Childbirth feelings and experiences: an interpretative methodological

Sentimentos e vivências do parto: uma abordagem metodológica interpretativa

Sentimientos y experiencias del parto: un enfoque metodológico interpretativo

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RESUMO

Objetivo: Investigar vivências da parturiente e os sentimentos que a envolveram nos momentos que antecederam o parto. **Método:** A Grounded Theory (GT) foi escolhida como referencial teórico e metodológico para este estudo. Onze puérperas foram entrevistadas e as questões abordaram a sua percepção, sentimentos e vivências acerca do acolhimento na unidade. **Resultados:** Da análise das entrevistas surgiram três eixos norteadores e estes foram construídos a partir de nove categorias. Constatou-se que as políticas e os programas de humanização na área obstétrica ainda não atendem às necessidades das parturientes, o que culmina em desajustes no processo de parto e nascimento. **Conclusão:** Análises deste estudo mostram que as mulheres são sensíveis a aspectos como relacionamento com os profissionais, cuidados centrados na pessoa com suas fragilidades e adequação do ambiente físico.

Descritores: Humanização na assistência ao parto; Parto; Enfermagem obstétrica; Acolhimento; Serviço de saúde materno-infantil.

ABSTRACT

Objective: to investigate the parturient's experiences and the feelings that involved her in the moments before the childbirth. **Method:** Grounded Theory (GT) was chosen as the theoretical and methodological framework for this study. Eleven mothers were interviewed and the questions addressed their perception, feelings and experiences about the welcoming in the unit. **Results**: From the analysis of the interviews, three guiding axes emerged and these were constructed from nine categories. It was found that humanization policies and programs in the obstetric area still do not meet the needs of parturients, which culminates in maladjustments in the process of childbirth and birth. **Conclusion:** Analyzes of this study show that women are sensitive to aspects such as relationships with professionals, care centered on the person with their weaknesses and adequacy of the physical environment.

Descriptors: Humanization in Christmas assistance; Obstetric nursing delivery; Reception Maternal and child health service.

RESUMEN

Objetivo: Investigar las vivencias de la parturienta y los sentimientos involucrados en los momentos que anteceden el parto. **Método:** La Teoría Fundamentada - Grounded Theory (GT) fue elegida como referencial teórico y metodológico para este estudio. Once puérperas fueron entrevistadas y las cuestiones abordaron su percepción, sentimientos y vivencias acerca de la acogida en la unidad**. Resultados:** Del análisis de las entrevistas surgieron tres direcciones que se construyeron a partir de nueve categorías. Se constató que políticas y programas de humanización en el área obstétrica todavía no atiende a las necesidades de las parturientes, eso culmina en desajustes del proceso de parto y nacimiento. **Conclusión:** Análisis del estudio enseña que las mujeres son sensibles a aspectos como relacionamiento con los profesionales, cuidados centrados en la persona con sus fragilidades y adecuación del ambiente físico.

Descriptores: Cuidado de la salud; Cuidado de enfermera; Seguridad del paciente.

ORIGINAL

Introduction

The implementation of public health policies for women began in the 1970s with the creation of the Maternal and Child Program. In the 1980s, the Comprehensive Assistance Program for Women's Health (PAISM) responded to a demand fostered by women and movements that supported their health and gave them a voice. [1]

The critical reflection on the process of childbirth and birth refers to the fact that the rights of women and newborns are based on the Universal Declaration of Human Rights, in which health is a basic right. The mother-baby binomial must be treated with respect and dignity and be entitled to harm-free assistance, as well as information that must be provided in accessible language.[2]

At the beginning of the 21st century, major changes and advances in the maternal and neonatal area culminated in the implementation of yet another public policy: the National Program for the Humanization of Prenatal and Birth (PNHPN), of the Special Secretariat for Policies for Women. [3]

In 2011, the Ministry of Health, due to the tripartite agreement, prioritized, among other Health Care Networks (RAS), the Cegonha Network (RC), which focuses on the pregnant woman and then the child up to 24 months and has as its principles respect, protection and fulfillment of human rights. [4]

