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CHILDBIRTH ATTENTION: IMPLEMENTATION OF NON-PHARMACOLOGICAL MEASURES TO ALLEVIATE PAIN

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ABSTRACT

Objective: To verify the use of non-pharmacological measures for the relief of pain in childbirth in the city of Ponta Grossa, as well as to identify the profile of women assisted in the gravidic-puerperal period. **Methods:** Quantitative, cross-sectional, descriptive study, carried out in the Maternal and Child Care Network of the city with 379 puerperae through the project "Good practices in labor and birth care". **Results:** The age of the women was predominantly between 23 and 32 years old. The vast majority had a steady partner, self-declared white, had completed high school, occupation was household, with income between 1,500.00 and 2,500.00 reais. During labor, 52.24% of the women did not use non-pharmacological methods for pain relief; when they did, the most frequent was showering, with 26.26%. **Conclusion:** With the obtained results, it is possible to contribute to the obstetric care team regarding the implementation of non-pharmacological methods, seeking to make practices more humanized and less interventionist, respecting women's rights.

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INTRODUCTION

Becoming a mother is a moment that brings with it a set of biological and psycho-emotional changes that lead to the development of responsibilities about oneself and the other, having a child demands acceptation about the transformation process that maternity revels. The apex of the changes occurs during childbirth, where there is a peak of hormonal release and a mix of emotions that often leads to a disorder in the woman's organism (Nagahama and Santiago, 2008; Marins *et al*, 2020). Since the 1940s, childbirth has ceased to be an event performed at home, bringing centrality to hospital institutions, generating an increase in medicalizations and invasive processes for the evaluation and control of the gravidic puerperal period and childbirth, reflecting in the rates of maternal and infant morbidity and mortality (Almeida *et al*, 2015; Andrade *et al*, 2017). In this context, the choice of the type of delivery has been the subject of constant discussion due to the growth of unnecessary cesarean surgeries. In an epidemiological cut, in the last ten years, Brazil had 17,413,292 (54.21%) cesarean sections, 14,665,658 (45.65%) vaginal deliveries, and 14.16% were unspecified.

Looking at the data for Paraná, it is observed that the rates of surgical deliveries exceed half, being 60.58%. At the municipal level, Ponta Grossa performed 29,941 (51.93%) cesarean sections and 27,667 (47.98%) normal deliveries, between 2008 and 2018. Data that reveal a deficiency in the process of naturalization and humanization of childbirth (Ministério da Saúde, 2020). From this perspective, the understanding regarding the interventions performed in parturients facilitates professional performance. It is found that many times procedures are used that exceed the priority limits such as the use of venous access, which reduces the woman's freedom of movement, the lack of choice of birth position, a right to be respected. The lithotomy position facilitates the performance of the professional who assists the birth, but hinders the expulsion process, increasing the rates of unnecessary interventions such as episiotomy (Reis *et al*, 2015; Medeiros *et al*, 2020). Thus, to ensure rights to pregnant women and their newborn children, government programs were created, such as the Program for Humanization in Prenatal and Birth, established by the Ministry of Health, aiming to reduce maternal mortality rates, peri and neonatal, improve access and quality of the gravidic puerperal process, ensure access to the proposed actions and the rights of humanized care to every pregnant woman. The Stork Network and the

