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Experience of professionals and residents working in the obstetric center on birth plan use

Experiência de profissionais e residentes atuantes no centro obstétrico acerca da utilização do plano de parto

Experiencia de profesionales y residentes que trabajan en el centro obstétrico sobre el uso del plan de parto

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Abstract

Objective: to know the experience of professionals and residents working at an obstetric center about birth plan use. **Method:** qualitative research, developed with seven professionals and five residents working at an obstetric center of a teaching hospital located in southern Brazil. Data were collected using a semi-structured questionnaire, from November to December 2020. The data obtained were submitted to thematic content analysis. **Results:** the lack of knowledge or updating emerged as one of the reasons for not using the birth plan, in addition to inadequate sizing to meet the service demands. Among the possibilities for birth plan use, there is the elaboration during prenatal consultations and the performance of a multidisciplinary team. **Conclusion and Implications for practice:** The search for knowledge is the main key to increase feasibility and, consequently, the use of this document during prenatal and labor. Knowledge about birth plan use promotes conditions for women to exercise autonomy and role during labor, childbirth and birth.

Keywords: Pregnancy; Women's Health; Parturition; Decision Making; Labor, Obstetric.

Resumo

Objetivo: conhecer a experiência de profissionais e residentes atuantes no centro obstétrico acerca da utilização do plano de parto. **Método:** pesquisa qualitativa, desenvolvida com sete profissionais e cinco residentes atuantes em um centro obstétrico de um hospital de ensino localizado no sul do Brasil. A coleta de dados ocorreu por meio de um questionário semiestruturado, no período de novembro a dezembro de 2020. Os dados obtidos foram submetidos à análise temática de conteúdo. **Resultados**: a carência de conhecimento ou de atualização surgiu como um dos motivos para a não utilização do plano de parto, além do dimensionamento inadequado para atender às demandas do serviço. Entre as possibilidades para a utilização do plano de parto, têm-se a elaboração durante as consultas de pré-natal e a atuação de uma equipe multiprofissional. **Conclusão e Implicações para a Prática:** a busca pelo conhecimento é a chave principal para aumentar a viabilização e, consequentemente, a utilização desse documento durante o pré-natal e trabalho de parto. O conhecimento acerca da utilização do plano e parto promove condições para o exercício da autonomia e protagonismo da mulher durante o trabalho de parto, parto e nascimento.

Palavras-chave: Gravidez; Parto; Saúde da Mulher; Tomada de Decisões; Trabalho de Parto.

Resumen

Objetivo: conocer la experiencia de los profesionales y residentes de la salud en el centro obstétrico sobre el uso del plano de parto. **Método:** investigación cualitativa, con siete profesionales y cinco residentes sanitarios en un centro obstétrico de un hospital localizado en el sur de Brasil. La recopilación de datos se produjo mediante un cuestionario semiestructurado, en el período de noviembre a diciembre de 2020. Los datos obtenidos se sometieron a un análisis de contenido temático. **Resultados:** la falta de conocimiento o de actualización surgió como una de las razones para no utilizar el plan de parto, además del inadecuado dimensionamiento para satisfacer las demandas del servicio. Entre las posibilidades para la utilización del plano de parto, está la elaboración durante las consultas prenatales y la actuación de un equipo multiprofesional. **Conclusión e Implicaciones para la práctica:** La búsqueda de conocimiento es la clave para aumentar la viabilidad y, en cnsecuencia, la utilización de este documento durante el prenatal y el trabajo de parto. **E**l conocimiento sobre el uso del plan de parto y nacimiento promoverá las condiciones para el ejercicio de la autonomía y el protagonismo de las mujeres durante el trabajo de parto, el parto y el nacimiento.

Palabras clave: Embarazo; Salud de la Mujer; Parto; Toma de Decisiones; Trabajo de Parto.