The intention is that the Unified Health System (SUS) is increasingly universal, comprehensive, equitable and resolutive, focusing on humanized assistance. The Handbook for Reception and Risk Classification in Obstetrics, edited by the Ministry of Health in 2014, explains what is most current and specific to health professionals working in the area of obstetrics, imbued with the concepts of humanization, reception, defense of human rights, equity, regional differences and cultural diversity, as well as SUS principles and is in the process of being implemented throughout Brazil. [5]

User embracement is a technical-assistance action that provides for changes in the professional / patient relationship, as it is based on humanistic, ethical and professional concepts that insert the patient as part of the health production process. Aiming to assist the patient in his needs, listening to him and seeking resolution in relation to the health problems presented; it also strives for adequate answers to doubts and for effective referrals that are necessary. [6]

For the reception to happen, it is necessary that the professional is immersed in humanization during the service. The concept of humanized health care is not new; for some years now people have heard of humanized attention. In Brazil, however, this practice was evident from the National Humanization Policy - Humaniza SUS, created in 2003. [7]

The legal responsibility of the nurse in midwifery concerns the receipt of the low-risk parturient, hospitalization and normal delivery without dystocia, such as the issuance of a declaration of live birth, since admission and during labor. Nurses are responsible for providing guidance and meeting the demands of the parturient, identifying dystocia during delivery and, if they occur, conducting the delivery until the obstetrician arrives. In this context, the nurses' behavior gains space in the obstetrics team and deeply marks the situations experienced by the parturient women; so the importance of the profile of this professional.[8]

The lack of expertise and humanistic awareness in welcoming the mother/newborn binomial provides poor quality and highly interventional care for non-respect for basic human rights. These authors, from the existing literature that begins with human rights to public policies developed to assist women and children, understand the emergence of public policies aimed at humanization. [2]

From this perspective, it scientifically evidences that there is a need to address the theme that is increasingly discussed and inserted in the agendas of formulating public health policies. Based on the integrality of care, quality, holistic care, team work, welcoming and the "humanization" of health practices, they propose to debate the dimension and subjectivity of work processes in health services and the operationalization of these. [9]

Observing that it is necessary to realize that in pregnancy there is a wide change in the woman's life. She will need to restructure her roles - adjust to the role of daughter to the condition of mother and readjust her married life, economic situation and professional activity. Such biological, somatic, psychological and social changes can make women more susceptible and sensitive to events and thus trigger an emotional crisis. However, they can also implant a potential for resolvability and resilience. [10]

The nurse is a fundamental key for the reception of the parturient, both in prenatal care and in obstetric units, because normally the first contact of the woman with a health professional in health units will be with this professional. It is up to him to welcome, guide, humanize the service. The Ministry of Health, in its booklet on humanization in childbirth, states that "health units should receive women with dignity, [...]. This requires ethics and solidarity on the part of health professionals and the organization of the institution [...], so be welcoming ".[11] The research problem was based on the demystification of the perception, feelings and experiences about the reception in the parturient unit at moments before the birth, aiming to investigate the parturient's experiences and the feelings that involved her in the moments before the birth.

This study has relevance and international discussion in this context of care in obstetric units so that they can transform the reality experienced. Investigating the parturient's experience, as well as the emotions that surround her, knowing maternal perceptions and feelings during this trajectory become relevant from the premise that the knowledge related to the theme makes the professional who manages the care more human and welcoming.

Method

The present study has a qualitative approach and is of an interpretative character, since it allows analyzing the subjective experience of everyday events. Presented in 1967 by sociologists Barney Glaser and Anselm Strauss, Grounded Theory (GT) or Grounded Theory (TFD) was chosen as a theoretical and methodological framework. [12-13]

The research site was a common obstetric unit in the municipality of Barreiras, in the western region of Bahia between October 2014 and June 2015. All services offered are public, managed by the municipal administrative sphere. The unit is a regional reference and was in the process of implementing the Cegonha Network.

