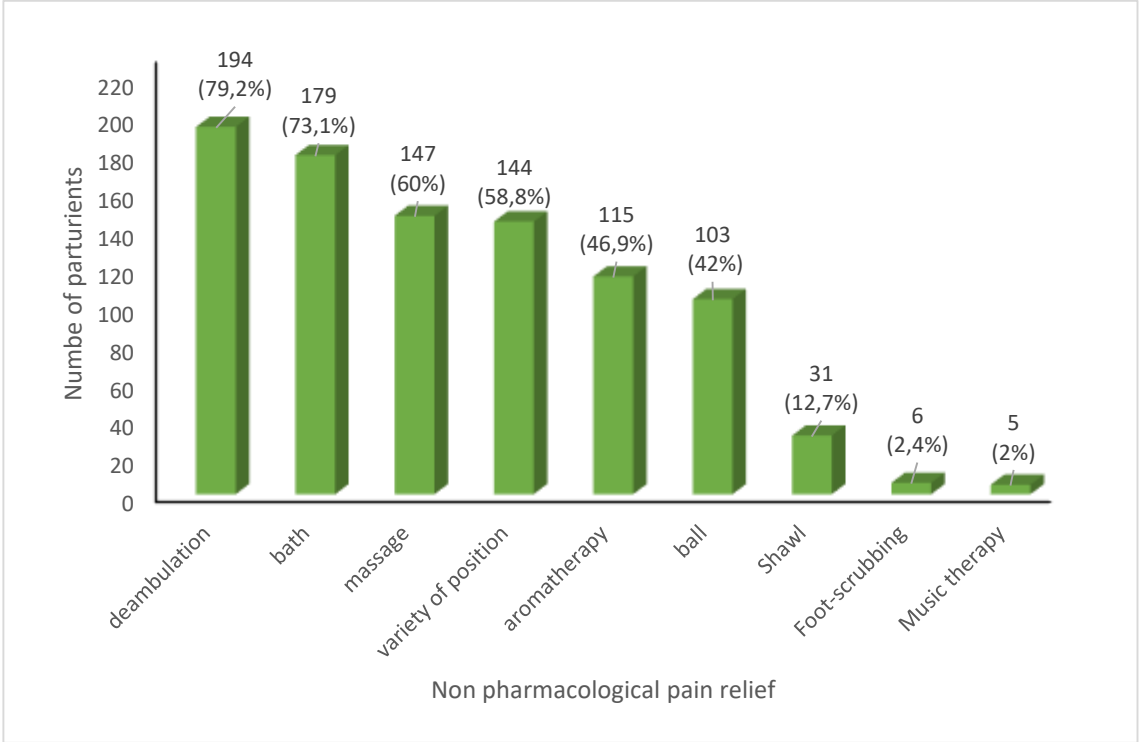


Figure 1. Sample distribution for non-pharmacological methods of pain relief during labor and delivery. Porto Alegre (RS), Brazil, 2016.

Table 1. Sociodemographic characterization of parturients. Porto Alegre (RS), Brazil, 2016.

Variables	n=232	n%
Skin Color		
White	168	72.4
Black	39	16.8
Yellow	1	0.4
Other	24	10.3
Marital status		
Single	215	92.7
Married	15	6.5
Divorced	1	0.4
Other	1	0.4
Level of education		
Incomplete Elementary school	14	6.0
Complete Elementary school	102	44.0
Incomplete High school	42	18.1
Complete High school	65	28.0
Incomplete Higher education	2	0.9
Complete Higher education	7	3.0
Most frequent occupations		
Housewife	122	49.8
Seller	11	4.5
Cashier operator	8	3.4
Clerk	7	2.9
General services assistant	6	2.4
Student	5	2.0
Packing assistant	4	1.6
Waitress	4	1.6
Secretary	4	1.6

Parturients assisted at the normal birthing center under study presented around two pregnancies each and more than six prenatal visits in the current gestation. All of them had undergone vaginal delivery in a previous

gestation. At hospital admission, almost (80%) of the parturient sample had intact amniotic membranes, and more than (45%) had amniotomy during the parturition process, according to Table 2 and Table 4.

Table 2. Obstetric data of parturients in the sample. Porto Alegre (RS), Brazil, 2016.

Variables	n=232	n%
Obstetric data		
Number of normal deliveries	232	100
Number of previous cesareans	14	6.0
Previous abortion	40	17.2
Bag of water in the hospital		
Whole	185	79.7
Broken	47	20.3
Had amniotomy	107	46.1
H3ad aminiorex	78	33.6
Amniotic fluid characteristic		
Not registered	1	0.4
Clear with grumous	211	91.0
Meconium red	20	8.6

n: Frequência absoluta; n%: Frequência relativa.

