
PERSPECTIVES OF NORMAL DELIVERY PAIN OF PRIMIGRAVID DURING THE ANTENATAL PERIOD¹

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ABSTRACT: This qualitative and descriptive study aims at analyzing perspectives on normal labor pain of primigravid and their relationships with the social-cultural context, as well as the antenatal care. Primigravid from a Public Maternity Hospital in Goiânia-Goiás, Brazil, were interviewed during the third quarter of pregnancy and their speeches were assessed through the use of the Method of Interpretation of Meanings. The ten participants presented normal pregnancy and they were between 18 and 31 years old. From the primigravid interviews emerged ambiguous perceptions and feelings, either as a natural phenomenon inherent to childbirth or as a suffering phenomenon. Notwithstanding, they supported their expectations concerning pain as a natural phenomenon regarding labor, with the perspective of having a healthy and satisfactory childbirth experience. These outcomes can subsidize educating actions in the antenatal period favoring a view towards women's integrality as childbirth agents.

DESCRIPTORS: Labor pain. Natural childbirth. Prenatal care. Obstetrical nursing. Women's health.

PERSPECTIVAS DE DOR DO PARTO NORMAL DE PRIMIGESTAS NO PERÍODO PRÉ-NATAL

RESUMO: Estudo descritivo de abordagem qualitativa com o objetivo de analisar as perspectivas de dor do parto normal de primigestas e suas relações com o contexto sociocultural e de assistência pré-natal. Primigestas de uma maternidade pública de Goiânia-GO, Brasil foram entrevistadas no terceiro trimestre de gestação, e suas falas, analisadas pelo Método de Interpretação de Sentidos. As dez participantes apresentaram-se com faixa etária entre 18 e 31 anos e gestação normal. Por meio da retratação social da dor do parto normal, ora como fenômeno natural inerente ao parto, ora como fenômeno de sofrimento para a mulher, as primigestas construíram percepções e sentimentos ambíguos. Mesmo assim, elas sustentaram suas expectativas no sentido da dor como fenômeno natural inerente ao parto, com a perspectiva de ter uma vivência parturitiva saudável e satisfatória. Estes resultados podem subsidiar ações educativas no pré-natal que favoreçam um olhar direcionado à integralidade da mulher como agente do parto.

DESCRIPTORIOS: Dor do parto. Parto normal. Pré-natal. Enfermagem obstétrica. Saúde da mulher.

PERSPECTIVAS DE DOLOR DE PARTO NORMAL DE PRIMERIZAS EN EL PERIODO PRENATAL

RESUMEN: Estudio descriptivo de abordaje cualitativo con el objetivo de analizar las perspectivas de dolor del parto normal de primerizas y sus relaciones con el contexto socio-cultural y de asistencia prenatal. Las primerizas de una maternidad pública de Goiânia-GO, Brasil fueron entrevistadas en el tercer trimestre de gestación y sus declaraciones fueron analizadas por el Método de Interpretación de Sentidos. Las diez participantes se presentaron con edad entre 18 y 31 años en gestación normal. Por medio de la retractación social del dolor del parto normal, ya sea como fenómeno natural inherente al parto, o como fenómeno de sufrimiento para la mujer, las primerizas construyeron percepciones y sentimientos ambíguos. Mesmo así, ellas han sustentado sus expectativas en el sentido del dolor como fenómeno natural inherente al parto, con la perspectiva de tener una vivencia durante el parto saludable y satisfactoria. Estos resultados pueden subsidiar acciones educativas en el prenatal que favorezcan una mirada hacia la integralidad de la mujer como agente del parto.

DESCRIPTORIOS: Dolor de parto. Parto normal. Atención prenatal. Enfermería obstétrica. Salud de la mujer.