Four principles guided the investigation: studied reality immersion, epistemic advantage, continuous comparison and theoretical agnosticism. To

understand the welcoming reality from the parturients perspective, it was decided not seeking answers in ready, technical and political concepts related.[14-15]

For data collection, two instruments were used: a sociodemographic questionnaire covering: age, date of birth, civil status, number of children, origin, education, profession and prenatal care developed by the authors; and, a semi-structured script containing subjective questions, often adopted in the development of studies in which Grounded Theory is applied.[12-13] This script covered issues related to the subjectivity of the parturients connected to the feelings experienced, such as: on the path taken until their internment; on their arrival at this health unit, during the screening and hospitalization; service environment in screening; the care of nurses in this environment; the pre-delivery care environment and the assistance provided by the nurse and something about his experience at this time when he considered it more important.

The investigated participants understood parturients who: were hospitalized in the referred obstetric unit; they were received in the screening and the risk classification was performed by the nurse professional; had a parturition process in the first half of 2015, and they had at least 12 hours postpartum for normal delivery and 24 hours for cesarean delivery.

The interviews were recorded by an audio recorder and later transcribed in full. In this way, after the interview memorandum, the second phase, the analysis of the data was carried out in two stages: the coding and the construction of the categories.

In the analysis of the collected data, a process was established that started from the reality of the interviewees, which generated the theoretical model. There was an effort to sharpen his theoretical sensitivity to carry out the necessary groupings of grounded codes of the speeches. From the analysis of the interviews, in the context and because of the content analyzed for the quality of the speeches (codes), concepts were created.

The codes are grouped, not by pre-existing advice, but by similarities, differences and mutual implications, as soon as these categories arise. Thus, from a process of continuous comparison between deposits, codes and categories in the construction process, thematic events will emerge.

During the work of continuous comparison, new groupings of codes emerged that translated into nine categories that served as a basis for theoretical reflection. Using this model, it was plausible to answer the research question in a systematic way and further discussions on the topic became possible.

The analysis stage occurred concurrently with data collection. At the same time, the continuous search in the literature for concepts identified in the study allowed to relate them to each other and generate a theory as shown in Figure 1:

