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THE ORAL HISTORY AS A METHOD FOR UNDERSTANDING THE BRAZILIAN SEMI-ARID MIDWIVES' JOB[1]

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ABSTRACT

Objective: to understand the historical process of the midwives' job in the Brazilian Northeastern semi-arid region through the oral history.

Method: qualitative study carried out in nine municipalities of Cariri, in Ceará, with 16 midwives, using the oral history method. The semi-structured interview was used as a data collection instrument, with video interviews recorded. The reports were transcribed, textualized and transcreated, being analyzed according to the oral life history method.

Results: the insertion of women working as midwives took place in a transcendental or essential way. It was considered an autonomous gift, divine or learned by living with other more experienced midwives. Their knowledge varied between the empirical and scientific knowledge, having been modified over time, due to the growth of the medicalization, instigating the reflection due to the professional action focused on women's health. This valued the childbirth, making it a unique moment, respecting all its meanings and giving back to the woman her right to be a mother with humanity and security.

Conclusion: it was evident the natural and transcendental way in which the midwives were inserted in this role, motivated by the feeling of altruism in a historical and social context of absence to universal access to health, rural geographic location and little availability of human resources in health. Thus, their values and their importance in the Brazilian obstetric health scenario were evident.

DESCRIPTORS: Lay midwife. Obstetric nursing. Women's health. Culture. Memory. Life history traits.

HISTÓRIA ORAL COMO MÉTODO PARA A COMPREENSÃO DO OFÍCIO DAS PARTEIRAS DO SEMIÁRIDO BRASILEIRO

RESUMO

Objetivo: compreender o processo histórico do ofício das parteiras do semiárido nordestino brasileiro por meio da história oral.

Método: estudo qualitativo realizado em nove municípios do Cariri cearense com 16 parteiras, por meio do método da história oral. Foi utilizada, como instrumento de coleta de dados, a entrevista semiestruturada, com gravação das entrevistas em vídeo. Os relatos foram transcritos, textualizados e transcriados, sendo analisados segundo o método da história oral de vida.

Resultados: a inserção de mulheres no ofício de parteiras ocorreu de forma transcendental ou essencial. Foi considerado um dom autônomo, divino ou aprendido pelo convívio com outras parteiras mais experientes. Seus conhecimentos variaram entre os saberes empírico e científico, tendo sido modificados ao longo do tempo, por conta do crescimento da medicalização, instigando a reflexão diante da atuação profissional voltada à saúde da mulher. Isto valorizou o parto, tornado um momento único, respeitando todos seus significados e devolvendo à mulher seu direito de ser mãe com humanidade e segurança.

Conclusão: ficou evidente a forma natural e transcendental com que as parteiras foram inseridas neste ofício, motivadas pelo sentimento de altruísmo em um contexto histórico e social de ausência de acesso universal à saúde, de localização geográfica rural e de pouca disponibilidade de recursos humanos na saúde. Ficaram evidentes, deste modo, seus valores e sua importância no cenário da saúde obstétrica brasileira.

DESCRITORES: Parteira leiga. Enfermagem obstétrica. Saúde da mulher. Cultura. Memória. Traços de história de vida.

HISTORIA ORAL COMO MÉTODO PARA LA COMPRENSIÓN DEL OFICIO DE LAS PARTEIRAS DEL SEMIÁRIDO BRASILEÑO

RESUMEN

Objetivo: comprender el proceso histórico del oficio de las parteras del semiárido nordestino brasileño por medio de la historia oral.

Método: estudio cualitativo realizado en nueve municipios del Cariri cearense con 16 parteras, por medio del método de la historia oral. Se utilizó, como instrumento de recolección de datos, la entrevista semiestructurada, con grabación de las entrevistas en video. Los relatos fueron transcritos, textualizados y transcribados, siendo analizados según el método de la historia oral de vida.