INTRODUCTION

The normal birth, as a painful process, seems to be an experience as old as the human existence itself. The earliest known explanation for its origin is contained in the Holy Bible, in the book of "Genesis" (3:16), where God said to the woman: "I shall multiply the sufferings of your birth; you shall give birth with pain..."^{1,51}

During many centuries, the consecration of pain as suffering in the childbirth through the myth "you will give birth in pain" has been infused in the popular female imagery. Thus, it is a cultural and determinant component, from the emotional and physical point of view, that normal birth has connotation and significance of traumatic experience to the woman.² The normal childbirth pain is recognized historically and culturally as an experience related to the parturition process, associated with the idea of suffering and expected by most women from different cultures.^{3,4}

With the emergence of obstetrics as a science, natural childbirth is no longer an event belonging to the private sphere of the family or the body of knowledge about women. It became an institutionalized event and supported by technological innovations. Consequently, childbirth as a culturally contextualized event has been losing its essence before the parturition process control, female body management, and favoring the change of woman's position from protagonist to collaborator.⁵

These changes made women believe that technological interventions would benefit the parturition process fully, and even abolish pain. So, the development of medicine and technology also defined the predominant form that modern society came to mean normal delivery and, consequently, labor pain.⁶

As a social triumph, obstetrics care, in addition to maintaining the interventionist model of care, points out the surgical delivery as one of the solutions to the problem of normal delivery pain, based on the idea that women are not blamed for pain, but victims of their own nature.⁷ Then, through an elective cesarean, the normal labor pain could be avoided for most women treated in the private sector, becoming an intervention often held by several conveniences of the medical staff, and also, by the pregnant women.^{8,9} As a result of this culture of cesarean delivery, a strategy to avoid normal delivery pain and maintain medical power on the female body, it was developed women's insecurity in relation to their potential

to experience the parturition process as natural and satisfactory event, especially when it comes to coping with pain.

Due to this practice diffusion, at the end of the last century, Brazil became known as one of the countries with the highest rates of cesarean delivery. It significantly exceeded the 15% annual rate of total births recommended by the Ministry of Health (MS) and the World Health Organization (WHO).¹⁰ Therefore, since the 1980s and 1990s, the country has been in the process of transition, trying to reduce the rate of cesarean delivery, which during that period was around 40%.¹⁰

Currently, rates of cesarean delivery have increased continuously. Between 2000 and 2009, they were 38% and 50.1%, respectively, even with the Pact for Reduction of the Caesarean Rates to 25%, signed between the State Administrations and MS, in 2000.¹¹ Thereby, in 2009, cesarean delivery rates were higher in the Southeast (56.8%), South (56%) and Midwest (55.8%), and lower in the North (39.6%) and Northeast (41.3 %).¹²

Before this context, Brazil has also become the focus of attention by the increase of maternal morbimortality and perinatal.¹²⁻¹³ It was noted the relation between such increase and the current hegemonic interventionist model. This happened in public and private health systems, before an obstetric practice out of step with the international recommendations based on scientific evidences.¹⁴

A worrying obstetric practice is the "cesarean by request", also justified as a means of preventing normal delivery pain.^{4,10} This allows understanding the labor pain as an issue that deserves attention of the Public Health. From this perspective, the resumption of female leadership at the scene of normal birth and reduction of caesarean parturition becomes a challenge, for Brazil, before the Millennium Goals of the WHO until 2015: to promote the empowerment of women, reduce child mortality and improve maternal health.^{10,15}

This national scenario provoked several initiatives in order to change the paradigm of interventionist care for the humanized one, aiming to rescue the female nature and natural childbirth culture. Individual and institutional initiatives have been implemented to this purpose. Thus, it is possible to highlight the experiences of Galba Araújo, in Ceará (inspired by the traditional practices of midwives); Moisés Paciornick, in Paraná (squatting child birth); the Hospital Pio X, in CeresGO; the Network for the Humanization of Labor

and Birth (REHUNA); in addition to the creation of sites like "Labor Girlfriends", among others. All of them have contributed to the formation of an ideology of childbirth humanization, focusing on the satisfaction and safety of the woman and her child.^{7,16}

