

WOMEN'S AUTONOMY IN CHILD LABOR: CONTRIBUTIONS FROM A GROUP OF PREGNANT WOMEN

AUTONOMIA DA MULHER NO TRABALHO DE PARTO: CONTRIBUIÇÕES DE UM GRUPO DE GESTANTES

AUTONOMÍA DE LA MUJER EN EL TRABAJO DE PARTO: CONTRIBUCIONES DE UN GRUPO DE MUJERES EMBARAZADAS

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ABSTRACT

Objective: identify how the group of pregnant women has contributed to the strengthening of women's autonomy during labor and birth. **Method:** this is documentary research with a qualitative approach. The papers used to support this study are part of the database of the extension project of the Pregnant Women and Pregnant Couples Group of the *Universidade Federal de Santa Catarina* (UFSC). The inclusion criteria were the reports of women who addressed issues related to autonomy in labor, from 2015 to 2017. Eighty-eight reports of postpartum women were analyzed, selecting 21 who were under the study theme. Data collection was performed from August to September 2017. Data analysis was performed through content analysis. **Results and discussion:** the results of this study were presented in four categories: time to go to maternity, the awareness of the midwifery process, experiencing childbirth and the practices that interfere with women's autonomy. The pregnant group is an effective and important prenatal complementary tool for the consolidation of female autonomy in the parturition process. **Final considerations:** thus, the dissemination of groups of pregnant women is encouraged, as they stimulate the development of human potentialities, making women to be perceived as the central subject of their care, and becoming protagonists in their process of gestating and midwifery.

Keywords: Women's Health; Obstetric Nursing; Personal Autonomy; Patient Preference; Decision Making.

RESUMO

Objetivo: identificar de que modo o grupo de gestantes tem contribuído para o fortalecimento da autonomia da mulher durante o trabalho de parto e nascimento. **Método:** trata-se de pesquisa documental com enfoque qualitativo. Os documentos utilizados para subsidiar este estudo fazem parte do banco de dados do projeto de extensão Grupo de Gestantes e Casais Grávidos da Universidade Federal de Santa Catarina (UFSC). Os critérios de inclusão abrangeram: relato de mulheres que abordaram questões referentes à autonomia no trabalho de parto, no período de 2015 a 2017. Foram analisados 88 relatos de puérperas, dos quais foram selecionadas 21 que englobaram o tema do estudo. A coleta de dados foi realizada no período de agosto a setembro de 2017. A análise de dados foi feita por meio da análise de conteúdo. **Resultados e discussão:** os resultados deste estudo foram apresentados em quatro categorias: hora de ir à maternidade, conscientização do processo de partear, vivenciando o parto e práticas que interferem na autonomia da mulher. Encontrou-se que o grupo de gestante é uma ferramenta complementar eficaz e importante no pré-natal para a consolidação da autonomia feminina no processo de parturição. **Considerações finais:** dessa maneira, incentiva-se a disseminação de grupos de gestantes, uma vez que eles estimulam o desenvolvimento das potencialidades humanas, fazendo com que a mulher se perceba como sujeito central do seu cuidado, tornando-se protagonista no seu processo de gestar e partear.

Palavras-chave: Saúde da Mulher; Enfermagem Obstétrica; Autonomia Pessoal; Preferência do Paciente; Tomada de Decisões.

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RESUMEN

Objetivo: identificar cómo ha contribuido un grupo de mujeres embarazadas al fortalecimiento de la autonomía de la mujer durante el trabajo de parto y nacimiento. **Método:** investigación documental con enfoque cualitativo. El estudio se basa en documentos que forman parte del banco de datos del proyecto de extensión Grupo de Embarazadas y Parejas Embarazadas de la Universidade Federal de Santa Catarina (UFSC). **Criterios de inclusión:** relatos de mujeres que tratan de asuntos sobre la autonomía en el trabajo de parto entre 2015 y 2017. Se analizaron 88 relatos de púérperas de los cuales se seleccionaron 21. La recogida de datos se efectuó entre agosto y septiembre de 2017. El análisis de datos se realizó mediante el análisis de contenido. **Resultados y discusión:** los resultados se presentaron en cuatro categorías: momento de ir la maternidad, concienciación del proceso de dar a luz, viviendo el parto y prácticas que interfieren en la autonomía de la mujer. Se observó que el grupo de mujeres embarazadas es una herramienta complementaria eficaz e importante en el prenatal para consolidar la autonomía femenina en el proceso de partería. **Consideraciones finales:** se incentiva la diseminación de grupos de mujeres embarazadas porque fomentan el desarrollo de las potencialidades humanas, haciendo que la mujer se perciba como sujeto central de sus cuidados y la protagonista en su proceso de gestación y partería.