Almost 100% of the parturients were attended during the parturition process, (77.5%) of the women accepted clear liquids in labor and most of them used one or more non-pharmacological practices of comfort and pain relief. Women were able to choose the desired delivery position, such as the positions semi-sedentary (62.5%), lateralized (14.3%), squatting (3.0%), four supports (1.3%), while only (12.5%) gave birth in the lithotomy position. Three women underwent episiotomy

and (60.8%) presented some type of laceration, and the other parturients had intact perineum. Regarding the perinatal conditions, the neonates presented around 39 weeks and 5 days of gestation by the test of the baby and weight superior to 3,200 g. The Apgar in the first minute of life varied between 8 and 9 and in the fifth minute between 9 and 10. Of the total of newborns, more than 50% were female, as presented in table 3 and table 4.

Table 3. Birth data and perinatal outcomes. Porto Alegre (RS), Brazil, 2016.

Variables	n=232	n%
Had accompanying	220	94.8
Intake of clear liquids		
Position of childbirth	176	77.5
Lithotomy	29	12.5
Semi-existent	145	62.5
Lateralized	34	14.7
Squatting	17	7.3
Four supports	7	3.0
Performed episiotomy	3	1.3
Had laceration	141	60.8
Sutured the laceration	100/141	70.9
Child's Gender		
Male	109	47.0
Women	123	53.0

*husband (n=156 ± 70.9%), mother (n=28 ± 12.7%), sister (n=15 ± 6.8%) and others (n=21 ± 9.5%).

Table 4. Characterization of the sample - numerical variables. Porto Alegre (RS), Brazil, 2016.

Variables	n=232
Maternal age (years) - mean ± SD	25.5 ± 6.0
Number of prenatal visits mean ± SD	7.5 ± 2.9
Number of pregnancies - md (P25 - P75)	2 (1 - 3)
Apgar 1 min - md (P25 - P75)	9 (8 - 9)
Apgar 5 min - md (P25 - P75)	9 (9 - 10)
Gestational age by the baby (days) - mean ± SD	277 ± 22.3
Weight (g) - mean ± SD	3240 ± 449

SD: Standard deviation; md: median; P25-p75: 25-75 percentage.

DISCUSSION

The maternity adhered to the strategy of the Stork Network and the recommendations advocated by this policy in the care of childbirth and birth, constituting a reference in the state of Rio Grande do Sul. In this institution, the obstetric nurse is inserted in the delivery assistance of usual risk and, it seeks to implement pain management its care practice, characterizing a model of care centered on the physiology of childbirth and the role of women. All parturients in the sample used one or more non-pharmacological methods of pain relief during labor and delivery. For the World Health Organization (WHO), the inclusion of obstetric nursing in the delivery scene is an important strategy in the reduction of cesareans, and its staff acts in a humanized way, using non-invasive practices of pain relief, stimulating the autonomy of women and physiological delivery.¹³

When characterizing the profile of parturients that participated in this study, it was verified that the number of pregnancies registered varied between two or three for each woman. The mean maternal age was 25 years old and all were literate, with different levels of education. Currently, there is a reduction in the number of births in women under 24 years old, resulting in a progressive increase in maternal age, averaging 25.7 years old. Maternal education has been increasing proportionally to the population. In a survey carried out in 2009 in Brazil, (8.2%) of the puerperal women reported having between zero and three years of education, while (28.7%) were between four and seven years old and (63.1%) had eight years or more of study.¹⁴

The number of prenatal consultations is an important indicator of access to maternal and child health services. MS recommends at least six visits so adequate prenatal care is considered. Prenatal coverage since 2000 has been increasing considerably, as shown in the survey carried out between 2000 and 2009, in which the proportion of pregnant women with no consultation decreased from (4.7%) to (1.8%) in all the country.¹⁴ The results obtained in this study registered an average of 7.5 prenatal consultations per pregnant woman, which constitutes the growing scenario of coverage, in addition to meeting the MS recommendation.

Pain management includes a series of complementary practices and non-pharmacological methods, such as immersion or sprinkler bath, Swiss ball, aromatherapy,

music therapy, acupuncture, massage, continuous emotional support, woman verticalization and variety of position, among others. Pain during labor can lead to loss of emotional control of the woman, constituting a stressful and traumatic event that can lead to mental disorders. In this perspective, pain management through complementary and alternative practices has been implemented in the care of women in labor in a powerful way.¹⁵

One of these alternative practices is aromatherapy, which uses the power of plants through specific essential oils, such as jasmine and lavender, for the evolution of labor and pain relief. The essential oils used can be absorbed by inhalation or topical use on the skin. In the practice of foot-scrubbing, a few drops of diluted oils are also used in the water for the purpose of inhalation to reduce pain.¹⁶⁻¹⁷

However, ambulation is a therapeutic method capable of accelerating labor, facilitated by the upright position and the favorable effect of gravity, which, together with pelvic mobility, increases the speed of cervical dilatation and fetal decline.¹⁸ The variety of position is one a practice that should be encouraged during labor because the parturient change of position and can move according to their need, adopting a comfortable positioning when the contractions arise.¹⁹

Adopting alternate positions during labor promotes the speed of cervical dilatation, promotes pain relief during contractions and facilitates fetal descent. Therefore, the variation of positions between sitting, lateral decubitus, kneeling, crouching, four supports and standing, among others, can be encouraged.^{3,18}

