Vaginal birth and the female body in the puerperum: Contributions to obstetric nursing

RESUMO | Objetivo: descrever os significados e os sentimentos da mulher após o parto vaginal e identificar como a atuação da enfermagem obstétrica pode contribuir para melhores experiências no puerpério. Método: Pesquisa fenomenológica heideggeriana com 14 mulheres que passaram pelo parto vaginal. Realizada entrevista aberta audiogravada, para a constituição da Unidade de Significação e da compreensão vaga e mediana. Resultado: O vivido e os sentimentos da mulher após o parto vaginal significaram: ter medo de fazer sexo, sentir dor na relação sexual, achar que não ia voltar a ser normal, sentir o corpo diferente de antes, achar que a relação sexual mudou, perder o desejo sexual. Conclusão: A atuação da enfermagem obstétrica é necessária para melhores desfechos frente ao medo e à adaptação da puérpera ao retorno da atividade sexual, pontuando ações simples para a sexualidade da puérpera/casal, como: cuidados de higiene, uso de lubrificantes e estímulo à retomada da intimidade sexual.
Descritores: Mulheres; Parto normal; Período pós-parto; Enfermagem obstétrica; Filosofia.

ABSTRACT | Objective: to describe the meanings and feelings of women after vaginal delivery and to identify how the performance of obstetric nursing can contribute to better experiences in the puerperium. Method: Heideggerian phenomenological research with 14 women who underwent vaginal delivery. An open audio-recorded interview was carried out, for the constitution of the Meaning Unit and vague and median understanding. Result: The experience and feelings of the woman after vaginal delivery meant: being afraid of having sex, feeling pain in sexual intercourse, thinking that it would not go back to being normal, feeling the body different from before, thinking that the sexual relationship has changed, lose sexual desire. Conclusion: The performance of obstetric nursing is necessary for better outcomes in the face of fear and the adaptation of the puerperal woman to the return of sexual activity, punctuating simple actions for the sexuality of the puerperal woman/couple, such as: hygiene care, use of lubricants and encouragement to resume of sexual intimacy.
Keywords: Women; Normal birth; Postpartum period; Obstetric nursing; Philosophy.

RESUMEN | Objetivo: describir los significados y sentimientos de las mujeres después del parto vaginal e identificar cómo la actuación de la enfermería obstétrica puede contribuir para mejores experiencias en el puerperio. Método: Investigación fenomenológica heideggeriana con 14 mujeres que tuvieron parto vaginal. Se realizó una entrevista abierta grabada en audio, para la constitución de la Unidad de Significado y comprensión vaga y mediana. Resultado: La experiencia y sentimientos de la mujer después del parto vaginal significó: tener miedo de tener relaciones sexuales, sentir dolor en las relaciones sexuales, pensar que no volvería a ser normal, sentir el cuerpo diferente al anterior, pensar que la relación sexual ha cambia, pierde el deseo sexual. Conclusión: La actuación de enfermería obstétrica es necesaria para mejores resultados frente al miedo y la adaptación de la puérpera al retorno de la actividad sexual, puntuando acciones simples para la sexualidad de la puérpera/pareja, tales como: cuidado de la higiene, uso de lubricantes y estímulo a la reanudación de la intimidad sexual.
Palabras claves: Mujeres; Parto normal; Período posparto; enfermería obstétrica; Filosofía.

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INTRODUCTION

Women experience the pregnancy-puerperal process marked by changes considered normal and inherent to this moment, being physical, social and emotional. This situation can be aggravated when this woman, while parturient, undergoes interventions, even unnecessary ones, which have repercussions for the puerperal period, with limitations also in her self-esteem and sexuality. For a satisfactory experience in childbirth and in the postpartum period, the assistance provided at the time of childbirth must value the role of women, the physiology of childbirth and comprehensive and humanized care. [1]

Qualified obstetric care, rethinking the Brazilian obstetric model, also through the Stork Network, includes the presence of obstetric nurses and midwives with an evidence-based model of care, with shared work, guaranteeing women's sexual and reproductive rights and reducing unnecessary interventions. An example of these interventions is episiotomy not routinely recommended, as it can cause complications such as: pain in the birth canal, decreased sphincter control, dyspareunia, poor healing and decreased sensitivity in the genitalia, which affects the daily lives of many puerperal women. [2]

Efforts are ongoing to consider normal childbirth as a natural and physiological event, assisted by humanized care, but there are still difficulties in putting this into effect, as revealed in the research Born in Brazil: a national survey on labor and birth. This survey points to worrying rates about procedures, such as: more than 70% of women are punctured in labor; 37% suffer Kristeller maneuver; 56% undergo episiotomy; and many are deprived of having a companion. [3-2]

