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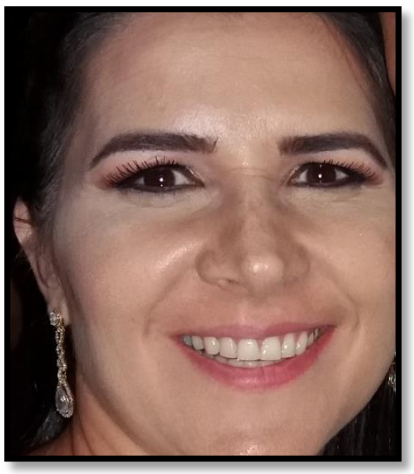

# Representations of puerperal women facing the assistance provided to their delivery: A descriptive study

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**Abstract**

**Objective**: To understand the representations of puerperal women regarding the assistance received during delivery. **Method:** A qualitative research study, carried out in two public maternity hospitals between August and September 2017 with 25 puerperal women. The methodological framework of the Collective Subject Discourse was used. **Results:** The speeches were grouped in two themes: 1) Humanization and satisfaction with the moment of delivery; 2) Inadequate ambience and suffering generated by assistance during delivery. **Discussion:** The puerperal women pointed out problems in the physical structure of the maternity hospitals, but represented the care received during delivery as satisfactory, as they reported having been supported by the health team. However, in some speeches unpleasant situations emerged, referring to the use of unnecessary interventions, non-reception and lack of privacy. **Conclusion:** The puerperal women were satisfied with the care received during delivery, although they showed some dissatisfaction. A discussion was held based on current scientific evidence regarding good practices of care during labor and delivery.

**Descriptors:** Natural Childbirth; Patient Satisfaction; Health Evaluation; Nursing Care; Women's Health.

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## INTRODUCTION

Childbirth assistance has undergone significant changes when understanding that women are the protagonists of their own delivery and that their desires must be respected; thus, technocratic assistance, characterized by traditional and routine interventions such as the lithotomy position and the practice of episiotomy, has been transformed into assistance that understands childbirth as a physiological event and a unique experience[1].

This assistance change is underpinned by the best practice of assistance to childbirth recommended by the World Health Organization (WHO)[2], and this is based on scientific evidence with the aim of guiding and improving care for normal delivery, providing humanized care, making a wonderful and satisfying experience for most women[3].

Thus, the adoption of good practices in childbirth is essential for the quality of care provided in assisting the mother-child binomial[4], being a fundamental factor for developing positive perceptions and feelings of this unique experience.

From the perspective of care qualification, patient safety is an important support in this process[5]. It is noteworthy that, in maternal and child care, quality care associated with patient safety is related to reduced mortality in this population[5].

Knowing that the moment of childbirth is unique and singular for the woman and that it can represent a moment of happiness and expectations, as well as suffering and disappointments, the following question emerged: How do puerperal women represent the assistance received during delivery in public maternity hospitals?

Given this context, this study aims to understand the representations of the puerperal women in relation to the care received during delivery, in order to analyze the quality of care during childbirth, so as to produce evidence of how the care process occurs, seeking the adequacy of care guided by practices based on scientific evidence.

## METHOD

This is a descriptive and exploratory study with a qualitative approach. This research is part of a broad research project entitled "Evaluation of care for normal delivery in public maternity hospitals in a municipality in the Brazilian southern region".

The selection of the puerperal women was carried out after collection of quantitative data, carried out in a consecutive and random manner, during visits to two maternity hospitals that provide childbirth care through the Unified Health System in a municipality in the Brazilian southern region. These maternity wards assist regular and high-risk deliveries, with assistance provided by obstetricians and obstetric nurses.

Only women who had a vaginal delivery were included and the exclusion

criteria adopted were the following: unfavorable clinical condition (some serious pregnancy/delivery complication) that makes it impossible to participate in the interview in the first phase of the study; and absence of a guardian to sign the Free and Informed Consent Form (FICF), when the puerperal woman was under 18 years old.

