Revista Brasileira de Enfermagem
REBEn



# Best practices in the delivery process: conceptions from nurse midwives

*Boas práticas no processo de parto: concepções de enfermeiras obstétricas*

*Buenas prácticas en el proceso de parto: concepciones de enfermeras obstetrices*

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**How to cite this article:**
Oliveira OS, Couto TM, Gomes NP, Campos LM, Lima KTRS, Barral FE. Best practices in the delivery process: conceptions from nurse midwives. Rev Bras Enferm. 2019;72(2):455-62. doi: http://dx.doi.org/10.1590/0034-7167-2018-0477

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**Submission:** 06-09-2018 **Approval:** 09-09-2018

**ABSTRACT**

**Objective**: to know the conceptions of nurse midwives about the care guided in the best practices to the women in the delivery process. **Method**: descriptive research with a qualitative approach developed in a Federal Maternity-School. Semi-structured interviews were conducted with 20 nurse midwives, and the speeches were categorized according to the thematic content analysis proposed by Franco. **Results**: the study reveals that care based on best practices should be based on scientific knowledge, avoiding unnecessary interventions and encourages the use of non-pharmacological techniques for pain relief, appropriate environment, individualized care, the bond between professional and parturient, as well as its role. **Final Consideration**: while criticizing the excess of interventions, nurse midwives value noninvasive techniques and interpersonal relationships, as well as the subjectivities of the parturient that contributes to the humanized care in the delivery process.

**Descriptors:** Nurse Midwives; Nursing Care; Comprehensive Health Care; Midwifery; Women.

**RESUMO**

**Objetivo**: conhecer as concepções de enfermeiras obstétricas sobre o cuidado pautado nas boas práticas às mulheres no processo de parto. **Método**: pesquisa descritiva com abordagem qualitativa desenvolvida em uma Maternidade-Escola Federal. Realizaram-se entrevistas semiestruturadas com 20 enfermeiras obstétricas, sendo as falas categorizadas conforme análise de conteúdo temática, proposta por Franco. **Resultados**: o estudo revela que o cuidado pautado nas boas práticas deve embasar-se em conhecimento científico, evitar intervenções desnecessárias e incentivar o uso de técnicas não farmacológicas para alívio da dor, a ambiência apropriada, a atenção individualizada, o vínculo e sintonia entre profissional e parturiente, bem como o seu protagonismo. **Considerações Finais**: ao tempo que criticam o excesso de intervenções, as enfermeiras obstétricas valorizam as técnicas não invasivas e as relações interpessoais, bem como as subjetividades da parturiente, o que contribui para o cuidado humanizado no processo de parto.

**Descritores:** Enfermeiras Obstétricas; Cuidado de Enfermagem; Assistência Integral à Saúde; Assistência ao Parto; Mulheres.

**RESUMEN**

**Objetivo**: conocer las concepciones de enfermeras obstetrices sobre el cuidado pautado en las buenas prácticas a las mujeres en el proceso de parto. **Método**: investigación descriptiva con abordaje cualitativo desarrollada en una Maternidad-Escuela Federal. Se realizaron entrevistas semiestructuradas con 20 enfermeras obstetrices, siendo las palabras categorizadas conforme análisis de contenido temático, propuesta por Franco. **Resultados**: el estudio revela que el cuidado pautado en las buenas prácticas debe basarse en conocimiento científico, evitar intervenciones innecesarias e incentivar el uso de técnicas no farmacológicas para alivio del dolor, el ambiente apropiado, la atención individualizada, el vínculo y sintonía entre profesional y parturienta , así como su protagonismo. **Consideraciones Finales**: al tiempo que critican el exceso de intervenciones, las enfermeras obstetrices valoran las técnicas no invasivas y las relaciones interpersonal, así como las subjetividades de la parturienta, lo que contribuye al cuidado humanizado en el proceso de parto.

**Descriptores:** Enfermeras Obstetrices; Atención de Enfermería; Atención Integral de Salud; Partería; Mujeres.

## INTRODUCTION

With the transfer of the home delivery to the hospital, it is notorious the increase of interventions in the delivery process, previously considered as a natural event. Due to the consequences for the woman and the newborn, there is a growing movement to encourage the humanization of delivery and birth based on strategies, mainly related to the use of soft technologies that enable the care of women in the best practices.