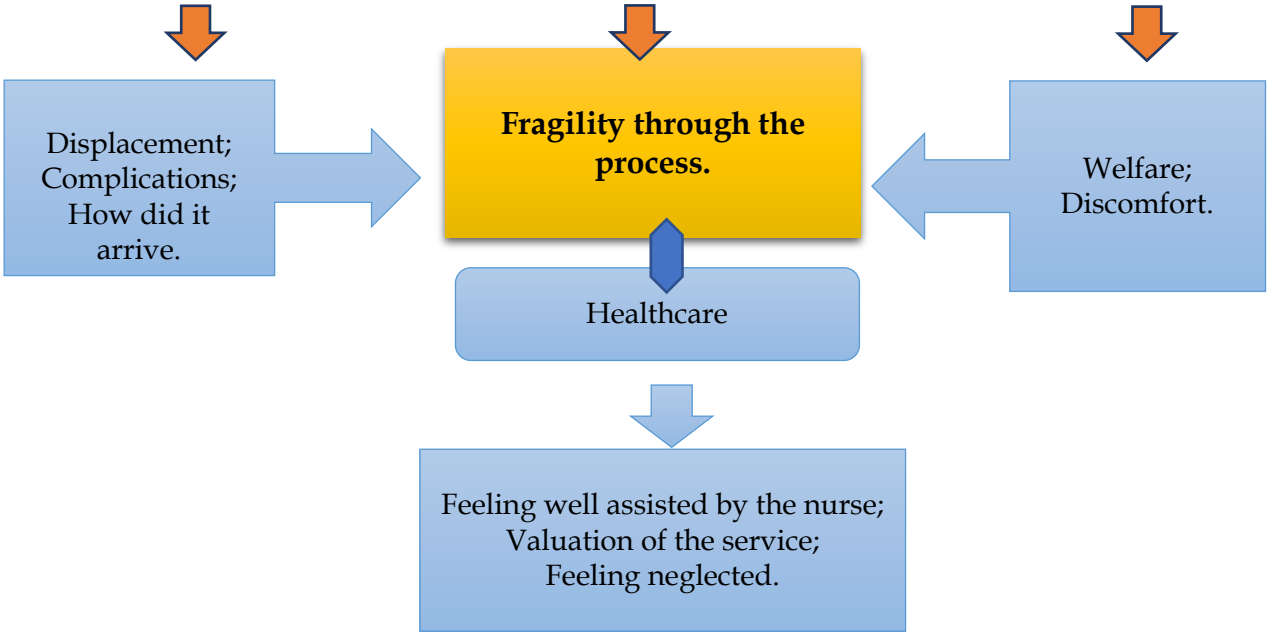

Figure 1- Overview of the three axes. Brazil, 2015.

In addition, the anonymity of the participants was ensured, which were encoded by the initial letter P, referring to the word "parturient", followed by a numeric number to differentiate them from each other, which referred to the number of the interview answered by the professional

Resolution 466/2012 ethically guided the study and approval was obtained from the Research Ethics Committee of the Pontifical Catholic University of Goiás, under CAAE 816,599, opinion number 816,599 and the ethical principles of the Declaration of Helsinki. In addition, a Free and Informed Consent Form was signed, signed in two copies, one for the researcher and another for the research subject.

Results and Discussion

We observed that a large part of the interviewees came from the city itself, the age group of the parturients varied between 16 and 36 years of age and with regard to parity, four interviewees were going through the experience of parturition for the first time (Table 1) .

Regarding their origin, more than half of the interviewees were residents of Barreiras, four of whom were from the municipality and three from the countryside. The others (n = 4) came from surrounding municipalities that do not have an obstetrics service. As for education, five had elementary school and five high school. Regarding the profession, four interviewees reported carrying out rural activities (farming) (Table 1). In total, eight of the parturients had a good level of prenatal care, as they had six to twelve consultations (Table 1).

Table 1- Sociodemographic profile of parturients at a low-risk maternity hospital, Brazil, 2015. (n = 11).

Participants	Age	No. of child-birth	Origin	Education	Profession	No. of prenatal consultations
P1	21	01	Barreiras	Incomplete high school	Administrative Assistant	8
P2	16	01	Barreiras- Zona Rural	Incomplete high school	Student	10
P3	27	04	Barreiras- Zona Rural	Incomplete Elementary School	Farmer	6
P4	18	01	Barreiras	Complete high school	Student	3
P5	19	02	Formosa Rio Preto	Incomplete Elementary School	Farmer	10
P6	36	03	Barreiras	Complete Elementary School	Housewife	7
P7	33	03	Wanderley	Complete Elementary School	Farmer	5
P8	22	03	Barreiras	Complete Elementary School	Housewife	3
P9	23	02	Riachão das Neves	Incomplete high school	Student	7
P10	31	02	Barreiras – Zona Rural	Complete high school	Farmer	12
P11	32	01	Cotegipe	Graduated	Shop assistant	6

The "Starting point" axis (Figure 2) includes the experience of the interviewee's displacement to the obstetrics service, the circumstance and / or the way that this woman arrived at the obstetric unit, the means used for such displacement and the perception about the fact. This axis exposes the following codes: I. The displacement, II. Complications of displacement and III. The arrival / How it arrived.

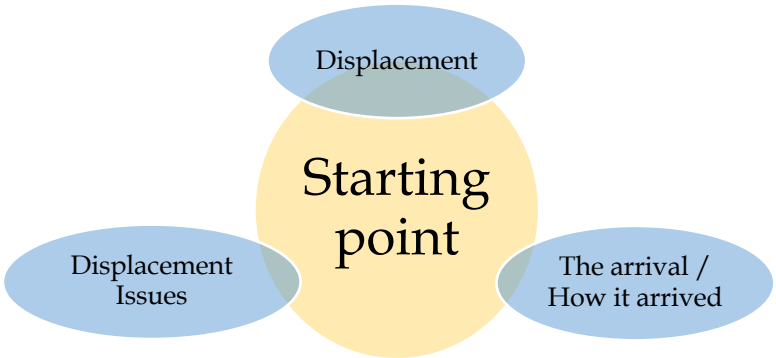

Figure 2- Thematic axis Starting point. Brazil, 2015.

