

## Humanization of childbirth: challenges of the Apice On Project

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**Abstract** *The movement aimed at the humanization of childbirth has found resistance to the implementation of a new care model. This article aims to analyze the challenges experienced in the implantation and implementation of the Apice On Project in a large hospital in Brazil. A study was carried out with a qualitative approach, through interviews with health professionals using content analysis, thematic modality. An ineffective management was verified when conducting health work, as well as a biomedical care model and insufficient training to promote changes in health practices. It is important to review the implementation strategies of the Apice On Project proposals, incorporating Permanent Education in Health as a strategy for the reflection and reconstruction of health practices. Expanding the investigation beyond the hospital service, contemplating the perspective of other scenarios, such as, for instance, assistance in primary health care, are recommended.*

**Key words** *Humanization of childbirth, Maternal and child health, Qualitative research, Hospitals, Apice On*

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## Introduction

It is not possible to look at the humanization of care under a conception that is alien to history, at risk of not identifying the processes at the roots of health practices and reinforcing the determinations of these aspects. It is necessary to understand that the hegemonic consolidation of the biomedical model, from the reduction of the disease process to the organic dimension, penetrates the body at increasingly deeper levels, appropriating human life, with the aim of normalizing it. The body is medicalized, that is, there is a process of inclusion of human conditions as an object of medical practice, in which the individual who is ill needs to be treated to adapt to social conditions, the same ones that determined their illness. Overcoming the authoritarian trait of the doctor-patient relationship must be defended, as it reduces the individual to an object that can be manipulated, depersonalized and deteriorated, obstructing their autonomy in the presence of a professional who monopolizes the power legitimized by the technical-scientific knowledge<sup>2</sup>.

The medicalization also extends to the female body, interfering with her sexuality and reproduction through the appropriation of what was determined to be the female nature. This medical practice was established in the 19<sup>th</sup> century, in the context of the formation of a capitalist society, within which the intervention and control of the human bodies, and more specifically, of female bodies, was necessary to guarantee the workforce. This is how medical practice establishes itself as interventionist, using the scientific discourse to discipline the subjects, educating women so that they are good mothers for the protection and survival of children who, later, will become the labor force. In this project of society, childbirth is hospitalized, with the transfer of the midwifery role from midwives to doctors, holders of the surgical knowledge and techniques in maternity hospitals<sup>3</sup>.

This hegemonic obstetrics, about a century later, is opposed by a new model of care, based on humanization. The focus is now on the physiology of the pregnancy-puerperal cycle, using science as a principle of practice, bringing the scientific production closer to the health needs of women and defending sexual and reproductive rights<sup>4</sup>. The demedicalization of labor and childbirth seeks to correct authoritarian and hierarchical behaviors, aiming to reduce the asymmetry of the relationships that were established between the different subjects and, therefore, let

women participate with autonomy and protagonism in their own pregnancy, childbirth and puerperium process<sup>4</sup>.

Humanization must be conducted in a politicized manner in institutions, through criticism and self-criticism in care, detaching itself from the messianic fiction, based only on empathy from oneself and condensed to a morally noble action dependent on each professional's good intentions. Additionally, there must be solid obstetric competence, based on scientific evidence, capable of differentiating inappropriate, harmful or ineffective interventions from the ones that are actually recommended. However, the health worker is little encouraged and has little structure for that, resulting in resistance to the new way of working<sup>4</sup>.

The long working hours and emotional stress demand increasingly more resilient workers, even under social relationships that produce suffering, generating greater vulnerability, deterioration and illness. These high psychological loads in the working process make professionals undergo a destructive movement to their own health, as it requires not only certain physical characteristics, but also psychological ones, that is, a multifunctional professional, permanently overloaded and pursuing unachievable goals<sup>2</sup>. The overload, the difficulty in conciliating attributions, the restriction of autonomy, the power relations and the disrespect for one's rights, result in the perpetuation of the dehumanized practices and the challenge of maintaining humanized ones<sup>5</sup>.

Considering the aforementioned scenario, there is a question whether there is room for structural changes and for the implementation of new concepts based on humanization, when considering the current infrastructure of health institutions, biomedical training, work relations and the logic of production. For that purpose, the new work process to be implemented comes in opposition to violence, by proposing the improvement of working conditions, the quality of care, the articulation of different available technologies and interpersonal relationships between health professionals and users. Therefore, one can perceive that it is necessary to humanize the health professional's work process, so that the care they provide can, therefore, be humanized<sup>6</sup>.