In the puerperium there are changes even in female sexuality due to the new reality as a mother, with her body and with the relationship with her partner, as there may be discomfort and comparison with the body image before pregnancy. Faced with this, it is important to understand and dialogue about the new phase and the couple's adaptation. The Ministry of Health (MOH) emphasizes the consequences of fulfilling sexual rights, such as autonomy to make decisions about the use of the body, freedom of expression, valuing female sexuality and actions to do so. [4]

It is important to maintain the approach between health professionals and patients since prenatal care, with actions of dialogue about lived experiences, discussing female sexuality and relating subjective aspects with objectives in the postpartum period. It is observed that the focus on female sexuality is still neglected, which has implications for women's health. [5]

The actions/guidelines for pregnant women are also deficient, and it is more common to address: the signs of severity in pregnancy, the risks of self-medication, smoking and alcohol consumption, the guidance of having a companion during childbirth, the link between the pregnant woman and the motherhood and empowerment for a good pregnancy, childbirth and postpartum period. In order for care to take place in an integral way from pregnancy to the puerperium, obstetric nursing is capable and committed to developing this. [6]

For the postpartum period, the MH recommendation is to direct the continuity of care to the puerperal woman before hospital discharge with a complete report on the birth and immediate and mediate postpartum. A home visit is also essential in the first week after discharge, because many women forget to return to the These actions are necessary in situations such as those reported in a study with puerperal women carried out in Recife, pointing out: very quick consultations, incomplete physical examination (restricted to the evaluation of the breasts and the way of delivery); baby-centered care and contraception, with insufficient guidance. [7]

The study is justified by the fact that the puerperium is a time of physiological, psychological and social changes in women's lives, which can also interfere with sexuality and demand adjustments in daily life and reorganization of sexual activity, compared to the period before pregnancy, which can take up to 12 months to materialize. [8]

Reflecting the event of vaginal delivery and the changes in the woman's life after it, the guiding questions of the research are: How did the woman feel after vaginal delivery? Does the parturition process contribute negatively to female sexuality? How can obstetric nursing contribute to better experiences? And as objectives: to describe the meanings and feelings of women after vaginal delivery and to identify how the performance of obstetric nursing can contribute to better experiences in the puerperium.

METHOD

Qualitative research in the area of obstetric nursing, supported by the Heideggerian phenomenological approach. The proximity of nursing studies with phenomenology is due to the characteristics of phenomenological thinking, which enables understanding through descriptions of the experiences lived by subjects, rescuing

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subjectivity and reaching the essence of the other. Thus, this approach aims to describe the phenomena as they occur, manifest and reveal their essence, in an intersubjective relationship. [9]

The study setting was not a specific location, but chosen by the interviewees: their home, work or place of study, in the cities of São Fidélis and Campos dos Goytacazes, in the state of Rio de Janeiro. The field stage took place from September 2018 to April 2019. The participants were 14 women who underwent vaginal delivery. They were invited through informal conversations, randomly and in the following way: the first woman was invited to the college where she studies, the researcher explained about the research and, thus, the other participants were indicated to each other. This referral procedure is called the Snowball technique.

Women over 18 years of age and under 60 years of age were included. Adolescent women were excluded due to the need for consent to participate in the research, which could delay the field stage. Women aged 60 years and over were also excluded, as they had the experience of childbirth in a longer period of time between their reproductive age and the current moment of their lives, with the possibility of not being able to detail what was experienced.

This number of interviewees was not pre-established, since for the phenomenological approach, data sufficiency, also called saturation in other methods, happens when the objectives are answered. In qualitative studies, an exact norm is not stipulated for the time in which the interviewer needs to remain in the data collection, being enough to identify the repetition of information, the redundancy, that is, the phenomenon apprehended, to stop the collection. [10]

After acceptance, a meeting was scheduled, mediated by ambiance, empathy, dialogue and subjectivity. The Free and Informed Consent Term (FICF) was signed and the open interview started. Participants were identified by codes and numbers, according to the order of interviews (E1, E2 and so on). A semi-structured script filled with information regarding the woman was used: age, number of children, partner, sexual activity, gynecological and obstetric history, option for normal childbirth, receiving information about childbirth and through whom, experiences during pregnancy and childbirth and assistance received.

> “In the puerperium there are changes even in female sexuality due to the new reality as a mother, with her body and with the relationship with her partner, as there may be discomfort and comparison with the body image before pregnancy.”

Following the script, the open interview in the audio-recorded phenomenological modality was started. To obtain the open discourse, the following guiding questions were also used in the script: How was it for you to experience normal/vaginal delivery? How did you feel about your sexuality? What did vaginal delivery mean to you? In the phenomenological interview, the interviewer needs to put his existing ideas in parentheses, suspended, so that the lived experiences are richly described and to arrive at the structures of meaning. [11] After recording, attentive listening, reliable transcription and the analytical step were performed.

