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Home care by traditional midwives in childbirth care

Cuidados domiciliares de parteiras tradicionais na assistência ao parto

Cuidados domiciliarios de parteras tradicionales en la atención del parto

Samara Calixto Gomes[I] *; Nayara Santana Brito*[I] *; Natácia Élem Felix Silva*[I] *;*
Edilma Gomes Rocha Cavalcante[I] *; Antonio Germane Alves Pinto*[I] *; Glauberto da Silva Quirino*[I]

[I]*Universidade Regional do Cariri, Iguatu, CE, Brazil*

ABSTRACT
Objective: to describe home care provided by traditional midwives during childbirth care. **Method:** this qualitative study, using the Thematic Oral History method, was conducted with 16 midwives from nine municipalities in Cariri, Ceará. Data were collected from July to December 2015 through semi-structured interviews, the reports were transcribed, textualized and transcreated. **Results:** midwives provided family care, vaginal delivery care, newborn care and immediate postpartum care. They used teas and prayers as an adjuncts to their craft. **Conclusion:** childbirth care by midwives centered on the women's and families' needs and, in some cases, extended to the home. Midwives knew the signs and symptoms of labor and acted on possible complications.
Descriptors: Midwifery; Perinatal Care; Obstetric Nursing; Home Childbirth.

RESUMO
Objetivo: descrever os cuidados domiciliares prestados por parteiras tradicionais durante a assistência ao parto. **Método:** estudo qualitativo conduzido por meio do método da História Oral Temática, realizado com 16 parteiras em nove municípios do Cariri cearense. A coleta de dados ocorreu entre julho e dezembro de 2015 por meio de entrevista semiestruturada, os relatos foram transcritos, textualizados e transcriados. **Resultados:** as parteiras prestavam cuidados familiares, assistência ao parto vaginal, cuidados com o recém-nascido e no puerpério imediato. Usavam chás e orações como adjuvantes do seu ofício. **Conclusão:** o cuidado das parteiras na assistência ao parto centralizava-se nas necessidades da mulher e da família, sendo, em alguns casos, extensivo à casa. As parteiras conheciam os sinais e sintomas do trabalho de parto e agiam nas possíveis intercorrências.
Descritores: Tocologia; Assistência Perinatal; Enfermagem Obstétrica; Parto Domiciliar.

RESUMEN
Objetivo: describir los cuidados domiciliarios brindados por parteras tradicionales durante la atención al parto. **Método:** estudio cualitativo conducido mediante el método de Historia Oral Temática, realizado con 16 parteras en nueve municipios de Cariri en Ceará. La recolección de datos se realizó entre julio y diciembre de 2015 a través de entrevistas semiestructuradas; los relatos fueron transcritos, textualizados y transcreados. **Resultados:** las parteras brindaron atención familiar, asistencia en el parto vaginal, cuidados al recién nacido y en el puerperio inmediato. Usaban tés y oraciones como complemento de su oficio. **Conclusión:** el cuidado de las parteras en la atención al parto se centraba en las necesidades de la mujer y de la familia, extendiéndose, en algunos casos, al hogar. Las parteras conocían los signos y síntomas del trabajo de parto y actuaban sobre las posibles complicaciones.
Descriptores: Partería; Atención Perinatal; Enfermería Obstétrica; Parto Domiciliario.

INTRODUCTION

The Brazilian political scenario in the 1970s and 1980s was marked by the process of redemocratization of the country, union struggle, popular participation and the leading role of the feminist movement. In parallel, there was consolidation of hospital- and medical-centered obstetric care, in which delivery was institutionalized[1].

Assistance to delivery changed; nonetheless, it is still a rite of passage for women and their families. Before the institutionalization of delivery, birth took place in the home environment; it was marked by affective family involvement and without interventions by health professionals[2-4].

In Brazil, a "traditional midwife" is the professional who provides home birth assistance based on traditional knowledge and practices[5]. Also called "sideboards", "*comadres*", "*cachimbeiras*", or "lay midwives"[6], they are women endowed with popular knowledge and who use knowledge acquired about delivery based on orality across the generations and with more experienced colleagues, without any recognized formal teaching[7]. In this context, the assistance practice of the Brazilian traditional midwives was allowed in the country until the 1970s and the time scope of their performance varies according to the regions and to the sociodemographic markers of the assisted population[8].