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INTRODUCTION

The care provided to women during the pregnancy and parturition process has undergone changes throughout history. Birth, previously exclusively assisted by women, known as midwives, and which took place in the family environment, from the 20th century onwards, became a hospital and surgical event.[1] During this period, with the advancement of technology and science, it was possible to establish an attention focused on the control of complications and possible maternal-fetal risks. It is in this scenario that the technocratic model of attention to birth and childbirth arises, limiting women's autonomy.[2]

Influenced by the new model instituted, professionals in the area of obstetrics incorporated these practices into their care for birth and childbirth. Normal birth came to be seen as a model of violent care, and, in order not to be victims of this form of care, they began to opt for abdominal surgery, cesarean section. Thus, cesarean section becomes the main route of birth, naturalizing childbirth through surgery.[1] However, it is known that elective cesarean section without indication can lead to complications and increased risks for women and newborns, when compared to normal birth.[2,3]

Contrary to this perspective, several social movements were initiated in favor of women's reproductive and sexual rights. The information about the humanized birth arises at this juncture. In the same period, in the late 1970s, the birth plan (BP) emerged as a facilitator for communication between pregnant women and health professionals, aiming to establish autonomy during the parturition process.[1]

BP is revealed as the first measures of a series of recommendations, established by the World Health Organization (WHO), called "Good Practices of Birth Care and Childbirth".[4] Through this document, Brazilian states begin to reflect on how they are conducting work and what role women are working in during this experience.[2,5] From this, a series of programs and ordinances were created by the Ministry of Health (MoH), in order to contemplate actions from the perspective of prenatal care, birth and puerperium, strengthening, above all, women's autonomy.[1]

With the growing progress in issues related to the humanization of birth and measures to reduce maternal and child morbidity and mortality, the MoH prepared, in 2004, the Brazilian National Policy for Comprehensive Care for Women's Health (PNAISM - *Política Nacional de Atenção Integral à Saúde da Mulher*), which has as one of its objectives to improve Brazilian women's living and health conditions.[6] Based on this need to continue leveraging and achieving the stipulated goals, in 2011, the *Rede Cegonha* (Stork Network) program was launched, which provides women with a care network, bringing the right to reproductive planning and humanized attention to pregnancy, birth and the puerperium, as well as ensuring children the right to a safe childbirth and healthy growth and development.[7]

Thus, in order for women to have greater autonomy and for the birth process to be humanized and individualized, it is essential that she be aware about the interventions that will be performed. Thus, for this empowerment to be realized, the pregnant woman can take advantage of tools such as BP.[3,8] BP is a legal document that must be presented at the time of hospitalization in writing and can be prepared together with the partner. In this document, the preferences and interventions that women consider unnecessary during labor and birth are included. It is recommended that BP be constructed after clarifying the physiology of labor and childbirth, having, above all, the understanding of the possibility of making choices.[1]

The WHO and the MoH guide BP use, as it provides women with more objective communication, encouraging their participation and decision-making in the parturition process, in addition to avoiding the need to verbalize their desires during labor and birth. In this tool, pregnant women can enter information regarding expectations regarding obstetric management, such as the desired route of birth, name support people who will be present, desired body positions during labor and birth, choice in relation to water and/or food intake, newborn care, medical interventions in the event of complications, in addition to observations related to cultural and religious aspects.[1] Still, its application also encourages birth to happen in a more natural way, with less risk of interventional procedures.[3]

A study conducted in Spain with 178 pregnant women, who had habitual pregnancy, showed that BP was used by 37% of women. The group of women whose compliance was low (less than or equal to 50%) had a cesarean section rate of 18.8%, and their children had worse results in Apgar and umbilical cord pH. Meanwhile, in women with high education (75% or more), the percentage of cesarean sections dropped to 6.1%, and their children had better results.[9] Thus, it supports the importance of implementing the BP, from the perspective of assisting in women's autonomy and role during parturition, enabling a less painful, pleasurable and, above all, unforgettable experience.[3]

Although BP is a document recommended by the WHO and the MoH, its use is still restricted, since many health professionals, hospitals and pregnant women are unaware of the existence of the document or have little knowledge about it, reducing the chances of its use.[3] Situations like this reinforce the need to deepen knowledge about BP during prenatal consultations, enabling the dissemination of this material and, at the same time, favoring its construction with the help of prenatal professionals.