Best practices in the delivery process are those closely related to the process of humanization in obstetric care. According to recommendations of the World Health Organization (WHO), these should guarantee autonomy, respect for the right of women and the family, empathic support for health professionals, encouragement to use non-invasive and non-pharmacological methods for pain relief, freedom of position, and use of the best evidence in clinical practice, among others. These recommendations contribute to the distancing of the technocratic model of health care and encourage practices that reflect qualitatively in the humanization of delivery, which is based on a framework of practices and attitudes beneficial to maternal and child health and constant professional updating[1-2].

In Brazil, until the end of the 19th century, natural deliveries were performed almost exclusively at home by nurse midwives and were usually centered on respect for the physiological process of the parturient and their autonomy. From the 1960s, with the advent of delivery hospitalization, the technocratic model began to predominate, whose obstetrical care was based on the standardization of institutional rules, medicalization and the use of advanced procedures, often unnecessary, conducted by professionals health, sometimes in an authoritarian way[3-5].

Influenced by the industrial capitalism of the twentieth century, the increase in interventions in the delivery process reaches more and more prominence, boosting its commercialization, especially the cesarean ones, since these were easily adapted to the capitalist perspective, since they can be realized with greater agility and quantity[6]. We should emphasize that the advance of such situations, conducted largely by doctors, was based on the spread of cesarean delivery as a type of delivery that does not bring complications to the woman, implying in a process of social naturalization of this form of birth[7].

Thus, with scientific progress at the time and especially with the improvement of medical specialties, cesarean sections are strengthened as an intervention because of their significant contribution to reducing maternal and fetal morbidity and mortality, among other reasons[8]. In this sense, the decision of the woman on the route of delivery is influenced by the hegemony based on the use of hospital-centered techniques in obstetric care[3,5], as well as misconceptions and tendentious about delivery routes, as revealed in a review article that the sexual dysfunctions and/or pelvic dystopias the validated justifications given by the women requesting cesarean sections[9] and according to a study with 20,000 women in five Brazilian macro-regions that related the desire for cesarean section to fear of pain in delivery[10].

However, the benefits and harms of normal deliveries and cesarean surgeries should be pointed out. There is agreement in the literature that normal delivery is safer compared to surgery, because it presents fewer risks of infections, hemorrhages, prematurity and general complications, besides favoring the production of breast milk through the release of hormones, such as prolactin and oxytocin, which are manufactured during labor, which contributes to the woman's faster recovery and allows greater interaction with the newborn[11]. For these reasons, elective caesarean section should be avoided, thus reducing possible maternal risks, such as bleeding, infection and anesthetic complications. However, it should be emphasized that there are situations where cesarean section is indicated, as in cases of placental abruption, cord prolapse, segmental distension, fetal centralization, among others[12-13].

Despite the risks associated with cesarean surgery, Brazil is currently one of the countries with the highest rates of this procedure in the world, when the last WHO recommendation was that it was between 10 and 15%[14], although today it is recommended that only when strictly necessary[15]. A study carried out in São Paulo, Brazil, with 920 postpartum women, showed that in private services these values are exorbitant, totaling 93.8% of cesarean surgeries, whereas in the scope of the Unified Health System (SUS), this percentage is around 55.5%[16].

In this context of high indexes of expendable interventions, the performance of nurse midwives is worth highlighting. In Europe, cesarean rates can be reduced, reaching 14.7% in some places, and these values are closely related to nurse midwives assistance, which is also effective in reducing unnecessary interventions and the use of noninvasive technologies care that respect the autonomy of women based on scientific evidence linked to best practices[16-17]. These behaviors reflect the predominance of the WHO recommendations regarding the use of these techniques in order to reduce the number of unnecessary interventions in the care of women in labor, as well as the strong performance of nurse midwives to reduce the rates of cesarean sections[5].

In view of the significant progress made with the participation of these professionals in the care for women in labor and the national and international policies that have been encouraging this path, there is also an incentive by the Ministry of Health (MoH) regarding the training of nurse midwives. This training process has been taking place from the specialization courses, including the Residency form, as well as the provision of training courses for professionals already in the public health services of the whole country. Such spaces of improvement are directed to the internalization of the best practices as guiding axis of the care to the woman in delivery process[18-19], therefore understanding nurse midwives as primary professionals for the consolidation of best practices in the care of women in delivery process, which may favor the reduction of interventionist behaviors and the number of cesarean sections.

## OBJECTIVE

This study aims to know the conceptions of nurse midwives about the care guided in the best practices to the women in the delivery process.

