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RESEARCH

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Experiences on the childbirth process: antagonism between desire and fear

Vivências no processo de parturição: antagonismo entre o desejo e o medo

Experiencias en el proceso de parturición: antagonismo entre el deseo y el miedo

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ABSTRACT

Objective: The study's purpose has been to discuss the women's experiences about the childbirth process. **Methods**: It is a descriptive study with a qualitative approach. The research was carried out at a Municipal Health Center in *Rio de Janeiro* city over 2015, and counted with 17 participating women being up to 42 days of postpartum period. It was used the technique of semi-structured interview, as well as the content analysis technique in the thematic-categorical modality. **Results:** The participants have experienced multiple childbirths, which have occurred in public maternity hospitals, and they did not receive prenatal orientation regarding the process. A more few observations are the following: they felt welcomed; related the pain of uterine contractions to physical suffering; during the childbirth labor they had the possibility of ingesting food and water; they adopted the lithotomy position; and their partner participated as companion. The health professionals, nonetheless, took a controlling stance on the participants' bodies during the childbirth procedure. **Conclusion**: The results confirm the importance of orienting the couples about gestation and childbirth in order to experience childbirth in an active and safe way.

Descriptors: Humanized childbirth, childbirth labor, childbirth, obstetric nursing.

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RESUMO

Objetivo: Discutir a vivência de mulheres no processo de parturição. **Método**: Estudo descritivo, qualitativo, realizado em um Centro Municipal de Saúde no Rio de Janeiro, em 2015, com 17 mulheres com até 42 dias de pós-parto. Empregou-se a técnica de entrevista semiestruturada e a técnica de análise de conteúdo na modalidade temático-categorial. **Resultados**: As participantes são multíparas, o parto realizado em maternidades públicas, e não receberam orientação no pré-natal sobre a parturição. Sentiram-se acolhidas, relacionaram a dor das contrações uterinas ao sofrimento físico, durante o trabalho de parto tiveram a opção de ingerir alimentos e água, adotaram a posição de litotomia, e o parceiro participou como acompanhante. Os profissionais de saúde, todavia, assumiram uma postura de controle sobre seus corpos no processo de parturição. **Conclusão**: Os resultados ratificam a importância de os casais serem orientados sobre a gestação e o parto, para que possam vivenciá-los de forma ativa e segura.

Descritores: Parto humanizado, Trabalho de parto, Parto, Enfermagem obstétrica.

RESUMEN

Objetivo: Analizar la experiencia de mujeres en el proceso de parturición. **Método**: Estudio descriptivo, cualitativo, realizado en un Centro Municipal de Salud de Rio de Janeiro, en 2015, con 17 mujeres con hasta 42 días de posparto. Se utilizó la técnica de entrevista semiestructurada y la técnica de análisis de contenido en la modalidad temático-categorial. **Resultados**: Las participantes son multíparas, el parto realizado en maternidades públicas, y no recibieron orientación en el prenatal sobre la parturición. Se sintieron acogidas, vincularon el dolor de las contracciones uterinas al sufrimiento físico, durante el trabajo de parto tuvieron la opción de ingerir alimentos y agua, adoptaron la posición de litotomía, y el compañero participó como acompañante. Los profesionales de salud, sin embargo, asumieron una postura de control sobre sus cuerpos en el proceso de parturición. **Conclusión**: Los resultados confirman la importancia de que las parejas reciban orientación sobre la gestación y el parto, para que puedan experimentar el parto de forma activa y segura.

Descriptores: Parto humanizado, Trabajo de parto, Parto, Enfermería obstétrica.

