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PERCEPTION OF BLACK PUERPERAL WOMEN ABOUT THE CARE RECEIVED IN CHILDBIRTH

PERCEPÇÃO DE PUÉRPERAS NEGRAS SOBRE OS CUIDADOS RECEBIDOS NO PARTO

PERCEPCIÓN DE LAS PUÉRPERAS NEGRAS SOBRE LOS CUIDADOS RECIBIDOS EN EL PARTO

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Objective: to describe the perceptions of black puerperal women about the care received during childbirth. Method: descriptive and exploratory research, with a qualitative approach, developed in a public maternity hospital in Bahia from March to August 2019, through semi-structured interviews with ten women. The systematization of data occurred by content analysis. Results: two analytical categories emerged: Humanization and good childbirth care practices; and Vulnerabilities in obstetric care. The perceptions were positive regarding the embracement, companion in childbirth and occurrence of some body relaxation technologies, but vulnerabilities were perceived, such as pilgrimage in childbirth, delay in care, culture of cesarean section and unsafe care. Final considerations: the perceptions of black puerperal women brought positive elements in the care received, but perceptions of vulnerabilities indicating reproductive injustices were also pointed out.

Descriptors: Parturition. Humanizing Delivery. Postpartum Period. Obstetric Nursing. Qualitative Research.

Objetivo: descrever as percepções de puérperas negras acerca dos cuidados recebidos durante o parto. Método: pesquisa descritiva e exploratória, com abordagem qualitativa, desenvolvida em uma maternidade pública da Bahia no período de março a agosto de 2019, mediante entrevista semiestruturada com dez mulheres. A sistematização dos dados ocorreu pela análise de Conteúdo. Resultados: emergiram duas categorias analíticas: Humanização e boas práticas de atenção ao parto; e Vulnerabilidades no cuidado obstétrico. As percepções foram positivas em relação ao acolhimento, acompanhante no parto e ocorrência de algumas tecnologias de relaxamento corporal, porém foram percebidas vulnerabilidades, como peregrinação no parto, demora no atendimento, cultura da cesárea e cuidado inseguro. Considerações finais: as percepções de puérperas negras trouxeram elementos positivos no âmbito do cuidado recebido, porém também foram apontadas percepções de vulnerabilidades indicando injustiças reprodutivas.

Descritores: Parto. Parto humanizado. Período Pós-Parto. Enfermagem Obstétrica. Pesquisa Qualitativa.

Objetivo: describir las percepciones de crías negras acerca de los cuidados recibidos durante el parto. Método: investigación descriptiva y exploratoria, con enfoque cualitativo, desarrollada en una maternidad pública de Bahía en el período de marzo a agosto de 2019, mediante entrevista semiestructurada con diez mujeres. La sistematización

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de los datos se llevó a cabo mediante el análisis de Contenido. Resultados: surgieron dos categorías analíticas: Humanización y buenas prácticas de atención al parto; y Vulnerabilidades en el cuidado obstétrico. Las percepciones fueron positivas en relación al acogimiento, acompañante en el parto y ocurrencia de algunas tecnologías de relajación corporal, pero fueron percibidas vulnerabilidades, como peregrinación en el parto, demora en la atención, cultura de la cesárea y cuidado inseguro. Consideraciones finales: las percepciones de puérperas negras trajeron elementos positivos en el ámbito del cuidado recibido, pero también se señalaron percepciones de vulnerabilidades indicando injusticias reproductivas.

Descriptores: Parto. Parto Humanizado. Periodo Posparto. Enfermería Obstétrica. Investigación Cualitativa.

Introduction

The perception of women about the obstetric care received has been widely discussed in Brazil and worldwide and is important to measure the quality of care and better meet their expectations and needs. It relates to various aspects intrinsic to care, such as the support and attitudes of the professionals involved, material and physical resources, possibility of family participation, linking to the perspectives of embracement, listening and their participation in decisions, as well as respect for culture[1].

According to the findings of national[2] and international[3] studies, most women are satisfied with the embracement and posture of health professionals or with the practice of childbirth and the care received, when culturally adequate, because the team should approach affectionately and assist the woman in an individualized way, aiming at a quality assistance.