In the thematic axis "Person in its context", category IV was obtained, after tireless readings of the interviews. Fragility through the process. Their codes cover the weaknesses that parturients perceived in the parturition process (Figure 3). It was possible to verify compliance with the Cegonha Network Manual and the need for adjustments, emphasizing the quality of services.

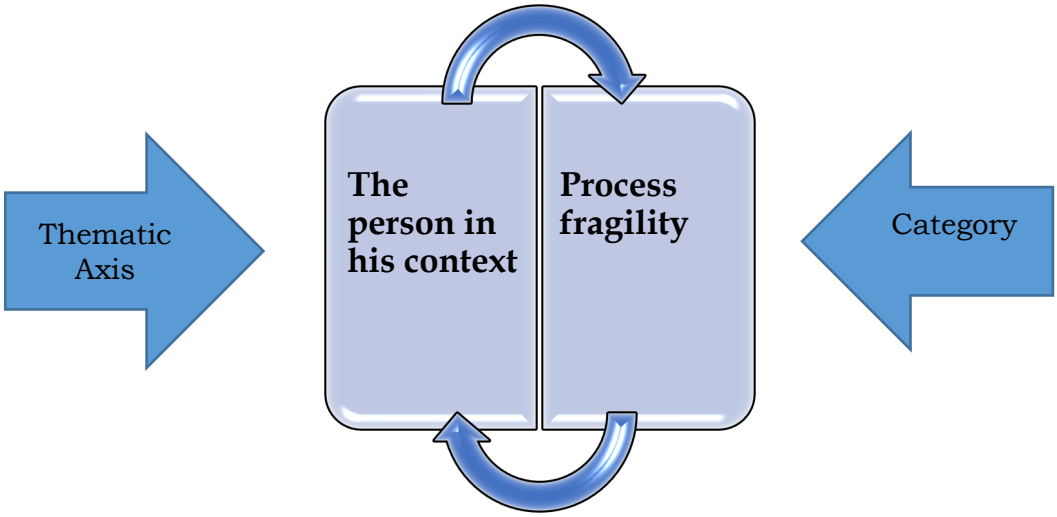

Figure 3- Fragility through the process.

The same thematic axis deals with the assistance provided to parturient women and the categories were highlighted: V. Feeling well assisted by the nurse, VI. Valuation of the service and VII. Feeling neglected, which elucidated, by their codes, the experience of the parturition process and the perception of the service provided (Figure 4).

