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Women's experiences about obstetric care received during parturition: a cross-cultural approach

Experiências de mulheres acerca dos cuidados obstétricos recebidos durante a parturição: abordagem transcultural

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Abstract
Introduction: the experiences around parturition have heterogeneous meanings in different cultural contexts. **Objective**: to describe the cultural experiences of women about the obstetric care received during childbirth. **Materials and methods**: qualitative research, with a transcultural approach, conducted by ethnographic methodological reference, with 13 key informants in a public maternity hospital in the state of Ceará, Brazil. The observation-participation-reflection enabler was adopted for data collection, recording observations in a field diary and individual interviews. The immersion process in the field took five months. The empirical material was submitted to the procedures of the ethno-nursing data analysis guide. **Results**: we apprehended six cultural themes from the empirical reality expressed in the cultural scenario and from the informants' point of view, that contemplated meanings attributed to motherhood, mode of delivery, diet, vaginal exams, companions, and care received during parturition. **Conclusions**: the hostile institutional environment, proscribed obstetric practices, and heteronomy in care was the core of the suffering of the parturients.
Keywords: labor; obstetric; nursing; anthropology; cultural.

Resumo
Introdução: as experiências em torno da parturição apresentam significações heterogêneas em contextos culturais diversos. **Objetivo**: descrever experiências culturais de mulheres acerca dos cuidados obstétricos recebidos no parto. **Materiais e métodos**: pesquisa qualitativa conduzida pela etnoenfermagem, com 13 informantes-chave em maternidade pública localizada no estado do Ceará, Brasil. Adotou-se para coleta de dados o capacitador Observação–Participação–Reflexão com registro das observações em diário de campo e entrevistas individuais. O processo de imersão no campo durou cinco meses. O material empírico foi submetido aos procedimentos do guia de análise de dados da etnoenfermagem. **Resultados**: a partir da realidade empírica expressa no cenário cultural e do ponto de vista das informantes, apreendeu-se seis temas culturais que contemplaram significados atribuídos à maternidade, via de parto, dieta, exames vaginais, acompanhantes e cuidados recebidos durante a parturição. **Conclusões**: o ambiente institucional hostil, as práticas obstétricas proscritas e a heteronomia no cuidado constituíram cerne do padecimento das parturientes.
Palavras-chave: trabalho de parto; enfermagem; antropologia cultural.

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Introduction

Care in the parturition process has historically occurred in home environments, under the responsibility of women, their families, and members of the social and community network based on oral and gestural knowledge experienced and transmitted between generations[1].

The appropriation of women's bodies and reproductive processes, in opposition to the culturally constructed conception of childbirth as a feminine, natural and physiological intimate and domestic event[2] shifted the comprehensive axis of parturition and established a medical-hegemonic obstetric model centered on a hospital-centric logic of care.

Alongside the institutionalization of childbirth, obstetric care, once integrated into the daily space and cultural context of women[1,3], became the object of professional action through medical care practices marked by intense technology, medicalization, pathologization, and surgical routines[2,4]. These interventions, legitimized as beneficial, altered the natural course of the parturition process by contributing to its control, acceleration and artificialization[5] In modernity, they have culturally produced the normalization of cesarean section as a way of giving birth and being born[6].

The idealized model of obstetric care is based on the humanization of care from the perspective of comprehensiveness and uses appropriate technologies that respect the physiology of childbirth, beliefs, and customs for the development of individualized, resolute, and quality actions by recognizing dimensions, relationships, contexts social, cultural and economic conditions in which women and their families are inserted [7].

However, there is still a long way to go to really implement culturally consistent obstetric care, as the training and performance of health professionals are impregnated by the biomedical model, evidenced by the reproduction of interventional care practices developed in a scripted, technical, and impersonal way and based on hierarchical relations of knowledge-power that reinforce postures, normative and ethnocentric discourses[4,8,9].

In this context, obstetric care routines [4,9] have transformed the experience of childbirth from a unique moment into an unfortunate event, as they have made women hostage to the objectification of interventions, leading to the loss of protagonism, autonomy, and the naturalization of violence in institutionalized childbirth [10].

In the context of investigations in the obstetric field, descriptive studies have focused on understanding the perception and satisfaction of women concerning parturition[11]. However, few studies seek to understand from an anthropological-cultural view the perspectives and expectations of care related to labor and birth[12].

The experiences around these complex vital phenomena have heterogeneous meanings in diverse cultural contexts as they bring visions, beliefs, and values (re)constructed from the uniqueness and culture of the parturient[4] and constitute an important dimension to the understanding of obstetric care. Thus, the present study aimed to describe the cultural experiences of women regarding the obstetric care received during childbirth.