INTRODUCTION

The object of this study is the experience of women in the childbirth process. The childbirth is considered a physiological process, individual and a social event that integrates the roll of the most significant human experiences for women. This moment, for many years, was a lived experience in the family and intimate sphere to become an institutional practice and regulated by public policies. Over time this natural act, which requires care and acceptance, has come to be seen as pathological, then favoring the impersonal and medical care approach.[1]

This paradigm change can be evidenced when the high number of cesarean sections performed in Brazil is observed. A study showed that the Brazilian public network accounts for 52% of deliveries, while 88% occur in the private network.[2] This result shows that our country has difficulties in reaching the goals set by the World Health Organization (WHO), regarding the cesarean procedure. The WHO recommends that only 15% of births should occur by surgical procedure.[3]

Nevertheless, the reasons for high rates of cesarean delivery can range from a negative experience at the time of childbirth to the failure to perform a planned natural childbirth.[4] An influencing factor is the cultural context, such as fear of pain, also by having their perineum deformed and then making sexual activity difficult, or even by believing that for a healthy birth the aid of advanced technologies is necessary. In this way, women believe that cesarean delivery is the best way to give birth, reinforcing the fragmented, curative and hospital health care model.[4,5]

For women who choose to give birth in a natural way, many are faced with a different experience from the idealized one, experiencing the childbirth in a frustrating way, since they need to submit to the orders of the health professionals regarding their care. In this way, they give up their protagonism and experience the childbirth process as a painful moment and, mainly, with great anxiety for not being prepared for it.[6]

Emphasis is given to the need for health professionals to provide women with a more humanized and less interventionist care, in order to understand how she experiences the childbirth process, without losing sight of her individual needs, respecting her rights as a citizen, and promoting their active participation and the power of choice over their own care.[6]

Despite the Brazilian Government's investment in the Humanization of Childbirth and Birth, it is necessary to train and sensitize health professionals with a view to changing the paradigm of the biomedical model.[7] It is also necessary that the professionals can understand and recognize that the way how they welcome and assist the parturient women will reflect directly on how they experience this moment, considered unique in their lives.

Considering the aforementioned, the following was delimited as a guiding question for this study: How do women experience the childbirth process?

The present study is justified by the literature findings where the care offered to women in prenatal care and in the childbirth process has a direct influence on the way they experience their childbirth, as well as on maternal and neonatal morbidity and mortality. Thus, to understand how women experience the process of childbirth, the individual and contextual factors that relate and ground this process is relevant to the area of women's health.

This study is part of a research project registered at *Universidade Federal do Estado do Rio de Janeiro (UNIRIO)* entitled: "*Women's health in the life cycle: biological, cultural and social aspects*" and contributes to the discussions at the *Núcleo de Pesquisa e Experimentação em Enfermagem na área da Saúde da Mulher e da Criança (NUPEMMC)* from the Maternal-Child Nursing Department of the Alfredo Pinto Nursing School at *UNIRIO*.

Thus, the aim of the present study was to discuss the women's experiences during the childbirth process.

METHODS

It is a descriptive-exploratory research with a qualitative approach. The study scenario was the waiting room of

a Municipal Health Center located in *Rio de Janeiro* city, which belongs to the Programmatic Area 2.1. Seventeen (17) postpartum women participated in the study.

Participants were within a 42 days postpartum period and met the following inclusion criteria: more than 18 years old, having given birth by vaginal or non-elective surgery to one or more newborns in any health institution, and also were in good physical and psychological conditions to voluntarily participate in the research.

Participants were initially questioned about the type of childbirth and the age of the newborn, in order to meet the inclusion criteria. Data collection was performed on Mondays and Wednesdays, days scheduled by the Health Unit for the vaccination of children. If that event was then confirmed, we would invite the woman to participate of the survey.

Data were collected from August to November 2015. Thirty-three (33) puerperal women were approached. From those, six (6) did not participate justifying fatigue in the postpartum and/or lack of time to participate in the research, due to the demands with the baby and the house. It should be noted that ten (10) women did not meet eligibility criteria because they underwent elective caesarean section.

The technique for data collection was the semi-structured interview. The script contained open and closed questions that dealt with issues related to the social, reproductive and living characteristics of women in the childbirth process. The interviews lasted approximately 30 minutes, being recorded on MP3 media player with the participants' prior authorization. The interviews were later fully transcribed, which allowed us to organize the data and to remember the interview.

