Pregnant Women's Knowledge about the Childbirth Process

Elenice Maria Folgiarini Perin
Nurse Specialist in Family and Community Health
PlanaltoCatarinense University
Lages - SC – Brazil

Margarete Veronica Jesse Dos Santos
Nurse Student of the Masters in Environment and Health
PlanaltoCatarinense University
Lages - SC - Brazil

Juliana Cristina Lessmann Reckziegel
PhD in Nursing
Professor at the PlanaltoCatarinense University
Lages - SC – Brazil

Abstract

This research has the objective of identifying the knowledge of pregnant women about the process of childbirth. Method: A qualitative study, developed with 15 pregnant women in the context of primary health care in a city in the Brazilian Southern Plateau. Semi-structured interviews were carried out, applying the thematic content analysis, through Atlas.Ti software. Results: Two categories were identified, covering the knowledge about the labor process and the labor representations. It became evident that women live a complex and intense process, being influenced by society, family, co-workers, friends, prenatal and hospital staff. They point out that during pregnancy; the information received is decisive for choosing the delivery method as well as, their role during the process of birth.Health professionals play a fundamental function in the instruction and deconstruction of myths for the woman and her family as protagonists in labor and delivery for a positive experience.

Keywords: Women's Health. Nursing. Primary Health Care. Labor. Delivery.

Introduction

Labor and delivery are complex experiences that involve the family nucleus and have transformative potential in people's lives (Velho, Santos and Collaço, 2014). Its representation shows a wide social heterogeneity, modulated by cultural, religious and ethnic characteristics (Prates et al., 2018).

Labor is considered a natural and physiological phenomenon, but the history of labor care dramatically changed (Prates et al., 2018). Initially, the women themselves assisted and developed a process of accumulation of knowledge about parturition, with the figure of the midwife as a helper in the course of labor and delivery. Later, physicians assumed the control of care, and the process of medicalization started (Nascimento et al., 2016).

Labor ceases to be private, intimate, and feminine and begins to be experienced in a public way, with the presence of other social actors (Prates et al., 2018). In this model, obstetrics was shaping and attention to labor and birth began to be marked by interventions in health, frequent cesarean practice, remoteness of the pregnant women of their relatives, lack of privacy and respect for their autonomy (Lima and Castro, 2017; Caus, et al., 2012). In another bias, the humanized maternity care starts slowly to grow. The concept is based in the respect, integrality and qualification of care (Nascimento et al., 2016).

In order for a woman to play her role during parturition, she must be aware of the events related to the birth process, being able to be part of the decision-making moments together with the health team (Castro, 2015).

Low-risk prenatal follow-up linked to the UHS, which occurs in the Family Health Unit, can increase the focus, with the target on health education activities aimed at healing doubts, fears, and myths about labor and birth, thus helping pregnant women become capable of assuming the leading role of the birth and birth process (Lima and Castro, 2017).

The protagonism is related to the capacity of understanding and knowledge about the experienced moment and consequent possibility of a conscious decision on the conducts that involve its body (Malheiros et al., 2012). In this perspective, the objective of this study is to unveil knowledge of pregnant women about the labor process.

Method

This is a descriptive and exploratory qualitative research carried out in the context of primary health care in a city of Serra Catarinense - Brazil. The participants were 15 pregnant women, who were between the 1st and 3rd gestational trimester, aged between 18 years and 36 years, mostly from low to medium schooling and precarious financial condition.

The individual interviews took place in a private room of a Basic Health Unit, had an average duration of 30 minutes and were recorded in audio. They followed a semi-structured script addressing the knowledge about gestation and delivery, experiences with the birth of previous children, fears and expectations related to the process of labor, the influences of family and socio-affective bonds. Data collection occurred between July and October 2016, the audio files were transcribed using Word® software and analyzed using Atlas.Ti® software version 6.0. The reference was the content analysis of Bardin (1977). During the process, codes emerged that came together in the elaboration of two categories.

All participants were informed of the research by signing the Free and Informed Consent Term, and approved by the Research Ethics Committee of the PlanaltoCatarinense University, under Opinion No. 1,649,178, according to the guidelines of Resolution 466/12 of the National Health Council (Brazil, 2012).