Materials e Methods

Study design

Qualitative research with a cross-cultural focus operationalized through ethnonursing, a methodological framework to understand the phenomena of a Domain of Investigation (DOI) related to cultural care, from different dimensions: etic (knowledge and professional nursing care)

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and the emic (internal knowledge of the informants, translated by popular care)[13]. In this study, the emic perspective is approached as the DOI addresses the understanding of obstetric care with a focus on maternal experiences related to institutionalized childbirth.

The recommendations of the *Consolidated Criteria for Reporting Qualitative Research* (COREQ) were used to guide the study.

Research scenario

The study was carried out from March to August 2016 in a public maternity hospital located in the Cariri region of Ceará, in the semi-arid region of the Brazilian Northeast, a reference for the care of women living in six municipalities that make up the Decentralized Area of the Health Region.

It is a region whose religiosity, with a strong Catholic tradition, constitutes a striking feature in the life and culture of the local people. There are several places of pilgrimage with monuments dedicated to the worship and devotion to popular saints. In addition, motherhood had a religious influence as, for a long time, nuns made up the administrative body of the institution.

Participants

Thirteen (n=13) parturient participated in the present study. The inclusion criteria were at least 18 years old women in labor. Those with clinical and/or obstetric complications were excluded. The participants were encouraged to openly and spontaneously share knowledge and stories from their experiences[13].

Enabling procedures and guides for data collection

The Observation–Participation–Reflection (O-P-R) enabling guide was used for data collection, consisting of four sequential phases: observation with active listening; observation with limited participation; participation with continued observation and reflection; and confirmation of findings; aimed at guiding the researcher to obtain focused information about the informants' experiences in a given cultural scenario[13].

In the first phase, observation focused on obtaining an expanded view of the phenomena by field recognition. In the second phase, punctual and detailed observations aimed at the insertion of participants into the cultural context. In the third phase, participant observation continued; complementary individual interviews were conducted to apprehend the views of the world, the feelings, meanings attributed, and the experiences about the phenomenon of study in the cultural context [13].

We chose to use "tell me about" (DOI/phenomenon of interest)[13] open-ended interviews with questions that emerged from the observation process, covering general aspects, and exploration of specific situations to deepen the understanding of the observations recorded in a field diary regarding their senses and meanings.

The interviews were recorded in audio, with the express authorization of the informants, held in the admission room and the obstetric bed, and then transcribed in full for analysis. The interviews were closed based on the theoretical saturation of the speeches and lasted an average of 50 minutes.

Finally, the fourth stage included reflective observations about the phenomenon; collection, review, and reassessment of the data to elucidate inconclusive points; discussion and confirmation of the findings with the informants; and, regarding epistemological and personal reflexivity, an analysis of the influence exerted by the researcher on the methodological course, the events and the participants with subsequent closure of data collection[13].

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The immersion process in the field lasted five months. The dynamics of the observation process occurred every day of the week during the morning and afternoon shifts. The interviews and observations were conducted by the main researcher (nurse, specialist in public health, and master's student in nursing) throughout the parturition process and the obstetric care routine, from admission to rooming-in.

Organization, presentation and analysis of data

We used the ethnonursing data analysis guide, which is composed of four sequential phases (1. data collection, description, and documentation; 2. identification and categorization of descriptors and components; 3. pattern and contextual analysis; 4. main topics, results, theoretical formulations, and recommendation), to facilitate data coding, processing, and analysis[13].

In the first phase, we conducted a detailed and grounded analysis of the raw data about the phenomena. During the second phase, we coded and classified data by similarities and differences and analyzed the meanings of the recurrent components. In the third phase, the ideas were grouped based on recurring patterns and meanings in context analysis. Finally, in the fourth phase, the abstraction and confirmation of cultural themes were conducted with subsequent analysis, synthesis, and interpretation of the findings[13].

From the empirical reality expressed in the analyzed cultural scenario and from the participant's point of view, six cultural themes were apprehended. The results were presented through excerpts from the interviews, identified through the use of codes composed of the initial letter of the word parturient, followed by a number that represents the order in which the interviews were conducted (Ex.: P1) to guarantee confidentiality, anonymity, and confidentiality of information.

Methodological rigor, ethical and legal aspects

We used specific qualitative criteria to ensure methodological rigor in the conduct of ethnonursing: credibility, confirmability, recurrent patterns, meaning-in-context, saturation, and transferability[13].

The women were informed about the study and invited to participate by signing the informed and post-informed consent terms.

