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PRÁTICAS OBSTÉTRICAS DE UMA PARTEIRA: CONTRIBUIÇÕES PARA A GESTÃO DO CUIDADO DE ENFERMAGEM À PARTURIENTE

OBSTETRIC PRACTICES OF A MIDWIFE: CONTRIBUTIONS FOR THE MANAGEMENT OF NURSING CARE WITH THE PARTURIENT

PRÁCTICAS OBSTÉRICAS DE UNA MATRONA: CONTRIBUCIONES PARA LA GESTIÓN DEL CUIDADO DE ENFERMERÍA A LA PARTURIENTE

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RESUMO

Objetivo: descrever as práticas obstétricas realizadas por uma parteira leiga tencionando uma reflexão sobre as contribuições dessas práticas para a gestão do cuidado de enfermagem à parturiente. **Método:** utilizou-se da história oral temática, na perspectiva qualitativa, tendo como participante, uma parteira leiga, residente em um município do Norte do Estado do Rio Grande do Sul, que atuou na assistência a gestantes, parturientes, puérperas, recém-nascidos e seus familiares. Na coleta de dados, utilizaram-se entrevistas e diário de campo. Os dados foram submetidos à análise temática de conteúdo. **Resultados:** demonstraram a atuação da parteira no pré-natal, no parto, no pós-parto e na condução de complicações, com práticas voltadas para a gestão do cuidado de Enfermagem durante o período gravídico-puerperal, pautadas na humanização do parto e nascimento, cuidado seguro e empoderamento da mulher. **Conclusão:** as práticas obstétricas realizadas pela parteira têm potencial para contribuir para a gestão do cuidado de Enfermagem à parturiente, embora algumas técnicas adotadas, nas décadas de 1940 a 1970, necessitem de respaldo científico.

Descritores: Tocologia; Parto domiciliar; Parto humanizado; Enfermagem obstétrica; Gestão em saúde.

ABSTRACT

Objective: describe the obstetric practices performed by a lay midwife with a reflection on the contributions of these practices to the management of nursing care to the parturient. **Method:** thematic oral history was used in the qualitative perspective, having as a participant a lay midwife, resident in a municipality in the North of the State of Rio Grande do Sul, which assisted in the care of pregnant women, parturients, mothers who has recently given birth, newborns and their families. In the data collection, we used interviews and field diary. The data were submitted to thematic content analysis. **Results:** demonstrated the performance of the midwife in prenatal care, in the delivery, postpartum and in the management of complications, with practices aimed at the management of Nursing care during the pregnancy-puerperal period, based on the humanization of childbirth and birth, safe care and empowerment of women. **Conclusion:** this description may contribute to the orientation of obstetrical practices for the management of nursing care, although some techniques adopted require scientific support.

Descriptors: Midwifery; Home childbirth; Humanizeding delivery; Obstetric nursing; Health management.

RESUMEN

Objetivo: describir las prácticas obstétricas realizadas por una partera laica teniendo una reflexión sobre las contribuciones de estas prácticas para la gestión del cuidado de enfermería a la parturienta. **Método:** se utilizó de la historia oral temática, en la perspectiva cualitativa, teniendo como participante una partera laica, residente en un municipio del Norte del Estado de Rio Grande do Sul, que actuó en la asistencia a embarazadas, parturientas, puérperas, recién nacidos y sus familiares. En la recolección de datos, se utilizaron entrevistas y diario de campo. Los datos se sometieron al análisis de contenido temático. **Resultados:** demostraron la actuación de la partera en el prenatal, en el parto, en el postparto y en la conducción de complicaciones, con prácticas dirigidas a la gestión del cuidado de Enfermería durante el período gravídico-puerperal, pautadas en la humanización del parto y nacimiento, cuidado seguro y empoderamiento de la mujer. **Conclusión:** las prácticas obstétricas realizadas por la partera tienen potencial para contribuir para la gestión del cuidado de Enfermería a la parturiente, aunque algunas técnicas adoptadas, en las décadas de 1940 a 1970, necesiten de respaldo científico.