The focus of the proposal on implemented and humanized care along with the Program for Prenatal and Birth Humanization (PHPN), which was established by Decree/GM number 569/2000 of the MS, in the perspective of women's citizenship rights, seeks to recover the active and central role of women in childbirth, with assurance of the natural process of childbirth and health from mother and child, with a minimum of intervention and compatible with safety.^{6,16} Effectiveness and safety of obstetric procedures along with quality assistance were identified as the tripod for humanization, for their relevance on ensuring women's satisfaction in relation to the birth process and hence the guarantee of their right to the childbirth as a pleasant experience.⁶

Globally, the movement for the humanization of labor and birth is related to the "Ideology of Childbirth without Pain" that was started by Dick-Read and Lamaze, from the creation of psychoprophylactic methods of reducing childbirth pain. In the second generation of this notion, it appears the valuation phase of the egalitarian or "pregnant" couple, and after that, the generation of childbirth ecologism, with the participation of the obstetricians Frederick Leboyer, Michel Odent and Moyses Paciornik, with concrete experiences to the preparation of childbirth and humanized childbirth.¹⁷

To expand this notion of humanization, in our country, there was an attempt to intensify qualification actions of health professionals in relation to antenatal care, during childbirth and postpartum. The proposal is to prevent that through institutionalized care, the scientific knowledge overlaps the female body nature, interfering in the guarantee of active participation and satisfaction of women, regarding the parturition process.

In this sense, it is essential that health professionals try to understand pain from the perspective of women in the prenatal period and according to their socio-cultural context.

This individualized vision may favor the educational process to the humanized obstetrical care in the prenatal period, with the active participation of pregnant women and positive connotation, from the fulfillment of their needs

and according to their expectations related to pain and normal childbirth.

Therefore, the following preliminary question guided the process of reflection of this study: what are the prospects for labor pain of primigravid and what is her relationship with the socio-cultural context and prenatal care? Based on this topic, it was proposed to analyze the perspectives for normal labor pain of primigravid and her relations with the socio-cultural context and prenatal care.

METHODOLOGICAL APPROACH

This is a descriptive and qualitative research and it was developed in light of Social and Strategic Research on Health.¹⁸ The study object from this type of research is essentially historical, qualitative and related to concrete problems of society. It conveys interests and visions of the world that were constructed and subjected to the current domination; it also enables that suspects' visions permeate the entire research process, existing identity between subject and object.¹⁸

In relation to the compliance with legal and ethical aspects for the research involving human beings, recommended by the Resolution 196/96 of the National Council on Research,¹⁹ the project was submitted for consideration and approved by the Committee of Ethics in Human and Animal Research of the Hospital of Clínicas of the Federal University of Goiás (protocol number 104/2006).

Women on their first pregnancy with 18 years, 36 weeks of gestation or more, enrolled in the program of low risk prenatal and with regular frequency in the routine care since the first quarter of pregnancy were invited to participate in this study. All of the women invited agreed to participate in the research and signed the Term of Free and Informed Consent. The approach of the pregnant woman, from the thirty-sixth week of pregnancy, aimed at favoring the dialogue on the topic of pain closer to the childbirth.

The fieldwork was carried out by conducting an individual interview, recorded by magnetic means at the time of antenatal consultation, at the obstetric outpatient of a public maternity hospital in Goiânia, capital of Goiás, Brazil, between March and October 2007.

The guiding questions about perspectives on normal labor pain emerged from the theoretical reference and they were assessed and validated by professors from nursing areas, in relation to its

relevance and consistency. These questions aimed at ensuring the free expression of perceptions, feelings and expectations of the participants about this phenomenon. The number of 10 participants in the research was defined from the criterion of ideas saturation implicit in the speeches, as presupposed by the qualitative studies.¹⁸

Data were analyzed through the Method of Meanings Interpretation.²⁰ This is a way of analyzing the meaning of words, actions, set of interrelationships, groups, institutions, situations and other analytical bodies, within a perspective of understanding currents of the social sciences.²⁰

Data interpretative analysis was initiated through the comprehensive reading of the selected material, followed by the exploration of such material and, ultimately, preparation of the interpretative synthesis.²⁰ From this movement emerged a broader thematic category, called "Revealing perceptions, feelings and expectations about the normal delivery pain".

