REVISTA ONLINE DE PESQUISA

CUIDADO É FUNDAMENTAL

Universidade Federal do Estado do Rio de Janeiro • Escola de Enfermagem Alfredo Pinto

RESEARCH

DOI: 10.9789/2175-5361.2018.v10i1.17-24

Práticas de atenção ao parto normal: a experiência de primíparas*

Care practices in normal birth: the experience of primiparous women

Prácticas de atención en el parto normal: la experiencia de las primíparas[I]

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How to quote this article:
Scarton J, Ressel LB, Siqueira HCH, et al. Care practices in normal birth: the experience of primiparous women. Rev Fund Care Online. 2018 jan/mar; 10(1):17-24. DOI: http://dx.doi.org/10.9789/2175-5361.2018.v10i1.17-24

ABSTRACT

Objective: To know the care practices developed by nursing professionals during the birth process from the perspective of primiparous women. **Method:** A descriptive and exploratory study with a qualitative approach, developed with ten primiparous women in the months of February to April 2014. Data were collected through semi-structured interviews and analyzed using Minayo's operative proposal. This study was approved by the Ethics Committee of the Federal University of Santa Maria, under CAEE 26452313.8.0000.5346. **Results:** Were structured into three categories from the World Health Organization Practical Guide with recommendations for safe practices in normal birth. **Conclusion:** It is considered the need to rethink and reformulate institutional care practices that are in disuse and investment in continued education and in the practice of care that contributes to the physiological evolution of childbirth.

Descriptors: Women's Health, Obstetric Labor, Parturition, Nursing.

RESUMO

* Article derived from the Master Dissertation entitled "Experiences of primiparous women in the practices of care for vaginal birth" presented to the Graduate Program in Nursing of the Federal University of Santa Maria (PPGEnf / UFSM), February 27, 2015.

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Objetivo: Conhecer as práticas de cuidado desenvolvidas pelos profissionais de enfermagem durante o processo parturitivo na perspectiva de mulheres primíparas. **Método:** Estudo descritivo e exploratório com abordagem qualitativa, desenvolvido com dez mulheres primíparas, nos meses de fevereiro a abril de 2014. Os dados foram coletados por meio de entrevista semiestruturada e analisados pela proposta operativa de Minayo. Este estudo obteve aprovação pelo Comitê de Ética em Pesquisa da Universidade Federal de Santa Maria, sob CAEE 26452313.8.0000.5346. **Resultados:** Foram estruturados em três categorias a partir do Guia Prático da Organização Mundial da Saúde com recomendações de práticas seguras no parto normal. **Conclusão:** Considera-se a necessidade de repensar e reformular práticas de cuidado institucionais que se encontram em desuso e investir na educação continuada e na prática de cuidados que contribuem para evolução fisiológica do parto.

Descritores: Saúde da Mulher, Trabalho de Parto, Parto, Enfermagem.

RESUMEN

Objetivo: Conocer las prácticas de atención desarrollados por profesionales de enfermería durante el proceso del parto por la perspectiva de las mujeres primíparas. **Método:** Estudio descriptivo y exploratorio con enfoque cualitativo, desarrollado con diez mujeres primíparas en los meses de febrero a abril de 2014. Los datos fueron recolectados través de entrevistas semiestructuradas y analizados con la propuesta operativa de Minayo. Estudio aprobado por el Comité de Ética de la Universidad Federal de Santa María, CAEE 26452313.8.0000.5346. **Resultados:** Se estructuran en tres categorías de la Guía Práctica de la Organización Mundial de la Salud con recomendaciones para las prácticas seguras en el parto normal. **Conclusión:** Se considera la necesidad de repensar y reformular las prácticas de cuidados institucionales que están en desuso y que se invierta en la educación continua y las prácticas de la atención que contribuyen a la evolución fisiológica del parto.

Descriptores: Salud de la Mujer, Trabajo de Parto, Parto, Enfermería.