A total of 344 women took part in the first phase of the research. For the second phase of the study, a random draw was performed and the sample consisted of 25 women. The interviews took place in the first home visit (within seven days postpartum). To this end, a telephone contact was made to confirm the address and to schedule the date and time of the interview. In the agreement between the availability of interviewees and interviewers, days and times were scheduled with the women who participated in the first phase of the research.

For delimiting the number of participants in data collection, theoretic saturation was considered as the moment when repetition or redundancy occurred in relation to the study object[6].

Data was collected from August to September 2017, through semi-structured interviews. The guiding questions used in the interviews to motivate the speech of the puerperal women were the following: Tell us about your experience during labor and delivery. Did labor and delivery take place as you planned? Tell me about where you gave birth. Tell me about the follow-up you received from the professional who was with you during labor and delivery.

The mean duration of the interviews was 36 minutes, considering the initial interaction and the interview. The interviews were recorded on a cell phone. At the end, the puerperal woman was asked to listen to the recording of the interview, guaranteeing her the right to change the information if she thought it necessary.

In the analysis of the speeches, the Collective Subject Discourse (CSD) was chosen for the construction of meanings, allowing for the approximation with the phenomenon under study.

The CSD is elaborated through fragments of various individual discourses. Each of the collective discourses is related to a specific position and opinion. It must be written in the verbal tense of the first person singular so that it represents a collective idea[7].

Three methodological figures were used for the research: the key expressions (KEs), the central idea (CI) and the collective subject discourse (CSD). The KEs are literal excerpts of the testimony that contain the essence of the speech; these excerpts were cleaned of particularities, expressions and ideas repeated and grouped according to the CI, which is the detailing of the meanings that are in the speeches. In the CSD there is grouping of KEs that are in the speeches, which have complementary or similar anchors and/or CI, representing the idea of the collective[7], thus the similar KEs

and that represent a collective thought were grouped.

The individual interviews were transcribed and identified by the letter P (puerperal woman) accompanied by a number, according to the order of the interview, such as P1, P2, and so on, respecting the condition of anonymity of the participants. Subsequently, repeated readings of each discourse were performed in order to appropriate them and identify the KEs and then the CIs.

For the formulation of the CSD, the KEs were grouped so that they formed a coherent discourse. For this, connectors were used in order to make sense of the CSD, without altering the sentence structure elaborated by the subject.

This study was approved by the Research Ethics Committee of the State University of Londrina/UEL under opinion No. 2,377,176/2018 and CAAE No. 76735917.0.0000.5231.

## RESULTS

A brief characterization of the puerperal women participating in this study indicates age between 15 and 35 years old. Most of them (22 puerperal women) with eight years of formal education. All with a partner. Of these, 18 had already experienced vaginal delivery, and 7 were experiencing childbirth for the first time.

In the process of analyzing the speeches of the puerperal women, four Central Ideas (CIs) emerged, which were grouped into two themes: 1) Humanization and satisfaction with the moment of delivery (CI 1 - Humanized care and team support); 2) Inadequate ambience and suffering generated by care during childbirth (CI 2 - Inadequate structure, but satisfactory care, CI 3 - Frustration in the face of the intervention performed, CI 4 - Disrespect and lack of empathy from the health professionals).

### Theme 1: Humanization and satisfaction with the moment of delivery

#### CI 1 – Humanized care and team support

Women who had previously experienced vaginal delivery revealed that the current delivery experience was better, associating it with the support received from several people.

The representations show that having been fully assisted by the team represented a humanized care for them, reporting that they could experience care such as: massage, use of the ball, hot bath, as well as offering help, support and information about what was happening to her during the delivery process.