Resultados: la inserción de mujeres en el oficio de parteras ocurrió de forma trascendental o esencial. Fue considerado un don autónomo, divino o aprendido por la convivencia con otras parteras más experimentadas. Sus conocimientos variaron entre los saberes empírico y científico, habiendo sido modificados a lo largo del tiempo, por el crecimiento de la medicalización, instigando la reflexión ante la actuación profesional orientada a la salud de la mujer. Esto valoró el parto, convertido en un momento único, respetando todos sus significados y devolviendo a la mujer su derecho de ser madre con humanidad y seguridad.

Conclusión: quedó evidente la forma natural y trascendental con que las parteras fueron insertadas en este oficio, motivadas por el sentimiento de altruismo en un contexto histórico y social de ausencia de acceso universal a la salud, de localización geográfica rural y de poca disponibilidad de recursos humanos en la salud . Se quedaron evidentes, de este modo, sus valores y su importancia en el escenario de la salud obstétrica brasileña.

DESCRIPTORES: Partería laica. Enfermería obstétrica. Salud de la mujer. Cultura. Memoria. Rasgos de la Historia de vida.

INTRODUCTION

The maternal experience is an important event in the life of women, which is marked by the transformation of their social role.[1] In some regions of Brazil, the obstetric care was provided by women from the community itself, and the technique used was acquired through the accumulation of knowledge about parturition. Then the woman whom the community considered to be the most experienced was recognized as a midwife and, over time, she transformed her gift into a profession, making experience her skill.[2-3]

In the Northeastern Region of Brazil, it is predominant the semi-arid climate, high temperatures, low rainfall, and this region is home to the poorest population in the country.[4] In addition to childbirth care, the midwives provided home care to the puerpera and to the newborn. Also called by many different names, such as bedpans, these women possess popular knowledge - often stemming from legends and gestational beliefs associated with nature.[5] They became responsible for the assistance and care to women during the pregnancy-puerperal cycle and to the newborn, based on oral and gestural knowledge experienced and transmitted between the generations.[2-7]

In Ceará, a Brazilian northeastern state, midwives are also known as "cachimbeiras" (pipe smokers), due to one of the main rituals performed during labor. The midwife, after smoking the pipe, would spit in her own hands and then pass it on the woman's belly, believing that it would accelerate the child's birth. After the newborn's bath, she would inhale the smoke and blow it into the child's navel, before covering it. They claimed that, in this way, they would hasten the fall of the umbilical stump.[8]

In this context, it is questioned: what are the trajectories and historical experiences of the midwives' job in the Brazilian northeastern semi-arid region? In carrying out this study, one makes a rescue of their memories, their values, their techniques and their rituals, which configure an ethos in the obstetric care, that is, what is considered important for the knowledge of the present and of itself, producing a reflection that guides the obstetric practices in the future.

In order to answer the previous question, it is necessary to carry out a study conducted by a methodological reference from social history: the oral history. Such method is justified because it allows accessing the memories and the symbolism of midwives, as well as it privileges the study of representations and assigns a central role to the relations between memory and history, seeking to carry out a more refined discussion of the practices and events of the past.[9]

This study aimed at understanding the historical process of the midwives' job in the Brazilian northeastern semi-arid region through the oral history.

METHOD

A qualitative study, in which the oral history method was used, which is a method and practice of apprehending narratives of witnesses, capable of promoting the analysis of the social processes.[10]

For the application of the oral history it is necessary to understand three concepts that hierarchize the stages of this method: target community,

colony and networks. A certain scenario is called destination community, where groups share the same behaviors and have as their mark a collective memory.[10] Thus, it was denominated community of destination the midwives or "cachimbeiras" of the region of Cariri, in the Brazilian semi-arid.