Low Risk Prenatal Care Program also present norms and measures of a more humanized assistance to maternal and child health (Ministério da Saúde, 2000; Ministério da Saúde 2011). In this direction, non-pharmacological methods stand out as substitutes for invasive interventions and medicalizations, which have been shown to be allies in the relief of pain in labor and delivery. These measures aim to offer comfort to the parturient woman by means of relaxation techniques, which provide a reduction of stress due to pain, leading to a better progression of labor (Marins *et al*, 2020; Andrade *et al*, 2017). Studies corroborate that the use of pain relief methods involves a set of elements and techniques aimed at the woman's comfort during labor, some of them are the sprinkling bath that causes relaxation and control of stress and anxiety levels, causing a reduction in pain complaints, the massage, commonly performed in the lumbosacral region, acts on the nervous system, allowing the release of hormones that stimulate relaxation and well-being, improving the woman's mood and consequent pain relief (Ministério da Saúde, 2011; Dias *et al*, 2018). The use of the Swiss ball aims to increase pelvic mobility, facilitating the descent of the fetus and enabling the adoption of vertical postures of the parturient, reducing the time of labor and helping the pain levels, it can be used associated with other methods, such as bathing, a combo that leads to greater relaxation and reduction of pain in women (Ministério da Saúde, 2011; Dias *et al*, 2018). Other methods that are allies at this time are the physical and emotional support that brings comfort and safety to the moment, enabling the best course of the birth, free movement is of great help to allow the woman to adopt the most comfortable positions for her. Breathing control is relevant for pain management, because it brings self-control to the woman and improves concentration, reducing the perception of pain. The use of music therapy and aromatherapy also bring benefits when correctly applied (Mascarenhas *et al*, 2019; Biana *et al*, 2021). Regarding the use of non-pharmacological measures for pain relief in labor and delivery, a study is necessary to understand in which population groups these measures are more common and the relationship with sociodemographic data, verifying the main reasons for implementing these measures and knowledge about the subject that is part of the rights of pregnant women, also evaluating the commitment of health teams in relation to raising awareness of pregnant women about good practices, seeking to understand the reasons for this lack of experience on the implementation of non-invasive measures (Almeida *et al*, 2015; Andrade *et al* 2017). Thus, the following question is asked: what non-pharmacological measures for pain relief during the labor and delivery process are used in the municipality of Ponta Grossa, Paraná?

Considering the scenario of hospitalization and systematization of childbirth, there is a need to raise awareness of the population regarding the approach of normal birth with more humane measures and the use of non-pharmacological methods for pain relief in childbirth, which involve from the presence of a companion to the use of measures that lead to a relaxation of the parturient woman, providing a better evolution of labor and delivery (Moura *et al*, 2007). These good practices of care should be increasingly frequent in the care of pregnant women and need to be addressed since prenatal care, so that when they arrive at the maternity ward they know the benefits that non-pharmacological measures bring and are more empowered of their rights. Faced with this demand, the team, especially the nursing team, needs to be active in providing guidance and clarifying doubts in order to transmit knowledge about the benefits of such practices. Also, set goals and encourage the implementation of these measures so that this population is reached and benefited, aiming that women's rights are ensured in accordance with current public policies (Andrade *et al*, 2017; Moura *et al*, 2007). Thus, the present study aimed to verify the use of non-pharmacological measures for pain relief during labor and delivery in the city of Ponta Grossa, as well as to identify the profile of the women assisted.

METHODS

Quantitative, cross-sectional, descriptive study, carried out in the Maternal and Child Care Network of the city with 379 puerperae through the project "Good practices in labor and birth care". The research data collection was performed in the vaccine waiting room of a children's hospital by previously trained nursing students. The instrument was a structured questionnaire containing information on sociodemographic characteristics, as well as issues related to pregnancy, labor and birth, and non-pharmacological measures for pain relief in labor. For this study was used the following variables from the database of the referred project, sociodemographic : age, marital status, color/race, profession, family income; related to childbirth: type of delivery and option of choice, professional who performed the delivery; related to the rights of pregnant women: observe if there was the presence of a companion, the use of oxytocin and non-pharmacological methods, water and food intake, the use of restraint, respect for privacy, clarification of doubts and rights throughout the delivery process; identify how the immediate puerperium was, if there was immediate contact with the baby, breastfeeding in the 1st hour and joint housing.