Results

Fifteen pregnant women participated, of these 07 aged between 18 and 22 years, four with 24 to 28 years and four with 31 to 36 years. 11 were married or in a stable union and four were single. With regard to schooling, five have until elementary school, nine to high school and only one with higher education.

Seven were primiparous and eight multiparous, and none experienced the birth of their children through surgery. Six were in the first trimester of pregnancy; seven in the second quarter and two in the third quarter at the time of the interview.

The qualitative analysis of the data allowed to identify two categories addressing the knowledge about the process of labor and the representations of labor described below:

a) Knowledge about the labor process.

It was observed that pregnant women's knowledge about the delivery process was strongly influenced by previous experiences and empirical knowledge, but after consultations with the nursing and health team, they reported that they were able to better understand the process, facing fears and insecurity. In addition, they reported that the pregnant woman's card/booklet provided by the health unit consists of an accessible resource for information on the health and maternity services routines, and is a stimulus for the search for deepening in other sources, such as the internet.

Some pregnant women also pointed to the workplace as a source of information about the birth process, as well as other segments of society, such as educational campaigns in information vehicles such as radio and television. But this information can also bring fear of labor, considering that in some moments they emphasize the tragedies that can happen. The pregnant women reported that the family and friends are a source of support, highlighting the presence of the mother of the pregnant woman and the partner as a source of security, helping in the decision making related to the birthing process.

Some pregnant women reported that participation in groups facilitates the exchange of knowledge, mainly related to the physiology of labor, care of the newborn and legal aspects, such as gestation leave and other benefits related to gestation, delivery, puerperium, and lactation. Another point worth mentioning was the maternity visit, cited as a source of great clarification about the process that will be experienced. Regarding the non-horizontal delivery positions, there was variation between none and little knowledge on the subject, besides the intention to delegate this choice to health professionals. Although they did not present reports of leadership in the choice of delivery position, they reported that contact with health professionals increases the access to information, helping in the empowerment to make other decisions. In the following speeches it is evident the knowledge of the pregnant women about the process of labor:

> *"...so after I read the card the doubts practically disappeared, so that was good, until the first consultation here nurse, she asked a lot of question, that's where I clarified it too" (E10)*

"I made the visit with you there in the maternity ward, I found it very cool, I found it very interesting, everyone can tell you what happened, how many hours you were in labor, what you did and what you did not do. Each has an experience, every labor, every woman is a different situation, and it's great to hear from people and people listen to people"(E 12).

"In the first birth, I did not know anything, in the other it was quiet" (E02)

"I listened on the radio and I was scared because the little baby died"(E08).

b) Representations of labor

The moment of labor was recognized as linked to medical care, with the leading role of the health team. Participants recognize the value of technical knowledge and believe that health actions are necessary. They recognized the figure of the Nurse as the main professional linked to the transmission of information on labor. When questioned about Doulas, the pregnant women presented little knowledge about the occupation in labor care.

In contrast, some situations have been reported as worrying, mainly the fear of the excessive accomplishment of invasive procedures in the delivery assistance, being the fear of the most cited episiotomies. Many of the pregnant women reported believing in labor as a natural moment in life, recognizing the importance of autonomy during labor and spiritual help for a positive outcome.

Another significant element in the representation of labor was choice by birth, and women presented arguments that justified their choice, citing normal labor as conducive to rapid recovery. Others claimed fear of the suffering that the healing of cesarean section could cause. The pain was also much cited by women, revealing that they make direct associations of this event with the occurrence of negative feelings. Many have pointed out that pain can be minimized with knowledge about labor since it allows to develop a greater role for the management of the body and health interventions performed.

There are still women who have the understanding that pain is the preparation of the body for birth, which is something natural and necessary, reporting that contact with the newborn brings pain relief. They emphasize that when they are aware of the physiology of labor they can request more attention from the health team and that the offer of non-pharmacological methods of pain relief by the obstetrician nurse and the other members of the hospital staff positively assist.

The following statements indicate the representations of labor:

"I was very tired, the bag also did not break alone ... then they put the serum in the vein and pushed the baby to be born, hence she was born" (E14).

"It is he from above (God) who knows, it is not us, I can not say anything..." (E09).

"In fact, from what I know, the Doula accompanies during the entire gestation, help is, in the question of breathing, I do not know, I do not know much, but I know that it accompanies you throughout the gestation..." (E07).

