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Delivery care practices in the experience of puerperal women: analysis in the light of humanization

Práticas de atenção ao parto na experiência de puérperas: análise à luz da humanização

Prácticas de atención de parto en la experiencia de las mujeres puerperales: análisis a la luz de la humanización

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Abstract: Objective: to analyze the experiences of puerperal women about the professional practices developed in delivery care in the light of the theoretical contribution of humanization. **Method:** qualitative research, with the participation of ten puerperal women who experienced vaginal delivery, through semi-structured interviews, developed between September and November 2019. Thematic analysis was adopted. **Results:** practices that distanced themselves from humanization, such as enema, water and food restriction, frequent vaginal examinations, episiotomy, Valsalva and Kristeller maneuvers, predominated. The practices that approached humanization were the presence of the companion, use of methods of pain relief in the delivery and early skin contact between mother and baby. **Conclusion:** the experiences of the puerperal women were mainly marked by harmful or ineffective professional behaviors, performed inappropriately and with little scientific evidence about their efficacy. It is expected to support the reflection on the need for review and updating regarding good practices of delivery care.

Descriptors: Nursing; Women's health; Parturition; Humanizing delivery; Humanization of assistance

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Resumo: **Objetivo:** analisar as experiências de puérperas acerca das práticas profissionais desenvolvidas na atenção ao parto à luz do aporte teórico da humanização. **Método:** pesquisa qualitativa, com a participação de dez puérperas que vivenciaram parto vaginal, por meio de entrevista semiestruturada, desenvolvida entre setembro e novembro de 2019. Adotou-se a análise temática. **Resultados:** predominaram práticas que se distanciaram da humanização, como enema, restrição hídrica e alimentar, exames vaginais frequentes, episiotomia, manobras de Valsalva e de Kristeller. As práticas que se aproximaram da humanização foram a presença do acompanhante, utilização de métodos de alívio da dor no parto e contato cutâneo precoce entre mãe e bebê. **Conclusão:** as experiências das puérperas foram marcadas, principalmente, por condutas profissionais prejudiciais ou ineficazes, realizadas de forma inadequada e com poucas evidências científicas sobre a sua eficácia. Espera-se subsidiar a reflexão quanto à necessidade de revisão e atualização quanto às boas práticas de atenção ao parto.
Descritores: Enfermagem; Saúde da mulher; Parto; Parto humanizado; Humanização da assistência

Resumen: **Objetivo:** analizar las experiencias de las mujeres puerperales sobre las prácticas profesionales desarrolladas en la atención del parto a la luz de la contribución teórica de la humanización. **Método:** investigación cualitativa, con la participación de diez mujeres puerperales que experimentaron el parto vaginal, a través de entrevistas semiestructuradas, desarrolladas entre septiembre y noviembre de 2019. Se adoptó un análisis temático. **Resultados:** predominaron las prácticas que se distanciaron de la humanización, como el enema, la restricción del agua y los alimentos, los exámenes vaginales frecuentes, la episiotomía, las maniobras de Valsalva y Kristeller. Las prácticas que se acercaron a la humanización fueron la presencia del compañero, el uso de métodos de alivio del dolor en el parto y el contacto temprano de la piel entre la madre y el bebé. **Conclusión:** las experiencias de las mujeres puerperales estuvieron marcadas principalmente por conductas profesionales dañinas o ineficaces, realizadas de manera inapropiada y con poca evidencia científica sobre su eficacia. Se espera que apoye la reflexión sobre la necesidad de revisar y actualizar las buenas prácticas de la atención al parto.
Descriptores: Enfermería; Salud de la mujer; Parto; Parto humanizado; Humanización de la atención

Introduction

In recent decades, there have been changes in social determinants and in the organization of health services in Brazil. In the care of delivery and childbirth, those changes have been allowed through the implementation of policies and programs, such as the *Rede Cegonha*, which proposed, among other actions, the adoption of practices based on scientific evidence. However, substantial challenges still persist, especially since there is low support of health professionals to strategies that could modify the current obstetric model, such as good practices of care for delivery and childbirth.[1-2]