The research was approved by the Research Ethics Committee under opinion No. 1,397,142 and Certificate of Presentation of Ethical Appreciation No. 52703715.0.0000.5055, as recommended by Resolution 466/12 of the National Health Council, which establishes guidelines and standards that regulate studies involving human beings.

Results

Participants characterization

The thirteen participants aged between 20 and 41 years old, predominantly with high school education (n=8), married (n=8), self-declared mixed race (n=12), Christian (n=13), engaged in paid or unpaid domestic activities (n=11), and reported a monthly family income equal to one minimum wage (n=13), with the current value being R$ 880.00. Regarding obstetric aspects, they were predominantly multiparous (n=11) and with a gestational age of 40 weeks or more (n=7).

Cultural theme 1: "Being a mother is hard, a loving suffering"

In this cultural theme, we explored the experiences of parturient and the meanings attributed to motherhood.

The maternal experiences during the clinical phases of childbirth were woven amidst feelings and pain, signified as 'suffering'. They described pain in different ways and it represents the main point of the

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parturient' suffering: *"[...] an unparalleled pain that has no end [...] I spent the whole night suffering, writhing in pain [...] I'm waiting for these pains to increase, women are animals that suffer"* (P4); *"[...] every ten minutes this boring, agonizing pain comes"* (P5); *"[...] every hour this nauseating pain comes [...]"* (P9); *"[...] the pain is so strong that you go to heaven and back, it's horrible, very strong and it doesn't stop, it's direct, it's so much pain that you ask for your death"* (P8).

Despite perceiving coping with pain as something difficult, the women were resignifying the process of becoming a mother and, in the end, the experience was considered gratifying: *"being a mother is good, apart from the pain I am feeling [...]"* (P4); *"[...] it's my third child [...] it's been a new [...] experience of being a mother [...], I suffered (in previous births) [...], but I did not remember anymore how strong the pain was [...] being a mother is good after the pain is over [...] the size of the pain we feel becomes the amount of love we have for our children"* (P7); *"[...] pain is the least of it for those who want a child, no matter how much they suffer, you at least have the satisfaction of having [...]"* (P5).

The birth experience has dichotomous feelings of conformism and nonconformity concerning pain. While some informants remained silent, others vocalized the pain and, when expressing themselves, were subject to a reprimand from professionals: *"I screamed a lot in pain [...] I made such a scandal that only God knows [...]"* (P8); *"I don't scream, I control myself, I know the pain, why am I going to cry? I turned to the wall and writhed in pain, I stayed in my corner, silent [...]"* (P3); *"[...] I am strong at this time (of childbirth), God gives the necessary strength"* (P3); *"[...] the nurse came to look at me and said: 'I thought I was already having (the baby) with those screams' [...] she even took me to the last room, she said: 'let's go to another room where you're making mommies scared and nervous'"* (P8).

Women resorted to divine designs when clinging to religiosity to explain the genesis of pain *"Adam and Eve sin; God, instead of punishing them both, said that he would increase the pains of Eve's birth, all that was left for us [...]: 'Woman, you have the natural sin of Eve'. Oh! Lord, My Jesus, forgive me, but this increasing the pain deal [...] It took a heavy toll, it was so good if you got pregnant and didn't feel anything"* (P9).

Although one informant mentioned feeling uncomfortable with religious artifacts present in the environment, *"I found it strange because there are (Catholic) images scattered everywhere"* (P8); religiosity was used as a comfort and coping strategy during this period *"this belly was a suffering [...] it was hard, feeling direct pain [...], but thank God it is coming to an end"* (P10); *"all the women in my family told me that it was a lot of pain, but at the time of suffering, I clung to my faith in God, because I am evangelical, so everything was peaceful* (P8).

Cultural theme 2: "If I were going to have a cesarean now, I would love it"

In this cultural theme, we explored the perceptions of parturient concerning the modes of delivery and the experiences around vaginal and cesarean delivery.

Despite pain being seen as a negative aspect, two informants mentioned a preference for the vaginal delivery route, meaning it is normal, healthy, with quick recovery, and allows greater autonomy in postpartum care (Note: native category, informants used the term 'normal' to designate vaginal delivery): *"I wanted normal because I have the facility to depend less on people because I don't have someone to take care of me and (household) things when I get home, which if it were a cesarean I would need (of somebody). And so, normal is a healthier thing, at least tomorrow I'm free (hospital discharge) because there's no cut, and recovery is faster. In the cesarean,*

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you do not suffer at the time, but you will suffer later" (P7); *"I wanted to have a normal one because cesarean is so bad. And the others (deliveries) were all normal, the recovery is faster, the pain is very bad, but it is bearable, the important thing is to be born healthy"* (P13).