INTRODUCTION

Gestation and delivery are shaped as natural processes[1] and the history of childbirth accompanies the history of humanity itself, it is considered a feminine activity traditionally performed in the home environment by midwives.[2] Thus, before the sixteenth century and for many years, birth was considered an event In which the woman participated actively in this process.[3]

However, from the seventeenth century, this trend changed due to the incorporation of surgeons in childbirth care. Therefore, the care provided to the woman and the family underwent significant changes, especially since the end of the nineteenth century when biomedical science began to treat the process of birth similar to that of illness which needs medical care, resulting in the institutionalization of childbirth.[4-5]

Although technical and scientific developments and the institutionalization of childbirth has reduced risk situations, it has also provided space for "dehumanized" practices. With this, the woman began giving birth in a hospital environment with the help of strangers who are not always welcoming.[6] Thus, historically, the woman has adopted a passive, apathetic and fearful attitude towards childbirth, since it came to be considered a "medical procedure" and of domain of health institutions, removing the woman from her role as protagonist.[3]

Given this context, a movement of humanization of childbirth emerges in Brazil in the 21st century, aiming to prioritize the use of appropriate technologies that are proven to be beneficial to the mother/baby binomial. In this direction, the Program for Humanization of Prenatal and Birth (PHPB), instituted in 2000, focuses on women and the rescue of human dignity and autonomy during the parturition process, seeking to consolidate the change in the service offered, based on humanized care.[7]

Besides that, the Stork Network arises which aims to structure and organize the attention to maternal and child health in the country, which has gradually been implanted throughout the national territory. This program identifies actions aimed at humanized care, delivery and birth, focused on the well-being of women and other people involved in this process.[8]

Among the actions, the creation of the practical guide prepared by the World Health Organization (WHO), with recommendations for safe practices in normal childbirth stands out.[9] The Law No. 7,498/86 and the Decree-Law 94.406/87 of the professional exercise which establishes the accomplishment of normal delivery without abnormalities by obstetrician nurse, recognizing the care provided by this professional category in the context of humanization of childbirth is also noteworthy. The Federal Nursing Council also determines that nurses are responsible for the Nursing care of expectant, parturient and postpartum women, the follow-up of the pregnancy and of the labor and obstetric assistance in an emergency.[10]

In the meantime, it is understood that health professionals, especially nursing professionals, should provide women with an enabling environment for them to actively experience the parturitive process. In order to do so, it is necessary to create interactive relational technologies, which lead to human relations of bonding and welcoming in order to meet the user's needs for care.[11]

Thus, it is considered relevant to discuss the care practices performed by nursing professionals in the assistance to normal delivery, which is characterized as positions facing development and social reality. That is, ways of care that aim to combine theoretical-technical knowledge with human sensitivity to pay attention to the individual in its biopsychosocial complexity.[12]

Thus, we have as a guiding question of the study: What are the care practices developed by nursing professionals in the parturition process of primiparous women? And as objective: To know the care practices developed by the nursing professionals during the parturitive process from the perspective of primiparous women.

METHODS

This is a descriptive and exploratory study[13] with a qualitative approach, carried out in the maternity unit of a hospital institution located in the countryside of the State of Rio Grande do Sul, its participants where ten primiparous women. Regarding the number of participants the data saturation method was used to observe as the goal proposed in the study was reached.[13]

Inclusion criteria counted in primiparous women who underwent normal delivery in the study location, who were submitted to delivery with gestational age equivalent to the term (37 to 42 weeks) and with live newborns; Who were hospitalized in the maternity hospital during the period of data collection and who had preserved psychic-cognitive conditions.

The exclusion criteria where multiparous women, primiparous who gave birth in another institution or at home, and primiparous whose pregnancy resulted in stillborn or fetal demise and the participants who refused to record their interviews.

Data collection was performed in February, March and April of 2014, through a semi-structured individual interview, recorded and later transcribed, which addressed issues regarding the accomplishment of care practices by nursing professionals in the parturition process. The interviews were conducted in a room attached to the maternity unit, but located inside the maternity unit, which ensured the viability of their participation and the secrecy of the information.