In this perspective, in case of humanized childbirth practices, it is essential that health professionals continue to study about new ways to help women in this process. In addition to respecting the physiology of birth and not intervening unnecessarily, they must recognize the social and cultural aspects of birth and childbirth; provide emotional support to women and their families; facilitate the formation of affective family bonds and the bond between women, children and family; create spaces for women to exercise their autonomy throughout the process; allow a companion of the pregnant women's choice; and inform women about all the procedures to which they will be submitted.[10]

In order to identify the scientific production about BP, a search was conducted in national and international literature using the keyword "birth plan" in the Virtual Health Library (VHL). The

productions available in the last ten years reflect the incipient debate on this tool on the national scene, in which only 148 studies were found. A small number of national publications on use were found, mainly involving the public health network. Nevertheless, international scientific production addresses this theme more frequently, since 758 studies were found. Many publications cover BP use from different perspectives, from women, health professionals and regarding maternal-fetal outcome. Moreover, the studies indicate the benefits of BP use, especially with regard to the empowerment of women during birth, in addition to helping to resolve anxieties and doubts regarding this event. This growing number of studies is a reflection of how BP is accepted in foreign countries, as it is incorporated into health services.

Thus, this research is justified by the need to deepen knowledge about BP use, since it is a tool that allows the empowerment of women during parturition. Based on this, this study, arising from the conclusion work of the main research, presents the following research question: what is the experience of professionals and residents working in the obstetric center regarding BP use? This research aimed to know the experience of professionals and residents operating in the obstetric center about BP use.

METHOD

This is a field, qualitative, exploratory and descriptive study.[11] The research was developed between November and December 2020 at an obstetric center (OC) of a teaching hospital located in southern Brazil.

The hospital institution is characterized by being a teaching, general, public hospital, which performs its care 100% through the Unified Health System (SUS - *Sistema Único de Saúde*). Regarding the OC, it is considered an open-door service and, therefore, both pregnant women with high-risk prenatal care and those at regular risk are treated at this location. The OC team consists of 52 medical professionals (preceptors and residents in the area of gynecology and obstetrics), 15 nurses, five obstetric nurses, in addition to 30 nursing technicians, six residents linked to the Multidisciplinary Residency in the area of women's and children's health care (professionals in nursing, nutrition, speech therapy, social work, physical therapy and occupational therapy and two residents linked to the Medical Residency Program in gynecology and obstetrics). The sector currently has 14 inpatient beds. The monthly average is around 1,420 hospitalizations.

Prior to the beginning of data collection, the possible participants were identified. For this identification, the registration form of the institution's OC professionals was used. After this stage, a previous meeting was held with the head of the service, to clarify the research. The researcher elaborated an inviting folder, and sent it to the head of the service. Subsequently, the survey was shared in some groups on WhatsApp. It should be noted that the researcher had a bond, as a professor of the nursing course, with the hospital where the research was conducted. Moreover, the research team was composed of nursing students who were close to the scenario through practical activities. The team was previously trained to collect information.

The population consisted of seven professionals from different health areas working in the hospital's OC, in addition to three students from the Multidisciplinary Residency and two students from the Medical Residency in gynecology and obstetrics; these were intentionally invited to participate in the research. Health professionals or residents working in the OC of that hospital for one year were included. Professionals and students who were on vacation, maternity leave or medical certificate during the data collection period were excluded from the research. The inclusion of new participants was terminated when the data saturation criterion was reached.[11] Thus, when the recurrence of information was identified and the objective of this study had been achieved, data collection was terminated. It is noteworthy that there were no refusals or withdrawals during the data collection procedure.

Data collection took place virtually, through a questionnaire developed by the main researcher at Google Forms. It should be noted that a pilot test was carried out in order to improve the data collection instrument. Regarding the questionnaire, it involved closed questions, referring to participant characterization, and open-ended questions, directed to the research objective.