Although some women are aware of and recognize the benefits of vaginal delivery, it is evident that there is an explicit preference or desire for cesarean delivery associated with reduced pain/discomfort and greater privacy: *"If I were to have a cesarean now, I would love it! [...] every year there was a boy. I'm afraid of being normal [...] the woman had it in bed, in front of everyone, she didn't want to be ashamed. Now it's healthier [...]"* (P1); *"I wanted a cesarean section because in addition to the pain being unbearable, at the time I put strength, I'm afraid of squeezing myself [...] to poop and feel ashamed"* (P10); "*I hope the doctor does the cesarean. I wanted to, it's better because my other boy almost died right away with so much pain [...]"* (P2).

Among some participants, childbirth is seen as an experience that needed to occur quickly. Due to the delay in vaginal labor, the women wanted to have a cesarean section to leave the hospital environment and end the 'suffering': *"The doctor performing the cesarean [...] I sign fifty papers, the less I look at these people's faces the better! The only face I want to see is my boy's"* (P3); *"I didn't want to be normal, stay here for so long a day (hospitalized) [...]. After we have a normal boy, it's so good, if it weren't for this delay"* (P4); *"Normal childbirth takes too long, we eat the bread that the devil kneaded, feeling direct pain, suffering. I wanted to have a cesarean to leave soon"* (P5); *"If I can't have normal, I'll have the surgery to take the boy out, because I can't wait to end this suffering [...]"* (P8).

Women resorted to religiosity to, through faith, request that their desires be asserted through divine intercession: "*I am praying that this child is not born for normal delivery. I hope God touches the doctor's heart and he has the goodwill to perform the cesarean* (P4); *"[...] I want it to be a cesarean [...] if it were to be normal, God gives courage, first cling to Jesus [...]. It's like the people say: first God, according to men, has this saying, you have to trust in God, I'm glad I have a lot of faith [...]"* (P6).

Cultural theme 3: "How can a person stay here without food?".

In this cultural theme, we explored the experiences of parturient regarding the diet during parturition.

The participants defined water and food restriction during labor as 'suffering'. The women described the negative experiences concerning the diet compared with previous births: *"I'm lying here suffering, without eating or drinking, waiting for God's will"* (P1); *"It's my second child, but I didn't suffer from the first one [...] I had snacks, lunch, had breakfast"* (P3); *"I already came prepared, I had a big breakfast because, the other time, I was hungry, they only gave me water, I suffered a lot [...]"* (P5).

The parturient are submitted to long periods of fasting during labor due to the possibility of performing a cesarean section or having their diets released depending on the vaginal delivery route being assumed by the professionals: *"It has been 24 hours since I ate and drank water, my mouth is dry and I have a weakness. I was supposed to, at least, put a serum, something to give me hydration, but they say that because it's going to be a cesarean, you can't"* (P6); *"I was very hungry, they didn't release food for me, I didn't even have lunch or water, they didn't give it to me, I think they thought I was going to have a cesarean [...]"* (P13); *"They let them eat, the diet was free, I think because they knew it was going to be normal"* (P12).

Diet decisions were centered on the medical figure and the behaviors adopted by

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other professionals, as part of the care routine, imposed on women: "*They just said they couldn't eat anything. And I didn't dare to ask why or to ask for anything* (P11); "*I said I was hungry, thirsty and in pain and the nurse: [...] 'I can't do anything, you won't eat because the doctor thinks you're going to have a cesarean"* (P9).

Among the set of routine obstetric interventions, the use of venous hydration and oxytocic during labor also stood out. Given the context of food restriction, these practices were valued by informants who believed that 'very strong serum' or 'injection of force' (Note: native category, participants used the term 'injection of force' to designate the use of oxytocin) would be responsible for alleviating hunger and increasing disposition during parturition: *"I hope the woman brings a very strong serum for this hunger to pass. He will give me a strength injection [...]. How can a person stay here without eating anything? The baby doesn't have any strength, even I don't have the courage"* (P3); *"They didn't give force injections, they didn't inject serum [...] without eating, without drinking a glass of water, to have a normal 4-kilogram child. I asked I begged, I begged them to put an IV in me because I was hungry, very weak, they wouldn't even let me drink water if it wasn't going to be a cesarean so they wouldn't let me eat?"* (P9).

Cultural theme 4: "They already line up to touch you"

In this cultural theme, we presented the experiences of parturient concerning vaginal examinations.