The objective of the research was explained as well as the Informed Consent Term (ICT) which was read and explained to participants over 18 years of age and to those responsible for those under 18 years of age. Participants under the age of 18 also received the consent form for an authorization regarding their participation. Also, the 24-hour postpartum period was respected for the interviews, due to the respect for the woman's integrity, but it was chosen to do the interview during this period because the experience of care at labor was accentuated in their memories.

Afterwards, the data collected were analyzed through Minayo's operational proposal[13], which is characterized by two operational moments. The first one consisted of the exploratory phase of the investigation, in which the understanding of the history of the researched group, its environments and its socioeconomic conditions was sought, among others. The second moment comprised the interpretation phase, which allowed the researcher to understand the central meanings of the study allowing the presentation of the final report of the research.

Ethical precepts were observed in accordance with Resolution No. 466/2012[14] of the National Health Council, which establishes parameters for research involving human beings. In order to guarantee the anonymity of the participants, these were named by the letter "I" of interviewee, followed by numerical sequence, observing the order of the interviews performed (I1, I2 ... I10). This research was approved by the Research Ethics Committee of the Federal University of Santa Maria under the Certificate of Presentation for Ethical Appreciation CAEE 26452313.8.0000.5346.

RESULTS AND DISCUSSION

The participants' ages varied between 15 and 29 years of age. In relation to the marital status, seven were in stable union and three had a marital status of single or married. As for schooling, five had completed high school, three did not, one had finished middle school and one did not finish it. Still, as for the occupation, one was a student, four worked as retail storekeepers, two were house wives, two were maids and one was a farmer. As for the monthly family income, three earned a minimum wage, one earned a minimum wage and a half, one earned two minimum wages, one earned three minimum wages and one earned four minimum wages.

Regarding the care practices provided in the parturition process, seven of the participants had indication of some type of non-pharmacological method for pain relief, prevailing ambulation and warm bath. Also, nine had the presence of a companion in labor, delivery and postpartum period. On the other hand, eight made use of drugs for induction during labor, such as oxytocin. Besides that, there was the performance of procedures such as tricotomy (seven), enema (seven) and episiotomy (nine).

The data from this study were structured in three categories based on the World Health Organization (WHO) Practical Guide.[9] In 1996, the WHO developed a practical guide based on safe care practices for normal childbirth. These categories are described as: proven beneficial practices that should be encouraged; conducts frequently used in an improper manner; clearly harmful or ineffective practices that should be eliminated (WHO, 1996).

Safe Practices for Normal Childbirth Care

In the search for understanding and knowledge about the care practices provided by nursing professionals in the parturition process, it was identified that the non-pharmacological methods for pain relief, which contribute to the physiological progression of childbirth, are covered in the care scenario of the present study. These methods are framed by the WHO in the category of proven beneficial practices that should be encouraged.[9]

"[…]I was oriented to walk while I was dilating, and she (nursing technician) told me to walk in the corridor to dilate faster, which is a lot better." (I10)

"Walking right at the beginning when I was six fingers dilated, before the saline, so I walked. [...] the Swiss ball was at the end, they said it was to fit better." (I9)

One of the non-pharmacological strategies for pain relief mentioned by the participants of this study refers to ambulation, which was oriented to help dilation, contributing

to the progression of labor and, in a way, shortening its duration. This practice of care, when properly oriented and stimulated, aims at allowing greater autonomy to the parturient over her body, allowing the woman to feel as an active part of this process. Ambulation, at the beginning of labor, was one of the most commonly used non-pharmacological methods. This care practice, an interactive relational technology, is considered by the WHO as a non-pharmacological alternative to pain relief.[9]

Similar results were found in the study[15] which analyzed the assistance performed by nurses in the follow-up of parturients. The data were collected in a book for the register of the nurse's actions in the assistance to the parturient of an obstetric center of a maternity hospital. A total of 938 deliveries were studied in the period from 2005 to 2006, and ambulation was the third most used method, appearing in 12.78% of deliveries, which is in line with the findings of the present study, where ambulation was performed for 50% of participants, being the non-pharmacological method most used.