The information originated from data collection was analyzed in full and reassembled into a file in Microsoft Word. Thus, the questionnaires were submitted to thematic content analysis,[12] in which the regrouping of the questionnaires and the re-reading of the content were carried out, for familiarization with the data. Subsequently, the generation of codes, search and review of themes took place, highlighting significant words and/or expressions. From this, it was possible to define and name the themes. At the end, with the production of a report, the interpretation of the results obtained from national and international theoretical frameworks in the maternal and child area was carried out.

The research was approved by the Research Ethics Committee on November 3, 2020, under CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 29688920.00000.5346, Opinion 4,375,270. The study was developed respecting the rules contained in Resolution 466/12 of the Ministry of Health's Brazilian National Health Council. Prior to the presentation of the questionnaire, participants assessed and signed the Informed Consent Form. To ensure anonymity, the names of health professionals were replaced by the letter "P", and of residents, by the letter "R", followed by a number.

RESULTS

Seven health professionals from the institution and five residents participated in the study, from different areas of activity, with all (100%) residing in the municipality. Among these, 91.66% (n=11) were female and 83.33% (n=10) declared themselves white. Regarding marital status, 50% (n=6) had partners, 41.66% (n=5) were single and 8.33% (n=1) were divorced. The majority 66.66% (n=8) had no children. Regarding family income, 66.66% (n=6) reported receiving more than six minimum wages, 25% (n=3), from four to six minimum wages, and 25% (n=3), from one to three minimum wages.

Of these seven professionals, 45% (n=5) were nurses, 8.33 (n=1) were nursing technicians and 8.33 (n=1) were physicians. Regarding the five residents, 8.33% (n=1) were residents in speech therapy, 8.33 (n=1) were residents in physiotherapy, 8.33 (n=1) were residents in nursing and 16.66 (n=2) were residents in gynecology and obstetrics. Most professionals and residents (58.33%; n=7) were between 18 and 30 years old.

In addition, in relation to the time of work in the OC, 41.66% (n=5) reported working from one to two years, this being the period of work of the five residents and one professional, 16.66% (n=2) worked from 2 to 3 years, 8.33% (n=1) worked less than one year, 8.33% (n=1) worked from five to six years, 8.33% (n=1) worked from six to seven years, 8.33% (n=1) worked from seven to eight years and (1) over 10 years. Of the total number of professionals who answered the questionnaire, 66.66% (n=8) have some specialization.

From the analysis of data from the questionnaires, two categories were listed, namely: *Reasons for not using the birth plan*; and *Possibilities for using the birth plan*.

Reasons for not using the birth plan

This study demonstrated some factors that make it difficult or prevent BP use, such as the emergence of a lack of knowledge or professional updating, according to several statements made by the research participants. Professionals and residents highlighted that this lack of knowledge drives the use of care practices already consolidated in the service, to the detriment of the care model centered on women and their families. The statements listed below, pertinent to the questioning about the reasons that lead to not using the BP, reinforce this finding.

> *Lack of knowledge of professionals* (P3).
>
> *Team that does not talk and does not update itself on the humanization of birth* (R1).
>
> *The non-acceptance of professionals, denial of this right to patients, lack of knowledge of professionals and patients* (P1).
>
> *Lack of interest from preceptors and medical residents* (R2).
>
> *Presence and/or assistance by outdated professionals, who are still focused on the medicalization of birth and cannot see women as a protagonist. I believe that the institutional hierarchy can also get in the way* (P7).
>
> *Lack of knowledge or non-use by professionals* (R4).

Another factor listed was the inadequate sizing of professionals to meet all the service demands. They also signaled that Primary Health Care (PHC), a service which is responsible for most of the prenatal care at usual risk, is a powerful space to work and encourage the construction of BP and childbirth.

> *Lack of quantitative and team collaboration, lack of empathy of some professionals. Lack of encouragement to perform the same during prenatal care* (P6).
>
> *Pre-ready and plastered birth plans, taken from the internet, which do not match the reality of our service, we do not have epidural birth analgesia, swimming pool, pre-birth room and individual beds, among others* [...] *the elaboration could be developed in the prenatal period, with the help and help of the team to answer questions* (P4).
>
> *When there is a line of care with a truly multi-professional prenatal care network of primary care that gives the pregnant woman the opportunity to know all the truths about the phase she is going through and not just the directed and mistaken guidance that exists today* (R3).
>
> *Great demands from patients and the lack of professionals, mainly from the nursing team, which makes assistance difficult* [...] *lack of an active and specific multidisciplinary team for the OC* [obstetric center], *currently we depend on opinions* [...] *being requested only in specific cases. The insecurity of professionals, especially the medical team, in relation to the birth plan, as the vast majority provide interventionist and authoritarian assistance, not allowing parturient women to express their wishes* (P5).