Colony is defined by general patterns of a portion of people who make up the same community of destination. It is a fraction of the whole, in which a group of people share interests, motives or other similar characteristics.[10] For the study, the most interesting group were the midwives or "cachimbeiras", that is, women who had popular knowledge, who lived in municipalities of the Cariri region and who had acted as a midwife in these places.[3]

The exclusion criteria were: being unable to collaborate with the research verbally or do not present self and preserved guidance.

The midwives were contacted and selected through visits of the researchers to the rural area of the municipalities belonging to the colony. On this occasion, the local residents were questioned about the presence of midwives in the region. This first midwife indicated by them was considered the zero point.

The data collection was started with the help of the zero point and, from it, the network was built. The network is a subdivision of the colony, in which individual parameters can be created to serve as criteria for the choice of interviewees. It always starts at the zero point, which was the first interviewed. From it, a second midwife was appointed, which in turn indicated a third, and thus a network of interviews was created.[10]

In this study, the networks were defined according to the cities visited, totaling 16 interviewees in nine municipalities of the colony. This number of interviewees corresponded to the total number of midwives located in the municipalities of Abaiara, Barbalha, Caririaçu, Crato, Farias Brito, Jardim, Juazeiro do Norte, Missão Velha and Várzea Alegre. Each municipality had its network composed from the first interviewed. The data collection period occurred from July to December 2015.

The semi-structured interview was used as a data collection instrument, which was videotaped and performed in the midwives' homes, in agreement with the availability of each one, by signing the authorization term for the use and assignment of image display right and of the Free and Informed Consent Tern (FICT). The illiterate participants put their fingertips on them. After the informal conversation began, a previous script was used, with questions that involved the participant's identification data. The interview was directed by the guiding question: "how have you become a midwife?"

With the testimonies collected, the videos were analyzed and the reports transcribed. The textualization happened with the transformation of these writings into a narration and, finally, the transcreation was made, in which the text was recreated, ordering paragraphs, removing or adding words and phrases, making possible the elaboration of a memorial about their histories of life, told by themselves.[10]

After the transcreation, data analysis was started, using the life oral history method.[10] A research based on this method offers methodological support to studies related to memories and life oral histories.

The empirical data were evaluated for internal coherence with the reading, as a whole, searching for deletions, contradictions, inconsistencies and anachronisms. For this, the evidence was placed within a broader context, considering the bias of the group selection.[11]

Regarding the ethical questions of the research, it was developed in accordance with the Resolution 466/12 of the National Health Council, which deals with research involving human beings. The research was submitted to the Research Ethics Committee (CEP - Comitê de Ética em Pesquisa) of the Regional University of Cariri (URCA), and was approved by the opinion No. 974.84 and CAAE 42109615.2.0000.5055. The midwives were identified by the letter P, followed by the cardinal sequence numeral of the interview.

RESULTS

During the interviews, it was prevalent the assertion that the insertion of women in the midwives' job occurred in a transcendental or essential way. Thus, it was considered an autonomous, divine gift or learned through living with other more experienced midwives.

God gave me this gift

On several occasions, the midwives considered their work to be divine, granted by God, which enabled them for the job. Some were illiterate, and the others had low schooling level, situations justified by the difficulty of access to school or due to agricultural occupations. Others claimed to have witnessed only their own births, and through the

empirical knowledge that came from observation, they have developed the practice of giving birth; for these midwives, their gifts arose naturally and intrinsically. Their techniques and rituals were similar. *It was a gift. It seems that it was sent by God* (P 01) *I have not learned from anyone. Jesus gave me. I had that job, so beautiful to God as it was! But thanks to Him none has died in my hand* (P 08) *In all that God has given me, that gift of my being* [...] *a prayer, he also gave me to be a midwife!* [...] *It was really my gift!* (P 16) *My own intelligence* [...] *God protected me. I would do it very quickly.* [...] *Only in the experience that I have! This is from birth, my child!* (P 14)