Table 1. Socioeconomic profile of the participating women during the data collection period at the Children's Hospital. Ponta Grossa– Paraná, 2022

Variable	n	%
Age group		
13 to 22 years old	98	25,86%
22 to 32 years old	*202*	*53,30%*
33 to 45 years old	79	20,84%
Marital status		
married	*179*	*47,23%*
Common-law marriage	67	17,68%
single	123	32,45%
divorced	9	2,37%
widowed	1	0,26%
Schooling		
illiterate/ until third year of elementary school	1	0,26%
until forth year of elementary school	1	0,26%
incompleteMiddle school	64	16,89%
completed Middle school	19	5,01%
incomplete high school	59	15,57%
completed high school	*134*	*35,36%*
incomplete Bachelor's degree	29	7,65%
completed Bachelor's degree	72	19,00%
Color/ race		
White	*260*	*68,78%*
black	18	4,76%
mixedrace/ mestizos	92	24,34%
yellow	6	1,59%
indigenous	1	0,26%
Didnotanswer	1	0,26%
Profession		
Domestic/ household	*172*	*45,38%*
student	22	5,80%
professor	20	5,28%
salesperson	10	2,64%
self-employed	8	2,11%
Other	147	38,79%
Family income		
UptoR$250,00	7	1,85%
FromR$250,00 to500,00	8	2,11%
from R$501,00 to 1.500,00	84	22,16%
From R$1.501,00 to R$2.500,00	*140*	*36,94%*
From R$2.501,00 to4.500,00	78	20,58%
From R$4.500,00 to 9.500,00	35	9,23%
More than R$9.500,00	11	2,90%
Do not know/ did not answer	16	4,22%

Source: Authors (2022)

The study included 379 puerperae, a probability sample calculated from the number of births in the city to allow statistical inference, considering a margin of error of 5%, confidence interval of 95%, and prevalence of the grievance of 50%, which allows calculating the largest possible sample. Inclusion criteria were: puerperal women users of the municipality's Health Network. Data were collected in the period from December 2018 to March 2019 and analyzed in the Statistical Package for the Social Sciences (SPSS) for Windows, version 15.0 and Stata version 11.0. and the results described in

frequency. To respect the ethical precepts, the study was approved by the Research Ethics Committee (REC) of the State University of Ponta Grossa (UniversidadeEstadual de Ponta Grossa - UEPG), under Opinion number 3.051.060.

RESULTS

The age of the women was predominantly between 23 and 32 years old. The vast majority had a steady partner, self-declared white, had completed high school, occupation was household, with income between 1,500.00 and 2,500.00 reais. During labor, 52.24% of the women did not use non-pharmacological methods for pain relief; when they did, the most frequent was showering, with 26.26%. In relation to childbirth, more than 50% of the puerperae reported not having the option of choice, the rate of cesarean sections exceeds half of the type of delivery performed by women. The professional who attended the births was predominantly the doctor. Among the interventions during birth, almost all mention the presence of a companion and a little more than half made use of oxytocin, as shown in Table 2.

Table 2 Type of delivery, professional who performed the delivery, and interventions during labor. Ponta Grossa– Paraná, 2022

Variable	n	%
Had option to choose labor position		
Yes	154	40,63%
No	*224*	*59,10%*
Did not know how to answer	*1*	*0,26%*
Type of delivery		
Cesareansections	*196*	*51,72%*
Vaginal sections	183	48,28%
Professional who performed the delivery		
Doctor	*339*	*89,45%*
Nurse	33	8,71%
Others	3	0,79%
Did not know how to answer	4	1,06%
Presenceof a companion		
Yes	*355*	*93,67%*
No	24	6,33%
Continuous use ofoxytocin		
Yes	*251*	*66,23%*
No	128	33,77%
Freedom to move and change position during labor		
Yes	189	49,87%
No	*190*	*50,13%*
Waterand food intake		
Yes	163	43,01%
No	*216*	*56,99%*
Use ofrestraint		
Yes	32	8,44%
No	*347*	*91,56%*
Immediate contact with the baby		
Yes	*340*	*89,71%*
No	39	10,29%
Breastfeeding in the 1st hour		
Yes	*293*	*77,51%*
No	85	22,49%
Joint housing		
Yes	*350*	*92,35%*
No	29	7,65%
Respecting the woman's right to privacy in the delivery room		
Yes	*358*	*94,46%*
No	21	5,54%
Clarification of doubts and information		
Yes	*346*	*91,29%*
No	31	8,18%

Source: Authors (2022)

During labor, half of the women said they did not use non-pharmacological methods for pain relief, as shown in Table 3. Of the women who reported using such methods, the most frequently cited were bathing and using a ball. There were women who used more than one method of pain relief. Of the 179 women who used pain relief methods, 12 had no prior knowledge of showering as a relief measure.