"The pain is not easy, the pain is a preparation, it is your body that is changing, so it is a pain that needs to be endured. But it is a very different experience, quite different, it is a pain that cannot explain. Here you are opening everything, you are opening, you know that your body there is no longer the same, that it is dilating. So that pain is a pain of, as I can explain, that pain has no explanation, it is pain without explanation, it is a good pain that at the time is not good" (E12).

In this research it was evident that women live a very complex and intense process, being influenced by society, family, co-workers, friends, prenatal and hospital staff. They point out that during the gestation the information received is determinant for the choice by the way of delivery and for its protagonist during the process of birth.

Discussion

The moment of labor is an event that can be influenced by cultural, religious, ethnic and social class characteristics (GAMA et al., 2009). At a time when the woman is vulnerable, therefore more susceptible to obstetric violence, where low schooling and the early age of pregnant women can be risk factors in this process. In this research, it was observed that the majority have a low level of education and that seven are less than 22 years old.

The study by Rattner and Moura (2016) shows that the higher the schooling and the age of pregnant women the proportion of births by cesarean section in Brazil is increased. Tesser et al. (2015) state that there is a great excess of cesarean sections in Brazil, being more prevalent in the supplementary sector (85% of those born by cesarean section). This information from the literature corroborates with the data found here, considering that none of the eight multiparas experienced the birth of the children through the surgical route.

Regarding the performance of prenatal care in the public health care network, Tesser et al. (2015) strengthen the importance of the team to instrumentalize and guide pregnant women and families regarding the benefit of normal birth and the possible complications of the interventions. Offering information to women and their families helps them to be protagonists of the process, giving subsidies to demand safe, dignified and humanized care. The family and society are very important in this process, especially for women who are experiencing gestation for the first time (Pinheiro et al., 2016). For Martins and Remoaldo (2014), the constant availability of the Nurse in attending the pregnant woman and responding to her needs becomes fundamental support for the experience of labor and birth. In the present study, we also observed that the nurse is the first contact when the pregnant woman has doubts and is the support in the gestation, being the professional that more passes information about the delivery.

The study shows that the reality of labor in Brazil, in the years 2011 and 2012 almost always with a lot of pain and excess of interventions, more frequently in public establishments (Leal and Gama, 2014). In this context, obstetric violence is unfortunately veiled, which becomes naturalized, thus strengthening the idea that the female being no longer has the physiological capacity to give birth without excessive intervention. Pires et al. (2010) point out that the medicalization of the pregnancy-labor process, the fear of pain, the convenience of the scheduled delivery date, and a negotiation/orientation process established between the pregnant woman and her family and health professionals strongly influence the choice in favor of cesarean.

When referring to the representation of pain in labor Pires et al. (2010) point out that the fear of pain, the risks that women believe to be involved in natural labor and the lack of knowledge result from the low preparation of these for delivery during prenatal care. The integrative review by Mafetoni and Shimo (2014) shows that pain tolerance increases when non-pharmacological methods are offered during labor, being recommended by the World Health Organization and improving the quality of delivery care.

Conclusions

It is perceived that there is a need to strengthen labor as a physiological process, natural, humanized, assisted by health professionals where health interventions should be based on up-to-date scientific knowledge, promoting women's autonomy as a protagonist in the gestation process, labor, and delivery. It is recommended that the researches in the area be expanded, collaborating in the construction of knowledge for the modification of the reality experienced during the assistance/experience of labor and delivery.

References

Bardin, L. (1977) Análise de conteúdo. Lisboa: Edições 70.

Brasil. Ministério da Saúde. Conselho Nacional de Saúde (2012) Resolução n. 466, de 12 de dezembro de 2012. Aprova diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília, Diário Oficial da União, 12 dez. 2012.Available online at: http://conselho.saude.gov.br/resolucoes/2012/reso466.pdf

Caus, E.C.M., Santos, E.K.A., Nassif, A.A. andMonticelli. M. (2012)The process of giving birth assisted by obstetrician nurse in a hospital context: mean for the parturients. Esc Anna Nery. 16(1) pp. 34-40. Available online at: http://www.scielo.br/pdf/ean/v16n1/v16n1a05.pdf