> *CSD 1-This time the assistance was good. There was no one to insist, I had total support for this. A lot of people were accompanying me, the labor itself was more painful than the first, much more, but I was accompanied the whole time. This time it was better,*

*everything was fine.* (P9,P11,P20)

*CSD 2-I was fully assisted all the time. They helped me, gave me a massage, put me on the ball, and indicated a hot bath. All the time I was assisted by them. It was better than planned, the professional help strengthened me, for me this was very important. They talked to me and made me feeling very calm. Everything they were doing to me I was informed before, when I asked something about what was happening that they didn't know, they sought help from anyone who knew how to answer and brought the answers. Always accompanying me, giving a lot of support, I liked being cared here. Support is essential.* (P1, P2, P18, P20, P22)

**Theme 2: Inadequate ambience and suffering caused by care during childbirth**

**CI 2–Inadequate structure, but satisfactory care**

The puerperal women presented the physical structure of the maternity hospitals as a problem, reporting that there is a need for repairs/reforms; however, even with these adversities, they reveal that the service was satisfactory and that they would seek it again in the event of a new pregnancy.

*CSD 3-I think it's not bad, it just needs repairs, normal, as in almost everywhere, it had to improve for the companion, the bathroom had to give a better renovation and have more bathrooms, the rooms are a little deteriorated, the floor is dangerous, people with the baby can slip down. The structure is a little infiltrated, as can be seen, the day I gave birth it was raining a lot, rooms were closed because they were flooded and this made me even more nervous, even the nurses were nervous. The structure could be a little better, but the care is great. If I have any more children, I would like it to be here again.* (P4, P6, P22, P25)

**CI 3 – Frustration in the face of the intervention performed**

Although most of the women represented the moment of delivery and the care received satisfactorily, for some, there were divergences in perception emphasizing that some procedures and interventions performed caused them to increase their pain and suffering to the point that they no longer wish to perform vaginal delivery as planned by them previously.

*CSD 4 - The doctor thought it was better then to help me, he broke the bag, and told me that he did it and was going to see what would happen if I was going to go into labor, increasing the dilation, then he told me to stay in fasting.* (P7, P8, P12)

*CSD 5 - They gave me serum and it didn't start because my body wouldn't accept it, I had to go for the second serum and even then it didn't dilate, until at night the doctor broke my bag, then it was time I started to feel pain, horrible pain, I suffered a lot, I always dreamed of having a normal delivery, but I didn't want it anymore, because it hurt. I wanted the delivery to be normal, natural, but from the beginning it was induced, it was painful because it was induced. I suffered a lot.* (P8, P13, P23)

**CI 4 – Disrespect and lack of empathy**

Some puerperal women represented their arrival at the service, as well as conducting their delivery, as inadequate, since they encountered professional attitudes that caused them discomfort and generated feelings considered negative.

*CSD 6 - In the screening, some professionals were coarse, they didn't pay attention, and it took me a long time to be assisted. When the doctor came in he put an intern to assist me, only he wasn't attentive, I told him that I was in a lot of pain, that I thought that the baby would be born that it was close.* (P7, P13, P23)

*CSD 7 - It was a normal delivery, very painful, there were a lot of people, and it was in a waiting room. And on this day they changed a lot of people that made me very nervous. (P8, P12)*

**DISCUSSION**

The puerperal women perceived the assistance provided by the health professionals during labor and delivery permeated with support, information and humanized care.

However, although pain represents a negative experience, the reports pointed out that the experience of intense pain from the contractions was minimized by the support received during labor and the provision of non-pharmacological methods of pain relief such as massage and warm bath, among others, which are beneficial for reducing pain, making the moment

more peaceful and also respecting the physiology of childbirth[8].

Although the childbirth pain influences women's satisfaction, a study found that this relationship is not as important and significant as the influence of the professional's conduct and behavior towards women, as it is a much more determining factor for their satisfaction with childbirth[9].

Professional support also helps to promote women's rights by ensuring that they are respected during labor and delivery[10].

A study shows that the problems encountered in childbirth care do not require technological devices, but rather empathy, as a process for the satisfaction of women and quality of care[11].

The speeches revealed that, although they recognize that the physical structure of the maternity hospitals presented problems, this was not a barrier to the quality of the care being received, representing satisfaction and emphasizing that they would use the service again in the next delivery.