Palabras clave: Salud de la Mujer; Enfermería Obstétrica; Autonomía Personal; Prioridad del Paciente; Toma de Decisiones.

INTRODUCTION

Thinking of the birth process in our contemporary society is very different from the past. In the past, the birth was held at home and focused on female actions, recognizing women's empowerment and autonomy. Today, with the technical-scientific advances to assist the pregnancy-puerperal cycle, the birth has become a hospital and the institutionalization has moved women away from family support, often making them only a passive subject and not the protagonist of the action. The removal of this role makes her fragile and submissive to an infantilized, weak, mischaracterized and violent situation.¹

In this scenario, at the end of the 1980s, in Brazil, with the lack of the women characterization, breach of human rights and the submission to a "cascade of procedures" - routine synthetic oxytocin infusion, artificial membrane rupture, trichotomy, episiotomy, among other unnecessary obstetric interventions – it is a movement that prioritizes the quality of interaction between the parturient and her caregivers and the exclusion of harmful behavior to remind and reinforce that the birth is a natural event and should be conducted with the minimum of possible interventions, ensuring the right of pregnant women to have qualified and humanized care.²⁻⁶

The strong criticism of the technocratic obstetric model ended when searching for better scientific evidence, national conferences, and the creation of programs and policies that

made commitments to guaranteeing the citizenship, sexual and reproductive rights of women and children.² From this perspective, the access to information is a very relevant factor for women to become empowered and to have the autonomy to make a conscious choice.³⁻¹⁰

Some care practices may favor or limit women's autonomy during labor. The practices that may favor the autonomy of the women during labor are extra-hospital care practices, supportive and comfort practices, and educational practices. The practices that limit the autonomy during the labor and delivery are authoritarian, standardized and routine practices, the impersonal and cold care practices and care practices that intensify the painful perception of the birth.²

Putting women in control of labor and birth is necessary to ensure autonomy, instructing their to actively decide on their own care, giving their a sense of security during this process. These actions are fundamental for women to be able to identify and decide which care practices may favor or limit their autonomy.

However, the current model has turned childbirth into disease and the woman became to be seen as a patient to be protected by the medical-hospital system. This phenomenon is strengthened by the precariousness of prenatal consultations and the lack of adequate information about women on maternity, showing the idea that prenatal consultation alone is not a space for knowledge-gathering information for women's empowerment.

One of the ways to complement and subsidize prenatal consultations is the groups of pregnant women as dynamic spaces that seek to promote health integrally, with clear and quality information to rescue women's autonomy. From this point of view and as a scenario of this research, the Pregnant Women and Pregnant Couples Group in UFSC seeks alternatives to implement and consolidate the good practices recommended by the World Health Organization (WHO) and scientific evidence, empowering pregnant women to have autonomy over their process of labor and birth.

Thus, one of Michel Odent's classic phrases is re-signified: "to change the world, it is first necessary to regain the autonomy of women so they can change the way of birth". This study aims to identify how the group of pregnant women and pregnant couples from UFSC has contributed to the strengthening of women's autonomy during labor and birth.

METHOD

This is a descriptive, documentary research with a qualitative approach. The study is an excerpt from the research project called "twenty years of the Pregnant Women and Pregnant Couples Group: historical trajectory, profile, impact,

perceptions and contributions to those involved", approved by the UFSC *Comitê de Ética em Pesquisa*, under Opinion 2.051.643. The documents used to support this study are part of the extension project database UFSC/Grupo de Gestantes e Casais Grávidos. The group was founded in March 1996 and aimed to provide educational and interdisciplinary care to pregnant women and their caregivers, based on body and postural awareness, breathing and relaxation techniques, knowledge and guidance on the pregnancy-puerperal cycle, exchange of experiences, experiences and yearnings regarding the birth process between participants and health professionals to train them and empower them so they can increase control over health determinants. It was opted to select the interview reports of the mothers participating in the Parents and Babies Reunion, an activity promoted by the project, which occurs one month after the birth of the last newborn in the group.