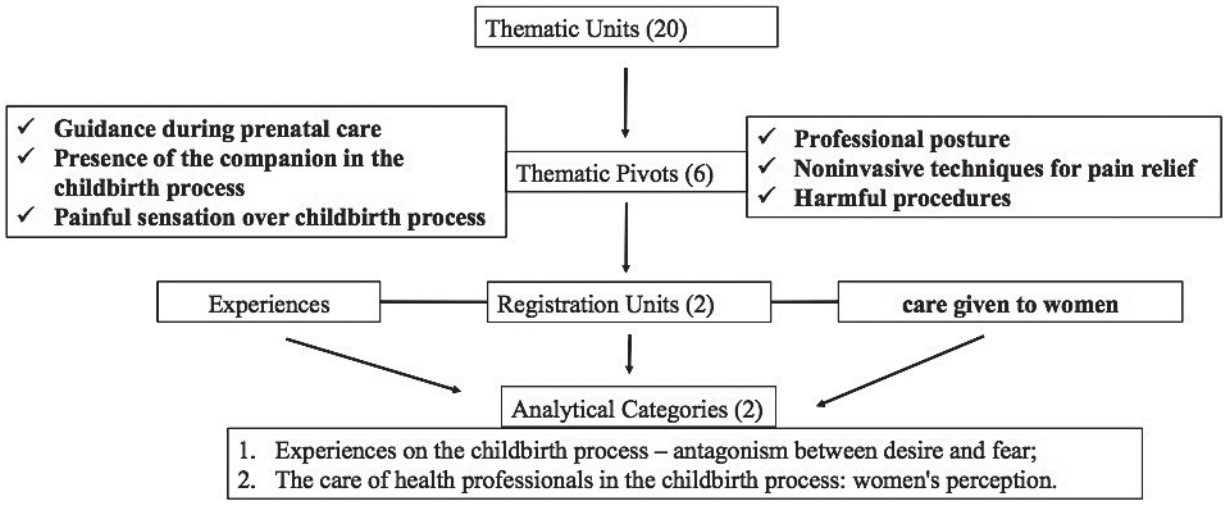
The interviews were conducted in a reserved room at the outpatient clinic, within the interval of administration of the vaccines. In order to guarantee anonymity, identification codes were adopted using the letter P, followed by cardinal numbers in ascending order (P01 to P17), according to the interviews. All participated voluntarily, by signing the Free and Informed Consent Term.

In order to analyze the data, the content analysis technique was used in the thematic-categorical modality,[8] taking into account the following steps: pre-analysis, material exploration, results treatment, inference and interpretation. In this study, the thematic unit replaced the statistical inference.

In the pre-analysis, the raw data was prepared, constantly returning to the research object, so that it was possible to establish the registration units, identified as: experiences and care, in order to extract the research corpus.

The second stage of the thematic analysis consisted of the exploration of the material with the objective of grouping the emergent subjects by approximation; alongside, we performed the technique of marking the signification units with colored pens. Twenty (20) thematic units emerged from this codification process, six (6) thematic pivots and two (2) analytical categories according to Figure 1.

Figure 1 - Thematic Pivots, Registration Units and Analytical Categories



Source: Authors.

This research was approved by the Ethics and Research Committee from the *Secretaria Municipal de Saúde e Defesa Civil do Rio de Janeiro (SMSDC-RJ)* under the Legal Opinion No. 1.180.473. The ethical aspects were respected according to the Resolution No. 466/12 from the National Health Council of the Health Ministry.

RESULTS AND DISCUSSION

Participants' characterization

Participating in the study were 17 puerperal women who were from 18 to 38 years old and living in the Programmatic Area 2.1. The majority (ten) declared themselves white skin; four were brown skin and three black skin. Among the women, ten lived with their partner in stable union, two were married and five were single. With regard to schooling, eight completed higher education, four women had a medium level, three had primary education and two had incomplete primary education. As for the occupation, 12 were in the labor market. The professions reported were, as follows: lawyer, teacher, communication professional, nursing technician, receptionist, domestic, diarist, public servant and nanny. Considering five who did not work, one was housewife and another one was student. The other three were unemployed.

In relation to the reproductive history, 10 were multiparous and seven were primiparous. Among the participants, four had experiences of spontaneous abortions and one had an unsafe abortion. As for the way of delivery, 12 had vaginal delivery. Regarding the gestational age, 16 went into labor between 37 and 40 weeks and one with 36 weeks. Among the puerperal women, five had their children in private maternity hospitals, 11 in public maternity hospitals and one had a planned home birth.