Despite the satisfaction told by women, other studies that also bring the perceptions of users of obstetric services demonstrate vulnerabilities in their knowledge about labor, since many of the practices to which they were subjected are unnecessary and harmful; even evaluated as positive, they cannot be characterized as humanized[4]. In this sense, other studies report that women suffer abuse, disrespect and mistreatment during childbirth. This treatment threatens the right to life, since every woman has the right to dignified and respectful health care[5-7].

The *Pesquisa Nascer no Brasil* (Being Born in Brazil Research) stands out, which brings evidence of barriers due to social inequalities that persist in Brazil to the present day, such as the difficulty of access to indigenous and black women, with lower education, number of pregnancies and residents in the North and Northeast regions. The research also shows higher percentages of obstetric violence among black women (black and brown), with lower education, aged between 20 and 34 years, from the Northeast, with vaginal childbirth and who had no companions during hospitalization, compared to white women[5]. These situations corroborate the discussion about reproductive dystopia, understood as perspectives of the aspects of reproduction, which, for the most part, revolve around an idealized white femininity[6].

In health care, racism can manifest itself in various ways, such as institutional, which almost always occurs implicitly, being called implicit racial bias when society maintains and reproduces a set of negative social stereotypes on the black population[8-9]. Implicit prejudices are the stereotypes or preferences for or against groups of people[10], according to which health workers(s) determine how the care, attention and care of people happen, given their racial belonging, creating a hierarchy in care, let live, let die. Thus, structural racism takes place, which is culturally consolidated in social, political, legal and economic relations, so that individual and institutional accountability for racist acts does not nullify the reproduction of racial inequality[11].

These adverse scenarios do not meet the humanization of childbirth care, as a public policy, which seeks to rescue female autonomy over the body itself at the time of childbirth,

leaving her free to interfere in care decisions, so that she can move around, eat, and place herself as comfortably as possible, respecting the limitations imposed when there is risk in pregnancy and childbirth[12].

Therefore, the objective of this article is to describe the perceptions of black puerperal women about the care received during childbirth.

Method

This is a subproject of a broader research entitled *Characterization of Obstetric Care in the Political Perspective of the* Rede Cegonha *in a Maternity Hospital of Recôncavo da Bahia*. The research is descriptive and exploratory, with a qualitative approach, ensuring the achievement of the proposed objective, and follows the criteria recommended for qualitative research according to the Consolidated Criteria for Reporting Qualitative Research (COREQ).

The study was conducted in a Maternity Hospital in the city of Santo Antônio de Jesus, Bahia, from March to August 2019. The study participants were puerperal women. This group was chosen for corresponding to the object of study and for having already lived the experience of childbirth recently, up to 24 hours, so that they expressed their perceptions about this phenomenon. The number of participants was defined by the criterion of saturation of responses. The study included puerperal women, aged over 18 years, who gave birth in the institution, who were not in restriction of visits or with some postpartum complications and who signed the Informed Consent Form (ICF). The exclusion criteria were postpartum women who presented some cognitive and/or language deficit. The participants self-declared their color, according to the categorization of the Brazilian Institute of Geography and Statistics (IBGE), black, brown, yellow, white and indigenous, considering black those who self-declared black or brown. All participants self-declared as black.

The collection technique was the semi-structured interview, using a form with sequenced questions. This subproject used the answers given by the puerperal women to the questions focused on their perceptions about childbirth.

Bardin content analysis was used[13]. The phases of pre-analysis, material exploration, treatment of results, inference and interpretation were attended. For better structuring of the analysis processes, a software for qualitative data analysis was used, which was the atlas.ti program, version 9 desktop trial and free.

Since this is a study involving the participation of human beings, there was approval by the Research Ethics Committee of the *Universidade Federal da Bahia*, Certificate of Presentation of Ethical Assessment (CAAE) 95102318.6.0000.0056, respecting Resolutions n. 466/2012 and n. 510/2016, of the National Health Council. The participants signed the ICF before the interview, being guided about the procedure to be performed to obtain data for the research, as well as the expected benefits and possible risks. To ensure anonymity and confidentiality, participants were identified with the letter “P”, followed by a cardinal number, related to the order of occurrence of the interview.

Results

The study included ten adult puerperal women, aged between 18 and 35 years, with a mean age of 26 years. Regarding marital status, 60% had a partner who lived with them, 20% were single and 20% did not report marital status. Regarding education, 60% had completed high school, 30% incomplete elementary school, 10% incomplete higher education. Regarding occupation, 20% reported working with administrative area, 10% as a farmer, 40% as *housekeepers* and 30% chose not to answer. Regarding housing, 60% of women live in their own homes, 30% chose not to answer and 10% in rented homes.