Regarding these practices, it is worth mentioning that they were recommended by the World Health Organization (WHO) in 1996, with the objective of conducting the work of professionals in the obstetric area. In this sense, it was proposed the classification of care

practices for normal delivery, in four categories according to ease, efficiency and risk,[3] which was adopted in the analysis of the on-screen study. Category A deals with demonstratively useful practices that should be encouraged; category B considers conduct to be clearly harmful or ineffective and should be avoided; category C, in turn, covers procedures with little evidence that should be used with caution; and, finally, category D lists professional actions that are often used inappropriately.[3]

Despite national and international attempts to propose a new mode of care for childbirth and birth, the hegemonic intervention model centered on the fragmentation and verticalization of professional actions remains rooted in health institutions, especially in the hospital environment. It is also observed that the culture of medicalization of obstetric care prevails, making invasive procedures convenient to professionals.[3-5]

Especially in Brazil, there is a context of an of elective cesarean sections epidemic, with increasing rates, in which women are often deprived of the decision-making power over their own bodies.[5] In a counterpoint to this context, there has been a movement of disruption with this hegemonic perspective and in favor of the adoption of practices based on the humanization of childbirth and birth ,4 with the WHO recommendations as a reference, for example.[3]

The definition of humanization, adopted in the present study, focuses on the production of new models of care and work organization.[6] In the scenario of parturition and birth, humanization encompasses respect for the choices of women, families and babies, as well as the right of dignified and respectful care, free from any type of violence.[7-8] In this sense, among professionals working in childbirth care, nurses have stood out for their engagement and commitment to humanized care based on good practices.[4,8] However, it is necessary that other professionals who assist the parturient also be able to rethink the obstetric model and, therefore, assume good practices as a possibility of transformation of the parturition process.

Considering the current panorama, in which, often, harmful, ineffective procedures with little scientific evidence are present in professional praxis, the importance of research that can analyze the experiences of puerperal women can analyze the experiences of postpartum women from professional practices in childbirth care is recognized. From this perspective, the study highlights that good practices can collaborate for real changes in the obstetric context.[4]

Through analysis of productions in the area,[1-2,4-5,8] it is perceived that there is a gap in research from the experiences of puerperal women about the implementation of good practices and/or the weaknesses existing in this process, since the findings refer to the perceptions of health professionals. Thus, this paper presents the following research question: what are the experiences of puerperal women about professional practices that approach or distance themselves from humanization in childbirth care? In view of the above, this study aimed to analyze the experiences of puerperal women about the professional practices developed in childbirth care in the light of the theoretical contribution of humanization.

Method

This is an exploratory and descriptive research, with a qualitative approach, developed in southern Brazil. The health care network of this scenario has a philanthropic hospital, which serves 13 municipalities in its region, and 16 Family Health Strategy (FHS) services located in the urban region. In these services, in addition to the attendance to users, practical activities and curricular internships of health courses students of a public educational institution are also developed.

The participants were contacted in four of the 16 FHS in the municipality. In this sense, it is worth mentioning that there was a draw of four FHS to carry out the research. The justification for performing this procedure was concentrated on the desire to obtain the perception of puerperal women living in different locations, seeking a greater variety of

experiences, since the fact of living in the same region could imply the participation of women with experiences and perceptions very similar to the theme.

To perform the draw, the researchers initially made a division of the municipality map into four regions. On this map, there was the location of the 16 FHS and within its region, each received a number from 1 to 4. Next, the researchers inserted this range of numbers into an online form and performed the individual draw of each region, thus reaching the choice of the services in which the participants would be located.