Experiences on the childbirth process – antagonism between desire and fear

Women need to be aware and prepared to experience the childbirth process as a moment of pleasure and security, as follows:

> They [health professionals] guide us very well. I did my prenatal there [in the maternity], I had lectures and various information. For me, the childbirth labor was good... I knew the pain would pass. (P04)

> I received information about everything I would feel during childbirth labor, that I could choose the best way to have my baby, non-pharmacological methods and the right to doula in public maternity. (P14)

Another participant stated that she received information during the prenatal care by the medical professional that accompanied her in the private network about the risks of an unnecessary cesarean section and the benefits of a normal birth, as follows:

> I have received guidance on normal delivery and cesarean delivery. [...]. My husband and I opted for normal birth and the doctor respected our decision. (P16)

Contrasting this fact, 11 participants stated that they did not receive prenatal orientation about childbirth.

> I had my baby lying down, building strength. They only gave me this option, of giving birth lying down. They did not talk about other forms of normal birth. (P11)

> I have not received any guidance on [non-pharmacological] techniques to improve pain. I even saw the ball there, but I was already in bed suffering. They did not offer me at any time, suddenly if it had been offered, I would have used it. I also did not walk; I spent most of the labor in bed lying down. (P01)

> I do not think they felt the need to orient me, just because I had already had a normal delivery and two cesareans. I lay there all the time, and they did not even ask me if I was comfortable [...]. I ordered food, but the doctor said it was not time to eat. They thought I was pretty sure of myself, I think so! (P15)

Another aspect that contributed positively to the experience of childbirth labor and delivery, was the presence of a companion of the woman's choice. In this sense, 12 participants were advised about this right in prenatal care:

> It's my legal right! I knew I had the right of someone to accompany me during childbirth labor and delivery. During the visit to the maternity hospital and during the prenatal period, I learned that I would have the right to companion. (P03)

> In the group of pregnant women at the Family Clinic I was told that I had the right to have a companion, and that I could choose. (P12)

It should be noted that four participants revealed the lack of knowledge about this right, perceiving the presence of the companion at the time of childbirth, as a benefit offered by the health team.

> I had my midwife" throughout the labor, they were great and they gave me permission. (P01)

> During childbirth labor, the doctor let my husband stay in the room with me. But after he (the doctor) said that I would have to have a cesarean, he told my husband to leave (P17).

Regarding the choice of the woman by the companion, nine mentioned having as a preference the partner, the father of their future child, according to the following statements:

> I chose my husband. It was great [...] you have to have someone with you, because you get very tired, lose your strength, and have no desire to do anything. You have to have him to give you strength. (P06)

He [partner] helps me in things [...], it's support, comfort, security. (P07)

The option for the partner was also pointed out by the participant who performed the planned home birth.

The decision to have a child at home was mine and my husband supported me. I had my partner, my companion, my husband at all hours and in labor too. (P13)

In contrast, one interviewee revealed that the partner was their companion at their option. But, her emotional unpreparedness in the situation made her insecure and afraid, as follows:

A doula or someone more informed would have been better than my husband. Because she [doula] knows the whole process [childbirth] and passes more confidence. [...]. My husband was there, he held in my hand, but he was so terrified and insecure that it made me afraid. (P05)

Among the participants, 14 demonstrated satisfaction in the experience of their delivery. Although, nine women have pointed out that pain resulting from uterine contractions is unpleasant.

I felt a lot of pain in this childbirth labor. In the others, I did not feel it! [...] I enjoyed having my child in normal birth, but this pain! It should be forbidden to give birth without anesthesia. (P05)

I could not take pain anymore, I just wanted my son to be born soon. The pain is too much! I was told that I would feel pain, but it was too much [...]. I would have another child in normal birth, but I would prepare for it. (P17)

The participant who experienced the process of childbirth at home said she had a good and safe experience with regard to contractions, according to the statement:

The pain during the contractions was a natural process [...], I did not suffer. I already knew that was going to happen. So I prepared my head and everything went well! It was all very natural. Instinctive. (P13)

Three participants said they had no pleasure in the experience of the childbirth process and would not want to experience it in other pregnancies. For these women, the process of childbirth was a painful experience, suffering and permeated by fear.