Descriptores: Partería; Parto domiciliario; Parto humanizado; Enfermería obstétrica; Gestión en salud.

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INTRODUCTION

From the mid-twentieth century, childbirth and birth progressively stopped to be performed at home and started to happen in hospitals, making these physiological events institutionalized and treated according to the disease-based health model[1]. Although it is a normal and natural process, it is a vulnerable period for the health of the women, being influenced by the environment and sanitary conditions.

When the delivery was institutionalized, practices such as episiotomy, trichotomy, enema, and induction of labor began to be used without their routine use being supported by scientific evidence[1-2]. That is, obstetric and neonatal care focused on the biomedical model, with uncritical use of technical knowledge, being perceived as pathological.

In Brazil, women's health was incorporated into public health policies in the first decades of the twentieth century, limited to the period of pregnancy and childbirth. In 1984, under the influence of the process of construction of the Unified Health System (SUS), municipalization and regionalization of the health system, mainly by the Family Health Program, the Ministry of Health (MH) developed the Comprehensive Health Care Program of Women (PAISM). The Program included educational, preventive, diagnostic, treatment and recovery actions, and assistance to women in the gynecological clinic, prenatal care, delivery and puerperium, climaterium, family planning, sexually transmitted infections, uterine cervix and breast cancer, as well as other needs identified from the population profile of women, subsequently contributing to the construction of the National Policy for Integral Attention to Women's Health (PNAISM)[3].

Therefore, the Ministry of Health has launched health policies aimed at humanization such as the Childbirth and Birth Humanization Program (PHPN)[4] as one of the bases for the construction of the Stork Network[5]. These two initiatives aim to qualify the care provided to the woman and the newborn in the family planning, the pregnancy-puerperal cycle, and healthy development.

When considering women holistically and integrally, the humanization of childbirth provides innumerable benefits. Through it, the women's autonomy is sought, encouraging the woman to decide for her own body, as the protagonist of her delivery, enabling her to decide on her movement, position, food and other preferences in the process of parturition. In this sense, it is up to the health team to assist the parturient in an individualized, respectful and welcoming way, promoting safe care[6].

In the meantime, the Obstetric Nursing practice in Brazil shows the construction of a more promising panorama for childbirth and birth care. It is considered that the care model is responsible for this impact based on the humanization of care given to women and the newborn and based on public health policies[7].

In Brazil, Nursing is performed by the nurse, by the Nursing technician, by the Nursing Assistant, and by the midwife. In childbirth care, for each of these categories, different practices related to parturient care and normal childbirth are involved. However, it is the responsibility of the nurses to follow-up and observe the evolution of labor, delivery and emergency obstetric care and delivery without distraction[8].

In obstetric and neonatal care, the management of nursing care is a fundamental element for the qualification of care. The role of obstetrician nurses is to promote good practices, humanization of care and protagonism of women, and be a mediator of the implementation of a new model of obstetric and neonatal care[9].

The childbirth care practice was liberated in Brazil until the 1970s. From then on, there was a close relationship between obstetrical and obstetric nurses, culminating in the formation of the Brazilian Association of Obstetricians and Obstetric Nurses in the 1980s, defining the nursing professionals qualified to assist the delivery[10]. In countries such as the United Kingdom, midwives are still present in prenatal and postnatal care, and the presence of the midwife in the process of labor, delivery, and birth is associated with the contribution to the humanization of childbirth and puerperium[11].

This study is justified by the social representativeness and importance of the care provided by midwives, from the beginnings of mankind to the present day, considering the important performance of these professionals in scenarios, generally difficult to access by the community to health services in Brazil[12].

In this context, it is considered relevant to know the obstetric practices developed by midwives to contribute to the nursing care of the parturient, since the experience of these professionals can foster changes and innovations related to humanized and non-technocratic care

in the pregnancy-puerperal period, as well as in the care of the newborn.

Thus, this study aims to describe the obstetric practices performed by a lay midwife with a reflection on the contributions of these practices to the management of nursing care to the parturient.