Then, participants who corresponded the following selection criteria were identified: being a puerperal woman who had a vaginal delivery in the hospital of the municipality and who was experiencing the late puerperium (between the 11th and 42nd day after the baby's birth).[9] In this sense, it is noteworthy that the study had as participants ten puerperal women. Therefore, it is worth mentioning, for example, that women who had fetal losses or with hospitalized newborns would also be included, because these situations would not impair the analysis regarding the theme of the study (professional practices developed in childbirth care in the light of the theoretical contribution of humanization).[6] However, these situations were not found in the group of participants. Furthermore, it is emphasized that there was no refusal or withdrawal during the production of the data, and the capture of new participants was ended when the data saturation criterion was reached.[10]

For this, after the puerperal consultation performed by the nurse, the women were approached personally and individually in each of the FHS drawn by the academic participants of the research team. The nurse informed the students about the puerperal women who had experienced vaginal delivery so that the invitation could be performed. At that time, after the presentation of the Free and Informed Consent Form, they were invited to participate in the research.

The most appropriate day, time and place was questioned. Regarding the scenario, all puerperal women chose their own home and the room was the place chosen by them to perform the production of the data, which were obtained between September and November 2019, through a semi-structured interview developed by the two students who composed the research team; the students were trained by the responsible researcher. All team members have previous experience with the use of the interview technique.

The open interview script was prepared for the purposes of this research and contained personal identification data and information related to the professional practices adopted in women's labor and delivery. During the production of the data, the participant was asked to report what had occurred when she looked for the hospital institution for the birth of her baby. During the puerpery's testimony, some questions were asked in order to deepen the interview.

In this sense, during the interview and according to what was being exposed by the participant, some of the questions raised were: Did you have any companions? Is this person the one you'd like to be accompanied by in childbirth and birth? Did you go into labor spontaneously or did you need any medication? Did they offer you any liquids or food during labor? After you got to the hospital, was there a waters break? During labor, what did you do? Was enema done? Was trichotomy (vaginal hair scraping) done? Was vaginal touch done? Was it the same health professional who attended you from your arrival to the birth of the baby? Did they ever ask you to push? Who, when and why did someone ask you to do that? At the time of delivery, has anyone squeezed/climbed on your belly to help the baby get out? Was episiotomy/cut/"pike" performed? After the baby was born, what happened?

The interviews had an estimated duration of 10 to 20 minutes, were audiorecorded with a smartphone and finished when all questions were answered. They were then transcribed in full by typing in the Microsoft Word. The data were submitted to thematic analysis,[10] based on

scientific evidence for good delivery care practices as a theoretical framework, according to WHO recommendations.[3]

The research commended the guidelines and regulatory norms of research activities involving human beings, in accordance with Resolution nº 466/2012. Before data production began, the project was approved by the Research Ethics Committee under CAAE number 13460719.3.0000.5323 and process number 3,535,870, on August 27, 2019. To preserve anonymity, the alphanumeric system was used in the presentation of the statements of the puerperal women, through the letter P, accompanied by the numbering (P1, P2, P3...), symbolizing puerperal, considering the chronological order that the interviews took place.

Results

The ten postpartum women interviewed were between 20 and 35 years old and were between the 11th and 42nd postpartum day, and all were undergoing puerperal follow-up in the FHS. Among them, five had high school, and nine had a stable union. One participant was a domestic worker and three were working in fixed paid work.

All of them lived with their children and only one did not live with her partner. Two of the participants were primiparous. All of them had prenatal care, two of which performed less than six consultations during follow-up. Regarding the planning and desire to gestate, two puerperas mentioned that they did not planned or desired the pregnancy.

Through analysis of the findings, these were organized into two categories. The first was called “Practices that approached the humanization of childbirth” and the second “Practices that distanced themselves from the humanization of childbirth”.

Practices that approached the humanization of childbirth

There are many practices with the potential to reassure women during the process of parturition and birth. One of these is related to the presence of the companion, in such a way that it promotes safety to the woman. Some interviewees stated that a companion of their choice was present in the pre- and/or postpartum period.