I did not like it. I would not live it again! I was very scared and I hated it because of the pain. (P01)

It was horrible, this delivery was much worse than the first, because I had already gone through this. But this one was suffered too much, the whole night with much pain, one contraction after another, I contracted all. Nobody could control me. (P05)

The care of health professionals in the childbirth process: women's perception

As for the assistance received by the health team, provided by the professionals in the institutions, the majority (16) felt welcomed and satisfied, as stated below:

I really enjoyed the service [...] I was treated very well, they treated her (daughter) very well. (P01)

They (the professionals) were very attentive, they left me unworried. (P02)

Liked the service. They had a lot of patience because I'm very nervous. I cried a lot of pain, I cried [...]. They were great. (P03)

They were very attentive, although there has a very large turnover of doctors there. All the doctors that talked to me [...]. (P06)

Among the women interviewed, 11 were attended in the public network, 5 in the private network and 1 hired a team to perform the planned home birth.

One of the participants wished to experience the parturition process in a public maternity and not in a private clinic, although she had the right to have a health plan, as the speech presents:

Although my family has been against me giving birth in a public hospital, I know I made the best choice. There were trained professionals, humanized obstetrician nurses and my rights guaranteed. They respected me, they respected my daughter... It was great. (P14)

Another woman decided to have her child at home, after learning that some friends experienced this way.

I did a lot of research on the Internet, I heard many reports, I went to pregnant groups because I wanted to go home. The staff I chose gave me the right directions, on time. I had two obstetrician nurses attending my birth at home. (P13)

Among the participants, 12 had vaginal deliveries and the other (five) were submitted to cesarean section due to obstetric risk during the parturition process. Of the women who had vaginal deliveries, nine gave birth in the lithotomy position (dorsal decubitus), being perceived by them as a natural position for that moment. They also asserted that no other positions were offered to give birth.

One woman revealed that she has gotten to choose the position to have her child, and chose for the squatting position.

> I was feeling comfortable sitting and I ended up having my baby in a sustained squatting position. (P14)

One of the participants described that when she was admitted to the maternity ward during an expulsion period, she told the professionals that she had a hip prosthesis. Faced with this health problem, this woman was not offered a safer or more comfortable position to give birth, and she submitted the position chosen by the professional who attended it, according to the following report:

> I lay in the position of childbirth with my legs raised. [...] I was actually afraid to be in that position because I wear a hip prosthesis. Then the entire gestation I was afraid of (prosthetic) disengaging. In fact, he did not have this option (to give birth in another position). In this maternity does not have that option. (P08)

It should be noted that in the pregnant woman's card there was no record of her orthopedic situation. Nonetheless, she reported receiving excellent care and demonstrated satisfaction with such care during the prenatal care and childbirth.

> In prenatal care they did not write anything on my pregnant card about my prosthesis [...]. They (professionals) were wonderful! I was very well attended and my daughter also. It was great. (P08)

With regard to the adoption of effective practices that contribute to the participation of the parturient woman during childbirth labor, this study revealed that ten women used non-pharmacological techniques for pain relief.

> I just took a hot bath, the ball did not. [...] I preferred the warm water because it calmed me down a bit. It helped a lot, because the contraction next time, the warm water gives a relief, gives you less pain. It's not that the pain does not come, but it's a little bit smaller. (P06)

> The nurse taught my husband how to massage my back [...]. That helped me a lot. She still guided me through a breathing exercise. (P12)

> I walked a lot, I stayed in the warm water, I did exercises in the ball, all this with my doula. (P14)

Six participants reported that the professionals guided them and offered the possibility for them to use those techniques, but they did not want it because they were unaware of the benefits of those techniques, according to the reports:

> They (professionals) said they had such a ball, but I did not want to. [...] What is that for? I understood nothing [...]. (P01)

> There was a bath and shower. They were educated, they told me it would improve my pain, but I did not believe it. (P05)

With regard to the ingestion of food and water during childbirth labor, five women did not have this option during labor, then being restricted to water intake, according to the statements:

> I could not eat during the childbirth labor, but just drink water. Only after I gave birth to my child, they did give me a snack. (P03)

> The doctor said it was time to eat nothing and I could only drink water. (P17)

These statements reveal their lack of knowledge about food intake during childbirth labor, which is also not part of the institution routine.