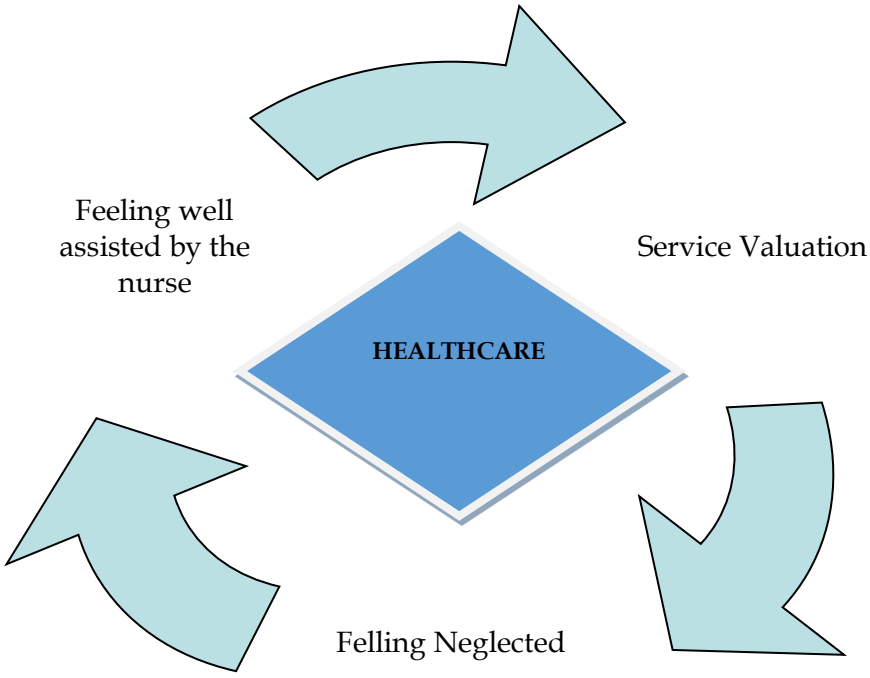

Figure 4- Healthcare (to the person in his context).

In the thematic axis that deals with the environment ("Physical environment"), categories VIII were verified. Well-being (approval) and IX. Discomfort. Their codes gave parturients a voice about their perceptions of the environment that welcomed them (Figure 5).

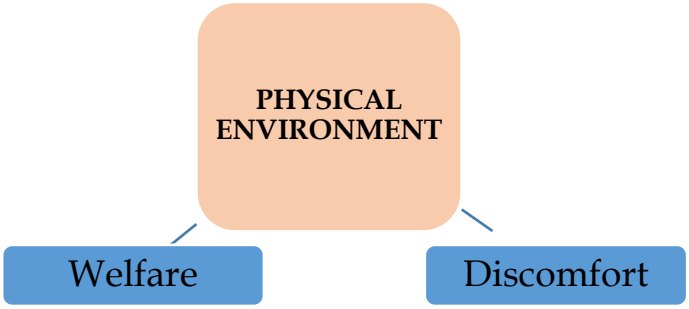

Figure 5- Physical environment.

In this study, evaluating the data from the socioeconomic questionnaire, it is possible to make some considerations related to the age group, in which the youngest participant was 16 years old, being a primiparous woman, living in Barreiras and carrying out a number of consultations as provided for in the regulations of the Ministry of Health - minimum six consultations. The oldest, multiparous parturient was 36 years old; also lived in Barreiras and had adequate prenatal care. [16]

A study carried out in Acre emphasizes that, although in a small proportion, there are women who have not undergone prenatal consultations or who have few consultations. This occurrence is related to the following factors: young age, less education, black women, multiparous and rural residents, a point that corroborates with our finding. [17]

In the thematic axis "Starting point", it was observed in the interviewees' statements that all believed they were in full labor when they went to the obstetric unit. Parturients P7 and P3 spoke with firmness and certainty about the decision to seek maternity. Parturient P2 reported that she was at the unit several times and that the therapeutic itinerary was tiring.

Obstetrics health services need to be prepared to meet the demand in a qualified and humanized way, presenting welcoming behaviors and without unnecessary referrals and procedures. The instruction, during prenatal care, about the signs and symptoms of the beginning of labor would collaborate so that the pregnant woman and her family would recognize them and would avoid the early visit to maternity hospitals.[18] The attachment of the pregnant woman to the unit in which she will deliver the child, from Primary Care and in the continuity of care, is an attribute of the Rede Cegonha that can greatly contribute to improving the quality of care offered.[19]

The National Policy on Women's Health[3,11,19] provides for actions by the multiprofessional team from prenatal to the puerperium, including obstetric consultations and hospitalization, when necessary. The guidelines that women and partners / family members should receive in this context would also be responsible for preventing obstetric violence, in the opinion of Pedrosa and Spink.[20]

A feeling of relief, calm and well-being was experienced by three women in this study: P7, P8 and P10. It should be noted that they were in the second or third delivery, that is, they already knew the obstetrics service. The parturients P4, P6, P9 and P11, had an appointment prior to the day of their delivery, in which the obstetrician could verify the need for cesarean delivery, thus returning the following day for hospitalization. The interviewees, P1 and P8, did not have a good perception of their arrival, were in pain, did not want to

return to their homes, however, it was what they had to do after medical evaluation and this left them very dissatisfied.