It was the way…it was not to let die

The average age of the midwives interviewed was around 75 years old. According to the reports, they began their work early in adulthood, around the age of 20, in the 1950s and 1960s. They were inserted in the midwifery job within a Brazilian historical context, in which access to health was not universal. Their performance occurred in rural geographic areas and they were motivated by altruism. *I would go because it was the only way* [...] *And it was difficult for the women in those "gojas" (sic)... there was a house here, and another one I do not know where. There, those who were closest, already attended those who were sick. Then I would get there sometimes, I had to act, it was almost at the last moment. Then I had to help the poor ones. It was no to let die* (P 04) *I was forced by the circumstances, you know? Forced! Soon, there was not even a hospital here. There was no comfort condition. The births were made at home. The way God wanted. I did a lot of complicated births* (P 12) *I went to live in Emboscada and there was no midwife there, there was no one! Then my neighbors, when they were going to deliver a boy, I was there!* [...] *everything would be alright! They are all alive, the children are alive, no one has died!* (P 14) *They would call... I would go. What can you do? To let die?* (P 15)

It should be emphasized that the material circumstances gave a mandatory character of the insertion of these midwives into this work, but there was a feeling of sadness due to the progressive extinction of their work, due to the increase of the health professionals' assistance in the care to the childbirth and the change of their scenario for the hospital. Thus, they exercised their social role with altruism, when promoting care to the parturient, when public policies were absent. *I did not find anyone else who wanted. I did not find anyone to put in my place* (her successor) [...] *Because after the appearance of the doctor and nurses, then you can no longer help anyone* (P 02) *I stopped delivering, because now women just want to go to the hospital. Then our work was ending* (P 06)

I did not choose any of this!

The desire to take care of the other was decisive for the insertion in the job. Due to all the difficulties inherent in working as a midwife, not all showed an interest in it. However, they overcame their insecurities in exchange for health care, which was offered to others.

Among the reasons that led them to work as midwives, two justified the financial interest, which led them to seek knowledge to pursue the profession. *When I became a widow, the first thing I bought was a loom... for me to weave a net to survive with the children. The children put a wheel and I would weave. But I could not take it because of my knee problems since that time* (P 03) *I had a friend who used to work in that maternity hospital. I only had this one. And she asked if I wanted to work. And I said: 'look, I used to live in a relatives'.* I had no conditions' [...] *Then I said I would go. Then I bought some little things, a towel, and the other day that she would come to get me. And I went to live there* (P 09)

The latter was included into the health service, achieving prominence in the community where she lived. In her reports, she said that the money was crucial to the livelihood of her family. Others provided service to the community without expecting financial returns. The payment was done by the offering of little pleasant things. The gift of these professionals was evidenced when they reported not having chosen this profession, while receiving different types of invitations and being called to be firm in this work. *Do you know what my husband used to say? He would say like this: 'you're going to be a midwife.' I would say: 'God forbid!' And then it was like that!* (P 03) *Because I did not have a vocation like that, right? I think it is a very big responsibility. That, to be a midwife, we have to care for the community and everything. It is not just at childbirth. You have to follow up* [...] *But midwives, when they have a vocation, they are more careful than the nurses* [...] *I did not have much vocation, but I liked to learn things* (P 07) *Then one day a scientist appeared, then he said looking at my hand: 'girl you are still going to be an assistant!' I said: 'For God's sake do not say that.' He said: 'It said and you will be, you will see! And you will be so happy; a woman will never die in your hands.' I said: 'no, but I did not want this job.'* (P 08) *I wanted to disappear, you know? 'I am not going anyway. I have no conditions!'* (P 12)

The midwives of the Brazilian semi-arid understood that the vocation for the childbirth was related to the complex attention capacity that the childbirth demanded, mainly because of its risks of morbidity and mortality. In this sense, the childbirth care began from the moment that the woman "fell ill", going into labor, and continued up to the household chores in the puerperium.