Considering the 12 women that had children vaginally, 5 were submitted to episiotomy. From those women, 4 were aware regarding the accomplishment of the procedure at the time of childbirth; however, 1 participant was unaware of the performance of this procedure in her body.

> I think I had to do this cut [episiotomy], because I took five points. So, he must have done it. (P01)

The childbirth process can be experienced either as a pleasurable or traumatic experience due to several factors that can influence the way the woman experiences her delivery. These include: the previous experiences of the woman or her relatives, the social context in which she lives and her understanding of childbirth, based on the care received by health professionals in the pregnancy-puerperal cycle.[9]

In this sense, prenatal care must be multiprofessional, welcoming and include educational activities to demystify beliefs and taboos from the reflection and construction of knowledge about this period.[4] The participants' reports showed the lack of guidance, which reflected negatively in their bodies and in the ignorance of their rights. A fact that suggests the absence of actions for the empowerment of the woman in order to live her childbirth as protagonist, then participating more actively of that moment.

Regarding the experiences of pain expressed by women, it can negatively influence the process of childbirth, since in Western culture this moment is associated with fear, pain and suffering.[4,11-13] Therefore, these feelings permeate women's perception of this process, sustained by a stereotype that society has built and has influence, especially in those who have not yet experienced this moment.[18]

Moreover, pain should be considered as a personal and subjective experience, which can be influenced by the information of the socio-cultural environment in which the woman is inserted, by the evolution of childbirth labor, and also by the guidelines received during prenatal care and

during pregnancy. Pain, then, can be experienced differently by each of the parturient women.[14]

It is considered that for women to experience childbirth as a natural and enjoyable event, it is necessary to train and inspire health professionals so that they can provide theoretical supports to women in order to make them aware about this moment, and also pleasantly experience it as safe as possible.

The results showed that the majority of the participants had an accompanist during the childbirth process. However, some perceived this presence as a benefit offered by health professionals and not as a right guaranteed by a Federal Law.[15] It should be emphasized that the information received during prenatal care is an opportunity for the exchange of knowledge and experience, especially among nurses, pregnant women and their caregivers, in which issues such as the legal benefits to women have to be addressed Including the law of the accompanying person.[16]

In this way, prenatal care is a fundamental tool to promote the women empowerment, allowing them to take control of the childbirth process.[3,10] Moreover, it is known that the presence of the partner during the childbirth process promotes greater confidence and tranquility. It influences the reducing of the duration of childbirth labor, the reduction of the use of analgesia and the construction of the family bond between father and son.[16]

In this study, most of the participants opted for the presence of the partner in the childbirth process. Nevertheless, it is known that man also needs to be enlightened so that he can contribute actively and safely in this period.[10] For many years in our society the role of man/family father was restricted to the role of provider of the home, and in this way the man understood that he fulfilled his social role.[17] Over the years, public policies and actions have emerged that aim to ensure the participation of men in the various spheres of women's health. The example of this was his inclusion in the scenario of the childbirth process with the function of accompanying and actively supporting his partner, experiencing the birth of his son.[18]

It is necessary that health care in the childbirth process be based on a comprehensive care, focused on individuality and that meets the needs of each woman.[3] Therefore, the care offered by nurses in prenatal care in the perspective of education In health is a fundamental instrument for improving the experience in the childbirth process.[19]

Most interviewees felt welcomed and satisfied with the care provided by health professionals. It can be affirmed that this perception contributed to her feeling safe in the process of childbirth.[20] Nonetheless, we can observe that despite this result, health professionals took a controlling position in labor and delivery, then leaving the woman submissive to the hospital routines and the orders of the professionals, and making them the object of their actions.