The shower bath reduces anxiety and relieves pain in labor, promoting relaxation. The hot bath stimulates the thermoreceptors of the epidermis, reaching the central nervous system and blocking the perception of pain. The heat of the water increases the blood circulation, reducing the stress caused by the contractions.²⁰

Massage is a method of sensory stimulation characterized by systemic touch and tissue manipulation. In labor, massage provides comfort, analgesia and relieves pain, as well as promoting a bond between the professional and the parturient. The Swiss ball or pilates ball is a feature used to facilitate the process of parturition and provide a position of greater comfort to the woman. The ball is also a playful instrument, which can contribute to the distraction of the woman in labor, making

labor calmer. This feature can be associated with other techniques, such as massage and shower bath, through pelvic stretching and active circumference exercise, among others.¹⁶ The continuous support includes offering physical comfort, emotional support and effective communication between the health team, the parturient, and her partner.²¹

The shawl is an exercise that uses a type of shawl used by Mexican women to carry the baby. During labor, this method is used with the parturient in the upright position or squatting, with the shawl tied at the top, or through pelvic stretches performed during contractions, associated with friction in the lumbar with this tissue.²²

Thus, the humanization of childbirth and birth constitutes a movement of struggle and appreciation of women as the protagonist of the process of parturition. It aims to rescue its autonomy and rights, giving it conditions of choice and participation during all phases of the reproductive life, starting with family planning, gestation, childbirth, birth and postpartum.

Regarding the presence of the partner during labor and delivery, it was verified that almost 100% of the women had an accompanist when giving birth. Federal Law 11,108, in 2005, guarantees women the presence of partners of their choice during the process of delivery, birth and postpartum.²³ These data are similar to those of Silva and colleagues in a normal delivery center, (94.5%) of the women with a partner in the delivery room.²⁴ Corroborating with these findings, Diniz and colleagues affirm that at this moment, the partner can transmit to the woman emotional support, encouraging her in the face of the experiences.²⁵

Despite advances in these spaces, some practices and pain management are still a challenge for obstetrics, due to the lack of studies and protocols that legitimize its implementation. In some maternity wards, women are still forced to be confined to bed during labor and delivery.²⁶ However, it is known that women should be encouraged to adopt the position they prefer and desire. Ambulation and upright positions reduce the duration of labor and reduce the need for analgesia.^{18,27-29} The verticalization of labor improves strength intensity, fetal oxygenation during the expulsive period, and increases the pelvic and anteroposterior pelvic diameters and transverse in the squatting and kneeling positions.³⁰

This study reported that in the expulsive period: (62.5%) of the women adopted the

semi-settled position; (14.7%), the lateralized position; (3.0%), squatting; (1.3%), four grants; and (12.5%) the lithotomy position. Although the lithotomy position is not the best option for women, it is still widely used in maternity wards. With the institutionalization of childbirth, women are routinely admitted and then oriented to use the dorsal position, as it facilitates obstetric intervention.²⁸ The episiotomy occurred in only (1.3%), and (60.8%) presented perineal laceration, and only (39.1%) required raffia, which indicates that most of the women had intact perineum. These findings show that the practice of episiotomy is carefully and selectively used, diverging from other studies that presented rates of 16% and 29.1% of episiotomies.³¹⁻³² Regarding the neonatal data found in this study, mean gestational age calculated by the baby remained above 39 weeks, the first-minute Apgar ranged from 8 to 9 and in the fifth minute from 9 to 10, and the mean weight was 3,240 kg. These perinatal outcomes characterize the usual risk or low-risk care performed by the obstetric nurse. These data corroborate a less interventionist delivery and birth attendance, evidencing that respect for the physiology of childbirth favors the health conditions of the mother/baby binomial.¹³

CONCLUSION

This study enabled to characterize obstetric-assisted deliveries in a normal delivery center regarding non-pharmacological management for pain relief in labor and delivery. From the total sample during the parturition process, almost all the pregnant women used some non-pharmacological method of pain relief, such as ambulation, bathing, massage, position variety, aromatherapy, ball, shawl, foot-scrubbing, and music therapy. All methods used in this study have low cost, easy applicability, and a non-invasive practice.

Women were able to opt for the position they wanted to give birth, which gave the parturient autonomy and respect. The care model sought to respect the physiology of childbirth and the use of interventions occurred selectively and judiciously. The perinatal outcomes were favorable and characterized the usual risk assistance performed by the obstetric nurse. These findings were similar to data from other national studies on the implementation of non-pharmacological management of labor pain and its perinatal outcomes.

The obstetric nurse's presence in the birth and birth scenario favors the implementation

of humanization practices and the recovery of women's protagonism.

Since this was a retrospective study, this study had as a limitation the search of information recorded in medical records, which impacted on its results. It is suggested that new studies, especially randomized clinical trials, related to the non-pharmacological management of pain, should be performed focusing on the efficacy and safety of the applicability of the methods in the parturition process.

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