The inclusion criteria were reports of women who addressed issues related to autonomy in labor from 2015 to 2017. Eighty-eight reports of postpartum women were analyzed, selecting 21 that addressed the theme of the group's contribution to strengthening women's autonomy during labor and birth.

Data collection was performed from August to September 2017. Data analysis was performed through content analysis, following the steps:

- pre-analysis, as the stage in which the documents for analysis were chosen, called as the corpus;
- exploration of the material, which consisted of a classification operation for the comprehension of the text, establishing the themes that when grouped by common characteristics, they originated the thematic categories according to the objective of the study;
- treatment of the obtained results and interpretation, in which the data analysis was based on theoretical foundations.

In this research, all ethical precepts were followed, ensuring rights to the participants in accordance with the Resolution 466/12 of the *Conselho Nacional de Saúde*.¹ The participants signed the Informed and Consent Form, ensuring the anonymity of identities by replacing the participants' names with the letter "W" for women followed by the ordinal number of each document.

RESULTS AND DISCUSSION

The results of this study will be shown from four categories: time to go to maternity, the awareness of the midwifery process, experiencing childbirth and the practices that interfere with the women's autonomy according to the reports of puerperal participants of the group.

TIME TO GO TO THE MATERNITY

Labor is characterized as a physiological process in which frequent and strong uterine contractions are able to perform cervical dilation, among other changes in the woman's body, allowing the passage of the fetus. This process is divided into periods. The first period is divided into two phases, the latent phase, in which there are short-duration contractions and cervical variation; and the active phase of labor, in which there are regular contractions and progressive cervical dilation. In this first phase, it is recommended that the parturient stays at home, as it is a longer phase.¹¹ WHO recommends that health professionals should hospitalize the parturient only when she is effectively in the active phase, with 4 to 5 cm of dilation, reducing unnecessary interventions.¹² Recognizing the signs of active labor and going to the maternity at the appropriate time was shown in the reports as an important contribution of the group of pregnant women in.

The group was excellent during the labor, there is nothing to say, it helped a lot, I stayed at home, I kept monitoring how long the contraction was, at night we decided to go to the maternity hospital to evaluate and there were already five centimeters (W2).

I spent a lot of time at home because I didn't want to go to the hospital and stay there, manipulating me (W18).

And then the contractions began. Then with each contraction, I crouched down. I had a normal lunch, and we tried to be quieter, my husband put on a song, and we tried to be in a quieter environment. I arrived with seven centimeters of dilation (W19).

The recognition of labor as a physiological process has empowered women strengthened the security and understanding that she can be in a warm and familiar environment, so this process evolves as smoothly as possible. Using non-pharmacological pain relief methods in their home, feeding, being in line with their body, and deciding when to go to maternity from the recognition of signs of labor was important autonomy practices, strengthened by the guidelines and the participation in the group.

THE AWARENESS OF THE MIDWIFERY PROCESS

Sharing experiences and knowledge based on up-to-date scientific evidence in the groups of pregnant women about the birth process reduces fear, strengthens potentials and provides more peace of mind to understand the rhythm and signals

emitted by the woman's body, increasing self-confidence and in the confidence of the midwifery process.¹³ When the woman does not receive adequate prenatal information, the time of birth is full of fear and anxiety.¹ Thus, the groups are characterized as an important tool for empowerment of women, as shown in the following statements:

I was very aware, I remembered, what was said in the group, that the contractions come in waves, I thought, it hurts, but it will pass and I kept thinking that and helped me a lot at the time (W2).

I always remembered something that was said in the group, which was not thinking about pain, it was about support pain, experiencing it and I did it, and it was not something suffered, it was not pleasant, right, but it was very cool (W8).

Since childbirth is culturally seen as a phenomenon that causes intense pain, it is necessary to demystify this legacy from the understanding of its real physiological process, encouraging women to know their body and to empower their care. The speeches showed that coping with the situation becomes possible when discussing the unknown, which causes fear and pain.