METHOD

This is a qualitative research, in the thematic oral history modality. The methodological reference was chosen for its pertinence and construction of knowledge from the clarification of experiences lived by the informant. This research method leads to understanding processes, including life, care, training, and midwifery assisted society. It has a social character, being defined as a strategy to build scientific knowledge based on empirical and practical knowledge in the different contexts of health and nursing(13). Furthermore, thematic oral history provides a dialogical way of discussing a specific subject, having a central focus(13).

Data collection was in October 2014, through four interviews with the midwife, lasting approximately 40 minutes to one hour. Each interview was guided by questions about obstetric practices based on the approach of specific topics in each scope of care provided by the midwife, from prenatal care to the puerperal period. The interviews were recorded and videotaped with a digital camera, performed at the midwife's residence, at a date and time suggested by the participant and in the presence of some children. In the fourth interview, the data saturation criteria were reached and data collection was completed. The field diary was used as a data recording technique by the researcher, enabling the expression of their perceptions about the study.

The interviews were transcribed in full in Microsoft Word® and submitted to thematic content analysis proposed by Bardin(14), with three stages: pre-analysis, material exploration, and treatment of results (inference and interpretation).

The research was approved by the Ethics and Research Committee of the Federal University of Southern Border under CAAE number 33711914.7.0000.5564 and respected the precepts of Resolution number 466 of December 12, 2012, which deals with research involving human beings. The participant agreed to participate in the study by signing the Informed Consent Term, as well as the Consent Form for Photography, Filming, and Recording. The participant's statements were identified with the letter M, referring to the midwife.

RESULTS AND DISCUSSION

The study participant was a lay midwife who worked for 33 years (between the 1940s and 1970s) in the care of pregnant women, parturients, puerperal women, newborns, and their families. At the time of data collection, she was 101 years old and, despite her advanced age, she was self-centered and alopsychically oriented, with unchanged memory. She was Catholic, widow and considered herself a housewife and farmer. Physical mobility was impaired due to amputation in the right leg due to thrombosis. In the year following the data collection, the midwife died from natural causes related to age.

The beginning of her role as a midwife was a demand from the community, which required a person who take care for women in the pregnancy-puerperal cycle. The initial basis of the care offered was the empirical knowledge with the passing of the action, was allied to the experiences and experiences of the midwife, consolidating and throughout the years she was associated with the experiences of the midwife and qualifying her assistance. During the interviews, the midwife did not estimate the exact number of pregnant women and babies assisted in the period that practiced obstetrics.

The participant is recognized in the region for having complied with the community's request and for the important role played in the health care of those people. This process of care, life, and assisted community is the focus of understanding thematic oral research(13). From the analysis of data and inferences, the following categories emerged and will be presented and discussed below: prenatal care; childbirth; postpartum care and management of complications.

Prenatal care

The midwife's role was active in the pregnancy-puerperal cycle of the woman when she was still required to provide assistance during prenatal care. At other times, the midwife was only called when labor had already begun, and this approach was up to the pregnant woman. When requested during prenatal care, the midwife provided information about pregnancy,

delivery, puerperium and performed a clinical evaluation of the pregnant woman and the fetus.

In this sense, one of the stages of the physical examination of the pregnant woman is evidenced, such as the Leopold-Zweifel Maneuvers, when the midwife expresses herself in the following speech: “[...] we feel even the little toes or the little head [...]” (M). This maneuver is commonly performed in the care of pregnant women to identify important aspects of gestation related to the health of the baby. From the second trimester of gestation, through abdominal palpation, it is possible to identify the situation, position, fetal presentation and amount of amniotic fluid, which may indicate a risk situation and fetal abnormalities(15).

In addition to providing direct assistance to the pregnant woman during prenatal care, the midwife took care of other necessary care for the time of delivery, such as cleaning the materials that would be used. They were cleaned and burned in the fire trying to sterilize them, as is evident from the following lines: “... it was burned [the scissors and the needle] also in the fire of the lamplight, I always burned it. At that time even, little things existed [...]”(M). “[...] a very clean cloth, very clean even [...] (M)”.