> *My mother was the escort of my choice.* (P1)
> *I chose to stay with my sister-in-law.* (P3)
> *In the pre-delivery and during, I just didn't have it because my mom was nervous and it didn't happen. I wanted it to be my husband, but he didn't have the courage [...]* (P4)
> *I had an escort mother.* (P8)
> *My sister was my company.* (P10)

Other practices that may demonstrate benefits to women relate to the use of noninvasive and non-pharmacological pain relief methods during labor and delivery. In this sense, hydrotherapy, ambulation and relaxation and squat exercises were mentioned as techniques used during the process experienced by the interviewed puerperal women.

> *She [nurse] told me to go more often in the bath to see the dilation [...] I just didn't go to the ball, because I was in pain from the last one and I couldn't take it anymore. But in the bath I went, I spent a lot of time in the bath.* (P4)
> *They just sent me* [health team] *to walk a lot. I walked a lot in that corridor.* (P6)
> *They put me in the bath and then they put me on an exercise to get more pain to go faster. They* [the nursing team] *said that they had to exercise, for the child to come faster.* (P9)
> *I used to do the exercises on the board* [it was a table provided by the Ministry of *Health in which there were images of the positions that the parturient can adopt during labor]. Helped me a lot. It was squatting. I even took a shower. It was much better.* (P10)

Direct and early cutaneous contact between mother and child were parturition living for one of the participants. She also cited support for the initiation of breastfeeding in the first hour after delivery.

> *She already left there [the delivery room] breastfeeding. After they win there, they already put the baby on the teat. It didn't take long, it was time to fix me and her.* (P1)

Through this last statement, it is worth mentioning that only one participant mentioned the practice of direct and early skin contact with her child, immediately after birth. Although questioned, the other participants did not mention this experience – they were was not offered this possibility.

Practices that distanced themselves from the humanization of childbirth

Considering that the practices that have distanced themselves from the humanization of childbirth are clearly harmful or ineffective and should be eliminated in the health services, some interviewees reported having been submitted to routine procedures, such as trichotomy, except those who have already arrived at the service with pubic hair shaved for having performed such a procedure in their homes.

> *There was no need to shave the hair, this I do at home.* (P2)
> *They didn't shave me, because I had shaved a few days earlier* [...] *the girl came with these devices* [...] *she saw and didn't need to.* (P7)

It was also verified that one of the participants claimed that she did not have the possibility of having a companion. According to her, in her case, no one was allowed to enter/participate during labor and delivery.

> *I was alone, they didn't let me. My sisters went with me, but they wouldn't let me in, I was alone. At the time there was only a nurse with me.* (P9)

Furthermore, prophylactic venous catheterization and intravenous infusion of physiological solution and/or exogenous oxytocin were mentioned by several puerperal women. Thus, it was evidenced as a routine practice and with the purpose of hastening the labor, delivery and birth of the baby.

> *They* [health professionals] *gave me that serum to make the pain worse.* (P2)

> *She* [nurse] *put IV, had little dilation, five fingers, then I put IV and in a little while I had seven fingers, then they took me inside and I gave birth.* (P5)
> *He* [doctor] *put the serum and I gabe birth, in a matter of minutes I gave birth.* (P6)
> *They* [health professionals] *even put* [venous] *access, but it was natural.* (P8)

The supine position remains adopted during labor. In some cases, it was configured as a (uninformed) choice of the woman and, in others, it departed as a restriction of the assistant team.

> *I just lay there, I couldn't walk [because I was doing induction with oxytocin].* (P3)
> *I was just lying in bed, because you can't get up [because I was doing induction with oxytocin].* (P7)

The interviewees also demonstrated that they were prevented from ingesting liquids or eating during labor. Some mentioned that they felt healthy and hunger and justified such deprivation by guidance from the health professionals of the service, being alleged the possibility of emesis, for example.