In this sense, it is clear that for both the mother and the baby, it is best when the woman is still in movement during labor. The vertical position favors the reduction of pain and time of labor and delivery, besides increasing uterine activity, it offers a lower risk of fetal distress and improves maternal comfort. In addition, this method is associated with lower rates of cesarean delivery and analgesia.[15]

Another practice of non-pharmacological care used in the study scenario was the use of the Swiss ball by two participants. This is a ludic device, built with elastic material, full of air, which helps in postural correction, relaxation, stretching and stimulates the pelvic floor musculature.

A study[16] evidenced that 40% of the obstetric centers, linked to the Unified Health System in the city of São Paulo, used this device as a method of obstetric care during the dilation phase. The benefits of using this method lie in the fact that the vertical position favors the force of gravity and, consequently, the descent and the fetal progression in the birth canal and also stimulate the spontaneous movements and allows the woman to have control, being aware of her own body. It is noted that the ideal moment for the use of the Swiss ball is during the active phase of labor since it is during this period that the contractions intensify.[17]

It is noticed, through research data, that nursing professionals play an important role in childbirth care and should use their knowledge in the service of the parturient recognizing the unique moment that is being experienced by her and her family. In this sense, nursing professionals need to incorporate in their attitudes as caregivers, practices that make it possible to contribute so that women experience the parturitive process in a pleasurable way.[2]

Regarding non-pharmacological methods, they can even be applied by the woman's choice companion, since their use does not require high technology. For the WHO, it is essential that non-pharmacological methods for pain relief be increasingly used as they are safe and less invasive.[9]

On the other hand, it is recognized that the use of non-pharmacological methods for pain relief contributes to the protagonist role of the parturient in the delivery process, reducing unnecessary and often routine interventionist practices. Therefore, these methods are fundamental in the current context of the birth in Brazil.[9]

Regarding care practices, routine care was identified including checking of blood pressure, auscultation of fetal heart rate (FHR), and vaginal touch examinations. Thus, in the research space of this study, these are performed at the admission of the parturient and continue during their hospitalization. Its justification is centered on the evaluation of maternal and fetal well-being.

"[...] they took me to the examination room, performed the vaginal touch examination, checked my blood pressure, heard the baby's heartbeat." (I9)

"[...] they evaluated me, checked the heartbeats, the blood pressure." (I7)

"[...] the girls (nursing technique) measured my blood pressure, they heard the baby's little heart when I arrived." (I5)

"[...] They checked my blood pressure, performed the vaginal touch examination, and listened to the little heart as well." (I8)

According to the testimonies, the nursing professionals performed a physical evaluation in the first contact with the parturient. In this evaluation, the auscultation of the FHRs, the checking of the blood pressure and the vaginal touch examination, which are mandatory procedures for the admission of the parturient, were prioritized. These actions need to be carefully developed, as they serve as a parameter for the definition of subsequent behaviors, and even for more complex care referrals, when necessary.[9]

In a study[18] that aimed to evaluate delivery and newborn care at a maternity and neonatal unit of a tertiary-level hospital in the interior of the state of São Paulo the following index were identified: 89% vaginal touch, 96.6% blood pressure and auscultation of the FHR and 89.7% evaluation of the uterine dynamics. It is evident that these results are consistent, in part, with the findings of the present research, since the evaluation of uterine dynamics is not reported in the participants' statements. Besides that, evaluation of other vital signs like body temperature and heart rate are not reported in both studies.

Frequently improperly used conducts

According to the WHO are among the frequently misused behaviors, the water and feeding restriction to low-risk parturients in maternity wards. However, in the testimonials, these care practices continue to be implemented.