In the process of data analysis, two categories emerged: Humanization and good practices of childbirth care and Vulnerabilities in obstetric care.

Humanization and good practices of childbirth care

This category presents the positive perceptions of puerperal women regarding care in childbirth. The statements referring to the puerperal women's perceptions of humanization and good practices can be seen from the perspective of the care received, the embracement and the assistance provided by health professionals:

> *My childbirth was great, very attentive, the doctor, the nurses, and the postpartum, everything was fine. (P1).*
>
> *They are always there asking if we need anything. (P3).*
>
> *The childbirth was peaceful, the doctors explained everything and paid a lot of attention. I don't have to complain. (P9).*

In this perspective of satisfaction in care, more than one health professional was described in the line of care, such as doctor, nurses and reception workers. There was the perception about the functioning of the service, the instrument of regulation, in addition to valuing the public service, the Unified Health System (UHS) in the preparation and during childbirth.

> *It was good. Good experience, I liked the nurses, the receptionist, the reception. I was satisfied with the attention of the doctor who performed my surgery, especially because he asked questions all the time and came see me too. (P2).*
>
> *[...] at childbirth, for them, a cesarean section would be necessary, so a regulation was made [...]. (P3).*
>
> *The great service [...] I have nothing to say, I had excellent service and I recommend it to anyone. I was monitored during pregnancy in the private sector and in the UHS, I'll tell you, my doubts were resolved in the UHS. (P5).*
>
> *Oh! mine was good, at least for the first time I came here, all the nurses who assisted me [...] the childbirth was with a nurse. (P8).*

In this context, the presence of the companion was reported as an important process in encouraging the woman in childbirth. One notices the perception of pain as a passing event.

> *It was good, it was calm, always supporting, always giving me courage and strength. It was quiet. My sister was present, which was good for me. It hurt indeed. It only hurt at that time there. I exercised, took a shower, squat is good. Going up and down. (P8).*

This report also showed the use of techniques that allow body relaxation and free movement of the woman that favor the development of natural childbirth, such as squat and bath stimulation.

Vulnerabilities in obstetric care

This category presents the negative perceptions of puerperal women regarding aspects that did not please them during childbirth, described as institutional vulnerability, vulnerability of the female body and cesarean culture, and unsafe care.

The puerperal women also revealed perceptions about the delay in waiting for care, as well as the pilgrimage at the time of childbirth. There was the difficulty of access to specific services in the place of residence, being necessary to solve the problem in another city.

> *[...] I arrived at the hospital at 8 am, it took me a while to be seen, but I was seen at 12:30 pm [...]. (P1).*
>
> *There was just a little delay in the screening. At the reception. (P4).*
>
> *I was supposed to go somewhere else, but I didn't go. I thought it was going to be normal. The city doesn't do it, I was going to be sent to another city, but it doesn't happen there, that's why I came here. I was going to Nazaré. (P2).*
>
> *I went to the hospital [...] which is the city in the region where we live. But when we got there, the service was really bad. As my aunt had already given birth here twice, she told me she was going to bring me here. (P9).*

The following speeches showed the perception of the puerperal women regarding the resolution of their childbirth situation, mostly by the surgical form. The decision and referral of the professional for cesarean childbirth without effective communication with the woman, reference of the vaginal touch as an examination preceding the resolution of the cesarean section and the perception of women about the speed in the decision and execution of this type of childbirth by the doctor. The speech of P3 shows divergence in the professional evaluation on the type of childbirth for the outcome of pregnancy.

> *He did the touch, said that I was only two cm dilated and that if I didn't improve, he would perform a cesarean section. It didn't progress, he did a cesarean section. (P1).*

> *The issue was at the time of childbirth, for them it would be a cesarean section, so a regulation was made, then the doctor evaluated it and saw that normal could be possible. (P3).*

> *[...] I got here, he just did the touch, said I was going to be hospitalized for a cesarean section and didn't explain anything else to me. (P6).*

> *I came because I had the 41-week problem, you know, and they say that after 41 weeks, labor can be induced nowadays, not in the past, as I was completing 41 weeks, then I arrived and I was also staying [...] It was very quiet, very fast [...] I immediately had a cesarean section, I think I arrived at around 8:20 in the morning, it was so quick. I thought it was going to be a cesarean section at night, it was so quick, I remember that the time the baby was taken at 10:10 am, it was very quick. (P7).*

Regarding unsafe care, there was a perception of a puerperal woman regarding the failure in the quality of care received. In this context, the insecurity of women was expressed by technical professional guidance and disregard for privacy at the time of parturition.