In the stage of interpretative synthesis development,²⁰ it was attempted to work with broader senses that articulated the research subjects' explanations and translated the logic of the whole material. So, in the text editing about data analysis, it was possible to link the objectives of the study, adopt the theoretical basis and empirical data according to the topic that emerged from the speeches.

PRESENTATION AND DISCUSSION OF RESULTS

The 10 primigravid participants in the study, at the time of the interview, presented normal pregnancies, ranging from 37 to 39 weeks, with frequency between six and eight consultations in the prenatal period, which is the minimum and satisfactory number recommended by the MS for monitoring the pregnant woman.²¹ Three primigravid reported their participation in a group of pregnant women in the Basic Unit of Family Health of their home sector, aiming at specific educational preparation for pregnancy, childbirth and postpartum.

The participants' age was between 18 and 31 years, with a mean age of 23.9 years, and belonging to the group considered with the least obstetric risk.²² Although the average education of the participants was 11.6 years, with complete high school education among most of them (six), only three were working and contributing to the

family budget. Eight women reported to live with a partner and want their pregnancy. The rest were single and assumed the unplanned pregnancy and motherhood with the support of their families. Most of them (six) were followers of the evangelical religion and lived (seven) in the city of Goiania.

The path taken by the participants of this research in order to predict the normal delivery pain was based on the fundamental information network of their socio-cultural environment and prenatal obstetric care.

They pointed out primary and secondary sources, as information sources about normal labor pain. Health professionals (physicians and nurses), pregnant women in prenatal, family and social environment women that had already experienced normal childbirth pain were cited as primary sources of information.

Media vehicles such as videos, magazines, newspapers, books, television and Internet have been highlighted as secondary sources. Some examples of these sources of information are presented in the following quote: *I searched for information on the Internet, with nurses at the hospital, at home and in books. I looked in the magazine, newspaper and even normal childbirth, which was presented some time ago on television; I watched it* (e6). According to the sources of information provided by the interviewee, it was possible to identify that the primigravid needs to understand better the parturition process, aiming to support her trajectory in order to form her own opinion about normal delivery pain.

To support the pregnant woman in the antenatal trajectory, especially in her first pregnancy, the Ministry of Health recommends that the assistance, apart from promoting all kind of care and obstetrical procedures with the objective of preserving the concept and pregnant woman's health, must also include educational activities in individual or group health that favor healthy life habits, as well as the preparation for childbirth and postpartum.²¹

Pieces of information acquired by the participants in the prenatal period have focused on biological, psychoaffective, socio-cultural and healthcare/institutional dimensions related to the normal labor pain, as portrayed in the following speeches: *I had lectures. The nurse told us to do breathing at the moment of the contraction pain, pushing and staying calm* (e10); *she [nurse] informed me that the physician does not like the woman who screams or cries, because she might disturb the job. She said: 'when you*

go to the maternity and you are in pain, do not kick with your legs, try to hold for helping the baby' (e5).

In the first report, the information conveyed by the antenatal team was related to the woman as an active agent in the birth process, emphasizing the importance of psychoaffective balance and use of non-pharmacological measures for pain management. On the other hand, it was given information of the woman as a passive agent, being reinforced the doctor's authority to lead the parturition process, when it was emphasized the necessity of obedience by the woman to the requirements of the assistance team in order to facilitate the childbirth.

This reinforces the idea from scientific and technical knowledge overlapping of the health professional to maintain control over the female body, the process of parturition and depersonalizing the feminine nature. Thus, through an asymmetric relation and domination by the healthcare professional, the woman stops exercising her autonomy as an active agent in the childbirth to encourage the obstetric care.²

The participants also point out, in their speeches, the pillars supporting the assistance visions that are present among the professionals group involved in the antenatal care of the maternity-study. The first speech represents a search movement by the practice of care humanization to the childbirth. The second already portrays the vision rooted in care medicalization, in which the protagonist of the parturition process is the physician. For some authors, these views may coexist in the same institution, differing according to the attitudes embodied by professionals during their training and contact with the institutional models.²³