"[...] I could not eat it either ... I could not eat until the time of the delivery ... nor water nor anything ... they (nursing technicians) said that it was for me not to feel ill at the time of childbirth." (I4)

[...] I felt sick because I did not eat or drink, you know? [...] she (nursing technician) said that I could only drink a sip of water, just to wet my mouth, that if I had to do a cesarean section, I would have to go without food and water [...]. (I6)

Guidance of not drinking liquids or eating foods was given to the participants by professionals in order not to cause greater complications at the time of the delivery or in the case of progression to cesarean section because of increased risk of aspiration. According to the reports, it is noticed that the participants of the study demonstrated submission to the orientations of the professionals.

Thus, in the case of a normal low-risk birth, wherever it develops, there is no need to restrict the woman's food or fluid intake.[19] Therefore, the woman's desire to eat and drink should not be interfered with during labor, since labor requires an enormous amount of energy, given the unpredictability of its duration. Therefore, it is necessary to replace the parturient's energy sources in order to guarantee fetal and maternal well-being, and severe restriction of water intake can lead to dehydration.[9]

It is added that, in the parturitive scenario, the food or liquid restriction is usually linked to the lack of knowledge and updating of the professionals, and also to the need to structure institutional routines, which disregards the needs of women and still insists on perpetuating the "old" model of interventionist and medical-centered assistance.

These findings were similar to those obtained in the study[20] which aimed to evaluate delivery attention from the perspective of adolescents assisted in a university hospital in Southern Brazil. The research was carried out with 269 adolescents, from July 2008 to October 2009, in which water and feeding restriction were present in 87.4% of the participant's cases. Still, in a survey[21] "Birth in Brazil", a hospital-based study conducted between 2011 and 2012, with 23,894 women, the results showed that the model of care for childbirth with frequent use of interventions, among them, water and food restriction, is not supported by international studies.

Participants also reported the use of intravenous drugs, described as synthetic oxytocin.

"[...] I arrived, they (the nursing team) attended to me. The nursing technician put me in the saline (with oxytocin)." (I2)

"[...] they gave me saline (with oxytocin) that was to help dilate, so it would heve contractions more often and stronger [...]." (I9)

"[...] she (nursing technician) was going to put it in a little bit more slowly (oxytocin) because I was in a lot of pain [...] but then they (nursing technicians) increased it." (I6)

The data revealed a reality marked by the routine use of oxytocin, cited by the study participants as "saline". The use of oxytocin enhances the pain state by generating more frequent and stronger uterine contractions. In relation to this, the literature[21] points out that professionals are aware that the use of oxytocin interferes with the physiology of childbirth, causes regular, strong uterine contractions and therefore greater pain and discomfort for the woman. However, even in low-risk normal birth, some unnecessary interventions are used in a high proportion, such as the use of oxytocin, which with or without success is used to reduce the time of labor.

These data are similar to those of the study[21], previously reported, in which the authors mention that oxytocin use was used in 40% of the participants. It is considered that the use of synthetic oxytocin, to a certain extent, has its benefits. However, the current model of attention to delivery and birth does not value the physiology of the parturition process and opts for over-medicalization routinely performed without taking into account the moment lived by each woman.[21] Thus, it is considered that the active management of labor with the use of early oxytocin should be reserved only for a few cases and its routine use in obstetric practice is not recommended, as it may even be harmful if used indiscriminately.

Practices that are clearly harmful or ineffective and should be eliminated

Still, regarding the care of the parturient, the fragments of the speeches of the participants below reveal the performance of outdated procedures that do not bring maternal or neonatal benefits and are considered by the WHO[9] as: Normal childbirth practices that are clearly harmful or ineffective and should be eliminated.