The statements in this category point to the need for action that goes beyond the biomedical care model, which is centered on the medicalization of birth care. This care model disregards woman role, corroborating the use of procedures not desired by her, disregarding the BP. In addition to this, they point to the BP construction in prenatal consultations in the PHC scenario.

Possibilities for using the birth plan

In this category, suggestions and other implications for the elaboration and support of BP in services were included. Professionals and a resident pointed out that approaching the BP elaboration during prenatal care is a decisive factor for its use to become more recurrent in the service, in addition to the fact that it may be more widespread among professionals and pregnant women.

> *We can encourage our prenatal patients to inform themselves in advance about the topic and to develop their own birth plans* (P3).
>
> *Talk to the team. Set as a team goal. Advocate in prenatal care* (R1).
>
> *I believe that, mainly, in prenatal care, as it takes time for reflection and assimilation of women's own choices, family and how they want things to happen at birth and childbirth* (P2).
>
> *That the incentive and guidance for completing the birth plan be implemented in the prenatal care here* [hospital institution where the professional works] *so that a greater number of pregnant women would arrive with it ready and acceptance by those more resistant professionals would become necessary* (P6).

Furthermore, the partnership with academia and the performance of a multidisciplinary team were also widely mentioned by the research participants. Having a multidisciplinary team expands the vision of care, enabling BP feasibility. Furthermore, the participation of academia in this scenario prepares the future professionals and expands its ability to articulate with other areas and knowledge. This association enables teamwork from the perspective of a more humanized and sensitive look.

> *Strategies that include guidance and encouragement to develop a birth plan during high-risk prenatal consultations. The consultation needs to be multidisciplinary and not just with medical professionals. Monitoring by nurses is also essential* [...] *I believe that visits to the maternity hospital during prenatal care are also important for pregnant women to get to know the place, form a bond with the institution and feel more comfortable and empowered for the birth plan construction* (R5).
>
> *Multidisciplinary team. Professionals encourage the pregnant woman to build hers. Talking during prenatal care with the pregnant woman and making this planning* (R1).
>
> *Involvement of the academy in high-risk prenatal care, I believe that nursing students could act, which would help to carry out the birth plan* [...] *there is multidisciplinary prenatal care in the hospital, but they could invest more in health education. Update of the medical and nursing staff on the birth plan. Institutional stimulus for birth plan implementation and use and good practices* (P5).

Also, professionals and residents mentioned that, in order to increase BP compliance, it is necessary for the team to be able and free from prejudice for guidance and construction, as well as that pregnant women themselves and their families seek information about the topic and the place where the birth will take place. In this regard, they will be informed to structure their material and the moments in which it can be applied.

> *We can develop a model of our own with all the possible options to be carried out in our service and offer it to the pregnant woman as a guide. We can offer this model, but leave the pregnant woman free to choose and edit as she wants* (P4).
>
> *Training of service professionals on the instrument and importance of adapting the mother's wishes to service protocols* (R2).
>
> *The openness of professionals to handling the plan. Training for unit professionals* (P1).
>
> *Guidance, I think that guidance and health education during prenatal care are the biggest facilitators for women to know about the birth plan existence and use. I also believe that the birth plan should be more widespread among professionals, through training, so that everyone respects and encourages its use* (R5).

The research participants recognize that this document has a positive impact on care. Additionally, they expressed that it should be used at various times of hospitalization.

> *There is nothing wrong with developing a birth plan that expresses the patient's wishes in order to make this moment even more special and pleasurable, and this should be encouraged* (P4).
>
> *I believe that in the reception itself and risk stratification, during the hospitalization guidelines and before the work starts, if possible* (P3).