Regarding the form of information acquisition, for most, it happened in a restrictive, direct and passive way, although some secondary sources of information have been acquired by the participants' initiative. None of the information obtained was strictly educational, since it was obtained under circumstances that, according to the interviewees, did not favor their questioning and discussion, in other words, it was not established the communication process. Consequently, there was no opportunity to clarify doubts for a better understanding of the process of pain in the childbirth as such, which favored the manifestation of doubt, insecurity and fear. This context is depicted in the following conversation, and highlighting prenatal care gaps: *we have no experience and we*

think the physician will speak about everything, but she does not speak. I had to keep on asking and the answers were superficial. For those who knew nothing it remained the same way. About labor pain she [physician] [...] just said that near the day I may feel that [contraction]. Then, I might be a normal case or not and the childbirth will be performed with the doctor who is working that day. Now, how am I supposed to know about pain? [...] I am still curious! (e10).

These data indicate that the current assistance model does not ensure adequate guidance on the parturition process, during the antenatal period. It corroborates findings from another study²⁴ on the perception of postpartum users of the Health Unique System (SUS) about prenatal care, which revealed that the focus of care during pregnancy, disregarding the PHPN, provokes information gaps and creates doubts and dissatisfaction in the pregnant woman. In the view of other authors,²⁵ the lack of dialogue between health professionals and pregnant women are factors that cause gaps in the information process, during the prenatal, creating anxiety, fear, insecurity and dissatisfaction among pregnant women.

These factors raise a reflection about the paradox of prenatal care presence and women's lack of knowledge on pregnancy, childbirth and postpartum. It calls the professionals attention the way that educational actions have been conducted mainly during the antenatal consultation.²⁶ According to the MS, in order to favor interpersonal relations and facilitate the process of communication between the health professional and pregnant woman, with emphasis on information and antenatal guidance, educational activities in groups must be linked to individual consultations.^{21,25}

Taking into consideration the issues raised before, it can be inferred that the systematic and participatory planning on educational actions by all the professionals within the obstetric team, with an emphasis on health promotion, would be the most appropriate to ensure women's effectiveness and satisfaction in relation to get information and guidance during pregnancy.

From the information propagated in prenatal care, family circle, social and media environments, different perceptions were produced about normal labor pain that refer to socio-cultural meanings attributed to this phenomenon, during the birth process. The perception of normal labor pain reproduced in the socio-cultural context and antenatal care of the participants pointed the attribution of ambiguous meanings to the pain. This

is presented either as a phenomenon inherent to the natural childbirth or a phenomenon of suffering, as it follows: *some women say natural childbirth is pretty bad, that we feel a lot of pain and suffering. Others say that normal delivery is better, that the pain is only there at the time of the childbirth, and after that process there is no dependence on others like in the cesarean one, which is a surgery* (e3).

The ambiguous meanings present in the socio-cultural context and assistance of this primigravid portray the historical and cultural construction of limits between the normal and abnormal axis of parturition and pain. This was established with the management process and medicalization of the female body from the institutionalization of women's care.⁵ The medicalized vision of childbirth collaborated in the form that modern society relates to it; and it also ordered the replacement of its natural sense of managing the process of birth through medical and technological rituals.⁶ Along with this process, the pain inherent to the childbirth also lost its natural characteristic and women began to perceive it as a phenomenon of suffering.

Before this context, the MS proposed changes in the paradigm of obstetric care, from the implementation of the Program for Humanization of Prenatal and Birth in the public system, to promote healthy labor and birth in order to rescue the natural childbirth and prevent antenatal and maternal morbimortality.¹⁶

Through the words of the respondents, it was possible to identify some structuring elements of the meanings attributed to the normal labor pain, as natural phenomenon and suffering phenomenon. These elements integrate biological, psychoaffective, socio-cultural and care dimensions related to pain, although they depict different perceptions of the socio-cultural and assistance environments: *as the name says, it is normal. You will have pain and childbirth without interference. They say it comes out very easily. They also say that labor pain is forgotten and it varies greatly from woman to woman* (e2); *they [aunts, mother] say it is quite painful, and I should choose the caesarean birth. That nobody deserves normal delivery. That I will pay for my sins* (e3); *others are even more exaggerated, they felt the pain of death, and they cried a lot due to pain. [...] that could appear several complications if there is not a good physician* (e4).