"[...] enema." (I3)

"[...] The cut (episiotomy)." (I3) (I8)

"[...] The girls (nursing technicians) did (tricotomy) one night before the baby was born." (I6)

"[...] the (intestinal) lavage [...]." (I10)

[...] the shaving of the hair (tricotomy) [...] they (nursing technicians) explained that the reason for shaving was to avoid infection, which was done both in cesarean section and normal childbirth [...]. (I4)

The girls (nursing technicians) did [...] the shaving of the hairs, right? [...] because they had to because it would be normal birth, right? [...] did enema because there could not be anything there right? Because of the baby. (I5)

The fragments of women's speeches reveal the performance of technical procedures such as enema, trichotomy and episiotomy as routine in the service. It is verified that routine and unnecessary practices continue to be implemented in the study scenario, even in the face of research that points out that such practices are obsolete and need to be discussed, rethought and reformulated in health services.

In relation to the realization of such procedures, it is necessary to emphasize the place of the woman in that event and the function that the professionals themselves assume.

It is known that in some situations, the woman may choose to use some of these practices and this decision must be respected. However, in order to manifest this choice, the parturient needs, first of all, to exercise empowerment, which is characterized by the right to free decision-making, the right to speak and to take an active stance during the parturitive process.[6] Which is possible from the moment the nursing professionals start to clarify the patient about the proper care practices, about its benefits and possible risks, so that the woman can exercise the will to conscious decision-making.

In the meantime, the current parturition process, with increasing use of invasive procedures, does not favor the physiological evolution of labor. Therefore, it should be pointed out that these resources should only be used when there is a real need, so the trivialization of interventions should be avoided.[22] Concerning this aspect, the research "Born in Brazil" showed that the medical class does not value the scientific knowledge encompassed in the scientific environment.[23] Good practices of childbirth care are less frequent than interventions during labor and childbirth, and, on the other hand, the knowledge gained from scientific research on the effectiveness of these actions is not considered perpetuating the reproduction of routine unnecessary practices.[23]

Literature[21] indicates and reinforces that the practice of such conduct is ineffective and that, to a large extent, it does not bring benefits to the woman. For example, tricotomy, episiotomy, and enema practices are discussed in a study[20] which brings data similar to this one, in which the tricotomy was performed in 32.8% of the parturients, enema in 13.7% of the parturients, and the episiotomy in 89.6%. Still, the WHO 2009 establishes that such procedures are considered unnecessary, without scientific evidence and that they should only be performed at the request of the woman.[9]

It should also be noted that, regarding the practice of episiotomy, there is no reliable scientific evidence to confirm that it should be performed, especially when the individuality of each case is disregarded. It is worth mentioning that, at some point, this procedure may be necessary, however, there must be a plausible indication for its realization.[9]

Some participants revealed that nursing professionals still advocated the implementation of institutional routines, such as those previously mentioned and also the restraint to the bed. And in this context, the attitude of moving and acquiring a comfortable position during the uterine contractions started from the parturient's own will, that is, from the female instinct facing the situation of pain in labor.

[...] In fact, I started to walk and when the pain came, I crouched and pushed. So that helped at the time of the delivery [...] but it did not come from them (nursing professionals) [...] I stayed up all night. I kept walking in the hallways. Then she (nursing technician) came and said, "You have to lie down so we know" [...] but if I was in massive pain, I could not lie down. How could I lie down? (I6)

This statement reveals that the attitude of walking was an initiative of the participant and there was still interference from the nursing professional who questioned her attitude. Thus, the importance that the professionals should respect the way in which women would like to carry out their labor is confirmed, and it is up to the professional to provide parturition support and for the women to choose what suits her best, at a time when she must be the protagonist.[17]

It is also noted that these behaviors differ from the WHO recommendations[9], which affirms that, in addition to the support provided by professionals during labor, it is essential to orient the woman during the progress of labor to adopt the position she wishes, in bed or not. This means that if she does not want to, she does not need to be restricted to the bed in the supine position, since she has the freedom to choose a vertical, sitting, standing position, as well as walking, without interference from service providers, especially during the first stage of labor.