It is emphasized that the infrastructure (physical space, material resources/equipment and human resources) is directly associated with quality of care and that investments are necessary, as they can directly influence maternal and neonatal morbidity and mortality[12]. Corroborating, the puerperal women represented the need for infrastructure repairs, in the understanding that they would have better quality assistance.

In this way, it is understood that adjustments in the physical structure are necessary, in line with the objectives of *Rede Cegonha*, as this strategy has made it possible to change this environment to ensure more qualified care and respecting the change in the obstetric model, in favor of a respectful performance; it is emphasized that the studied maternity units already present a perspective of these adaptations, one with the reform of the physical space and the other with transfer to a newly built place. Another study, which corroborated the speeches of some puerperal women who reported that they would return to these maternities in the case of a new pregnancy, pointed out that when users perceive the quality of care as good, they are more likely to resort to it again[13].

In the women's speeches, situations that could constitute obstetric, institutional and verbal violence were highlighted, highlighting the care provided without scientific evidence and associated with suffering, inadequate reception, delay in care, and lack of privacy at the time of delivery.

The evidence demonstrates that the reported interventions (amniotomy, use of oxytocin, fasting) do not promote benefits when labor has a physiological evolution and, on the contrary, can lead to intercurrence[4].

The practices revealed by the puerperal women, such as fasting,

amniotomy and routine induction, can be considered as obstetric violence and contribute to a negative view of childbirth, leading some of them to opt for the cesarean section, for fear of experiencing another painful delivery and full of interventions[14].

These practices revealed by the puerperal women are used inappropriately most of the time, being considered as harmful to labor. The WHO emphasizes that it is necessary that women in labor do not remain fasting, as water restriction can lead to dehydration, thus the woman needs to replenish her energies, with the aim of preserving maternal and fetal well-being[2].

Regarding the use of oxytocin, it is emphasized that its use in some situations brings benefits; however, the active management of labor, with the use of early oxytocin and amniotomy, should be well indicated, as its use routinely is not recommended and may be harmful. Routine isolated use of oxytocin in order to shorten delivery is still a widely used practice, being considered unnecessary[15].

The welcoming received by the puerperal women with rude attitudes and lack of attention is not compatible with welcoming attitudes, defined as an action and an attitude of inclusion, of empathy, being considered one of the pillars of the humanization of the health services[16].

Women welcomed with attention and interest by the professionals in their first appointment feel more satisfied with the attention received, as it is configured as a relief measure for the fears arising from the parturition process. Therefore, the professionals who perform the reception need to be sensitized to understand this process[17].

The lack of privacy associated with nervousness in the speech of the mothers tends to have a negative impact on the experiences of the women[18].

Thus, it is emphasized that care for women during labor and delivery must not be based only on hard technologies, but mainly on light technologies, which involve empathy, concern, interest, motivation, kindness, respect and acceptance[12].

This research has as a limitation the fact that the study was carried out in only two maternity wards located in the same municipality, not allowing for the generalization of the results.

## CONCLUSION

After analyzing and interpreting the speeches, it is considered that the objective was achieved, considering that the representations of the puerperal women in relation to the assistance received during delivery were possible. However, new studies are needed to understand quality of care from the point of view of the professionals, as well as the health manager.

Although the puerperal women pointed out problems in the physical structure of the maternity hospitals, they represented the care received during

delivery as satisfactory, as they were supported by the health team.

However, in some speeches unpleasant situations emerged, characterized by the use of unnecessary interventions, non-reception and lack of privacy.

The divergences presented in the speeches regarding the assistance received during delivery reassert the benefits of care based on scientific evidence, guided by good practices in childbirth care and the need to deconstruct the technocratic model of childbirth care.

Thus, the study demonstrates that, to avoid unnecessary interventions, simple short-term attitudes are effective, and do not require investments, but rather the awareness of professionals and the fulfillment of what is recommended by the public policies of childbirth care, consistent in humanized care based on scientific evidence, respecting individuality and women's rights.

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