Upon arrival at the maternity hospital, women are referred for medical screening/clinical and obstetric evaluation. Among the procedures, the women undergo cervical examination and, depending on their clinical condition, they are admitted.

However, after admission, the women reported that the vaginal examinations were consecutive, unnecessary, with risks, and characterized as additional suffering: "*[...] the doctor performed the sterile glove examination [...] the nurse did it again, it was not necessary [...] it can harm the baby*" (P10); "*They did the touch exam [...] they didn't say anything else [...] and did another one [...]. It seems the doctors don't trust what the others said. We are the ones who suffer, who have to go through it again [...]*" (P11); *"Two rings at once, I think it's unnecessary"* (P3).

Vaginal exams are an embarrassing and unpleasant experience when performed without privacy, professional explanations about their indication, and consent: "[...] *or how are you. It's just putting your hand in. There were times when she was embarrassed because there were a lot of people around [...]"* (P11); "*[...] besides being in the middle of a lot of people" (P10); "[...] I had the feeling that he had put the whole arm inside me* [...]" (P3).

Despite the dissatisfaction with the way cervical exams were performed, the women did not express their discontent due to the fear of not being admitted to the hospital: "*And we cannot even complain, because we are afraid of being sent back home [...]*" (P3); "[...*] there were times when they did it two in a row, but I couldn't say anything, complain. I just wanted it all to pass soon, quick to go home [...]*" (P11); "[...] *I don't know why they are still doing it [...] if they already know it's going to be a cesarean [...] I just don't say anything because I'm afraid, because they're doctors, but I don't think it's necessary"* (P6).

During the vaginal examination, the participants in situations of obstetric violence reported that excessive manipulation, pain, and discomfort were higher when exams were performed by doctors and/or male students: "*When he (doctor) was doing the touch [...] I heard him making a joke in the room [...] and I pretended I wasn't even listening. He would say to the other doctor: 'look, man, she's just closing her legs. Was it like this to do it?"* (P9); *"When one of them did the touch*

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test, the other came to do it too, because it was just two. There is already that thing of being two men [...] and they are very aggressive, after the touch exam I was bleeding [...] very nervous, I cried, I was shaking all over [...]" (P6).

These aspects resulted in the reports of dissatisfaction from the informants who perceived that the repetition occurred for academic learning: *"At the time of the touch, the doctor stays and some others [...] this thing is annoying, one comes and does it, then another comes. It makes people sorer; I know it's because they have to learn"* (P6); "*[...] I said to the boy: [...] 'you won't do it again to me. The nurse came to say that they already line up to touch me. I doubt I'll let them, just make one and that's it, they don't boss me around, they don't own my body"* (P1).

Cultural theme 5: "I came with my husband but he can't stay with me!"

In this cultural theme, we present aspects related to the inclusion of companions and the support received during parturition, choices, desires, and experiences of parturient concerning (non) follow-up.

The women reported being alone during the clinical stages of childbirth, mainly because they depended on the availability of a female companion from their social and support network: "*It's worse being alone. If my mother doesn't come, I'll ask my godmother to come with me"* (P2); "*I'm hospitalized and I don't have anyone to stay with me. It's so bad you feel alone"* (P8); "*And since I came alone, it was worse because if you have a companion to speak for you, to talk, to give support, it is better"* (P11).

Some informants had only the presence of their partners at the time of delivery. However, the institution and/or health professionals did not allow male companions: *"My husband had already said that he wanted to attend the delivery. But here they won't let him"* (P2); "*I have my husband to accompany me, but he cannot stay, they say it is because he is a man, he cannot see these things* (P8); "*I saw that many women brought their mother, aunt, a friend, a close person, but since my family lives far away, it was just me and my husband, but he can't come in to stay with me, he stayed outside, in agony without knowing, not knowing if I had already delivered the baby"* (P11).

The women formed a support network in which they provided mutual support. The newly admitted parturient without companions were welcomed by those who were hospitalized and their companions: *"But it was quiet, whoever was in the room saw that I was alone and got closer, started a conversation and this helped"* (P11).

The participants recognized the legal right to follow-up and emphasized that the support they received allowed them to feel more secure as the companion actively collaborated to claim their care needs, making the birth process smooth: "*I thank God for having a companion who helps a lot, and because she is a calm person, so we feel safer, calmer, we have someone to turn to, but also to be a companion, you have to be a person who knows how to talk, explain, seek to understand the reason of things, these medicine people study a lot, but there is a law, we understand something, the internet exists for us to get information"* (P6). *"[...] only now being able to have a companion makes you feel calmer. In the past, we couldn't, we were alone, my first child was here, just me and God. It's because nowadays it's the law, the person has the right to a companion, always had. Now I don't know if the hospitals, the management, accepted it, but here they didn't accept it, I came in and that was it, I was thrown"* (P4).