The analysis in phenomenological studies is based on the description of the lived phenomenon contained in the discourse, enabling the understanding of meanings through the constitution of Meaning Units (M.U.), vague and median understanding and hermeneutics, a stage of unveiling the Heideggerian meanings. We emphasize that this study advanced to vague and median understanding. Understanding demonstrates the possibilities of being and human experiences in the lived world, describing the phenomena as they are manifested and constituting the existence of the being-itself, also called Dasein. [12]

Qualitative studies such as this one have been carried out based on increasingly improved methodological rigor, using the Consolidated Criteria for Reporting Qualitative Research (COREQ) guide, which presents a list of procedures for the adequacy of manuscripts. This research was approved by the Research Ethics Committee of Faculdade São Fidélis - Society of Education, Culture and Technology São Fidélis LTDA - EPP, through Plataforma Brasil, with opinion number 2,763,518 and CAEE: 92477618.1.0000.8046. Study respecting the guidelines of Resolutions 466/2012 and 580/2018 of the National Health Council regarding ethical aspects, anonymity, data integrity and confidentiality.

RESULT

It was revealed that the participants were aged between 22 and 41 years. Most have a partner, active sex life and decided to give birth vaginally. Many interviewees did not receive information about this birth and what life would be like after it.

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The meanings described by the interviewees make up what in other studies is called a category, the Meaning Unit (M.U.), which presents parts of the interviewees' testimonies and has its header also formed from the speeches. The constitution of these units is made possible by the open discourse, generated from the guiding question of the phenomenological interview, where the essence of women emerged in response to the objective of the study.

In the description of the meanings, the experience and feelings of the woman after vaginal delivery meant: being afraid of having sex, feeling pain when returning to sexual activity, perceiving the body and sexual desire different from before and thinking that everything would not go back to normal because of some difference in the birth canal:

> [...] at first I was kind of scared [...] relationship with my husband [...] it seemed that everything was tight [...] I had stitches [...]. (E1)
>
> [...] I thought I was all blown up [...] you think about the sexual relationship, that you'll never get it again [...] I never wanted ["so-and-so", the husband] to touch me again [...] You feel pain [...] you get stiff [...] there was no lubrication [...]. (E2)
>
> [...] I was afraid to have sex [...] I was afraid that it would burst and I would start to bleed and I would die there [...] I said: no, only after 6 months! [...] I didn't think I was pretty, I thought I was ugly [...]. (E4)
>
> [...] I started to feel pain [...] we get very tired [...] the lust goes away and you are just a breast [...] we started to try [...] I felt pain [...] I felt that I was hurt inside [...] I was very scared [...] afraid [...] will it really heal [...] I had to take it a little point [...] I had no pleasure [...] then I had a little problem during sexuality, yes! [...]. (E5)
>
> [...] I don't want [sex] anymore [...] because it looks like it's going to open [...] this feeling [...] could touch the stitches [...]. (E8)
>
> [...] It was only with the cut mark [...] some sexual relations that I had, it hurt, burned [...]. (E10)
>
> [...] you are already terrified: hey, am I going to be like this [...] the prejudice itself, sometimes the man [...] he had this concern a lot [...] you get a little scared [...] that issue of the stitch, which hurts a lot [...] when you urinate, that is horrible [...] it burns too much [...]. (E12)
>
> [...] I felt that it has not returned to normal until today [...] the libido has not returned as it was before [...] like it lost a little sensitivity [...] to this day it is kind of numb still [...] the place that performed the episiotomy, it's like pulling [...] it hurts [...] the sexuality part, for me, was worse [...].(E13)
>
> [...] Ahhhh, it got a lot worse [...] I wasn't worried about the body before, but later, I found a lot of change [...] even for me to have sex again after delivery it took a long time [.. .] I couldn't even think about it [...] I was very afraid of hurting [...] and it hurt [...] a lot! [...] if I could, I would do that surgery to fix everything [...] he [husband] said it was different [...]. (E14)

These M.U., which present the meanings and describe the phenomena as they were manifested, provide support for the analytical stage.

DISCUSSION

The discussion in phenomenological studies is called vague and median understanding in the interpretation of meanings and in the discussion of these findings with productions on the subject.