Table 3. Non-pharmacological methods for pain relief used during labor. Ponta Grossa– Paraná, 2022

Variable	n	%
Use of non-pharmacological methods		
Yes	179	47,23%
No	198	52,24%
did not answer	2	0,53%
Method		
Use of the ball	9	5,03%
Showering	*47*	*26,26%*
Massage	1	0,56%
Chair (cavalinho)	0	-
Exercises	1	0,56%
Other	1	0,56%
Combined methods		
Use of 2 methods	*81*	*45,25%*
Use of 3 methods	30	16,76%
Use of 4 ou 5 methods	5	2,79%

DISCUSSIONS

Regarding the sociodemographic profile, the findings are in agreement with the studies carried out in the cities of Sorocaba (SP) and Porto Alegre (RS), which indicate a predominance of young women in favorable age for pregnancy, with a fixed partner, declared white, with complete high school education, housewives, with income between R$1,500.00 and R$2,500.00 (Almeida *et al*, 2015; Mielke *et al*, 2019). It is noteworthy that more than half of them did not have a choice of position on the birth. Data that interferes directly with the comfort of women, the vertical positions bring greater benefits, more rhythmic and regular contractions, improved uterine dynamics and shorter duration of delivery, there is also a help of gravity (Nilsen *et al*, 2011). In a study conducted in Porto Alegre in 2016, women could choose the delivery position, 62.5% chose to have their baby semi-sitting, 14.7% lateralized, 7.3% squatting and 3% in four supports, only 12.5% gave birth in the lithotomic position (Lehugeur *et al*, 2017). In another study, conducted between the years 2008-2009, brings a more appropriate result for the choice of positions, being prevalent the semi-sitting with 186 and in left lateral decubitus with 186 parturient, only 46 chose the lithotomic position (Nilsen *et al*, 2011). It is noticed that there is a predominance of the lithotomy position in births in Brazil, a position that leads the woman to have less independence in her labor, hindering the movement, increasing suffering, fatigue, the duration of the expulsion period and obstetric interventions. It is worth emphasizing the importance of encouragement by the professionals of assistance to women regarding the choice of position, since the vertical ones are more advantageous (Nilsen *et al*, 2011).

Slightly more than half of the deliveries performed were cesarean sections, in contrast to the study that shows a normal delivery rate of 76.3%. In this context, it should be noted that the World Health Organization (WHO) recommends that the total number of cesarean deliveries should be 15% in relation to the total number of deliveries performed in a health service (Mielke *et al*, 2019; ANS). As for the professional who assisted the delivery, the present study points out similarity to that performed in Maringá (Nagahama and Santiago, 2008), in which the medical professional was the protagonist, evidencing the doctor/patient domain that is still very explicit, from the beginning of the hospitalization of the delivery, it is perceived that the doctor inspires confidence and professionalism for the resolution and conduction of the whole process, but there is an increase in interventions and procedures that are often unnecessary (Leal *et al*, 2020). Many women have the erroneous view that the medical professional is the most qualified to conduct the birth and decide issues related to it, such as the route of delivery and the position to be born, for example, depriving the freedom and right of choice of

women in all factors related to pregnancy and parturition, it is seen and guaranteed that who should conduct the birth is the woman (Leal *et al*, 2020). Related to the companion, studies (Andrade *et al*, 2017; Souza *et al* 2021) show the presence in more than half of births that occurred, being in agreement with the present study that had a positive result for the presence of the companion of the woman's choice. The presence of a companion is a woman's right and is guaranteed by Ordinance No. 1,459 of June 24th, 2011 establishing the Stork Network (Ministério da Saúde, 2011). It is proven that the presence of companions throughout the gestational process, delivery and postpartum brings considerable benefits, emphasizing that the companion is a fundamental part of protection and promotion of good practices in assistance, and can be seen as a measure of pain relief, associated or not with other methods. Having someone who is trusted provides the woman with greater security and tranquility to go through the entire process, especially the pain, besides reducing the rates of cesarean sections and the duration of labor, leading to a positive view of the woman in relation to the entire progress of labor, making birth more natural and humanized (Nascimento *et al*, 2010).