The infection control was performed by the sterilization of the materials, and using aseptic techniques performed by the midwife, such as hand washing and oral cavity hygiene, as seen in the lines: “... but God no ... She washed her hand very much [...]” (M). “[...] and the mouth also, we have to wash our mouth well...” (M). Hand hygiene is important in the prevention and control of health care-related infections. This practice is directly related to patient safety. When it is not performed, there is the risk of safety of professionals and patients, in a current scenario of an increase in the number of infections caused by multiresistant microorganisms. Even today, adherence to hand hygiene (HH) by health professionals is low when compared to the recommendation in national and international guidelines. Moreover, the performance of HH is more significantly related to the safety of the professional, being less frequent before aseptic procedure and before contact with the patient(16).

Although there was not personal protective equipment such as gloves and masks, the midwife had an understanding of the importance of performing techniques that would minimize the transmission of infections. These techniques were important because of close contact with the parturient and sometimes because of the need to perform invasive techniques such as vaginal touch.

Thus, the midwife's performance in prenatal care took place through activities related to the pregnant woman's clinical, gynecological and obstetric evaluation, the evaluation of the baby, guidelines for maternal and fetal well-being, and the organization of the materials that would be used in the monitoring of labor and delivery.

Childbirth

In the process of parturition, the midwife was available to the pregnant women and she was called when the first signs of labor appeared. According to her, there were several signs that the birth was close: “[...] before the baby was born, sometimes there was blood...” (M) and when the bag brakes”[.. .] the hot water come, you know that is the water of childbirth [...]” (M), “When the bag brakes, we have to see how the child is [...] so we experience with the fingers [she showed the middle and index finger signaling how the vaginal touch was performed]” (M).

After the signs mentioned, the midwife verified the fetal presentation, the conditions of the maternal pelvis and the characteristics of the cervix, through the vaginal touch. Regarding the fetal evaluation, auscultation of the baby's heartbeat was performed as a way of assessing the child's well-being and identifying fetal distress.

In addition to performing technical procedures during the follow-up of the pregnant woman, it was found that the midwife also provided emotional support to work better with pain from labor and delivery. She commented patiently about the birth of the baby and showed respect for the position adopted by the woman at any stage of the parturition process.

Regarding the position adopted by the pregnant woman, the midwife affirmed that the parturient's autonomy was considered by the position she felt most comfortable with, as can be seen in the lines: “[...] sit and prop up a woman, a good midwife always prop them up [...]” (P). “[...] ah she does not need to lie down. No. There were many of them who did not have to lie down [...]” (P). “[...] she was sitting [the parturient] on a bench like that one [...]” (M). In this context, a study that aimed to identify practices adopted by obstetrical nurses in public maternity hospitals in the Southeast of Brazil corroborated the practices

adopted by the midwife when verifying that 65.5% of the parturients chose to give birth in vertical positions, followed by semi-vertical positions 15.9 %, with only 3.7% of the women adopting the lithotomy position to give birth. Other instruments, such as the obstetric bank were used in 11.0% of deliveries to stimulate upright positions and free pelvic movement of the parturient[17].

In addition to respect for the parturient's rights of choice with freedom and privacy, the appreciation of the uniqueness of each parturient and family are considered to be good obstetric practices, useful and that should be encouraged by health professionals attending childbirths and births[7]. The midwife used the main elements of management of care in its individual dimension, considering the individual's conceptions about being healthy[18].

In the expulsive phase, after the parturient had adopted the position that best suited her and was encouraged by the midwife, the baby was expected to arrive. At times, when labor was prolonged or the need for intervention was identified, the midwife mentioned to help with the birth of the baby by performing a cut in the woman's vagina.

The midwife's speech referred to the practice of episiotomy and episiorrhaphy: “[...] I cut, to the child be born [...] only if the child was not born [...]” (M) and “[...] as we have to sew [...] after the baby was born [...] what a complicated thing, is not it? [...]” (M).