In the speech of the interviewee 2, it was evidenced the physiological aspect in the delivery process and the pain that accompanies it. And also, it is pointed out although it has a specific pattern,

it might differ from one woman to another, and even between successive deliveries of the same woman.²² This specific variation is related to physiological, psychological and socio-cultural aspects involved in the parturition process. Therefore, this process cannot be merely understood as a biological event.²⁷

In the speech of the interviewee 3 is explicit her choice of cesarean delivery as a measure of women's deprivation of undesirable pain in normal childbirth. The normal delivery pain is portrayed as a cause of suffering for women and, consequently, as a cause of "cesarean by request".^{4,10}

The element "pain of death", which is expressed in the words of the respondents 3 and 4, is pictured in two ways. First, it is linked to the presence of a high standard of pain considered intolerable by the woman, and second, it is linked to the risk of death from obstetric complications during normal childbirth. Labor pain is also portrayed as a "punishment" for women, and its meaning is related to the need for experiencing pain as a process of purging their sins, conceived as the occurrence of unplanned pregnancy, which was the case of the interviewee 3. Here, it is shown the ancient taboo of pain as a divine suffering for motherhood, because of Eve's disobedience to God's word.²⁸

The ambiguous meanings of pain, which were presented in the socio-cultural context of antenatal care in each one of the interviewees, supported the construction of their perceptions about normal delivery pain that was still abstract for them. But, before an ambiguous social retraction, most participants built a perception strongly linked to the physiological sense of pain as inherent to the childbirth: *I believe it will be a nice pain, natural and fast as I was told by my mother-in-law* (e8); *after feeling pain, I think the woman will feel stronger. Feeling that moment as the most important, that she made it, she went through everything and all worked out* (e9).

On the other hand, some interviewees pointed to elements identified as critical in the construction of pain perception, and also, as suffering and traumatic process for some women: *many women have the opportunity of normal delivery, but they prefer the cesarean one because they heard wrong and negative stories about childbirth pain. This makes the person suffer a lot* (e8); *a lady told me that her daughter's doctor encourages women to the cesarean birth, because the normal labor is very hard for women* (e9). Conflictive perception about normal delivery pain was also

demonstrated by a respondent, in view of favorable and unfavorable factors on that was portrayed in the social environment, as follows: *when I said it was my first child, they [colleagues] told me I would not want another one, because childbirth hurts. Then, I began to think of pain as a beast-of-seven-heads (e1).*

In one study performed with primigravid, in the metropolitan region of Fortaleza-CE, about feelings and expectations on childbirth, the labor pain was also identified as a "villain".²⁹ The information derived from women who had already experienced labor pain was impacting to the emotional fragility of pregnant women, due to the lack of knowledge regarding the process of labor and birth.

According to the interviewees' reports, the presence of ambiguous perceptions about normal delivery pain in the socio-cultural and prenatal care environments arouse different feelings and expectations, as well as the manifestation of religious beliefs related to the future experience of normal labor pain.

Before the socio-cultural meaning of pain, as a natural phenomenon inherent to childbirth, emerged optimistic feelings like hope, peace, determination and curiosity: *I am more curious than anxious. I am not afraid of that pain, no. [...] despite hearing a lot of bad things, I think positive. It did not change my point of view. I intend to have a normal childbirth anyway (e2).* However, before the meaning of pain as a suffering phenomenon, it appeared some feelings of concern expressed by fear and insecurity: *I think it is a terrible pain, difficult to bear. This brings terror to us, just by thinking about it. At the moment of giving birth, it will be even worse, because before birth, you already feel so much pain when it starts to harden [belly] (e4).*

In the study³⁰ conducted with pregnant women and users of the SUS, at a public maternity hospital, in Salvador, Bahia, it was identified the expression of fear before the possibility of future experience in the normal delivery pain, doubts regarding the capability to have a normal childbirth, the risk of dying during childbirth and maltreatments by the health professionals. Pregnant women who participated of another study conducted in Juiz de Fora- MG, also showed fear of childbirth, referring mostly to the pain.³¹

The religiosity expressed by the interviewees contributed to the presence of optimistic feelings on the future experience of pain and strengthened the sense of pain as a natural process component: *God does not give more pain than we can bear. I believe*

God wants me to have a normal and quiet delivery (e2).