As for oxytocin, most parturients made continuous use, often unnecessary intervention, because not all women have the indication for its use, and it may be beneficial to contain bleeding, for example, or accelerate a labor that is evolving within the expected time. This practice is considered harmful according to the Good practices for labor and birth care booklet organized by the WHO (WHO, 1996). Freedom to move around and change position during labor were not an option for a little more than half of the parturients. Better results were expected, since these actions should be encouraged for the best progress of the birth (Souza *et al*, 2021). A study (Lehugeur *et al*, 2017) showed that 58.8% of women varied positions during labor, in another women had this freedom, being able to change positions throughout labor, it is observed in this research that the information of which position was used more was not obtained, due to the alternation of positions and postural adjustments made by women (Nilsen *et al*, 2011). Walking can be considered a measure of pain relief, in a study (Andrade *et al*, 2017), this method was applied in 16.2% of labor. Another practice, the ingestion of liquids, in the present research falls short of the study (Lehugeur *et al*, 2017) in which 77.5% of women accepted clear liquids during labor, evidencing that the woman's right to light food and fluid intake throughout the process was not considered (Ministério da Saúde, 2014). Regarding the immediate contact with the baby and breastfeeding in the first hour of life, most parturients were able to experience these moments. This was an expected result, since these practices belong to the "Golden Hour", a term used for the first hour of life of the newborn, which includes techniques that bring benefits to the mother and the baby, providing the first mother-baby contact, providing the beginning of breastfeeding stimulus, increasing the bond, also helping uterine involution by the release of oxytocin that breastfeeding provides, reducing the risks of postpartum hemorrhage, among others (Abdala and Cunha, 2018).

Regarding the immediate contact with the baby, one research (Nagahama and Santiago, 2008) registered that most of the newborns had skin-to-skin contact with the mother soon after birth, and another (Andrade *et al*, 2017) evidenced that half of the women had skin-to-skin contact with their child in the first moment of life. The joint housing was also possible for most of them, allowing the newborn to stay with his mother during the entire hospitalization, strengthening the mother-child bond in the first hours of life, promoting the experience of routine care exchange, breastfeeding, and the father's participation in the whole process of baby care (Rogerio *et al*, 2020). Almost 100% of women reported that they were not restrained, had their privacy maintained and their doubts clarified. A result that meets the Good Practices for Childbirth and Birth, showing that these rights were respected (WHO, 1996), positively influencing the comfort in labor and delivery. Related to non-pharmacological methods for pain relief, slightly more than half of the parturients did not have access to these benefits. As in a study conducted by Andrade (Andrade *et al*, 2017), showing a percentage of only 23.1% for women who used pain relief methods. Results that make us question the offer of these methods to women, since it is evident that the knowledge about them is superficial. The use of non-pharmacological methods for the relief of pain in childbirth is part of a process related to the humanization of childbirth care, which involves prenatal, delivery, and postpartum, aiming to rescue the physiological process of being born, leading to a positive birth, without trauma, with the woman being the protagonist. For there to be the implementation of measures that favor the humanization process, it is necessary to qualify the assistance teams, especially those who work directly with women, aiming to reduce unnecessary interventions, respecting the aspects of human physiology (Moura *et al*, 2007). For the team to have confidence and security about these methods, it is necessary to bring evidence that proves the benefits that their use brings to the woman in her process of parturition, requiring a set of educational actions for this understanding, increasingly seeking the implementation of a humanized system. From this, the application and offer of pain relief methods will be better accepted and understood by the community in general, because it is the function of assistance to bring knowledge through health education, increasingly ensuring the humanization of the entire gravidic-puerperal process (Moura *et al*, 2007; Oliveira *et al*, 2013).