> [...] *I was in labor. I thought it was bad because it was thirsty, hungry, everything.* (P2)
> *They offer nothing. I felt thirsty, but I didn't want to ask.* (P3)
> [...] *they* [nursing team] *don't let me. I don't know why they say it's not for taking anything. I was already thirsty before I won, but she said I couldn't drink water, and then I waited. I asked for water and she said that now, it was to wait a little bit.* (P8)
> [...] *I couldn't drink water or eat anything.* (P10)

The participants reported being submitted to repeated vaginal examinations, and these were performed by more than one health professional. One of them even mentioned that a professional injured her while performing such a procedure.

> *When I got there, first it was a doctor who touched it, then it was the doctor.* (P2)

> *The head nurse and the doctor did* [the vaginal exam]. *Sometimes, she would do and call the doctor, then the doctor would come and evaluate again.* (P4)
> *The doctor who did* [vaginal exam] [...] *had a head nurse who did it too.* (P5)
> [...] *the doctor did it, the doctor did it, another nurse did it.* (P6)
> [...] *the nurses did it and the doctor later, before going to the room, three people did it.* (P9)
> *Two doctors and a nurse touched.* (P10)

The interviewees claimed that they were encouraged to perform the prolonged and directed pull effort (Valsalva maneuver) during labor. This guidance was transmitted by physicians and nurses.

> *She* [doctor] *just said that when the contraction came for me to do it like I was pooping and not sucking.* (P4)
> *The nurse told me to push, I did. There was an hour that I stopped. She said: Mother, make an effort that the head is coming.* (P7)
> *The doctor asks not to scream and force the child to come.* (P9)

Almost all interviewees underwent amniotomy during labor. The artificial rupture of the amniotic membranes was justified by the professionals for the purpose of reducing the time of labor and favoring the descent of the fetus. One of the puerperal mentioned ignorance about the real reason for performing this procedure.

> *The doctor tried to let it break by herself, but she didn't come, so the doctor said she was going to make the waters break and I said "okay".* (P4)
> *The doctor broke my bag, but I don't know why.* (P5)
> *They broke up, so that the child could go down and I could make it normal, understan*d? (P6)
> *The doctor made the waters break. She said that because the lap was up there and he needed to go down, I had contraction, had dilation, but he did not go down. So it was taking too long* [...] (P8)
> *They [health team] asked me if I wanted to be in pain or if I wanted to break the bag so it wouldn't be so long, so I wouldn't feel so much pain? I chose to break the bag so the pain would come faster.* (P9)

The interviews also made it possible to verify the performance of pressure from the bottom of the uterus during labor, called the Kristeller Maneuver. A puerperal woman pointed out that professional conduct, combined with comments made at the time, caused her negative feelings.

> *I felt very bad* [when they performed the pressure of the bottom of the uterus], *it is a very bad feeling, because the girl said she was running out of time, that she had to take, take, take, and push with her hand and everything and she didn't come.* (P3)

The practice of episiotomy also emerged in the interviewees' reports. It is noticed that they were not previously informed about the procedure and it is considered that it was performed after local anesthesia, since they did not feel it while being performed.

> [...] *they made the cut, but it was better that it came.* (P4)
> *I think the doctor did it, but I didn't even feel it, they didn't say anything to me.* (P7)
> *They made the cut, but I didn't even feel it.* (P10)

According to the participants, umbilical cord clamping was performed immediately after birth. In these cases, it was possible to observe the performance of the procedure precociously.

> *She* [newborn] *was on top of me and I hadn't even seen it, so he* [doctor] *cut it* [umbilical cord] *and I didn't even feel it.* (P1)
> *As soon as he was born they cut the cord.* (P3)
> [...] *they put it on top of me and cut* [the cord]. (P5)

The findings showed that health professionals do not wait for the cord pulse stop. Moreover, such conduct seems to represent a routine in the service.