## METHOD

### Ethical aspects

The research is linked to the matrix project "Social actors and factors involved in the delivery process", approved by the

Research Ethics Committee (REC) of the *Maternidade Climério de Oliveira* (MCO) of the *Universidade Federal da Bahia* (UFBA). The ethical and legal components were respected in all stages of the research, in accordance with Resolution 466/12 of the National Health Council (*Conselho Nacional de Saúde*).

### Type of study

This is a descriptive and exploratory study with a qualitative approach.

### Methodological procedures

#### *Study setting*

The study was conducted at a medium-sized Federal Maternity School located in the northeast of Brazil. This was a pioneer in obstetric-gynecological care in the country, and is currently a reference for teaching care in Obstetrics, Neonatology and Perinatal Health. Such maternity has different settings of care for women, such as Ambulatory, Joint Housing, Kangaroo Nursing, among others, and this research is directed to the Obstetric Clinic (OC).

#### *Data source*

Twenty nurses, 18 women and two men at the Obstetric Clinic (OC) of the institution participated in the study. It should be noted that in this sector there were 33 nurses, 23 specialists in Obstetrics and 10 in Women's Health.

As an inclusion criterion, we adopt nurse midwives that are active in the maternity care process referred to in the OC; who had at least one year of professional experience and six months of attachment in the maternity of the research. Nurse midwives who only held administrative positions and/or were removed from office for any reason were excluded. Considering these criteria, three nurses did not participate in the research: two due to the experience time less than 12 months and one due to medical remoteness.

#### *Data collection*

The data collection took place between June and September of 2017, using as technique the interview guided by a semi-structured form. It contained closed questions regarding the characterization of the participants, namely: gender, age, race/color, professional training time and experience in obstetric care in the study maternity; besides the following guiding question: tell me about the care of women in the delivery process. It is important to mention that this tool was previously tested with two nurses from another institution, in order to adapt it to meet the study object.

The interviews were conducted in private rooms in the maternity ward at previously scheduled times, according to the availability of the participant, being recorded with the aid of a smartphone and having an average duration of 60 minutes. After this stage, the interviews were transcribed in full and received identification codes from the abbreviation "N" referring to the "Nurse", followed by the Arabic numerals corresponding to the order of the interviews (N1, N2, N3, etc.) with to preserve anonymity.

#### *Systematization and data analysis*

The data were organized from Franco's methodological framework [20]. Based on the Thematic-Categorical Content Analysis, the speeches were submitted to the unitarization process, which required a re-reading of the messages attributed to the study object, favoring the identification and definition of the units of analysis (concepts, phrases, themes or words), being segregated in Registration Units and later in the Context Units.

Taking into account the compositions of the Registration and Context Units, these were re-elaborated with the purpose of exhausting the inferences regarding the object of the research, which resulted in the emergence of seven categories: *Care should be based on scientific evidence*; *Care requires the interaction between professional and woman*, with subcategories: *Bond establishment; Reach of the attunement of midwifery*; *Care requires an appropriate environment*; *Care requires individualized care*; *Care requires respect for the role of women; Care requires the use of non-pharmacological techniques for pain relief*; and *Care should avoid unnecessary interventions*.

## RESULTS

The nurse midwives interviewed had an average age of 31 years, most of them women (only two men), mulatto (n=15), and four-year average time in the Obstetrics. From the speeches it was possible to capture the conception of nurse midwives about care for women in the delivery process, illustrated from seven scientific categories:

### Care should be based on scientific evidence

Nurse midwives believe that care in the delivery process requires a practice anchored in scientific knowledge.

> *In order for you to take part in this kind of assistance, you have to study and practice, because you will have to support it with a scientific foundation.* [...] *must involve technical and scientific knowledge to ensure humanization in the care.* (N5)

> *Qualified care must be based on scientific knowledge. It is not an empirical care, since humanized care must be based on scientific evidence.* (N3)

### Care requires the interaction between professional and woman

According to the following statements, care requires the interaction of the nurse with the woman, which crosses through the establishment of bond for the reach of the attunement to midwifery. In this way, this category presented the following subcategories:

### Bond establishment

The study reveals that nurse midwives conceive the importance of bonding, which favors the trust of the parturient and the identification of the needs of women in delivery process, and may also reflect in their relationship with pain.

> *It is necessary to create a bond* [...] *to understand their needs so that they can trust me* [...] *to the extent of achieving self-control under their pain in the delivery process.* (N3)

> *The issue of bonding requires trust and helps in the possibilities of reducing the pain process, as well as reducing the feeling of vulnerability and threat at the moment of delivery.* (N20)

**Reach of the attunement of midwifery**

The study also shows that the interaction between the parturient and the nurse midwife allows synchronization between the two, to the point that the demands begin to be perceived without the need for verbal communication.