EXPERIENCING CHILDBIRTH

The use of non-pharmacological methods of pain relief in labor brings a more humanized approach to care and helps women experience this time more comfortable and less traumatically.¹⁴ Data showed that women who were aware of the process enjoyed the process of protagonism during the labor and delivery.

I said I wanted it as natural as possible. The doctor asked me to get the stool and set the scene on the floor, I asked him to dim the light, at the time I remembered what we said in the group (W9).

That shower in the back is everything good; I hugged the ball and the shower in the back, it gives you relief, it seems like you feel the little baby coming down and down (W5).

I tried not to scream, but I made some sounds all the time, noises that made me keep focused on childbirth and made me breathe. I remembered the reports of the group, that when they wanted to push, lacerated, then I thought, now it comes to the force and I need to be calm. It may

come as many contractions as necessary, but I will not do much force, I was concentrated there (W20).

Corroborating the reports of the women, OMS stated that the complementary pain relief methods should be privileged during labor care especially the non-pharmacological techniques, considering them as recognized and useful practices that should be encouraged. These practices are intended to make childbirth as natural as possible, reducing unnecessary interventions and cesarean sections and drug administration, as they increase pain tolerance and, consequently, the participation in the parturition process.¹⁵

The free movement of the body is important for the good evolution of labor. Giving freedom and supporting the woman regarding the movement and the choice of the midwifery position is to promote the humanization of the assistance at birth.¹ In terms of the most vertical positions, autonomy allows the empowerment of women during the midwifery process.¹ Research has shown that the instrumentalized women in the importance of freedom of position and movement, expressed more satisfaction of control over their labor process and a better experience of childbirth.

It was squatting, the doctor wanted me to lie in the bed, so I said no, I want squatting, and she was born very well and it was all very quiet. There was no intervention, the doctor just gave her to me, and it was very quiet (W1).

It was exactly what I wanted, it was a really cool experience because things are really changing, it was squatting, they didn't do an episiotomy, I got on the pilates ball, in the shower, they turned the light down. I delivered on the stool, it was very amazing, they put music (W4).

The good practices learned and stimulated in the group of pregnant women when put into action are important for promoting women's autonomy in the process of labor and birth., respect for the feelings and welcoming of the team regarding the parturient's demand, use of non-pharmacological pain relief techniques, freedom of choice of position and place of midwife, and the promotion of an appropriate care environment were among these practices shown in the study as positive for the development of autonomy and, consequently, related to a positive experience of delivery.

The presence of the partner is also recognized by OMS as essential for the humanization of labor care. Its permanence ensures more comfort to the parturient, as it brings part of its known environment into the institution.¹⁶ The presence of the partner also inhibits unnecessary interventions and even violence.¹⁷⁻²⁰ Thus, the group of pregnant women encourages

the participation of the partner during the whole process and it should be of the free choice of the woman. This role was observed in women's reports:

The presence of the partner, I do not know how it would be without him, because he was the support I had (W12).

My partner was wonderful, he was there giving me a massage, then there was contraction and more massage and we would go everywhere walking in that hospital (W3).

The importance of the participation and preparation of the couple and especially of the partner in the group is highlighted to act effectively in the process. The caregivers performed beneficial activities in the development of delivery. The fact that they hold their hands and help their breathing made the environment more welcoming and safer for their partners, who were able to act more actively in conducting the delivery.

Also, professionals should learn to perform their care activities together with the partner, making him an important ally for the good evolution of childbirth.

THE PRACTICES THAT INTERFERE WITH WOMEN'S AUTONOMY

The medicalization of the childbirth has shaped women to a new social posture, submerging their autonomy during the parturition process, giving the health professional the power over the women's body who often uses unnecessary interventions and behaviors that compromise the physiology of the female organism to accelerate the natural process of childbirth.² Regardless of socioeconomic group, Brazilian women with habitual obstetric risk are being unnecessarily exposed to the risks of iatrogenic childbirth.²¹ A study especially addressing women in the southern region identified high rates of episiotomy, Kristeller maneuver, oxytocin use, dietary and water restriction, among other harmful behaviors.²² When being instrumentalized in the groups, women began to recognize practices that negatively interfere with the autonomy and protagonism of childbirth.