The statements in this category show that, in order to increase BP use compliance, there needs to be a partnership between health professionals and pregnant women. It is essential that there is a search for knowledge between the two parties, for whom, in this way, the elaboration of the document is compatible with the reality in which they are inserted. Moreover, multidisciplinary interaction also strengthens assistance, while enabling the execution of work that respects the particularities.

DISCUSSION

In the statements, it can be observed that the professionals considered BP use as an important factor for the empowerment of pregnant women and also as a guiding instrument for the team that will assist them during labor and birth. However, they listed the lack of scientific knowledge as the main factor for not using BP in the service. At the same time, they recognize that it is essential that the team maintain a routine of continuing education, so that they can keep up to date and, in this way, develop care with greater uniqueness. Through this, workers are provided with both personal and professional development. Providing these learnings is the way for developing new skills.[13]

Still, many professionals and residents considered that, in order to have a greater BP use, it is necessary to have an explanation of this document in PHC. A recent study carried out in the state of Pernambuco, with 80 pregnant women who underwent usual risk prenatal care in a basic unit in the municipality, showed that 88.7% said they had no knowledge about BP. This study showed that the lack of knowledge on the subject made it impossible to carry out and apply BP. Thus, it is clear that there is a gap in information, since professionals develop the theme in question with difficulty, or, in many cases, they do not even do it.[14]

In another study, carried out in a Family Health Strategy on the western border of Rio Grande do Sul, with 15 generalist nurses, revealed that the professionals interviewed did not know BP, and, even those who knew, had a mistaken notion of the document, confusing it with prenatal care, requesting exams and choosing the birth route. Despite this, the interviewees recognized their weaknesses and showed interest in seeking updates on the

subject. However, also mentioned that it was difficult to prepare the document, due to the excessive demand for work and non-compliance of the maternity to BP, in addition to the small number of professionals with knowledge and acceptance of BP.[15]

Linked to this fact, another relevant point for the service to be more humanized for pregnant or parturient women can occur through the performance of a multidisciplinary team, which plays an important role in the smooth running of the service. Recently, a survey was conducted in a public hospital in southern Brazil, which was composed of a multidisciplinary team, consisting of a physician, nurse, nursing technicians, nursing assistants, social worker and professor. The study revealed that when professionals were able to plan and execute care together, the team's level of satisfaction with the service was higher, allowing the team to strengthen their personal relationships, making them more consistent and lasting.[16]

In a survey carried out with 12 pregnant women in the state of Santa Catarina, most (83%) interviewees considered the role of nurses to be important in prenatal care consultations. Through the reports, the interviewees showed a preference for consultations with professional nurses, because they seek to welcome and develop the consultation with attention and calm.[17]

In addition to this, expanding knowledge on the topic of BP during academic training was also pointed out by the interviewed participants as a strategy to be used to obtain greater engagement in its use. A recent study, carried out with students from the undergraduate course in obstetrics at *Universidade de São Paulo*, pointed out that the elaboration of this document has proved to be a powerful ally in the search for women's empowerment and role during work. Additionally, the use of this strategy enables information, decision-making and shared responsibility between the health professional, already trained or in the process of training, and women.[18]

In addition, it is clear that in recent years there have been transformations in the national scenario in relation to women's health. Thus, it is necessary that there are interventions in different perspectives, among them that of promoting quality of care focused on women's needs, requiring transformation and updates in health professionals' work and, therefore, their training process.[19]

Although the number of studies on the subject has increased in recent years, it is possible to see that there is much to improve, since most pregnant women do not have knowledge about what it is and how to prepare a BP. In the state of Rio de Janeiro, a survey was carried out with 11 pregnant women who underwent prenatal care at a Birth Center. Of this total, only one of the interviewees mentioned knowing the BP, and the others stated that they did not know any information about it. Moreover, many stated that, after being introduced to the BP, they felt the urge to discuss with the team how they could prepare their document and that having this knowledge allowed them to feel more human.[3]