Episiotomy is associated with clinical variables: primiparity, lithotomy position in the expulsive period, epidural analgesia, instrumented delivery, use of oxytocin in labor, induction of labor, post-term delivery, which may influence the increase of the rates. Other variables are protective factors against this procedure and are related to fetal weight of less than 2,500 grams, as well as to maternal age greater than 35 years old[19].

Women who have had normal birth have little knowledge about the procedure and some recognize it as normal and necessary for birth. In the meantime, it is incumbent on nurses and health professionals to provide guidance on the practice of episiotomy, noting that such a procedure should not be routinely performed because of a lack of scientific evidence to support it[7,20].

Care for placental deprivation occurred cautiously due to the risks, which may involve bleeding and retention of placental remains, as observed in the midwife's speech: “[...] and we take the placenta with all the affection [...]” (M). Then, the placenta revision is recommended for its condition, structure, integrity and umbilical vessels, ensuring placental remnants or membranes are not left in the uterine cavity[21]. However, this care was not mentioned by the midwife, and it was not possible to conclude whether it was performed.

Although at the time the midwife acted, the technological devices were not currently available - equipment, medications, materials, and supplies - using the empirical knowledge and the experience of the midwife for the childbirth. This is evidenced in the two practices performed at birth and quoted in the lines: “[...] for the child to come, we have to, these fingers here [showed index and middle fingers], very clean, have to put (M) and “[...] when he cries, that he drowns, you give him a little bit of warm water, you turn the child [...] then they swallow that water, then they vomit the water of childbirth... and then it drowns again, we shake them. And he patted their seats [...] right there [...]” (M).

Compared with the last speeches and showing the midwife's assistance at the time of the baby's birth with the placement of the fingers in her oral cavity, besides the use of warm water with the effect of clearing the airways after delivery, were not found in the literature, evidences of approaching these techniques, nor scientific support for the accomplishment of such conducts.

The skin-to-skin contact between the mother and the newborn was practiced by the midwife, being supported by the following lines: “[...] when the child is born, he comes, he cries, we go there, put him there on her lap [...] then we put the child in that cloth there, you understand? [...]” (M).

Thus, a study that analyzed good practices in obstetric nurses concluded that 97% performed early contact between the mother and the newborn and stimulated breastfeeding within the first hour after delivery. Besides facilitating the thermoregulation of the baby, this action stimulates breastfeeding in the first hour of life[22]. Also, it contributes to the bonding between the mother and the newborn.

As for the care of the newborn, they also involved handling with the umbilical stump, as is evident in the lines: “[...] and cut a piece of belly button like this all day [...]” (M), “[...] I cut the

navel, and washed it. At that time we washed it. Then, we would not wash it anymore ... A cloth with oil would be passed on the children [...]" (M). In this sense, the recommendation is that the cord clamping occurs when the pulse ceases physiologically, between one and five minutes after birth[21]. Although this is the recommended, the care taken by the midwife differed a little from the way they are practiced today, especially in the care of the umbilical stump of the newborn.

The care given to the baby in the first hours of life such as performing a physical examination, even if simplified, is an important method possible to identify abnormalities. This was verified by the midwife: "[...] we put his hand on the child's mouth, to see whether he is healthy or not, the little feet [...]" (M). When citing the verification of the child's mouth, it is suggested that she was observing the presence of some bad palate formation.

Through the statements of the midwife, it was possible to show that her care was not restricted only to the mother, but also contemplated the newborn. Similar results were also found in a survey of the experience of traditional midwife care. In addition to care for women during childbirth, the care to the newborn was also carried out, extending from the immediate postpartum period, to follow the evolution of the mother-child binomial[23].

Postpartum Care

The puerperium is a transitional period in which the woman gradually returns to the state of her pre-gravid state through local and systemic changes caused by pregnancy[24]. The care taken by the midwife contemplated a prolonged and daily follow-up of the woman and her baby to assist her in the hygiene of the newborn, as can be verified: "[...] so I took care of him for twelve days, it seems that […]" (M); "... every noon, I worked, and I was going to wash him [...]" (M).