> *It wasn't a very good experience. I was admitted on Tuesday, I was losing fluid, the doctor admitted me, the other doctor released me on Tuesday. So I went home, when I came back yesterday, I had already lost more, when the doctor did the ultrasound, the baby was almost without any liquid, so much so that my baby is all shedding, some said I was capable of having a cesarean section, others said that it would have to be normal. If I waited a little longer, my son could have been born dead [...] During the childbirth, the room was very crowded, the people were impatient, but after the postpartum period, things improved a lot. The service, the way of talking to us, even medicating. (E10).*

Discussion

The perception of puerperal women who signaled satisfaction in the care received is related to some practices discussed in the context of humanization of childbirth. More than one professional is cited in the line of care received, such as embracement, signaling that there is a way to care attentive to the needs of the user. In this sense, the care provided and the attention of the team make a difference in this process. During labor, the pregnant woman should have the support of the entire health team, since the qualified monitoring, experience and commitment of humanized and ethical professionals ensure a childbirth without suffering[12].

Thus, humanizing childbirth does not only mean making the birth happen, it is relevant to perform the techniques of the processes, giving women freedom of choice in decisions about their body[14]. Although only one study participant reported the presence of a companion, there is a need to stimulate this practice, including extending it to prenatal care[15].

Considered good practice, the presence of the companion brings support, safety and reduction of obstetric interventions, such as oxytocin infusion and Kristeller maneuver, reduces the pain and feeling of loneliness of the puerperal women, stimulating the courage to face discomforts. A study conducted with 3580 puerperal women in Brazil revealed that the presence of companions is associated with greater qualification of care, because it favors higher prevalence of other good care practices, such as breastfeeding in the first hour of life, use of non-pharmacological measures for pain relief, greater movement and choice of position in the expulsion period[15].

Moreover, good practices, such as free movement and squat, perceived by women in this study, cause relaxation of the pelvic muscles and faster progression of the fetus in the course of childbirth; bathing can also generate this well-being in the puerperal woman. These and other non-pharmacological technologies favor the demedicalization of the body and help women relax, relieve pain and bring a feeling of embracement and warmth[16]. However, many other technologies, as integrative and complementary practices, such as acupuncture, hypnosis, massages, footwork, music therapy, chromotherapy, have their benefits recognized and recommended by the World Health Organization (WHO), but do not appear in local reality. Therefore, there is a need for progress on these recognized practices that, consequently, will contribute to the improvement of service and care for these women.

Health professionals, especially nursing team, can advance the qualification of this care, share information and active listening, so that childbirth is humanized and obstetric violence is prevented.

These perceived positive aspects may be results of the *Rede Cegonha* policy, among other initiatives and movements that have potentiated changes in the care model, in favor of a more humanized and respectful care[15]. Nevertheless, despite advances in reducing obstetric violence, the high rate of cesarean sections without clinical indication is a challenge.

The culture of cesarean section highlighted in this study corroborates the world statistics that infer an upward trend in this procedure, although a study of meta-analysis of moderate evidence indicates that women with this type of childbirth have greater chances for post-natal infections and maternal mortality[17]. However, there are growing forecasts seen until 2030, surpassing the WHO's recommendation to limit this procedure by up to 15% of total childbirths. Despite the recognized importance of this technology in the prevention of morbidity and mortality, cesarean section has been offered unevenly around the world, since, in case of need for evident maternal and neonatal risk in Africa, it is less accessible for black women in that place, leaving them more vulnerable to death. In Latin America and the Caribbean, there was a significant increase in cesarean sections from 22.8% in 1990 to 42.2% in 2014, being a total of 850,000 cesarean sections unnecessary[18].