The World Health Organization recommends that women freely choose the position that offers them the most comfort during childbirth labor and delivery.[3] It is up to the health professional to offer all possibilities and to stimulate her in the choice she satisfies best. Yet, the lithotomy position was chosen by the professionals because it is the most comfortable, not giving the opportunity to choose the woman who referred to this practice as a natural delivery.[21]

This situation demonstrates the great paradox that health issues represent, since on the one hand we have the public policies that define what should be considered integral care for women, and on the other hand, users do not realize how this care is insufficient. In this sense, it is rescued that the reception is one of the guidelines of the *Rede Cegonha* (Stork Network) that aims to expand and strengthen women's access to health services in an integral way, performing a resolute care to the health needs of the mother-child binomial.[10]

The various Technical Manuals of birth and childbirth model in Brazil, which are so well drafted and example to other countries, are based on the humanization of care and should be part of the daily life of professionals working in the public and private network. Still, the rigid and archaic posture of some professionals may be an obstacle for women not to be protagonists of their birth.

Non-pharmacological techniques for pain relief in labor, such as a soaking bath with warm water, breathing orientation, and muscle relaxation are part of the emotional support and are considered as light care technologies, at no cost to the institution and that promote greater Comfort for women. This reality should be put into practice by health professionals in a systematized manner throughout the national territory independent of social class. Furthermore, it should be presented to pregnant women during health education activities.[4,14,19]

In contrast, the supply of oral fluids and foods should be stimulated among pregnant women at normal risk. However, some participants reported zero diet. The replacement of energy to ensure the well-being of the mother and fetus during childbirth labor is a demand that must be considered in view of the caloric expenditure and is part of the protocol of assistance during the childbirth process.[21]

Good practices should be the driving guide for all health professionals working in the pregnancy-puerperal cycle, in order to guide their actions. It is considered that the registration in the medical record and the card of the pregnant woman by the health professionals is of fundamental importance to inform the possible health problems that can influence in this process, avoiding obstetric risks that can culminate in an unfavorable outcome. In this study, it was observed that during the prenatal follow-up of a woman, the professionals did not report a severe orthopedic problem on the pregnant woman's card. This could lead to maternal and neonatal risk.[3]

Additionally, the results show that the fact that the participants reside in the South region of *Rio de Janeiro* and have secondary and higher education did not guarantee them the autonomy to participate actively and choose the best way to give birth.[13] The lack of health education in the prenatal care, positive personal and family models to follow, and lack of respect for their individuality, led to the parturient women to be submissive to the actions perpetrated by the professionals, then not recognizing this attitude as obstetric violence.[1,19]

Therefore, it is believed that women and men need to be inspired throughout their lives, through educational actions

that should be part of elementary and secondary education content, as well as prenatal care, so that they can experience the process of childbirth without fear and suffering, associating it as a moment of pleasure and autonomy, and this way the woman can assume the leadership of her childbirth.

CONCLUSION

The study participants experienced the childbirth process pleasantly and safely. This feeling of satisfaction is associated to the reception and care received by the health professionals in the pregnancy cycle, and the presence of the independent companion of having been assisted in either public or private network.

Fear and pain were part of the participants' childbirth process. Those feelings were related to the suffering, as well as revealing the attitude of the health professionals who took control over the women's bodies. So, this research reinforces the thinking that women need to be empowered throughout life, especially in prenatal care, so that they can demystify the childbirth process as an experience based on pain and suffering, and also can experience it in an active and satisfactory way.

Furthermore, the results indicate the importance of the nurse in the prenatal care offering an individualized, holistic care, with the purpose of letting the couples aware about non-interventional care and the possibilities of using light technologies during childbirth. In order to do so, it is necessary for professionals to be stimulated to attend the individual needs of the women and their relatives, in the perspective of integrality and equity, in order to inspire them to live a successful childbirth process.