The benefits of normal birth, which were highlighted in social and assistance environments, were more significant than pain to the respondents. According to them, the benefits of a normal delivery for women and children outweigh the possible discomfort related to pain. Because it is natural, healthy, ensures faster recovery after delivery and it is less risky than surgical delivery, which involves anesthesia: *I do not worry so much with pain, but the health of my baby and recovering well after the normal delivery (e4); I prefer normal childbirth because of the recovering, it is healthy, there is no anesthesia (e8).*

Although the information from the socio-cultural and prenatal care environments were insufficient to ensure clarity and safety, the participants had expectations of future experiences with pain strongly linked to a natural event: *I hope I will not have all that pain they are talking about, and I am going to be as happy as my sister-in-law. She had no pain. She had normal dilation. She arrived one day and the next day she was at home. I think every woman dreams of having a normal delivery like that. I have been dreaming a lot about it (e5).*

Studies^{25,31} on primigravid expectations, who use the SUS, about the type of delivery, also noted the majority preference by normal delivery. This preference was justified because normal birth is natural, with faster recovery and less risk and discomfort in comparison to the cesarean one.

In general, according to the results of this study and through the information conveyed in the antenatal period, the primigravid sought support of their expectations towards pain as a natural phenomenon inherent to the childbirth, with the perspective of having a healthy and satisfactory parturition experience.

FINAL CONSIDERATIONS

The contact with the essence of womanhood, favored by the occurrence of pregnancy, provoked in the participants the need for a socio-cultural rescue of concepts related to childbirth and motherhood in order to better understand them. Therefore, information about normal delivery pain acquired relevance for them. In this trajectory, their perspectives for normal labor pain were mediated by the network of information that is present in the socio-cultural context of antenatal care.

Although the access to information about normal delivery pain has occurred through vari-

ous sources, the pieces of information did not reach an educational character favoring the promotion of psychoemotional safety to the primigravid regarding future parturition experiences. Ambiguous perceptions of pain were built according to its portrayal in the socio-cultural and prenatal care environments. This helped to generate, in the participants, ambiguous feelings of restlessness, suffering and optimism at the same time.

It is noted that the need for information, expressed by the participants about normal delivery pain, was not significantly perceived by the professionals of the obstetric care team. Antenatal information could have been constituted as an educational instrument for the promotion of safety and more optimistic feelings about childbirth and pain to the participants.

Another factor to be mentioned is the relationship between the information ambiguity about normal delivery pain and socio-cultural, political and ideological construction of childbirth pain, like the suffering imposed to the woman. This ideology reflects the ambiguous image of the female body. The woman is represented in the socio-cultural discourse and obstetric care for her physiological capacity to give birth, but, it is emphasized her fragility linked to the pregnancy and childbirth, considering the boundaries between normality and normal delivery risks.

The labor pain fear, which is present in the participants' speeches, evidences, somehow, the relation of power in the obstetric care system of the country on the female body, and the way is being processed in order to maintain its management and medicalization. These factors may constitute one of the mechanisms to facilitate the perpetuation of the idea on performing caesarean section to avoid normal delivery pain.

In face of all these ambiguities, the participants presented the perspective of future experience of pain as a natural phenomenon inherent to childbirth, and also, a safe delivery considering they did not have the power of choice and decision about the care process during the antenatal period and childbirth.

Accordingly, the results of this study might provide a tool for antenatal obstetric care in the operationalization of individual, group and community educational actions in order to promote the efficient placement of information related to pain and childbirth, as well as favoring a look directed to the woman's completeness as social actor and childbirth agent.

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