Discussion

In view of the findings of this research, it is necessary to reinforce that, according to Law Number 11,108, of April 7, 2005, the parturient has the right to have a companion throughout the period of labor, delivery and postpartum. The Law also guarantees the pregnant woman her

free choice, and may be the baby's father, the current partner, her mother, a family member or a friend. It is noteworthy that the Law cannot be disrespected by the institution or by any member of the health team,[11] being subject to complaints in case of non-compliance.

However, in the reports of the puerperal women, it was possible to verify that the presence of the companion was only allowed before and after delivery, contrary to the legal aspects of the legislation. In addition, it was identified that the interviewees could only enjoy female companions, because it is a recommendation of the service, again opposing what proposes the law in question.

From this perspective, it is important to highlight that the companion in labor and delivery offers several benefits to the woman.[12] He is able to provide security and tranquility and, with this, help in reducing pain and the duration of labor. Therefore, their presence needs to be further stimulated by health professionals, since it helps and encourages during the parturition process,[13] besides contributing to the promotion of individualized care, considering the subjectivities of the parturient.[14] For these effects to be, in fact, enjoyed, the woman needs to have someone of her choice, regardless of gender. Furthermore, their permanence must take place from the beginning to the end of the process, regardless of the time that labor and delivery last.

As practices that approached the humanization of childbirth, it was found the use of non-pharmacological methods of pain relief during labor. In this case, procedures cited by the puerperal were hydrotherapy, ambulation and relaxation and squat exercises. Noninvasive strategies for pain relief in labor are recommended prior to the use of pharmacological resources. Among them, we highlight the offer of immersion in water, massage and relaxation techniques, acupuncture and hypnosis developed by qualified professionals, music therapy, among others.[15]

Authors emphasize that a measure of comfort for many women is hydrotherapy, especially during the first stage of labor. Water favors relaxation and greater capacity to sustain contractions, besides providing a humanized experience.[16] This practice reduces labor time, as it is favored by gravity, since the woman remains in an upright position. In addition, there is ambulation, which also contributes to the baby's descent and consequent increase in dilation.[17-18]

The movement and adoption of comfortable positions for women need to be prioritized.[15] However, in the present study, the interviewees claimed that they remained more restricted to the bed, mainly due to venous infusion.

It is important to emphasize that the parturient needs to be stimulated to alternate positions during labor. Therefore, it is necessary to allow her to choose other positions, such as squatting, sitting, lateral decubitus, which contribute to the prevention of perinal lesions, better biomechanical behavior of the bone pelvis and its ligament muscle structures and, consequently, fetal descent.[19-20]

Direct and early cutaneous contact between mother and child and support for the initiation of breastfeeding in the first hour after delivery also emerged as professional practices developed in the care of delivery and birth. Regarding skin-to-skin contact, it is known that the newborn can remain on the mother's abdomen and/or thorax after clamping the cord, using the mother's body as a heat source, making sure that the child's positioning allows effective respiratory movements.[16]

Therefore, it is advisable to stimulate skin-to-skin contact immediately between mother and baby, right after birth. Routine procedures such as weighing, measurements and bathing should be postponed in order to avoid separation between mother and child, except in cases where there is a request from the woman herself and/or when really necessary. In the same direction, the stimulation of breastfeeding in the first hour of life is essential, and has numerous benefits.[15]

A study conducted at the University Hospital accredited with the title of Baby-Friendly Hospital, in Recife, justifies breastfeeding in the first hour of life because it is a strategy of excellence, which contributes to the adaptation of the newborn in an extrauterine environment. It also highlights that the timely onset of breastfeeding is a necessary measure to regulate the child's blood glucose and temperature, as well as his cardiorespiratory condition.[21]

In the case of practices that distance themselves from humanization,[6] it was observed, in the findings of the on-screen study, the occurrence of professional conducts that are classified in the literature as clearly harmful or ineffective and should be avoided.[15] Among these, we highlight the performance of enema and trichotomy, routine intravenous infusion in labor and routine prophylactic venous catheterization.