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Corresponding author: Samara Calixto Gomes. E-mail: samara.gomes@urca.br
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However, in Maranhão, there are still reports of the performance of these women in low-income communities almost entirely located in rural areas and in peripheral neighborhoods of the cities. Midwives in the rural area form a reciprocity network and there is no financial return announced by the work developed, whereas midwives in the urban area have levels of associative organization characteristic of a professional category, establish partnerships with various government institutions and some charge for the assistance they provide in deliveries[9].

After a commitment made under the Millennium Development Goals and the National Pact for the Reduction of Maternal and Neonatal Mortality, in 2004, Brazil initiated an articulation between the knowledge of the traditional midwife and the biomedical knowledge as a strategy to reduce maternal mortality. This articulation was also possible through the expansion of the Working with Traditional Midwives Program (*Programa Trabalhando com Parteiras Tradicionais*, PTPT), initiated in 2000[8].

That same year, after the creation of the Humanization Program for Prenatal, Delivery and Birth (*Programa de Humanização do Pré-Natal, Parto e Nascimento*, PHPN), there was the possibility of including home delivery and birth in the Unified Health System (*Sistema Único de Saúde*, SUS) and sit was ought to promote the training of the professionals to work with the traditional midwives in the North and Northeast regions[5].

Considering the weaknesses in universal access to health and the lack of human resources in the regions of the Brazilian semiarid region, the insertion of midwives in these places becomes a strategy for the reduction of the maternal and neonatal morbidity and mortality indicators[9]. Given the above, the objective was to describe home care provided by traditional midwives during the assistance provided to delivery.

The relevance of this study lies in the fact that research studies on the assistance provided by traditional midwives rescues memories, values, techniques and rituals, allowing to reveal a different ethos of care, based on altruism and knowledge, often empirical, but respectful to culture and efficient for the health needs of populations where the principle of universality is not yet consolidated.

METHOD

A qualitative research study conducted using the Thematic Oral History method[10]. This method is justified because it enables access the midwives' memories and symbolisms, privileges the study of the representations, attributes a central role to the relationships between memory, history, practices and events of the past[10,11]. The study followed the rules adopted by the Consolidated Criteria for Reporting Qualitative Research (COREQ)[12].

The research was carried out in the municipalities of Abaiara, Barbalha, Caririaçu, Crato, Farias Brito, Jardim, Juazeiro do Norte, Missão Velha and Várzea Alegre, located in the Cariri region, which is located in the south of Ceará. The region is composed of 29 municipalities, and presents a territorial extension of 5,460,084 km^2 and a total population of 601,817 inhabitants[13].

Data collection took place between July and December 2015 and was initiated through an active search in each municipality in the region. When the respondents were found, there was a prior presentation by the researcher and her team, followed by the appraisal of the Free and Informed Consent Form (FICF) and of the authorization term for use and cession of the right to display the image of the interviewees. From the first midwife identified, considered the zero point, the indication of another midwife was requested, which configured the network of informants by municipality.

The study included 16 midwives who met the following inclusion criteria: women who were part of the interest group, endowed with popular knowledge, known as traditional midwives or "*cachimbeiras*", living in municipalities in the Cariri region of Ceará, and who worked as midwives in the territory. The following were adopted as exclusion criteria: being unable to collaborate with the research verbally or not presenting preserved self- and environment orientation. Of the midwives found, only one refused to participate in the research, without justification.

All the interviews took place in their homes, with the participation of other people not participating in the research, such as the interviewees' spouses, relatives and neighbors. A semi-structured form was used with questions that involved identification data of the participant and the care provided in the assistance provided to delivery. The interviews were videotaped and directed by the following guiding question: "How did you become a midwife, madam?" A field notebook was used before, during and after data collection. After data collection, the videos were analyzed and this stage was ended when theoretical data saturation was verified.

The analysis of the qualitative material followed the assumptions of oral history. The reports were transcribed, textualization happened with the transformation of these writings in a narrative and, finally, there was transcreation, in which the text was recreated, ordering paragraphs, removing or adding words and phrases, making it possible to elaborate a memorial about their life stories[10].