The midwife quotes another care carried out in the puerperium: "[...] the woman lays down [...] on her back, then she presses the woman from her feet to her head, so after the baby was born [...]" (M) and "To do a massage, and he [husband] helped me, helped do the massages here" (M). In the context of care management, the family, represented by the husband, who is one of the actors considered in the dimension of family care, is related to support in different moments of the individual's life[18].

The presence of the companion, in this case, the husband, is mentioned only in the postpartum period, a fact that does not allow concluding whether it occurred at another time. Despite the participation of the companion in the process of birth and delivery, in health care facilities, this process has been challenged since 2005. The physical environmental conditions of the hospitals, the qualification of health professionals for the reception of the companion, and the attitude of the pregnant women to their rights should be considered[7].

Regarding to the return of the sexual activity of the puerperal woman, it was possible to observe the science of the midwife in the attempt of anticipation of the sexual act, by the companions of the women: "[...]there was already something else on top […]" (M). In the last speech, it is believed that the midwife referred to the sexual practice soon after the birth. It is important to advise the couple on the return of sexual activities, approximately 42 days after delivery, considering the conditions of each puerperal woman[24].

Conducting complications

The obstetric practices described so far were performed by the midwife in conditions of normality throughout the labor process, delivery and postpartum. However, in situations where complications were observed at some stage of the pregnancy-puerperal cycle, behaviors were quickly performed by the midwife so the situation did not worsen. When questioned about the existence of these complications, it was observed that some outcomes were not favorable: "[...]many women suffered, poor women" (M).

One of the complications cited was related to the threat of abortion evidenced in the midwife's speech: "[...] she spills the blood, then that´s it [...]" (M). Another aspect evidenced by the midwife related to complications of labor included the pelvic position of the baby: "[...] he came seated [...]" (M). The conduct, in this case, was: "[...] it is the mother who has to turn, not the child [...]" (M); "[...] do so with two fingers, but do not have a nail [...]" (M) and "[...] then we have to do it like this ... otherwise, it is up to the doctors [...]" (M).

In the case of pelvic vaginal deliveries, these should be performed in the absence of contraindications, under the guidance and consent of the pregnant woman regarding the risks and benefits of the two delivery routes. The

vaginal delivery is safe if assisted by trained professionals, in safety conditions and selection criteria, not being diagnosed only in the expulsive period and in twin pregnancy. Hospitals have specific criteria and care in these situations, generally described in the protocol[25].

Situations reported by the midwife were also evidenced in another study, which identified the main problems perceived by midwives in their practice. Among these problems, there were the out-of-position baby and pregnancy bleeding, among other complications such as “cord wrapped baby”, delivery and postpartum, delivery fever and eclampsia[23].

In this way, the way the midwife conducted the mentioned complications is observed. However, in some cases, even when performing their behaviors and the non-evolution of labor, the midwife accompanied the woman to the doctor, informing her condition: “[...] yes, if she is suffering, the child does not come, then we go to the doctor [...]” (M); “[...] the doctor goes to the woman's side and goes to the doctor: 'Look, I brought this lady who is not well here' [...]” (M).

The fact that the midwife accompanies the parturient to the doctor, providing the meeting between professionals and users, confers one of the dimensions of care management in the professional scope, with relationships based on technical preparation, ethics, and links. In addition to the professional dimension, the management dimension of systemic care can be associated, characterized by the connection between health services to establish networks of care[18].

Also in this context, in situations where the need to transfer some pregnant women to the medical care in the hospital scope emerged, the midwife's care regarding the hygiene of the woman was observed: “[...] to take her to consult, you have to prepare her very clean [...]” (M).

Some complications culminated in a cesarean section, as the midwife points out: “[...] I would go there, he would mark the operation for a person, it is not, to perform the cesarean section [...]" (P). However, sometimes, the midwife did not agree with the adopted behavior, as is evident in the lines: “ [...] I say, 'No, it is not so doctor' [...]” (M); "[...] it was the operation, the cesarean, but we could not do it [...]” (M).