In this sense, the professional should encourage the parturient to change positions. It is important that one stresses that during the latency phase and in the initial active stage of labor, she may walk, as this will increase her comfort and facilitate the progression of labor.[11]

In this way, the nursing professional should represent the foundation of care. It needs to be present, to guide and also to help the woman in the good evolution of the childbirth, in order to make this experience positive to the woman and her relatives. Differently from this premise, there is an account of Kristeler maneuver at the time of delivery.

[...] she (nurse) had to give an aid in the belly by forcing it down (Kristeler's maneuver) [...] it hurt a little [...] I think it was the most painful part [...] (The nurse) did not explain why she was doing it. (I9)

From the report, the most painful part of the birth did not involve the pain of the contractions, but the pain caused by an intervention, which is recognized as a procedure that has no scientific evidence for its accomplishment. Therefore, the experience of the participant's first childbirth was marked by pain and suffering caused by a completely unnecessary procedure. It is considered that this experience can leave profound marks on the participant, because the memories that remain of this event depend, to a large extent, on the care provided or imposed by the team.

It is interesting to note that among many other interventions and institutional violence in childbirth care, Kristeller's maneuver is proven to be an unnecessary practice, which should be removed from this scenario.[21] These same authors, in the "Birth in Brazil" research, point out that the Kristeller maneuver was present in 37% of cases of women with habitual obstetric risk, demonstrating that the findings of the present study are still in agreement with other studies, even with risks superimposed on this maneuver such as uterine rupture, fractures in the newborn, among others.

It is also evidenced that when the participant states that they did not explain to her why they were doing this

maneuver, her choices were disregarded and her right to voice was dismissed since she did not even understand what was happening. In addition, it is understood that the procedure was performed without taking into consideration the woman/person being cared for.

The information provided to parturients is usually restricted to the need for her to push, to remain in a "comfortable" position for the professionals, restricting it from other relevant positions. However, these are guidelines that place women in a position of submission and passivity, ignoring their natural instinct, their autonomy, and their ability to give birth.[6]

In this line of thought, one reflects upon the role of the nursing professional during the parturition process. It should promote care based on empathy, dialogue, clarification of doubts, opportunizing and encouraging women's choices, and protecting them from situations of imposition, rape and violence of their body.

CONCLUSION

It is noted that the parturitive process experienced by primiparous women is marked by beneficial and non-beneficial care practices. Some care practices favor and respect the physiology of childbirth, such as the use of non-pharmacological methods for pain relief and care practices that assist the woman as a human being in the process of parturition. However, care practices that deprive women of the role of protagonists and that disrespect the physiological evolution of childbirth continue to be implemented, as seen in this study.

This study demonstrated that, although there is a policy focused on the humanization of labor and childbirth, an alert through a national survey entitled "Born in Brazil", that which still predominates is the model in which the professional appears as the holder of knowledge and the one who has the control over the process of giving birth and not the woman. This shows that there are still no major changes in the current context of delivery and birth care.

Another aspect worth pointing out is related to the nurse professional who is little mentioned by the participants in the testimonies, being the nursing technician in charge of the procedures. The nurse usually acts in the care of deliveries with some difficulty, being the nursing technician, in the majority of the times, responsible for the care to the other parturients. This fact reinforces the need for the maternity wards to have a larger number of nursing professionals so that they can accompany the parturient throughout the parturitive process and not only in complex situations.

It is hoped that this study will stimulate the reflection of the main involved in the care of child delivery, in the sense of rethinking and reforming practices of institutional care that are in disuse and invest in practices that contribute to the physiological evolution of childbirth and that restore women to the role of protagonists of their own childs labor.

It is important to emphasize the need for continuing education of professionals who work in childbirth care, seeking to update the professionals with fresh knowledge and the institutions with beneficial practices for parturient care. Also, it is recommended to offer training courses that allow better training of those involved in childbirth care.

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Received on: 07/23/2016
Reviews required: 03/14/2017
Approved on: 01/04/2017
Published on: 05/01/2018

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