From the transcribed material, analytical categories were constructed, guided by the thematic axes of greater significance that emerged from the midwives' life experiences: family care; care in delivery and birth; and postpartum care.

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The research was developed in accordance with Resolution 466/12, of the National Health Council, and was approved on March 3rd, 2015 by the institution's Research Ethics Committee (*Comitê de Ética em Pesquisa*, CEP), under opinion number 974,849. The participants' anonymity was ensured by using the letter "P" along with the order number of the interviews (P1, P2, ..., P16).

RESULTS

The participants' age ranged between 68 and 92 years old. Most of them (12) were rural residents. Some (02) declared themselves still active. They started working in the 1950s and 1960s, describing a period of greater activity between 1980 and 1990. They were called upon at the beginning of labor. The main transportation means were horses. On many occasions, the route was made on foot, what was hampered by geographical barriers.

Family care

The midwives reported about the care provided to the families, which involved feeding the woman and her children, as well as cleaning and organizing the house. They reported that, as a result of the puerperal woman's rest, community support was indispensable.

> *I was going to make some tea, because sometimes had a small boy... I stayed with her and taking care... I made porridge for him (the baby boy) [...] Swept the house... (P1).*
>
> *It was such a great protection... That they spent five days lying down [...] I would sit in a corner and the people doing something around in their house. The most important was to put water... And sweep the yard, wash clothes... (P5).*
>
> *I killed capão (chicken), I made a pirão for them! I swept the house, washed the dishes... While she was there suffering and the pain was increasing, I went (P11).*
>
> *So that, to be a midwife, we have to assist the community in everything. It's not just at delivery. You have to follow up... (P9).*

Delivery and birth care

To assist in delivery, midwives used peppermint, black pepper and corn teas to increase the number of uterine contractions or prevent postpartum hemorrhage. They lacked personal protective equipment and, according to their empirical knowledge, improvised to provide assistance and conduct the delivery. Another care strategy used by the midwives was the use of prayers to speed up the child's birth and delivery. The most cited saints were: Our Lady of Good Deliveries, the Holy Trinity, Jesus, Mary and Joseph, Saint Raimundo Nonato and Saint Margarida.

> *I made a little black pepper tea. I used to put three little black peppers [...] Then I made that little bit of tea and gave it to the woman to drink [...] To relieve pain (P5).*
>
> *Gave mint tea [...] And for blood "loss" [...] We pull five little feet of corn, step on it, boil it in water and give it to drink! (P8).*
>
> *When it took time, I fixed the woman, made a "caquiado" (maneuver with slight abdominal compression) and it quickly came (P13).*
>
> *I always prayed to Our Lady of Good Deliveries. I used to say the whole prayer, but when the boy came down, I said this part: 'Give me the grace to have a happy birth. Make my baby be born healthy, strong and perfect'. Our Lady always helped (P16).*

It is noteworthy that the midwives reported receiving spiritual warnings that signaled whether delivery care would be successful or if there would be complications, which influenced their decision-making process to monitor the woman during delivery or not.

> *And when it worked, I heard the voice of an angel saying: 'Go, you're happy!' When it didn't work, he said: 'Don't go, no!'. Then, I gave up. Later I learned that either the mother or the child had not resisted (P8).*
>
> *When they called me the first time, I was afraid. I felt like disappearing, you know? 'I'm not going at all. I have no conditions!'. But there was something inside me telling me to go (P12).*

In regard to the expulsive period, some midwives advised about the most appropriate way to give birth, with positions that varied between lying down, squatting or standing and on the moment to proceed with the abdominal pulls. This care with the parturients made them safer and encouraged to face labor with the midwives.

> *She could be standing up, lying down, stay on the walls, at the head of the bed, pushing hard [...] Prayed the Salve Rainha like this, with the holy cross signal... I used to fix [...] it here on the bottom of the belly. And telling her to stay right for the child not to mess up or bend her head, or bend anything! (P15).*

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> *The woman was lying here (on the bed) and I did it like this: 'Oh, spread your legs here.' The child was already at the door. Here I pulled the child, the child came out! I said: 'You can add strength that the child is still missing the arm, the shoulder.' She put on strength... and the shoulder came out! I took it... ready [...] She was satisfied (P2).*
>
> *In the past, women said it was better with us. That they had less fear. At the hospital, they are more afraid (P6).*

As for birth, the midwives described the moment of immediate care for the newborn (NB), which involved cutting the umbilical cord, cleaning the body and mouth to mouth or mouth-nose aspiration, which, when performed, they proceeded washing their own mouths with *cachaça*.