In Brazil, efforts are ongoing to reduce the high frequency of cesarean delivery in public and private hospitals and to increasingly encourage natural childbirth. In 2015, the National Supplementary Health Agency (ANS - Agência Nacional de Saúde Suplementar), together with the Institute for Health Improvement (IHI) and the Hospital Israelita Albert Einstein, implemented, supported by the MH, the Adequate Childbirth Project for actions such as: improving the quality and safety of childbirth care, identifying innovative and scientific care models, valuing the empowerment of women, enabling family participation in the parturition process and ensuring the physiological evolution of childbirth. [13]

The woman's decision and positive experiences about normal childbirth are influenced by the assistance received from prenatal consultations, which, in addition to the assistance itself, should provide guidance on how the gestational period, labor and the postpartum period are. The prenatal consultation also contributes to the reduction of maternal and fetal morbidity and mortality and contributes to positive postnatal results by providing complete information about childbirth and the puerperium. [14]

The puerperium is a time of transformations and changes for women, such as: stress, fatigue, low self-esteem, lack of time for themselves and the vulnerability of sexual dysfunction. This dysfunction can be caused by pelvic floor muscle trauma and perineal trauma, evidenced by decreased arousal, libido, lubrication and pleasure. [15]

Discomforts in the birth canal occur as a result of physiological situations of trauma or interventions, such as episiotomy. Procedure not recommended in a healthy body and not without the consent of the parturient, as it violates sexual and reproductive

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rights. Data indicate that many women are still subjected to episiotomy unnecessarily. The World Health Organization (WHO) does not intend to prohibit the procedure, but to restrict it to situations considered necessary. [2]

The return to sexual life, marked by fear of having sex, pain and reduced libido, goes against the fact that there are many factors that influence sexual activity: hormonal changes, depression and insufficient knowledge about sexuality, thus contributing to dissatisfaction in sexual life. [16-17]

The sexual response will depend not only on physiological experiences, but also on psychological ones, and it suffers interference in any type of delivery, being perceived with more fear after vaginal delivery, which can cause trauma due to compression of the fetal head. However, there is no evidence that this type of delivery is more harmful to future sex life compared to cesarean section. [5]

These sexual experiences, considered negative, can be avoided when the woman receives timely information regarding the return to sexual life, which is still insufficient, both for those attended by the doctor and the nurse. These professionals need to be more sensitive, deconstructing false beliefs and taboos, going beyond the approach to sexually transmitted infections, addressing possible sexual dysfunctions in the puerperium and valuing the psychosocial well-being of women. This approach should involve empathic and enlightening communication. [17]

The nurse is able to provide comprehensive assistance to women in the pregnancy-puerperal process, offering information related to the puerperium, a period permeated by: estrogen and progesterone deficit, increased prolactin, loss of sexual desire, libido and vaginal lubrication, dyspareunia , fear and concern with the return to normality of the genital system and with the possibility of a new pregnancy, situations that interfere in the woman's sexual life. The nurse should advise on: the use of lubricants, encouraging dialogue and rapprochement with the partner, returning to the couple's intimacy, family planning in the postpartum period and any clarification considered important for the moment. [4]

The performance of obstetric nursing is revealed as an important tool of public policies for childbirth care, bringing reflections and proposals for change in the technocratic model of obstetric medical care. And, based on scientific evidence and following the WHO guidelines for the humanization of care during labor and birth, obstetric nursing values the physiology of childbirth, the role of women, the reduction of interventions in childbirth, the use of non-pharmacological pain methods, respect for beliefs and the effective participation of women/family in parturition. This reveals the breaking of paradigms in biomedical hegemony and values the autonomy and positive experiences of women who undergo vaginal delivery. [18]

> “By identifying the fragility in care regarding adequate guidance since prenatal care so that the puerperium could be lived in a more comfortable way for the new daily life for the woman/baby, for the body that gave birth and for the experience of sexuality, it is evident that obstetric nursing needs to occupy its proper space in the integral care of this woman”

The limitations of the study refer to the fact that the research was not carried out in a health institution, which would make it possible to understand and reflect on the assistance received and on the experiences lived by women, as a time frame in a specific scenario.

The contributions of the study include rethinking the nursing care provided in the prenatal period, placing the woman for labor with the possible actions in this parturition process, as well as in the puerperal period, identifying the difficulties not only with the care and adaptation to the arrival of the child, but also with the puerperal woman herself in her physical and emotional dimension, which can affect her daily life and her relationships. It also contributes to boosting the performance of obstetric nursing, which is necessary in basic health care until delivery and postpartum, but which is not yet present in this proportion.

CONCLUSION

Concerns and difficulties about sexual activity in the puerperium and the return of the body to the non-pregnant state revealed fear, low self-esteem, lack of libido and pain in the first sexual intercourse. For good postnatal results, with an understanding of the moment and how to experience it, the physical and psychological dimensions need to be addressed by qualified professionals and in a timely manner, punctuating simple actions for the sexuality of the puerperal woman/couple, such as: hygiene care, use of lubricants and encouraging the resumption of sexual intimacy.

By identifying the fragility in care regarding adequate guidance since prenatal care so that the puerperium could be lived in a

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more comfortable way for the new daily life for the woman/baby, for the body that gave birth and for the experience of sexuality, it is evident that obstetric nursing needs to occupy its proper space in the integral care of this woman, reflecting safety and quality, as evidenced in public policies and scientific productions.

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