Cultural theme 6: " The nurses are great, but the interns (nursing) are better"

In this cultural theme, we present the aspects related to how the parturient

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perceived nursing care during the clinical phases of childbirth.

When referring to labor as a 'suffering' due to the uterine contractions pain, some participants qualified the obstetric care as satisfactory because of the birth process speed: *"There was not much suffering because my suffering was spent at home [...] it helped [...] my baby was born quick [...] I thought it was good because I arrived and quickly delivered [...]"* (P10); *"I will not say it was good because pain isn't good, it is suffering, but the care and delivery did not take long [...]"* (P12).

Although one participant was unable to distinguish between the professional categories responsible for providing care: *"To be honest, I only know who is a nurse and who is a doctor if they have their name on the uniform"* (P2). Some reported that the nurses helped attentively during labor (Note: Native category, the participants used the term 'nurse' to designate nursing technicians, nurses, and nursing students): *"The nurses were sweethearts, easygoing, they helped me. I feel grateful, it was a blessing that God put in my life [...]"* (P12); *"The service is good, the nurses care too much about the patients"* (P4).

However, there was a difference in the reports concerning the obstetric care offered by 'old' nurses (service professionals) and 'new' nurses (nursing interns). The parturient had a negative view of the service nurses due to the incipient care during labor: "[...*] the older nurses don't even dare"* (P12); *"Nurses are stone cold [...] from time to time they come [...] they don't take long, they leave in a hurry"* (P7); "[...] t*he nurses are a very busy people, they don't stop to talk properly, they just arrive, do what they have to do and that's it, and we lie there, alone, we can't go out, walk, do anything, like if we were sick"* (P6).

On the other hand, the presence of interns in the service was a determinant of the parturient' satisfaction concerning obstetric care due to the continuous monitoring during the clinical stages of childbirth *"[...] there were some very young nurses helping, talking, saying that we were going to make it, that we were strong* [...]" (P12); "[...] *I was well treated [...] there were three very young nurses helping me, giving me a massage on my back, walking with me in the hallway, and helping with the ball. The pain came, they gave massages, they diminished [...] they helped me, from beginning to end, until the moment the baby was born [...]* (P13); *[...] the nurses are great, but the interns are better because they care about you [...] they stay by your side all day [...], but it also depends [...] if you are lucky"* (P7).

Other informants complained about the imposing attitude of professionals or indifference during care: *"[...] the nurses are boring [...] they arrive wanting to order [...] things to be done, they don't say anything and they think it's bad because the people do not collaborate [...]"* (P5); *"I have been in pain since yesterday, no one came to comfort me, they only come to cause more pain. I'm thrown [...] waiting for God's will"* (P1); *"They don't care about us, I'm just another one who arrives to give birth"* (P3).

Difficulty in obtaining information related to care or the technical language adopted by professionals is evidenced, which made it difficult for the parturient to understand: *"Nurses always say they don't know things we ask, that they can't answer"* (P6); *[...] you ask things they say to ask the doctor [...] they pretend that they are not listening"* (P12); *"I didn't understand [...] they speak in a language that I don't understand. Then I didn't ask either, I kept silent, ashamed"* (P7); "*And the person asks and says things, they don't give much importance, they think we don't understand"*.

Based on their experiences, the women had a negative perception of the work of nursing professionals: "*They don't even ask the doctor, to begin with. How will they know? That's why I say that nurses*

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don't know anything [...]" (P6); *"[...] they only work for the money, they don't have a vocation, the gift of dealing with people, it seems that they don't do it for pleasure"* (P2).

Discussion

The social representation of motherhood identifies parturition as an experience marked by pain and suffering. The expression and reaction to pain as a subjective behavior occurs due to the emotional, environmental, and social interpretation structured by the cultural and ethnic variations of the individuals[14,15,16].

Social representations about pain are historically and culturally infused in the female imagination as they are linked to the discovery and/or resignification of the process of becoming a mother[17]. Thus, it would represent the "price to be paid" that could be "forgotten" with the reward of the birth of the child, reinforcing the connotation of a "good mother" who suffers when giving birth to fulfill her social role[15].

As a result of the naturalization of this aspect, vaginal delivery acquired a connotation of suffering, which means a traumatic experience expected by most women from different cultures[18]. Between screaming and silencing, these reactions relate to the different ways instituted to cope with pain.