The surgical procedure can also lead to great anxiety due to fear of anesthesia and errors during the anesthetic-surgical procedure.[21] Therefore, the reception with risk classification in obstetrics provides for the performance of a careful evaluation for hospitalization of pregnant women in labor. Therefore, there is an appropriate time for hospitalization to occur, with a view to minimizing the risks for pregnant women and the fetus. In addition, the ideal is that both remain as short as possible in obstetric facilities, as prolonged hospitalizations can cause changes in their emotional state and hinder the delivery process.[7,19,22-23]

In the thematic axis, the person in his context sought to highlight the weaknesses during the process and aimed to highlight the feelings of the parturients, in their reports, they showed feelings considered negative: "fear", "insecurity", "felt bad", "risk of the baby dying "," fear of hospitalization ". Such feelings may be present to a greater or lesser degree, depending on what is experienced in the obstetric environment under study.

Labor is experienced as a drastic change in body dynamics in a few hours, with uterine contractions and pain. The woman often wishes to have self-control and actively participate in that moment, which is not always guaranteed to her. Due to this context, the pregnant woman may show great concern for herself and the baby, and may feel guilty if something goes wrong.[24-26] And even, in general, the organization of health systems and the professionals themselves instigate this thought of holding women accountable for events that harm their health and that of the baby, constantly attributing to their choices the results and events with pregnancy, childbirth and puerperium.

In the category dealing with assistance, it was possible to cover issues related to feeling well assisted, valuing the service and feeling neglected. All involve the nurse's assistance provided in the research environment. The interviewees had a good perception of this service. There were reports of feelings / perceptions such as: "zeal", "attention", "support", "efficiency", "security", "speed of service", "well-being", "calm and education in service". This clearly configures the relationship and the humanized care that one wishes to have and as recommended by the manual of the Ministry of Health Humaniza SUS[19] and the other assistance protocols.

Another literature also indicates that many obstetric units have been changing their care based on current legislation; as an example, the study by Rattner[27], which emphasizes the promotion of humanized care and the presence of the obstetric nurse, midwife or doula to promote the well-being of women during childbirth. [28-29]

In the thematic axis "Physical environment", the categories Environment approval / Well-being and Discomfort (which the obstetric environment caused) were consolidated. The environments explored in the research were all in which the parturient was: reception, screening and pre-delivery. Thus, it was possible to list some considerations.

Many of the interviewees reported the environment as good, welcoming, organized and comfortable and one of them, even, reported being better than some private service environments. It is important to emphasize that five of these women came from surrounding municipalities that do not have assistance in obstetrics, thus, without any experience in obstetric environments to have

comparative parameters. However, in their common sense, these environments were approved.

RDC No. 5030 guides the construction of hospital environments and assists in the planning and organization of these and, with the institution of Rede Cegonha[4], it became necessary to adapt the environments in obstetrics based on local demand.

Thus, it is essential to point out that the parturient woman is the protagonist of the event and has space to exercise her choices in a conscious and oriented way. Therefore, its delivery must be considered in its various dimensions, as a biological, social, affective event in which assistance must be provided based on scientific evidence and ethical and humanistic precepts.

This research was limited by the fact that perhaps the understanding of these parturients cannot represent that of all the others. However, it does not imply that the study identified the reality of a public health institution and, consequently, stimulated improvements in care programs and institutional protocols in management with regard to the care inherent to parturient women.

Conclusion

Parturients were fragile as a result of the parturition process. Many pointed out good experiences in this phase, however, they were dissatisfied at times, both due to the fact of not complying with the laws and policies that govern women's health, and due to the deficient nursing care provided. The verified reality can be justified by the service being undergoing an implementation phase, thus, the study demonstrates that the needs are not being met.

The weaknesses presented by the women in the research lead us to reflect on points that are subject to improvement or change. The welcoming of the team needs constant improvement so that the quality of care is maintained, as it became evident that the environment, not only physical, but procedural, interferes positively or negatively on the woman who experiences the moment of parturition.

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