> *I felt more connected to the woman* [...] *we almost did not talk during labor and yet I understood her. I only intervened, touched and spoke when it was strictly necessary. She realized that we did not even need to speak to communicate* [...]. (N5)

> *We live the moment with her, because we are in tune together. There's no way you cannot get involved. It becomes one. She can settle down, stay calm, she can control the pain.* (N7)

**Care requires an appropriate environment**

Nurse midwives signal the relevance of the ambience in care to women in delivery process, which provides a safe and embracing environment.

> *When you are caring for the woman, other people should only get into the environment if necessary. It must be just you and the woman. She will feel more secure and you will be able to establish a connection.* (N5)

> *It is essential to have an environment so that there is a meeting between the person who is offering the care and the person who is receiving it.* [...] *an environment of embracement is one that is conducive to care being offered in a humanized way.* (N4)

**Care requires individualized care**

The interviewees also refer to the saliency of knowledge about personal data, Obstetrics and social context, as well as the perception of women during the delivery process, which favors individualized care.

> *The woman for me is unique. It is the woman who went in labor and that I need to know her name, age, the experiences of deliveries, the reason for choosing for motherhood and her project of happiness.* (N1)

> *Each patient needs an individualized care* [...] *to call her by name, to value her complaint so that she knows that she is being cared for. It's wonderful to have the sensitivity to understand how far I can go and the care I'm offering is good for the woman!* (N4)

**Care requires respect for the role of women**

The nurse midwives report the appreciation of respect for the role of women in the delivery process humanized from a participatory care.

> *I consider a humanized, individualized care, one that is based on respect for the woman's choices in the delivery process. We must provide information about the risks, benefits and consequences of each choice.* (N3)

> *Respect her will, guide and show that she is free to choose, even if she wants the involvement of the family member. All this is necessary so that naturally the woman develops the main role that she wants* [...]. (N8)

**Care requires the use of non-pharmacological techniques for pain relief**

The speeches indicate that the nurse midwives understand that care for women in delivery process is based on the use of noninvasive techniques and that favor pain relief.

> *At midwifery, I offer women the methods available for pain relief such as ball, ponytail, shower, ambulation, massage.* [...] *if you are predisposed to be together, it does and you will realize what it reacts to and feels better about. Do not just say, 'Do this and that'.* (N5)

> *We explained about massages, aromatherapy, penumbra, ball exercises, ponytail, warm bath. We try to explain to her that the pain is inevitable, real and what she will feel, but that these techniques can relieve pain.* (N7)

**Care should avoid unnecessary interventions**

By criticizing the use of some unnecessary interventions in the delivery process, nurse midwives signal that they compromise care, awakening to the need to avoid them in order to promote parturient care.

> [...] *a woman who is in an extended labor, with 7 cm of dilatation, with an amniotomy evaluation in order to accelerate the contractions, in my conception the first option would be to find out if I can move it or use some non-pharmacological technique. Most of the time interventions happen because they do not understand the context of the woman.* (N1)

> [...] *the patient is touched by several professionals, sometimes three times in less than five minutes. We worked with the woman for hours, so we know if they can give birth normally.* [...] *the problem is when, even with increasing dilatation and normal cardiotocography, cesarean referral occurs, especially when they are primigravidae. This situation is discouraging for us.* (N14)

## DISCUSSION

The research reveals that in nurse midwives conception, care based on best practices for women in the delivery process must be based on scientific evidence, which underlies and guides the practice of professional care and, consequently, a humanized care. A study conducted in five hospitals in the Southeastern United States with 433 nurses also considers the importance of Evidence-Based Practice (EBP) when they argue that scientific knowledge supports attitude, level of ability and organization in care, providing improvements in the work performed nurses and, consequently, the quality of care provided to individuals[21].

We should highlight the association between EBP and the improvement in care practices verified in a study carried out in São Paulo, Brazil, with 50 puerperae and 102 charts from July to November 2014[22], which presented similar results with a survey of nurses in San Diego, California[23]. An Australian study advances on the effects of EBP on the practice of Nursing care by highlighting its salience for acquiring greater professional security, contributing to the training of differentiated professionals in the sense that they complete the graduation more technically prepared[24]. The interface between technical and scientific knowledge was also pointed out by nurse midwives, who acknowledge both the update on midwifery and its practice, which was also signaled in Brazilian studies, which complement that this practice provides less interventionist care, favoring bond establishment[18,25].