In Brazil, reflections on the humanization of labor and birth were intensified in the late 1980s, brought about by the sanitarian, feminist and political redemocratization movements. Throughout this process, they have built criticisms of the hegemonic medical model by detailing the

acknowledgement of sexual and reproductive rights, the quality of the interpersonal relationship between health professionals and users and the democratization of the established power relations<sup>4</sup>.

Several government initiatives were created within the sphere of the Brazilian Unified Health System (SUS, *Sistema Único de Saúde*). In 2000, the Prenatal and Birth Humanization Program (PHPN, *Programa de Humanização no Pré-Natal e Nascimento*) collaborated with the creation, in 2011, of the 'Stork' Network (RC, *Rede Cegonha*), which comprise strategies instituted by the Ministry of Health to modify childbirth care, with the gradual implementation of a humanized model<sup>7</sup>. Civil society has had an important influence over the creation and monitoring of these public policies since their inception. In 2004, the National Policy for Comprehensive Attention to Women's Health was launched, with a strong contribution from social movements, health workers and specialists. At that moment, the diversity of women is recognized: black and indigenous women, rural workers, among others; in addition to the different cycles of life, emphasizing sexual and reproductive rights<sup>8</sup>.

To support the RC, in 2017, the Apice On Project (Improvement and Innovation in Care and Teaching in Obstetrics and Neonatology) appears and starts to contribute to the operation and expansion of good care and management practices, based on the principles of humanization, in hospitals linked to educational institutions, concentrated on the humanized training of new professionals. It aims at having an impact on the entire network, from scientific evidence-based qualification in the fields of care during childbirth and birth, care for women in situations of sexual violence, abortion and legal abortion, and postpartum and post-abortion reproductive planning<sup>9</sup>.

The ministerial milestones contemplate both advances and setbacks, disputes and consensuses, which took place in a scenario of 30 years of SUS, essential for the existence of the public policies mentioned above. Despite its relevance, SUS has been systematically threatened by recent political setbacks in Brazil<sup>8</sup>. The current counter-reforms, with increasing privatization, outsourcing, public-private partnerships and network fragmentation, have characterized a period of attacks on social rights and policies, making it essential to demand both adequate funding and the change in care models, for humanization and participatory management<sup>10</sup>.

Considering this context, the aim of the present study is to analyze the challenges experienced in the implantation and implementation of the Apice On Project in a large hospital in Brazil.

## Method

The research used for a qualitative approach, to extend the understanding of the processes, subjects, social relations and structures, which, in turn, are depositories of meanings, aspirations, beliefs and values<sup>11</sup>. Therefore, the field work constituted a possibility to get closer to the challenges faced for the implantation and implementation of the Apice On Project, starting from the reality experienced in a large hospital in the interior of the state of São Paulo, Brazil.

The participants were health professionals belonging to the referral team of the inpatient unit and the obstetric center. Thus, nine gynecologists and obstetricians, six nursing technicians and nursing assistants, four resident physicians from the 2<sup>nd</sup> and 3<sup>rd</sup> year of gynecology and obstetrics, three nurses and two anesthesiologists who had performed activities in the assessed institution for a minimum six months were included in the investigation. First-year resident physicians in gynecology and obstetrics were excluded because they had less than six months of experience.

A semi-structured interview script was used to collect data, consisting of the characterization of the participants and guiding questions: "What do you consider to be humanized care for pregnant women, postpartum women and babies?"; "Give examples of behaviors and techniques that you consider to be humanized"; "Do you promote this humanized care? If not, why? If so, how?"; "Do you believe that humanized care is the woman's and baby's right? If not, why? If so, why?". The interviews were carried out by two researchers. A pilot was designed to standardize the data collection strategy against the triggers and to train the interviewers, under the supervision of a supervisor with a PhD degree.

The researchers identified the referral team professionals that belonged to the assessed health unit, who were approached at the workplace, but in a reserved place. When these professionals were available to participate, they signed the free and Informed Consent Form (FICF).

Data collection was carried out from April to December/2019. Saturation was reached with 24 interviews, that is, the obtained content, allowed the understanding of the internal logic of the

group of professionals in relation to the object of study<sup>11</sup>. The dialogues, with an average duration of 40 minutes, were recorded and transcribed in full by the researchers and validated by the advisor.

Content analysis in thematic modality<sup>12</sup> was used. For that purpose, a pre-analysis was carried out, which consisted of transcribing the interviews in full, allowing the impregnation of the speeches' content, as well as the resuming of the research assumptions and objectives. This moment allowed the researchers to have an overview, apprehend the particularities and define an initial classification scheme consisting of the categories: how care is performed, definition of humanized care and women's rights, potentialities of the humanized care practice, challenges of the humanized care practice and strategies, the Apice On Project, and care protocols.