Silence can represent courage, strength, self-control, and "symbolic resistance, a refusal to submit to the meanings that the institutional environment imposes on parturient and the birth process"[17:1486]. On the other hand, when women vocalize, it is referred to as weakness and incapacity by opposing culturally constructed representations of pain as a natural and expected event during parturition, which is the object of reprimand from professionals during care[17,19].

Beliefs based on religious values were intrinsically related to the moment of parturition and influenced the woman in this period. Reinforcing this aspect by the historical and cultural consecration of pain as a "punishment for women, its meaning is related to the need to experience pain as a process of purging sin" [18:824] by Eva's disobedience to the word of God and painful childbirth represented "as a suffering of divine design to motherhood" (18:824) which is associated with the biblical passage "To the woman he said, I will make your pains in childbearing very severe; with painful labor, you will give birth to children"[18:820].

Women are prone to cling to religiosity in the hope of receiving divine protection during pregnancy and childbirth[14]. Thus, pain, as a condition inherent to parturition, and religious aspects constitute central cultural elements that determine maternal "suffering" - from an emotional and physical point of view - and, consequently, influence preference for a particular type of labor[14,20].

The symbology around vaginal delivery brings together different views as it can be considered natural, humanized, uneventful, and quick to recover[20] and an intense, painful, exhausting, and terrifying experience linked to pain[15].

Concerning pain, arguments centered on the assumption that women should not be seen as "guilty who must atone, but as victims of their nature"[21:628] have legitimized the excessive use by health professionals of technological interventions such as beneficial to parturition[18].

At the same time that it spreads the fear of feeling pain during childbirth, the culture introjects cesarean section in women as the best form of birth, which is considered an alternative capable of relieving pain and suffering often requested by women and practiced in obstetric care[15,21].

The motivations for performing a cesarean section have been presented paradoxically in clinical practice as they bring together conflicting views related to the medical recommendation, convenience, or interest and the choice, preference, or desire of the woman[6].

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Good practices based on respect for the physiological process, judicious use of available technological resources, and low levels of interventions should be encouraged to promote healthy labor and birth[22]. However, with the institutionalization of childbirth, women are submitted to unnecessary routine procedures and obstetric examinations[3,23].

The World Health Organization (WHO) stratifies care practices related to labor and birth into degrees of recommendation[22]. In the analyzed scenario, the following practices stood out, in detriment of some proven practices that should be encouraged[22:] intravenous infusion during labor (a harmful or ineffective method that should be abandoned), routine use of oxytocin (there is insufficient scientific evidence to support a clear recommendation), restriction of food and fluids during labor, and repeated or frequent vaginal examinations by more than one caregiver (often inappropriate).

As a rule, health professionals prescribe routine fasting for parturient based on the view of childbirth as a pathological event that may, at any time, require surgical intervention, thus avoiding possible complications[24]. However, there is no scientific evidence to support the use of this practice in women at low risk of complications since the restriction of liquids and food does not influence the rates of cesarean sections, instrumental deliveries, APGAR score lower than seven, and duration of labor[25].

Although the National Directive for Assistance at Normal Childbirth recommends liquids ingestion (preferably isotonic instead of just water) for women in labor and light food[26] for women without imminent risk factors for general anesthesia, the rates of diet zero for parturient are high (74.8%)[27].

The use of intravenous hydration as a routine procedure does not present nutritional benefits concerning the supply of liquids and makes it difficult for women to move freely[28]. In addition, negative experiences during parturition may be associated with restriction of oral intake[25].

Data from the 'Nascer no Brasil' survey showed the combination of amniotomy and infusion of intravenous oxytocin under the pretext of active management of childbirth to accelerate normal-risk labor and reduce the number of cesarean sections, with techniques used respectively in 38.2% and 40.7% of the women investigated[27].

However, active management is associated with a small reduction in cesarean rates and its benefits should be considered against the use in women at usual risk since it is considered a prescriptive and interventionist practice[27,29].

In addition, the indiscriminate use of oxytocic is a potentially harmful practice with adverse effects resulting in a cascade of interventions that leads to a series of maternal and neonatal complications, increased pain, and less autonomy, control, and satisfaction in women[29-32].

There is no consensus regarding the regularity, quantity, reasons, and indications for performing vaginal exams[33]. Although they are a diagnostic tool frequently used in clinical decision-making by providing information on the physiological progress of labor[23,34,35], there is no evidence to support or reject the use of vaginal examinations in routine to improve maternal-fetal outcomes[36]. This practice becomes an unnecessary intervention used routinely during care[33] with the potential for adverse consequences[36].