> *I received the children, I would try to cut the navel, bathe, change the clothes (P6).*
>
> *When the child was born and was unable to breathe, I would go with my mouth, suck on his nose and spit. Even when he took his breath. It was how I did the cleaning for a child [...] But I didn't swallow. When I did the cleaning, I said: 'Hey buddy, bring a sip of cachaça so I can wash my mouth.' [...] I poured cachaça, washed and spit (P8).*

Care during the puerperium

For traditional midwives, the greatest concern during care for women was placental delivery due to the risk of hemorrhage and death. For this reason, they prayed and carefully observed the remains of placental tissue. After delivery management, the man of the house was responsible for burying the "delivery". They also emphasized the importance of hygiene guidelines and, subsequently, of the home visits as part of the care during the puerperium.

> *Delivery prayer (placenta) costs, is very little: 'Saint Margarida, this woman is neither pregnant nor gave birth yet! Get that piece of dead meat out of this belly!'. So, he comes soon! (P14).*
>
> *When the placenta came out, we dried it very well [...] If there is a part that doesn't have that little plastic, there's still blood. You need to be careful! If there is only a little meat, there will likely be bleeding afterwards (P7).*
>
> *[...] If it's not well (delivery), the woman dies (P4).*
>
> *I was still going there [...] to see how I was guiding because it was still the time that many women still thought, that they could not take a bath... And we who were already aware of life, knew that we had to guide people, that they could shower and that they could clean themselves [...] I had to give this assistance [...] (P12).*
>
> *Tell her husband to dig a half-deep hole and bury it! Far away from the house! Far (P5).*

Another relevant point in the puerperium was the evolution of the umbilical stump, which was one of the main concerns of midwives in the puerperal visits, which took place between the third and eighth postpartum days. In addition to that, they also pointed out that the care related to the umbilical stump has changed based on new knowledge and on the availability of alcohol.

> *Before, you tied the navel all the way. I learned that I didn't need to. And before, I didn't have any alcohol to wash anything. After I received the material, I started to go with 70% alcohol (P1).*
>
> *I took care of the boy too. I went to their house every day to see how he and his mother were doing. When it was eight days late, I stopped. It was the time I saw if he escaped or not (P8).*

DISCUSSION

Home care provided by traditional midwives during the assistance provided to delivery was an extension of their physical and social body. In this scope, the report of the process experienced by the midwives points out that the act of giving birth is a ritual that is part of their social reality.

In this practice, common activities are identified, such as preparing food for puerperal women and using medicinal herbs[9]. The basis of care came from her empirical knowledge and experiences in serving women in the pregnancy-puerperal cycle[8]. Thus, the midwives believed that their profession was related to the complexity required by childbirth, involving techniques, practices and rituals with care directed to the parturient woman and her family context[9,14,15]. In this scope, extensive to home care and community support.

The midwives had practices such as: position of the child in the belly; body techniques for safe delivery; measurements/right time for cutting the umbilical cord; use of medicinal plants during delivery and puerperium, and ways to be born. This traditional knowledge surrounded their lives and came from their experience as mothers and women[15-17]. Thus, they shared the know-how across the generations of midwives with diversities of logics of birth assistance beyond the molds of instrumental rationality science[17].

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In the scope of religiousness, the custom of praying during delivery constitutes one of the midwives' identity traits, evoking protective saints to guarantee positive outcomes in the process of delivery and birth[9]. This relationship in the giving-receiving-rewarding process is considered a duty in view of the gift for this vocation and their relationship with God, as a means of paying off a debt[18]. These perceptions between the midwives' skill and gift were also identified in this study, when they reported foreseeing the delivery condition and the relationship established with the puerperal woman and the family.

The care by midwives in the expulsive phase of labor encouraged the parturients to overcome their fears and feel safe. In the home deliveries, the midwives recognized the importance of family support, the trust deposited in them and the bond[19].