Castro, C.M. (2015)The meanings of planned home brith for women from the municipality of São Paulo. Cad. Saúde Colet., 2015, Rio de Janeiro, 23 (1): 69-75. Available online at: http://www.scielo.br/pdf/cadsc/v23n1/1414-462X-cadsc-23-01-00069.pdf

Gama, A.S.G., Giffin, K.M., Angulo-Tuesta,A., Barbosa, G.T. and d'Orsi, E.(2009)Women's representations and experiences with vaginal and cesarean delivery in public and private maternity hospitals. Cad. SaúdePública. 25(11) pp. 2480-2488. Available online at: http://www.scielo.br/pdf/csp/v25n11/17.pdf

Leal, M.C. andGama, S.G.N. (2014)Birth in Brazil. Cad. Saúde Pública. 30(supl.1) pp. S6. Available online at:http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2014001300001&lng=pt&nrm=iso&tlng=pt

Lima, P.M. and Castro, J.F.L. (2017) Guidelines during low-risk prenatal care for a humanized delivery: a comparative study between two Family Health Units. Rev. Bras. Pesq. Saúde. 19(2) pp. 115-123. Available online at: http://periodicos.ufes.br/RBPS/article/viewFile/18869/12846

Mafetoni, R.R. andShimo, A.K. K. (2014) Non-pharmacological methods for pain relief during labor: integrative review. Rev Min Enferm. abr/jun; 18(2): 505-512. Available online at: http://www.dx.doi.org/10.5935/1415-2762.20140037

Malheiros, P.A., Alves, V.H., Rangel, T.S.A. and Vargens, O.M.C. (2012) Labor and birth: knowledge and humanized practices. TextoContextoEnferm, 21(2) pp.329-337Available online at: http://www.scielo.br/pdf/tce/v21n2/a10v21n2

Martins, M.F.S.V.,Remoaldo, P.C.A.C. (2014)Representations of the midwife in the perspective of the pregnant woman. Rev. bras.enferm. 67(3) pp. 360-365. Available online at: http://dx.doi.org/10.5935/0034-7167.20140047.

Nascimento, J.P; Mattos, D.V.; Matão, M. E. L.; Martins, C.A. and Moraes, P.Á. (2016). Woman's empowerment in planned childbirth at home. Rev enferm UFPE on line., 10(Supl. 5) pp. 4182-4187. Available online at: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/viewFile/11162/12686

Pinheiro TM, Marques SIR, Matão MEL and Miranda D.B. (2016) Factors influencing the indication of the delivery route. R. Enferm. Cent. O. Min. 1(6):2066-2080. Available online at: http://www.seer.ufsj.edu.br/index.php/recom/article/view/986/1013 acessoem 16/11/2016

Pires, D., Fertonani, H.P, Conill, E.M., Matos, T.A., Cordova, F.P. and Mazur, C.S. (2010) The influence of professional health care on the choice of type of childbirth: a socio-anthropological perspective on supplementary Brazilian health care. Revista Brasileira de Saúde Materno Infantil, 10(2), 191-197. Available online at: https://dx.doi.org/10.1590/S1519-38292010000200006

Prates, L.A., Timm, M.S., Wilhelm, L.A., Cremonese, L., Oliveira, G., Schimith, M.D. andRessel, L.B.(2018) Being born at home is natural: care rituals for home birth. Rev Bras Enferm. 71(Suppl 3) pp.1247-56. [Thematic Issue: Health of woman and child]. Available online at: http://dx.doi.org/10.1590/0034-7167-2017-0541

Rattner, D. andMouraE.C. (2016) Births in Brazil: association between type of delivery and temporal and socio-demographic variables. Rev. Bras. Saude Mater. Infant. 16(1) pp.1-9. Available online at: http://dx.doi.org/10.1590/1806-93042016000100005

Tesser, C.D, Knobel, R., ANDREZZO, H.F.A. and DINIZ S.D. (2015)Obstetric violence and quaternary prevention: what it is and what to do. Rev Bras Med Fam Comunidade. 10(35) pp.1-12. Available online at: http://dx.doi.org/10.5712/rbmfc10(35)1013

Velho, M.B.,Santos, E.K.A. andCollaço, V.S. (2014) Natural childbirth and cesarean section: social representations of women who experienced them. **Revista Brasileira de Enfermagem.**67(2) pp.282-289. Available online at: http://dx.doi.org/10.5935/0034-7167.20140038