Bonding is also understood by nurse midwives as an important care for women in the delivery process. They believe in the value of the trust, an essential process so that they can recognize the demands of the parturients, so that they can favor the tranquility for the same ones in the delivery. Research carried out with 18 nurse midwives at a Delivery Clinic in Rio de Janeiro, Brazil, points to the relevance of the interpersonal relationship between nurse and woman, since the human bond is a factor related to emotional support, which interferes with the parturition process[26]. This is because among the elements capable of promoting relaxation and reducing the painful perception of the parturients, one finds the contact with the trustworthy professional, conveying the same safety and comfort. These sensations of embracement, support and support can be facilitated by the midwife/woman relationship that are achieved through spaces of listening, dialogue, appreciation and respect for the experiences of the parturient based on the desire of the professional to be present in the delivery process[26].

The importance of nurse midwife's presence in bond in the interviewees' speeches is evident. Confirming about the salience of the presence, a qualitative study carried out at a maternity hospital in Norway with nurse midwives, points to the relevance of continuous follow-up and support to the parturient[27]. A study in Australia pointed out that women need to establish the relationship with the nurse for care in the delivery process, this relationship in turn favors the existence of bond[28]. Being present motivates a relation of encounter, which is based on the philosophy of Martin Buber[29], which presupposes this essential moment for the face-to-face encounter, sometimes supported in the presence of silence from the other.

This silent interaction, understood as nonverbal or therapeutic communication, can also be considered a form of care based on the best practices to the woman in delivery process, because it favors the freedom of expression of the same[30-31]. Nonverbal communication was also studied in the Netherlands, based on an observational research with a group of 20 nurse midwives, which found the existence of this process of interaction also in the prenatal, contemplating also that this approach gives them support for decision-making, leading the woman-centered clinic[32]. Therefore, the behavior in the care permeates the interaction between the nurse and the parturient, enabling a connection that culminates in the attunement of midwifery.

Attunement happens through the looks, touches and gestures that are expressed by the parturient in labor, which can be recognized by the nurse midwife. By virtue of this, it is possible to perform care for women in the delivery process by building a relationship of closeness and intimacy. Such a relationship favors the identification of situations that bother women at the time of pain, in addition to promoting freedom of expression and creating a space of openness for care by nurses[26,31]. It is about the involvement and disposition between the parturients and the health professional, a connection that favors the bond, resulting in the harmony during midwifery, which is pointed out in a study carried out with 12 parturients and eight Colombian nurses[33].

Desiring to reach the interaction, the interviewees also defend the importance of environment as one of the elements of best practices, in the sense of enabling the connection between professional and parturient. Besides the adequate physical space, the environment includes a set of physical and emotional characteristics of the subject, important for the establishment of interpersonal relations, but also contributes to the consolidation of humanization of health[34-35]. Research carried out in Ceará, Brazil, with eight parturients, evidenced the need of the environment to promote an embracing space, respecting the privacy in the delivery process[36]. In this sense, the environment interferes in the relationships, so it can be inferred that a warm environment facilitates humanized care in health.

Another conception linked to the best practices that emerged from the study points to the importance of looking at the subject as a single being, which requires the identification of the parturient by her name, knowledge about her obstetric situation, as well as her anxieties and expectations. For them, individualized care enables the implementation and evaluation of the systematization of women's care. Integrative review carried out in national and international databases revealed that individualized care during midwifery enables appropriate assistance to biopsychosocial needs, which guides the identification, planning, execution and evaluation of the behaviors to be adopted[30]. In this individualized care, the experience of midwifery is consolidated only and effective, since the woman is understood in its essence, directing the care associating the fulfillment to the expectations of the same one and criteria assistance to promote the quality of the care.

Given the above, health professionals need to consider the individuality and subjectivity of the parturient, valuing the sharing of experiences and knowledge through intersubjectivity, in order to direct a project of happiness. According to José Ricardo Ayres[37], this project encompasses the conception of life of the people we care for in the care delivery. It is not a project characterized by the definition of tasks and deadlines to reach a goal, but that implies a compression of the "lived experiences, shares, intersubjectivities, interactions and openings". Specifically in the delivery process, it is relevant to seek the woman's life history, which is marked by individual and collective experiences, which leads to an understanding of her subjectivity and acceptance/openness to care, from intersubjectivity aggregating the other's gaze into the relationship.