The midwife also counteracts the use of forceps: “[...] I said, 'But why this doctor? Why this thing on the child's head? [...]” (M). The use of forceps is considered when fetal distress is identified or the second period of labor is prolonged[21].

Through these reports, it was possible to observe the challenges faced by the midwife participating in the study when complications occurred at some stage of the care provided by her. The research concluded that the main problems faced by midwives are related to the lack of material for deliveries and the protection of diseases, lack of support from the health services, lack of transportation, low pay, difficult births, among others[23].

Despite the complications during her practice and the difficulties in dealing with such situations, the midwife thanked for never having experienced the loss of a parturient and/or baby: “[...] I worked thirty-three years in this service and never, thank God, did not the mother die nor a child [...]” (M).

Although there were complications during the pregnancy-puerperal period, in the same way, that they occur today, the midwife had methods based on her experience and empirical knowledge for the most adequate conduct in each case, even without the possibility of enjoying technological development, and/or diagnoses of the present time.

Through these reports, it was possible to observe the challenges faced by the midwife participating in the study when complications occurred at some stage of the care provided by her. The research concluded that the main problems faced by midwives are related to the lack of material for deliveries and the protection of diseases, lack of support from the health services, lack of transportation, low pay, difficult births, among others[23].

In this context, the use of herbal teas was the way the midwife found and arranged to conduct labor and control the negative outcomes. The midwife cites the use of marjoram tea and rhubarb for hemorrhage, Coix tea to assist in fetal expulsion and mint and peach teas for other not mentioned occasions. Studies regarding the use of teas in the parturition process are necessary.

Alternative practices for pain relief were also used by the midwife: “She took a shower and had hot coffee [...]” (M); “[...] to warm up a cloth and put on the pain [...]” (M); “[...] Ah, I would do some exercises, turn around and turn back [...]” (M). In the meantime, currently considered as non-pharmacological methods of pain relief, the use of hot water in the immersion or spray mode is recommended for the relief of pain during

labor. Also, the pregnant woman was encouraged to wander and adopt vertical positions[21].

Permeating the currently recommended obstetric practices and those performed by the midwife, based on their empirical knowledge and experiences, it was possible to identify their performance from the discovery of the pregnancy of the woman, through labor and delivery, immediate postpartum and sometimes remote puerperium. It was also verified the midwife's care directed to the newborn, from aspects related to the immediate bond with his mother until care with his hygiene, contemplating the entire pregnancy-puerperal period of the mother-baby binomial.

FINAL CONSIDERATIONS

When describing obstetric practices performed by the midwife, it was shown that they have the potential to contribute to the humanized care at childbirth and birth, whose techniques are now performed under the backing of scientific evidence.

The analyzed history allows a nursing care management during the pregnancy-puerperal period for the humanization of care. Also, when accompanying the midwife's trajectory throughout the theme, evidenced by her orality, it is concluded that she was responsible for actions that culminated in the assistance of many women and babies with consequent family expansion and focused on safe care. However, despite the benefits of some techniques adopted by the midwife at the time of her performance, some are currently not indicated in the literature, generating the need for scientific support.

As contributions to the Nursing care management, there are the obstetric practices that have contributed to the humanization of childbirth and birth, to female empowerment as well as to positive maternal and fetal outcomes with patient safety practices. Thus, even though the aspects related to care management were unknown, the care provided by the midwife was based on the dimensions of individual, family, professional and systemic care.

The potential of oral history is highlighted, thematic as a research methodology by conferring visibility and recognition to people who have contributed and/or stood out in a given context. By giving a voice to the person to record his history, the relevance that the empirical knowledge and the experience of this one represent to the current scientific fact is recognized.

It is expected that this study will provide the reflection of the professionals who work in the obstetric scenario and have the potential to facilitate the analysis of their actions, behaviors, and interventions during the care provided to pregnant women, women in labor, new mothers and newborns, qualifying the assistance provided to this area of care.

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