Research (Nagahama and Santiago, 2008) carried out between 2005 and 2006 in two hospitals in Maringá contrasted with the result of the present study, showing a percentage of 67.3% for the use of at least one pain relief method. Another study, in a public maternity hospital in Goiás, brings positive results regarding the use of these measures, indicating a percentage of only 18.4% for not using any method (Hanum *et al*, 2017). In a city in Rio Grande do Sul, it was also found a wide use of non-pharmacological methods for the relief of labor pain and freedom of position during labor, with coverage of 90.5% of women, leading to a reduction of obstetric interventions that occurred in 44.4%. Assistance with fewer interventions, respecting the physiological process of parturition, leads to greater satisfaction of women regarding childbirth, increasing their self-confidence in their ability to give birth, providing safety and comfort for the entire process (Reis *et al*, 2015). Regarding the method most used by women, most studies agree on the warm bath. We noticed a preference for it in this study with 26.26% and in other studies with 84.5% (Medeiros *et al*, 2015) and 48.2% (Nagahama and Santiago, 2008). Some studies show that walking is preferred by women with 85.2% (Reis *et al*, 2015) and 16.2% (Andrade *et al*, 2017). In the present study, the combination of more than one pain relief method had a very relevant percentage, reaching more than half of the parturients with 64.8%. As well as in research that had 72.7% of women who used more than one method. It is evident that the association between the methods leads to greater benefits in relation to pain relief, improving the woman's experience of childbirth (Medeiros *et al*, 2015).

It is complemented about the importance of the obstetric nursing team in humanizing the entire routine of the care process, as well as the doctor, nursing has a key role throughout the process of parturition. It is emphasized that the nursing care model is focused on care and the general aspects of the reproductive process, from physiological to emotional, differentiating them from the medical professional (Nagahama and Santiago, 2008). Therefore, it is evident that the nursing approach should be comprehensive, seeking ways to minimize the bad experiences of patients, improving in the application of non-pharmacological methods for the relief of pain in childbirth, being listeners and responsible for a humanized care that leads to the well-being of women, making childbirth a pleasurable moment. It is considered that a caring assistance and approach increases the professional-patient bond, improving the woman's positive experiences, often helping with the pain (Nagahama and Santiago, 2008; Nascimento *et al*, 2010). Thus, the results obtained in the research can contribute to the teams that provide obstetric care in the municipality to rethink their practices, based on scientific evidence for the use and expansion of the offer of non-pharmacological methods for the relief of pain during labor and delivery, generating an improvement in the quality of parturition in

the municipality, rescuing the protagonism aiming to provide safe, humanized care, in addition to maintaining a less interventionist care.

CONCLUSION

The use of non-pharmacological methods for the relief of pain in childbirth in the city of Ponta Grossa is present, but its application is still scarce. Most women studied were young, with a steady partner, declared to be white, with complete high school education, household occupation and average income between 1,500.00 and 2,500.00 reais. The percentage of non-use of non-pharmacological methods for pain relief stands out from those who used some method. It is evident the need to raise awareness of the population in general about the benefits that non-pharmacological methods for pain relief in labor bring, especially the team that works directly in assisting the delivery process. Therefore, it is emphasized that the education of these professionals must be permanent, seeking the improvement of humanized care. It is concluded with the results of the present study, the need for the evolution of labor and birth care practices, especially by the nursing teams that have a fundamental role in the application of these measures, because they act directly with the patient and can interfere positively or negatively in her birth, making the application of pain relief methods relevant, contributing to the positive experience of the woman in relation to the entire process of parturition, reducing the rates of unnecessary obstetric interventions, leading to a humanized and respectful care. It is hoped that this study will contribute to future research on the subject, aiming at the advancement of humanized obstetric practices, respect for the physiological process of childbirth, and ensuring women's rights. As for possible limitations, it is worth mentioning the fact that some of the participants did not recognize some of the measures employed as opportunities for pain relief during labor and delivery, which shows that the methods are little addressed by professionals during prenatal and labor care.

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