Respect for the subjectivity of the individual is one of the aspects of humanization in the field of Clinic of the Subject, which is based on the amplification of the compression of the person beyond the biological risks. It also considers the emotional, social, economic, and cultural aspects brought by the subject, as well as the collective and political issues of the subject[38-39]. This

expanded understanding of the subject favors their participation and autonomy in health care, which also emerged as nurses' conception of care in the normal delivery process.

Humanized care and its applicability in practice is closely related to the guarantee of women's right to choose in the delivery process, and women should be assured the right to an informed choice about the risks and benefits of their decisions[3-4]. This right refers to autonomy, which is related to respect for the role of women in the delivery setting, as nurse midwives value the importance of participatory and individualized care, providing information to the woman about the risks and benefits of each choice[40].

It should be noted that the role of women makes it possible to minimize the unnecessary interventions that, according to nurse midwives, cause dissatisfaction, such as excessive vaginal touches, amniotomy and cesarean section without indication. These data are also corroborated by the *Nascer no Brasil* survey, which points to routine amniotomy and cesarean section with no indication as frequent dispensable interventions in the country[10]. Research with puerperal women in Brazil reveals that they lacked therapeutic communication during some visits and procedures, such as vaginal touch and amniotomy, which triggered a feeling of anguish for the person cared for[30]. Specifically on the successive and indiscriminate vaginal touch made by more than one evaluator, most often in a shorter time interval than the recommended one, it is worth pointing out that this impairs the physiological evolution of delivery as well as causes discomfort in the woman and edema in the vulva, which makes them more nervous and insecure[41]. In the conjuncture of unnecessary interventions, nurse midwives have stood out in the continuous follow-up of women in the low-risk delivery process, since they make possible the change of the obstetric and neonatal model directed to the incentive of the best practices, being the interventions realized when there is need and support of scientific evidence[42-43].

The study also revealed the importance of the use of non-pharmacological techniques for the relief of pain in nurse midwives and their presentation to the parturients. In 1996, the World Health Organization created a classification of delivery-oriented Based-Evidence Practices on scientific, emphasizing those that should be carried out and, on the other hand, discouraged by health professionals[3]. A study carried out in Rio de Janeiro, Brazil, which evaluated records of 2,194 deliveries performed by nurse midwives showed encouragement to the non-pharmacological techniques of pain relief in the delivery process, such as: change of position, movement, use of warm water in the shower, music therapy, aromatherapy and reduction of the number of episiotomies[5].

Best practices are not limited to the use of non-pharmacological techniques for pain relief, including the elements mentioned here by nurses as care for women in delivery process, such as the scientific evidence that supports the interaction between health professionals and woman, grounded in the establishment of bond and in the reach of the attunement for midwifery. Still, it encompasses individualized care according to the specifics of each woman, respecting their role, as well as makes it relevant to avoid the use of unnecessary interventions in the delivery process.

### Study limitations

Although the research is limited by having a homogeneous study population with regard to training as nurses specialized in Obstetrics, it is important to mention that this orientation is not restricted to this category, since it is knowledge that can extend to any professionals of health care services to the parturient, who can adapt their behavior based on good practice. This process can be conducted by maternity managers, considering the specifics and needs of each service, through education in service so as to better prepare the professionals to take care of the delivery process.

### Contributions for the sectors of Nursing and Health

The research contributes to the area of Nursing, by enabling a reflection on the interpersonal relations that permeate the conceptions attributed to care guided in the best practices in the delivery process by nurse midwives. It is a matter of providing care in health practices aimed at valuing the demands of women, and incorporating their perceptions during care with the support of scientific evidence. In addition, the research suggests the foundation between the technical and humanistic knowledge as axis for the care carried out by nurse midwives, providing the quality in the health practices.

## FINAL CONSIDERATIONS

The study points out that nurse midwives conceive that care based on best practices for women in the delivery process should be supported by scientific evidence, which directs their behavior towards other forms of care. Imbued with such a conception, they believe that care requires the interaction between the professional and the woman, achieved through the establishment of the bond and the attunement of midwifery. In order to do so, we need an individualized care, respecting the role of women and adequate environment. Added to this, nurses understand that by avoiding unnecessary interventions and using non-pharmacological techniques for pain relief, they are also performing more humanized care.

These findings lead to the understanding that care in the delivery process is not restricted merely to assistance from the use of invasive procedures, as it also requires a set of knowledge and soft technologies that contribute to a more participative and integral care to the parturient.

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