However, in health services, there is a high frequency of cervical exams during labor at short intervals, by several examiners[23,37], especially among primiparous women[23]. Excessive[34], unnecessary[37] indiscriminate, and disrespectful[35] routine vaginal examinations imply negative feelings, risks, embarrassments, and traumas due to the intimate nature that influences women's experience of parturition[23].

In addition to the physical and psychosocial discomforts, some women

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reject cervical exams because they feel like "living models" once many professionals are trained during shifts and their excessive performance occurs for learning purposes, appearing as an aggressive procedure for women, especially when without their participation, understanding, and consent[35].

In practice, learning needs seem to be overvalued at the expense of women's autonomy or bodily integrity, as they do not have the right to choose or to informed refuse[38]. Abuses of this order remain normalized by an institutional culture that does not recognize such acts as violations of rights and shows that the training apparatus approaches women only as the object of its action and continues to reproduce ordered practices[38].

The insertion and participation of the companion of the woman's choice during obstetric care have been pointed out in the literature as a practice proven beneficial for women with the birth experience and favorable maternal/neonatal outcomes[39].

However, with the institutionalization of childbirth, obstetric care subjected women to institutional routines[3,39], determining the removal of their family members, isolation, and restriction to bed in an unknown environment surrounded by strangers, which added to the negative attitudes toward some health professionals regarding care are factors that trigger and potentiate anxiety and fear altering the physiology of childbirth and impose on women a frightening experience of abandonment, sadness, and loneliness[40-41].

Data from the survey *"Nascer no Brasil*" showed that 24.5% of the women did not have a companion at any time during parturition, the main reason being the lack of permission from the hospital (52%)[42]. Institutional compliance with legislation (Federal Law No. 11,108/2005) that guarantees the presence of a companion of the woman's free choice during the clinical phases of childbirth and postpartum must be imperative in health services[40].

The presence of the baby's partner and/or father during the clinical stages of childbirth results in positive feelings associated with birth transmits confidence and security, helps in the formation of the bond with the child and the consolidation of the family bond, configuring itself as an act of valuing women that strengthens the marital relationship[40].

In some hospital institutions, the denial of the right to a companion during parturition associated with the non-establishment of continuous care actions by health professionals results in negative experiences for women such as loneliness, fear, and sadness, the opposite of the principles of humanization of obstetric care[41].

The attitude of health professionals is a determinant of care that has a lot of meaning when attitudes of interest and responsibility permeate care as users feel valued and their health needs are met[43].

However, there is often a fragility from the user in understanding or even a lack of definition, in terms of identity and constitution, of what is obstetric care, as the direct assistance of the nurse during the clinical phases of childbirth is strongly influenced by interventionist medical practices[32] and is compromised due to the centrality of managerial actions, with care attributions sometimes being delegated to others[44].

In this sense, the presence of nursing students is valued by women as they assume a leading role in direct care. This participation approaches a humanized model of childbirth care and reinforces the importance of relational aspects as essential during parturition[45]. The continuous monitoring manifested by proximity, concern, and willingness to care associated with qualified listening to the needs contribute to the comfort of the parturient and facilitate the delivery[41].

However, in obstetric care scenarios, it is evident that health professionals use knowledge-power relationships, underlying discourses of

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appropriation/control of the female body, and of parturition, which legitimize the arbitrary use of care behaviors, violate rights, violate dignity and maintenance of physical, psychological and moral integrity[3,10,16,33,34,37,46]. These situations constitute a type of naturalized violence that demean the assumptions of informed consent, care based on scientific evidence, and the ethical principles that underlie practices in obstetrics[23,35,37].

Thus, is evident the need to implement care and educational programs that train health professionals to develop cultural skills and promote empowerment and autonomy of women to co-participate in actions and decisions[39,47], to overcome the standardization and generalization of care actions to socioculturally contemplate the health needs[48], and contribute to the promotion of culturally congruent care based on the humanization and integrality of obstetric care.

Conclusion

In the present study, participants' experiences regarding obstetric care occurred in a hostile institutional environment, under violations of rights, violence, and practices that emphasize heteronomy and suffering as central elements of the process of becoming a mother.

These experiences were determined by characteristics from the culturally established medical-hegemonic model of care during labor and birth, as it centers on interventionist practices; medicalization, abusive use of techniques and technologies; disregard for women's individuality, and the sociocultural aspects that resulted in the standardization and generalization of care actions, reinforcing the prescriptive and imposing profile of obstetric care.

Ethno-nursing emerges as a method for rescuing cultural experiences of women who give meaning to institutionalized childbirth, revealing dimensions involved in obstetric care, and pointing out ways to reorient the obstetric care paradigm toward culturally congruent care.

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