I saw how it was that the women said

The knowledge forms of the midwives varied between the empirical and the scientific knowledge. Some received guidance from their mothers, grandparents, close relatives, or people who considered them fit for the job. Women who were midwives in the community for a long period and for individual reasons had to leave work, having to pass on their functions to the women they trusted. *Then I went I kept doing it* [...] *I trusted her a lot and she talked a lot to me, about how she did the deliveries, and I started doing it* [...] *Maria de Lurdes has taught me everything* (P 01) *Yes! My mother had already died, but she motivated me later, before she died* [...] *I had not done a delivery yet. She taught me before she died!* (P 02)

Of the interviewees, few had the opportunity to receive guidance from other midwives, being passed on with the attention they deserve. Most of these women learned only by observing their own childbirths or some midwife's work in their community. *I faced it because I saw it was how the women said it* (P 06) *With that I watched women have babies. From 16 years old to now, I started delivering. I was not afraid; I used to observe the way my grandmother did it* (P 13)

Among the midwives, only three reported having formal, systematized knowledge received in health and teaching institutions where they were able to enhance their gifts with the help of science. At the time, they learned the basic care of general hygiene and other restricted types of care, related to the pregnant and newborn. *A nephew of my husband, at that time he was walking... so... talking to the mayor... So he told me to take a course in Crato obstetrics, so I could see if I was engaged in earning from the city hall* [...] *Nothing came from the town hall.* [...] *Then I took the course and was called to do the deliveries here* (P 03). *I took an apprentice course* (P 09) *I took the course, but I had never made a delivery on my own* (P 12)

DISCUSSION

The gift is a signifier used as innate ability, coming from the Latin *donum*, which means giving and merit. It can be considered a natural gift, aptitude and even a special ability for a given situation or action. In theology, it is considered a grace or spiritual good provided by God.[12]

The similarity between their techniques and rituals is reflected in the development and sharing of gifts. The individual journeys were repeated, even in different geographic areas. Thus, they were then presented in an essential way, or socially constructed and shared in a cultural heritage.

The perspective of an essential gift comes from the belief that the phenomena of the empirical world exist because they are reflections of an inner essence common to a particular social group that leads them to be the way they are. Thus, an essence does not change.[13] Its principle is to believe that everything is a natural and intrinsic matter.

On the other hand, to the perspective of he social construction, man is not born intelligent, but he is also not passive under the influence of the environment, that is, he develops according to external stimuli, acting on them to build and organize his own knowledge , in an increasingly elaborate way.[14]

The midwives of the Brazilian semi-arid region reconstructed and integrated knowledge, acting in a historical context, in which access to health services was not universal, which produced a social demand for the care provided by these women, especially in the lower social classes and rural areas. In this sense, the obstetric care is influenced by historical, political and epistemic changes in the world, and each social context has different models of obstetric care. In Brazil, the current model still produces iniquities in care.[15-16] These iniquities raise a reflection on the obstetric care model, which has presented a strong technological component and little emphasis on subjectivity. Thus, the technical competence has been valued, to the detriment of the human and relational dimensions of a person's care.[17] This technological component, observed in the Brazilian social context, if used in an excessive or unnecessary way, can pose risks to the health of the woman and the newborn.[18]

However, since the 1990s, a counter-hegemonic movement has emerged, organized in favor of the humanization of the delivery and childbirth, which strives for appropriate care to childbirth and, above all, the elimination of unnecessary interventions. The focus on women's autonomy and the implementation of good obstetrical practices is an imperative condition for the quality of the care provided.[19]

The qualification of this care is still a goal to be achieved. This focus should be centered on the woman, encouraging her to participate in the de-

cision-making, with less interventionist, evidence-based and humanized practices that are critical to the achievement of quality.[18-20] This results in an ethical attitude.