Then, the material was explored, with the distribution of excerpts from the speeches and, subsequently, a dialogue with the parts of an excerpt from a given class. After that, a description of these fragments of statements was created. Through inference, the cores of meaning were identified, being grouped into topics. In this article, the topic "challenges in the implantation and implementation of the Apice On Project" and their respective cores of meaning will be presented, as depicted in Chart 1.

Subsequently, an essay was written on the topic, with the presentation and interpretation of the Results<sup>12</sup>.

The research was approved on September 4, 2018, by the Ethics Committee of the researched institution, under Opinion n. 2.872.218 and Certificate of Presentation for Ethical Appreciation (CAAE) n. 95474418.4.0000.5413. To maintain the confidentiality of the participants and safeguard their names, the speeches were coded using the abbreviations: ANE – anesthesiologist; GOA – gynecologist and obstetrician attending physician; NAT – nursing assistant and technician; NUR – nurse; RES – resident physician of gynecology and obstetrics.

## Results

### Characterization of the health professionals

Twenty-four health professionals were interviewed: nine (38%) gynecologists and obstetricians, six (25%) nursing assistants or technicians, four (16%) gynecology and obstetrics residents, three (13%) nurses, and two (8 %) anesthesiologists.

### Topic Presentation: challenges for the promotion of humanized care

#### Ineffective management in conducting health work

The infrastructural aspect is an important condition for the transformation of care processes. But it does not, by itself, ensure the implementation of humanization. The challenges faced in this context include: insufficient beds in the maternity and pediatric ICU, inadequate parturition structure, contributing to the high rate of Caesarean sections, lack of equipment and supplies, inappropriate reorganization of the obstetric center, and physical facilities that are incompatible with humanization and with patient privacy.

*There are not enough beds, it doesn't have an adequate physical space. There are many pregnant women admitted at the ER. If someone comes in labor, we have nowhere to put them (NUR3).*

*Here the Caesarean section rate is high, higher than it needs to be, because we have a small infrastructure for vaginal birth (GOA7).*

*There is a lack of technology, equipment, which prevents the medical team from providing adequate humanized care to the patients (RES1).*

*There is no material, not even for teaching the residents. They don't have video laparoscopy, which is mandatory in the gynecology residents' curriculum (GOA4).*

**Chart 1.** Cores of Meaning and Topic, 2021.

Cores of meaning	Topic
Ineffective management in conducting health work	Challenges in the implementation and Apice On Project implementation
Biomedical care model	
Insufficient training to promote change in health practice	

Source: Authors.

An interdisciplinary, trained and cohesive team is crucial to facilitate the implementation of humanized care. The shortage of professionals limits the transformation in the obstetric and neonatal scenario. It is observed that without obstetric nurses it is not possible to carry out an adequate monitoring of the labor and that without anesthesiologists, analgesia in vaginal delivery becomes unfeasible. Low wages and work overload result in unattractive jobs, leading to a shortage of health workers in the institution. However, even with the permanence of the professionals, humanization is not ensured, as the precarious and exhausting work conditions generate risks and do not allow the incorporation of these practices into the service routine.

*We have a shortage of clinical, obstetrics staff, obstetric nursing, nursing technicians, anesthesiologists, who are required 24/7, but who remain on call. [...] It's a difficult job, financially it's not very attractive, so it's difficult to bring in more people (GOA4).*

*Analgesia is performed by the anesthesiologist who is on duty, but it is an anesthesiologist who is responsible for obstetrics. So, we use their skills for Caesarean sections and not for analgesia. We are very worried, because this is an open-door service. We are afraid of performing analgesia during a vaginal delivery and need an anesthesiologist for an emergency case (RES3).*

*Very often, overcrowding, the large number of cases and lack of time prevent you from providing this type of care. Humanization requires time and often you don't have it (GOA6).*

*I realize that, sometimes, professionals can't help but being unhappy at the workplace. I can't tell you if this is something that happens to everyone, but what I do know, based on actual evidence, is the work overload added to the difficulties in the work routine (NUR1).*

*I think that regarding this question 'look, let's see the patient as a holistic being, the biopsychosocial sphere'. But what about the biopsychosocial sphere of the employee? Of the professional? Of the medical student? Of the doctor? Where is it? Nobody talks about it. [...] And this happens here. Everyone comes to work sick. Everyone. So, there's a lot of that. I think the way Medicine is practiced has to change (GOA2).*

Equally relevant are the difficulties related to ineffective management, which includes the distancing of managers from the daily work routine, inconsistency in the delegation of management positions, delays in hiring, demand for results avoided due to personal affinity, failure to implement protocols, suggestion of practices in

non-compliance with legislation and lack of evaluation regarding the meeting of schedules and assignments, creating obstacles to the fluidity of the teamwork process. It is also demonstrated that the management of the local service manages but does not receive support from the different government spheres.