And there is the procedure of going to the operating room, there is no option to stay in the room, stay in the position I wanted. Then I arrived and I was in that position with my legs like this [showed lithotomy position] and I didn't like it anymore. And I think it took a while because I had no option to change positions, you know? (W21).

They said they would put oxytocin and I said I didn't want to, and they did it, it was terrible the worst hours of my life, so I already wanted everything, even cesarean section, and the doctor told me to calm down, for me it was a relief and the cesarean was a frustration because I wanted the normal delivery (W10).

Excessive use of painful interventions, such as synthetic oxytocin, leads to a progressive increase in interventions and lack of control of the parturient's perception of what is physiological. Also, the imposition of a place and a position to midwife was considered by women as an important point of disrespect to the physiological process of birth, while deconstructing the environment that she and her partner considered safe. The research called "Born in Brazil" revealed that good childbirth care practices were offered to less than 50% of women, even though there is no scientific evidence to support care based on too many interventions, resulting only in iatrogenic and cultivation of a negative experience of childbirth.²³

This practice is observed as a violation of women's human and reproductive rights. In some countries, such as Venezuela, obstetric violence is recognized as a crime against women and is characterized by the appropriation of women's bodies and reproductive processes by health professionals, based on dehumanized treatment, abuse of medicalization and pathologization of natural processes, causing the loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the women's quality of life.²³ In Brazil, the discussion on obstetric violence has advanced by the increasing dissemination of this problem in research in health and Nursing, as well as in the media. Santa Catarina as the place of this study is the first and only Brazilian state to enact a law on obstetric violence, requiring the implementation of information and protection measures for pregnant women and parturients.²

The access to coherent, clear and evidence-based information is the essential basis for the parturient woman to have autonomy in deciding which procedure she wishes to accept or refuse.²⁴ When there is a dialogue between the professional and the woman/caregiver, the parturient woman increases her feelings of safe to decide, describing the quality and humanized care.³ Data reveal that there are professionals who guide and respect the opinions of parturient women and others who disregard them.

They came to talk to me because they wanted to induce me with oxytocin and wanted to know what I thought, so I asked them to give me some time to think. Everything they do, they explain to me (W14).

Then he had an episiotomy, as much as I had placed in the birth plan I did not want it (W21).

The empowerment of women based on knowledge of the scientific evidence acquired in the group is based on decision making on the right to informed choices and shared decisions between the patient and the delivery care professionals. The previous understanding of the birth process makes the woman safer and more confident so she has a positive experience of childbirth, especially when she perceives the recognition of her experiences, opinions, and decisions in the professional, promoting her right to her own body and autonomy. As noted in the report, even described in the birth plan that did not want an episiotomy, the professional performed it, not respecting the bioethical principle of autonomy. This means even if the woman has the necessary knowledge, she often cannot have autonomy in decisions about her own body.

FINAL CONSIDERATIONS

This study observed that the group of pregnant women is an important and effective complementary tool for the consolidation of female autonomy in the parturition process. It also makes women aware of the physiology of labor from the recognition of its stages, enhancing the autonomy of the parturient by recognizing the appropriate time to go to maternity, if this is her desired place to deliver; strengthens coping with the labor, based on knowledge of their right to good childbirth and birth care practices, including the use of non-pharmacological methods of pain relief, free movement and position, the presence of a free-choice partner and proper environment; instructing the pregnant woman and her partner to make decisions consciously.

However, the participation in the group, the search for information and the preparation of pregnant women for childbirth do not reflect the certainty of care without unnecessary interventions, because there is still a large asymmetric relationship between the professional and the patient. From this perspective, it is necessary that women continue to participate in discussions about sexual and reproductive rights and public health policies.

The educational process developed in the groups of pregnant women creates a positive impact on society that may impact on the recovery of the values of childbirth care. The dissemination of a group of pregnant women is encouraged, as they stimulate the development of human potentialities, making the woman perceive as a central subject of care, becoming a protagonist in her process of gestating and childbirth.

This study had a limitation of the analysis of reports already described in databases, not exploring further issues related to female autonomy in labor. It is recommended that further studies be conducted to reflect on the strengthening of autonomy as a group of pregnant women.

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