In Brazil, this percentage is 55.5%, almost four times the acceptable rate. Private hospitals have up to 90% of cesarean sections[19]. It is therefore a facet of obstetric violence, because it corresponds to the unnecessary medicalization of the female body in parturition and associated with the increased risk of unfavorable maternal results. In this way, energetic strategies to curb it become indispensable, including professional technical training for qualified management of labor, ethical discussions and strengthening of puerperal women by the desire for a normal childbirth, from the perspective of timely education during prenatal care[20], in addition to the expansion of care by obstetric nurses in the childbirth care team, with their performance associated with the development of good practices and better perinatal results[21].

The decision and rapid execution of cesarean section by medical professionals, cited by some women, and the satisfactory orientation not received before the procedure denote the existence of demand for more information by the puerperal women and refer to ethical issues. The lack of access to information has an influence on the autonomy of choices[20,22]. Other reports indicate the satisfaction of some puerperal women with the resolution of childbirth, while their speeches bring little evidence for the indication of the procedure, individual vulnerability of women regarding their knowledge and the local culture of cesarean section. In this sense, the general conduct for positive birth experiences, including cesarean section decision, does not follow a systematic clinical reasoning based on clinical protocols from Brazil and the World Health Organization, since there is a low implantation of these devices[21].

The perception of delay in service and persistence of pilgrimage at the time of childbirth, seen by the difficulty of access to specific services in the place of residence, reveal institutional vulnerability and need for qualification and expansion of care network, proposed by the current policies, in which the description of the regulation of the service from one service to another also occurs, revealing signs of articulation of network services.

In this study, the puerperal women self-declared as black, with a low socioeconomic profile, very similar to the majority of the clientele that has access only to the UHS. Brazil has enormous racial and socioeconomic inequality, which reflects the high maternal mortality rates of black women. In the case of reproductive health, there is a strong link with the lack of access to quality care services. There is evidence that black women with low purchasing power are at greater risk of dying from obstetric causes linked to skin color[23], revealing obstetric racism and

reproductive injustice, important contemporary terms to highlight the needs of coping with the violent experiences of professionals and health systems that run counter to the essential demands of black women[6-7].

Unsafe care and disregard for women's privacy and autonomy at the time of parturition, also described by puerperal women in this study, have been reported in several Brazilian and global realities and also constitute situations of obstetric violence and racism. This has been a banner of struggle of feminists, social movements and anthropologists, seeking changes in the way of giving birth, and denounces the need to improve the quality of care, insistence and expansion of state actions and social control, since studies in Brazil show that well-conducted public policies can increase the satisfaction of women with the care received and change the scenario of care for childbirth, reducing unnecessary cesarean sections and negative maternal and neonatal outcomes[21].

The limitations of this study concern the moment of the interview, when the puerperal women had just experienced childbirth, and research on the service was not expanded through an observational look.

The study contributes to the evaluation of the implementation of the local *Rede Cegonha* policy and the need to strengthen vulnerable policy axes. Thus, the network and consortium articulation of small cities in the region need to be revisited by local and regional administrations. It also unveils the demand for university extension actions that can be planned for the formation of new experiences in the humanization of care provided to mothers and to favor the dissemination of successful care, as well as strategic actions for the expansion of the local debate on the Policy of Good Practices of Humanization of childbirth, birth and puerperium.

Final Considerations

The perceptions of black puerperal women about the care received during childbirth brought positive elements in the context of embracement, presence of a companion and the occurrence of some non-pharmacological practices for body relaxation. However, the findings also point to perceptions of vulnerabilities in the care received, indicating reproductive injustices and possibilities of obstetric racism that require confirmation by other studies, especially by the delay in health care, pilgrimage at the time of childbirth, many occurrences of cesarean sections and existence of unsafe care.

Strengthening network care and permanent education strategy focusing on the wide range of technologies, cultural competence and the approach to racism are necessary actions that can generate better quality in embracement, humanization and the advancement of good practices that still appear incipient in the local reality, strengthening the current public policies. It is also necessary to promote greater access to information for women, contributing to the process of their empowerment and enhancing their autonomy in childbirth decisions.

Collaborations:

1 – conception and planning of the project: Amália Nascimento do Sacramento Santos;

2 – analysis and interpretation of data: Thaís Emanuelle Bomfim Aragão;

3 – writing and/or critical review: Thaís Emanuelle Bomfim Aragão and Amália Nascimento do Sacramento Santos;

4 – approval of the final version: Thaís Emanuelle Bomfim Aragão and Amália Nascimento do Sacramento Santos.

Competing interests

There are no competing interests.

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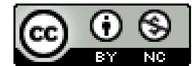

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