REFERENCES

1. Aguiar JM, D'Oliveira AFPL, Schraiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. Cad. Saúde Pública 2013; 29(11):2287-96.
2. Leal MC, Gama SGN. Nascer no Brasil**.** Cad. Saúde Pública 2014; 30(suppl.1):S5-S7.
3. Organização Mundial da Saúde. Assistência ao parto normal: um guia prático**.** Brasília: OMS; 1996.
4. Bittencourt F, Vieira JB, Hidalgo ACCA. Concepção de gestantes sobre o parto cesariano. Cogitare Enferm. 2013; 18(3):515-20.
5. Vasconcelos MFF, Nicolotti CA, Silva JF, Pereira SMLR. Entre políticas (EPS – Educação Permanente em Saúde e PNH – Política Nacional de Humanização): por um modo de formar no/para o Sistema Único de Saúde (SUS). Interface (Botucatu) 2016; 20(59):981-91.
6. Silva U, Fernandes BM, Paes MSL, Souza MD, Duque DAA. O cuidado de Enfermagem vivenciado por mulheres durante o parto na perspectiva da humanização. Rev Enferm UFPE. 2016; 10(4):1273-9.
7. Reis CSC, Souza DOM, Nogueira MFH, Progianti JM, Vargens OMC. Análise de partos acompanhados por enfermeiras obstétricas na perspectiva da humanização do parto e nascimento. J. Res.: Fundam. Care. Online 2016; 8(4):4972-79.
8. Bardin L. Análise de Conteúdo. Lisboa: Edições 70; 2010.
9. Matão MEL, Miranda DB, Costa BP, Borges TP. A visão médica do parto domiciliar: factível ou utópico? R. Enferm. Cent. O. Min. 2016; 6(2):2147-55.
10. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Atenção ao pré-natal de baixo risco. Brasília: Ministério da Saúde; 2012.
11. Siebra MA, Brito RC, Monteiro DMS, Monte NL. A dor do parto normal: significados atribuídos pelas puérperas usuárias do SUS. R. Interd. 2015; 8(2):86-93.
12. Almeida NAM, Medeiros M, Souza MR. Sentidos da dor do parto normal na perspectiva e vivência de um grupo de mulheres usuárias do Sistema Único de Saúde. Rev. Min. Enferm. 2012; 16(2):241-50.
13. Nascimento RRP, Arantes SL, Souza EDC, Contrera L, Sales APA. A escolha do tipo de parto: fatores relatados por puérperas. Rev Gaúcha Enferm. 2015; 36(esp):119-26.
14. Medeiros J, Hamad GBNZ, Costa RRO, Chaves AEP, Medeiros SM. Métodos não farmacológicos no alívio da dor no parto: percepção de puérperas. Revista Espaço para a Saúde 2015; 16(2):37-44.
15. Brasil. Lei nº 11.108, de 7 de abril de 2005. Altera a Lei 8.080, introduzindo o direito ao acompanhante de escolha durante o trabalho de parto, no parto e no pós-parto imediato. Diário Oficial da União 8 abr. 2005; Seção 1: 1.
16. Brüggemann OM, Ebsen ES, Ebele RR, Batista BD. Possibilidades de inserção do acompanhante no parto nas instituições públicas. Ciênc. Saúde Coletiva 2016; 21(8):2555-64.
17. Cúnico SD, Arpini DM. A família em mudanças: desafios para a paternidade contemporânea. Rev. Pensando Fam. 2013; 17(1):28-40.
18. Moreira APA, Nunes IM, Almeida MS, Santos ACC. Preparo paterno para serem acompanhantes no trabalho de parto. Enfermagem Obstétrica 2015; 2(1):3-8.
19. Progianti JM, Costa RF. Práticas educativas desenvolvidas por enfermeiras: repercussões sobre vivências de mulheres na gestação e no parto. Rev Bras Enferm. 2012; 65(2):257-63.
20. Velho MB, Santos EKA, Brüggemann OM, Camargo BV. Vivência do parto normal ou cesáreo: revisão integrativa sobre a percepção de mulheres. Texto Contexto Enferm. 2012; 21(2):458-66.
21. Rio de Janeiro. Secretaria Municipal de Saúde. Protocolo Assistencial da Enfermagem Obstétrica da Secretaria Municipal de Saúde do Rio de Janeiro. Rio de Janeiro: Secretaria Municipal de Saúde; 2013.

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