Practices with little evidence and should be used with caution were identified,[15] as the case with routine precocious amniotomy in the first stage of labor, bottom pressure during labor and early umbilical cord clamping. Finally, it was also verified that procedures were frequently used inappropriately,[15] such as water and food restriction during labor, a stimulus for induced pulling before the woman feels involuntary desire, for example.

With regard to trichotomy, it is already recognized that this practice was incorporated into the routine of hospital institutions through the justification of reducing infections and, in the case of the evolution of labor to the vaginal route, facilitate the suture of the episiotomy. However, currently, it is known that the risk of infection is not reduced with the performance of trichotomy. On the contrary, the procedure causes irritation, redness, burning and itching, and can also increase contamination by diseases such as human immunodeficiency virus (HIV) and hepatitis, both for the professional and for women, thus representing an unnecessary procedure and that should only be performed if requested by the woman.[22]

Prophylactic venous catheterization and intravenous infusion of exogenous oxytocin routinely were also evidenced in the participants' statements. They claimed that these practices

were developed by health professionals to reduce the time of delivery and the suffering caused by contractions. The use of oxytocin for stimulation of childbirth may be unfavorable, both for the newborn and for the woman. This practice is associated with an increase in cesarean rates, the use of epidural analgesia and intrapartite maternal fever, and therefore, this procedure needs to be evaluated with caution.[23]

Water intake, preferably of isotonic solutions, is a practice that needs to be stimulated. Parturients who are not under the influence of opioid drugs or who are not at risk of undergoing general anesthesia may take a light diet.[15] However, in the present study, it was found that the women attended at the service in question were mostly instructed to remain fasting throughout the parturition process.

Participants also reported repeated vaginal examinations by more than one health professional. The reports demonstrated the embarrassment of women, besides the lack of concern about the intimacy and individuality of these patients during these evaluations. A study developed in a teaching hospital in the capital of Rio Grande do Sul also identified an excessive number of vaginal examinations in the same patient. In addition, the authors highlighted that none of the parturients were submitted to the frequency of touches respecting the recommendation every four hours, which demonstrated too many evaluations.[22]

Moreover, in the present study, it was observed the orientation for the participants to make the effort of prolonged and directed pull (Valsalva maneuver), as well as their submission to the Kristeller maneuver by health professionals. In this context, the literature is emphatic in indicating that parturients should be encouraged to perform spontaneous pulls during the second period of labor, avoiding directed pulls.[15] In addition, these maneuvers are considered unnecessary and harmful procedures that can lead to perineal injury, in addition to psychological trauma to women and physical to the binomial.[22]

By allowing women to experience childbirth actively, her role in this process is restored. Otherwise, when health professionals address her naming her as "mother" such conduct can be considered as a practice of decompensation and accountability of women, who distance themselves from humanization.[6] When the parturient does not behave as expected by health professionals, it can be considered as decompensated and, in these cases, is responsible for the generation of stress in the environment.[24]

It was observed in this research that one of the participants reported having been oriented to push and that when she chose another behavior, the health professional addressed her as a "mother" and again guided her about what she should do. In addition, another participant also reported having been instructed by the professional not to scream and push. In both situations, it is possible to infer that there is the idea of power, infantile treatment and/or restriction of the image of the woman to the role of mother, dismissing her from decisions about her behavior and about the body itself during the process of delivery and birth. Therefore, these behaviors can be placed as practices that distance themselves from humanization.[6]

It is understood that the assumptions of the humanization of childbirth indicate the need for a new posture of health professionals. The relationships between professional and user appear as a core issue of care, and it is necessary to consider how individuals are approached and treated, as well as how their doubts are clarified and/or how their demands are heard.[25]