The ethical attitude in obstetric care requires sensitivity, which deserves to be apprehended in conjunction with both empirical and scientific knowledge. The obstetric care is a knowledge that results from an active process of interpretations and meanings about the pregnancy-puerperal cycle within a specific cultural, social and economic context.[21]

The obstetric care is better understood as the interaction with the different contexts of everyday social, cultural and spiritual life of women. Thus, caring for a parturient requires knowledge and respect for their knowledge, values and beliefs. In this sense, the care provided by the midwives is capable of producing a sense of security and satisfaction in the process of delivery and giving birth.[16-22]

Thus, this care is articulated to the individual and social dimensions, involving the application of scientific and local knowledge, and considering the subjective dimensions and social representations as a form of knowledge elaborated and shared. Such social representations favor the identification of the elements that contribute to the construction of know-how.[23]

The midwives' worldview on aspects of care and childbirth care allows an understanding of the complexity of the obstetric care, as well as the re-signification of the knowledge that guide these practices, since it was extended to the newborn, family and physical space. The work done by these women raises a reflection on the limits and possibilities of scientific knowledge and popular knowledge. In this study, it is inferred that the empirical evidence is centered expressively on the popular knowledge related to the childbirth care and its mechanisms of insertion and learning of this job.

Knowledge and cognition are distinct concepts. The first means the constitution of a complex process of rationalization, identification and classification of objects, while knowledge designates the process by which the subject of knowledge undergoes a modification during this learning.[24]

And scientific knowledge is described as an absolute truth until another paradigm surpasses it - which does not apply to popular, more flexible and tolerant knowledge. The traditional knowledge refers to information accumulated throughout life in a given community, in relation to its practices, values and culture, in short, to its experiences. This knowledge is neither permanent nor unshakeable, as it is generated, modified and reformulated by the community. Popular knowledge is transmitted from generation to generation through an informal education based on observations and imitations.[25]

In the field of midwives, their knowledge was modified over time through the growth of medicalization, which gradually transformed the physiological act of childbirth into a pathological event, with the imposition of the medical participation, in which the female autonomy over her own body was gradually replaced by the bio-powers of science and its increasingly advanced technologies.[2]

The normative, ethical and epistemic aspects of obstetrical nursing are corroborated, demonstrating the need to value the childbirth as a unique moment, respecting all its meanings, and restoring to women their right to be a mother with humanity and security.

The midwives constructed a set of representations of obstetric care in their interactions and daily social practices that can be constituted as a future possibility of educational practice, involving health professionals, for the possibility of recognition and articulation of the different ways of knowing how to provide care, creating their own social identity. However, the passion and commitment to the obstetric care increases the emotional cost of midwives.[22]

It is pointed out that there is a gap in the literature regarding research that deals with the values and perceptions described through midwives' memories. One limitation of this study was the difficulty of locating them, given the invisibility of these women in public health agencies and the difficult access to their homes, since the majority resided in rural areas.

CONCLUSION

The midwives' job in the Brazilian semi-arid region was described as a gift, justified by the ease of applying techniques and rituals during births, in a natural, intrinsic and transcendental way. Some reports described their autonomous emergence or their transfer from other more experienced midwives, whose main method of learning is observation.

The midwives were inserted in this work motivated by the feeling of altruism in a historical and social context of absence of universal access to health, rural geographic location and little availability of human resources in health. However,

due to the complexity and the need for obstetric care required in labor, they presented an extended worldview of their concept.

Through the understanding of the context of insertion of these women into the work of midwives, it can be inferred that being a midwife in a region of extreme poverty and without universal access to health services means acting in a particular way, through their work, dedicating and giving themselves in the most necessary moments, providing services without announced financial return, with the objective of reducing the maternal and child morbidity and mortality.

This solidarity attitude would lead to an increase in the personal power of midwives in the community, which needed their services and, at the same time, legitimized it socially, which generated feelings of sadness due to the extinction of the midwife job.

The oral history proved to be a method capable of generating data such as those demonstrated in this study, which are close to the trajectories and experiences that make it possible to better understand a phenomenon - in this case, the midwifery role.

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