With regard to the moment of birth, the midwives had their *status* recognized when they managed to "secure the child" and by means of immediate procedures and care[18]. They carried out their activities with devotion, although they had scarce work material; for example, they did not have suitable resources for cutting umbilical cord or individual protection equipment.

A context still present in Brazil, when the performance of midwives in communities of difficult access is verified, with care based on empirical knowledge and practices that often occur below the necessary hygienic conditions[9,20]. Therefore, it can be inferred that even with the implementation of national public policies in the context of improving obstetric care, there is still lack of health and care conditions that promote safe birth in a universal, equal and egalitarian manner.

In assisting delivery, they sought to identify the structure and the placental integrality to avoid the risk of hemorrhage resulting from the presence of remains or membranes in the uterine cavity. This care is recommended as a good practice in assisting normal delivery and must be stimulated[8]. On the other hand, in relation to the immediate puerperium, the rituals and symbolism of the placenta identified in this study are similar to those observed in another survey carried out with midwives on procedures and restrictions for the "pregnant woman"[9], revealing that these care measures are configured as traits of sociocultural belonging of this group.

With potential to contribute to humanized assistance in delivery and birth, whose practices are now used under the sign of scientific evidence[8], the care provided by the midwives in this study was directed towards the expanded support for the family environment, promotion of comfort, maternal positions that favored vaginal delivery, establishment of bond and trust, evaluation of the delivery clinical periods and puerperal visits.

Therefore, it is noted that the performance of midwives was based on the humanistic perspective, as they sought to offer safe care, prevent complications, and respect the moment experienced by the woman and her family[8,21]. Currently, monitoring by means of home visits in the puerperium is carried out by the family health team, with a view to welcoming feelings and complaints, assessing the evolution of the postpartum period and of the mother-child bond, understanding that the puerperium moment demands certain psychical reorganization of women in the face of the changes and the resumption of their daily activities[22].

Humanized care in the national scenario is still a challenge, especially due to the medicalization of delivery and birth, which, in many cases, disregards the women's preferences and imposes obstetric practices, without sharing decisions[3,23,24]. Nonetheless, when women experience their leading role, there is greater satisfaction in relation to vaginal delivery, where they express positive feelings such as emotion, personal growth and a new identity as a mother. Among the advantages, they report rapid recovery and the possibility of resuming the routine of daily activities in a short period of time[25].

It was observed that the midwives acted with a woman-centered care view. In this cultural context, they sought to meet the individual needs and were protected by the concept of health and disease when they sought to support the puerperal women in the face of the changes in their new life cycle.

Midwives were the drivers of humanized and subject-centered obstetric care, creating and maintaining an informal support network for motherhood, in parallel with the public network[3]. However, they developed their assistance in a sociocultural context which presents the worst national social indicators, marked by scarce economic development, high poverty, precarious living conditions, configuring itself as the most unequal region of the country[26].

CONCLUSION

Traditional midwives represented the first line of health care for pregnant and puerperal women and newborns in communities that are difficult to access in a context in which there was no universal assistance provided by health professionals.

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In this sense, their care was centered on the needs of the woman and the family, being also extended to the house, starting with the first contractions and ending in the first week of the immediate puerperium. This process involved knowledge about the signs and symptoms of labor, knowledge to act in the face of possible complications and practices for the moment of birth. Among the set of care measures, the use of teas, prayers and rituals stand out, as sociocultural identity traces of these women.

It is concluded that it is necessary to adopt a conception of health that is sensitive to the practices of traditional midwives, and that are inclusive and integral to ensure the quality of assistance provided to the pregnancy-puerperal cycle. In the context of the medicalization of delivery and of the female bodies, midwives assumed the role of mediators, seeking alternatives between the current practices and their skills, their home remedies, the body techniques used and which are still part of the women's routine. Thus, the dialog between scientific and traditional knowledge is important, as this interaction will contribute to the design of public policies appropriate to the social reality of various rural communities across Brazil.

In addition, this study contributes to the preservation of memory and the importance of traditional midwives in the assistance provided to delivery. As a study limitation, the bias of the midwives' memory is pointed out, which has the potential to produce reports that cannot be confirmed with other historical sources.

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