Thus, it is clear that when pregnant women prepare the document together with the team, the level of trust between them increases. This process allows for the construction of a bond between the team and the pregnant woman, thus respecting the idea that each woman is unique, as is each birth, and that their particularities need to be respected and attended to. Moreover, professionals, knowing the system, will be able to inform and advise the personalized document construction, taking into account the reality of the service, but also paying attention to the needs raised by pregnant women.[3,19,20]

Therefore, with regard to PHC, the importance of professional nurses being trained and keeping up to date on changes in the women's health scenario is highlighted. When nurses demonstrate knowledge and use this tool as a means of empowerment for pregnant women, they find security and emotional support during pregnancy. Thus, the development of prenatal care is notorious when compared to one performed by a professional who is not up to date. In a study carried out in the state of Belo Horizonte, with postpartum women whose prenatal care was performed by obstetric nurses, the result was unanimous, highlighting the quality of the care offered and that consultations were carried out in a unique way[21]

Thus, developing strategies to provide moments of continuing education with health professionals is important, as it provides the search for updated knowledge. In addition, it favors interaction and exchange of knowledge among team members. Furthermore, using these strategies is essential for conducting evidence-based practice in this field of knowledge and practices.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The findings of this research made it possible to know the experience of professionals working in the OC regarding BP use. This study also allowed us to understand that multidisciplinary action is progressively indispensable in different spaces. It is understood that each professional is conditioned to observe a certain aspect of users, but when it comes to attending to labor and birth, parturient women benefit from the work of different professional emphases, making it possible to consider the individuality of each woman.

In addition to this, it was observed that the search for knowledge is the main key to increase the feasibility and, consequently, BP use during prenatal care and labor. It is important to emphasize that parturient women and health professionals are in harmony at the time of birth and according to any unforeseen events that may occur during childbirth.

Thus, for this process to be carried out with empowerment and responsibility, it is essential that health professionals and women seek to build BP together, during prenatal consultations, environment for listening to pregnant women and companions. Thus, it is clear that the PHC and the hospital environment must be in synchrony, advocating good health care practices and using procedures supported based on scientific knowledge.

The reasons for not using BP point to the lack of knowledge or updating of professionals and residents about the use of this tool, in addition to inadequate sizing to meet all the service demands,

which, according to participants, makes its use difficult. From this, there is a need for action that goes beyond the biomedical model of care and that overlaps woman role, considering parturient women's wishes.

Regarding the possibilities for using BP, participants listed its elaboration during prenatal care so that it can be disseminated in the services. Also, they mention the importance of articulation with the academy and the exchange of knowledge through a multidisciplinary team. This articulation can help to promote a humanized look at the parturition process, also contributing to BP compliance. Furthermore, it is necessary that there is a partnership between professionals and pregnant women, with knowledge acquisition, so that the elaboration and structuring of the document are in accordance with both parties' reality and particularities.

From the results of this study, it became evident that the search for knowledge should be the guide of the service, as well as the union between teams allows the development of greater trust, generating a safe and humanized place for parturient women. In this way, women will find subsidies that will bring them greater peace of mind and security during labor and birth.

Regarding the limitations of this research, we can mention the readjustments that were necessary in the methodology, as a result of the COVID-19 pandemic. This aspect made it necessary to modify the way of collecting the data, and the instrument was applied via Google Forms, since physical contact was limited and field research in the hospital environment was suspended.

As research contributions, there is the production of knowledge on health professionals' and residents' experiences about BP use. It is noticed that studies like this have the power to guide improvements for health services, both in the hospital environment and in PHC, in addition to encouraging the exchange of experience between different areas of knowledge and promoting teamwork.

It is also reinforced that the PHC corresponds to the space in which the first contact of pregnant women occurs with information that will serve as tools for empowerment, in addition to being the ideal space for the promotion of bonds that allow the verbalization of possible feelings and anxieties. In this way, parturient women, when they experience birth, will be safe to exercise their inherent role. Thus, professionals who work in the care of these women, during the pregnancy-puerperal period, must seek information and knowledge so that they can offer the conditions for the exercise of autonomy and role of women safely.

AUTHOR'S CONTRIBUTIONS

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