In addition, professional practices that discharge female protagonism during the process of parturition are framed as obstetric violence, which can be understood as a particular and complex form of violence against women, usually being naturalized in health systems and covering the performance of procedures without the consent of women, constituting a dehumanized treatment, abuse and disrespect to the parturient. This type of violence also comprises all the conducts that distance themselves from the humanization of childbirth

mentioned in this study and that can be configured as mistreatment and abusive practices performed by health professionals.[26-27]

In the same direction as the Valsalva and Kristeller maneuvers, in the study, amniotomy was developed in order to reduce labor time. However, it is essential to highlight that precocious amniotomy, associated or not with the use of synthetic oxytocin, should not be performed routinely in women who are presenting good evolution of labor. Artificial rupture of amniotic membranes is recommended in view of the suspicion of stop progression in the first stage of labor. Therefore, when indicated, the procedure should be explained to the woman and warn her that such conduct may shorten the period of labor, but, in a counterpoint, usually lead to increased intensity and pain caused by contractions.[15]

With regard to episiotomy, this is a practice that is still widespread in the obstetric context, although it can be considered a form of genital mutilation.28 It is generally associated with variables such as primiparity, lithotomy position during the expulsion phase, use of epidural analgesia, instrumented delivery, use of oxytocin during childbirth, induction of childbirth, and post-term deliveries.[29] However, it is related to the increased risk of third and fourth degree perineal laceration, infection and hemorrhage, urinary and fecal incontinence.[30] These findings justify the abandonment of this practice in current obstetric care.

Finally, the participants' reports demonstrated the clamping and early cutting of the umbilical cord, in addition to the pressure of the uterine fundus for the expulsion of the placenta. Both practices represent conducts without scientific support and, therefore, should be abolished from obstetric care. Thus, some care is indicated in the third clinical period of delivery, such as clamping and late cutting of the umbilical cord, preferably after the pulse stop, between the 1st and 5th minute after the baby's birth.[15]

In cases where there is need to provide emergency care to the woman and/or newborn, clamping and cutting of the umbilical cord may occur beforehand. The same criterion should be

followed for the discharge of the placenta, which must be physiological and respect the time and manifestations presented by the woman, from the identification of some sign and/or symptom that evidences that such organ is naturally peeling off from the maternal uterus.[15]

It is worth considering that this research was developed from the perspective of puerperal women, and may be configured as a limitation of the study, because it recognizes the importance of studies that can also point to the perspective of health professionals who work in the service that served as a scenario for data collection. With this, it's glimpsed, for example, a path to the development of research to identify the knowledge of health professionals about the practices of care for childbirth and birth, as well as the obstacles experienced in the implementation of them.

Conclusion

By analyzing the professional practices developed in delivery care, in the experience of puerperal women, in the light of the theoretical contribution of humanization, it was possible to observe each behavior and action developed. With this, it was possible to identify practices considered harmful and/or ineffective, such as enema, trichotomy, routine intravenous infusion in labor and routine prophylactic venous catheterization and Valsalva maneuvers. It was also possible to perceive the procedures that are developed improperly, such as frequent vaginal examinations, water and food restriction and episiotomy.

The practices that approached the humanization of delivery were the presence of the companion, use of pain relief methods in labor and early skin contact between mother and baby, which emerged timidly in the participants' statements. It was noticed that, although there is the possibility of the woman enjoying the presence of a companion during her labor and delivery, this right does not occur according to the legal provision. Moreover, some women were encouraged to use non-pharmacological pain relief techniques, such as hydrotherapy,

ambulation and relaxation and squat exercises. The early skin contacts between mother and baby, in turn, was observed in the statement of only one puerperal woman.

The results of this study can be considered as important contributions to the practice regarding the care of women, newborns and their families during the birth process. Those findings may serve to support the reflection of health professionals regarding the need to review and update good delivery care practices, in order to qualify care for this portion of the population. In teaching, it is expected that the knowledge produced from this study can stimulate the adoption of practices based on scientific evidence, contributing to the training and performance of critical professionals and aligned with the current guidelines of obstetric care.

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