*I don't have an available bed to admit patients, they are admitted and stay in the emergency room, on the chair, on the stool. Then someone comes and talks about humanization? It's easy to sit behind the desk talking about things - come experience the reality! Come here to see things when you don't even have an anesthesiologist, when you don't have a neonatologist to assist. It's an administrative problem (GOA5).*

*The emergency room isn't derelict yet, because someone went there and took over, because it had reached a state of apocalyptic chaos and then a person was assigned to take care of it, who did a really nice job and continues to do so. But, like this, there is a lack of assigned people, that is, the boss of everything is the boss of nothing (GOA9).*

*The manager thinks that we have to perform anesthesia in more than one room. The management turns their back on the laws, because even they make some deals for the colleague to surreptitiously do more. This is done at the institution. They always suggested performing anesthesia in more than one room (ANE1).*

*There are two main factors that leads to not being firm with the team. One of them is fellowship, camaraderie, not wanting to get someone upset with you. Another thing is that, above all, more than hiring capacity, it is necessary to have agility in hiring. The bureaucracy lacks agility (GOA 9).*

*The problem is this: everything that you are going to bring in, that you are going to start, I believe there is some resistance. The problem is to implement [protocols], after you implement it, it becomes a routine (ANE2).*

*The issue is organization, management, fluidity of actions by the professionals here. [...] Streamlining these processes would bring better assistance. [...] It [the hospital] doesn't assist [more people] not because it lacks the capacity, but because all of these processes are not entwined, one into the other, so there's no delay (ANE1).*

*The management is doing what it can, but it's difficult. The feeling I have is that it's a bit neglected here. The state government does not take care of it, the City Hall does not take care of it, the federal government does not take care of it either. It's a game of push and shove. I don't feel investments coming, new materials, I don't feel that (GOA4).*

The services constitute the care networks and, therefore, face the existing challenges, beyond the analyzed institution. This can be demonstrated by the disconnection of the care line for pregnant women, postpartum women and newborns, between primary and tertiary care, which disconnects prenatal care from the moment of delivery and birth. Primary care is ineffective in promoting prenatal care due to the lack of professionals, material resources and equipment, which can contribute to unfavorable outcomes. The regulation of beds in the care networks that comprise SUS is flawed, compromising the management of the users' health needs between services.

*There is a lot that could be solved in primary care and that comes here to us as an emergency case, which could have been prevented and avoided in primary care. So I think there are a lot of problems here, but there are a lot of roots out of there (NUR3).*

*The big problem in obstetrics in SUS today is the absolute dissociation in SUS between prenatal care and birth. Prenatal care is conducted in a wrong, incorrect, inept, negligent and stupid way. Then the tertiary service arrives and they want us to perform a miracle (GOA9).*

*Most emergency room consultations are not urgency and emergency cases, they are structural problems in the system; the patients come here because there is no doctor in their basic health unit (GOA6).*

*Sometimes there is a serious case that needs to be treated and we are attending to simple things that have not been seen by a doctor from a secondary hospital or basic health unit, and it ends up really taking our time and increasing the flow (RES4).*

*There are no beds here and the guy sends a patients because he is the boss. This is not a referral, because according to the CFM Resolution, referral with zero vacancy can only be done by a regulatory physician or by a physician from here who accepts zero vacancy. Is that what happens? No. The person violated the code of ethics because this is not a transfer, this is taking a patient who needs hospital assistance and discharging them, giving them a hug and sending them to another hospital. The patient leaves by default, either on transfer or discharged. If they did not go by default and were not transferred, you discharged this critical patient. This is a serious medical offense. The institution doesn't make a point of respecting the rules and we are working double shifts every time someone is having a break. To solve the overcrowding problem, that's how it gets solved (GOA9).*

### The biomedical care model

The situation shown in these notes indicates disagreements and difficulties in effectively complying with a care model that ensures humanization. In the assessed institution, a technocratic, biologist and interventionist model prevails.

*I feel very little respected when I am at the woman's side, playing the role of a doula, of an obstetric nurse, which we do too. This was all seen as a joke. They [the doctors] arrived and said that the birth was their business, that they were going to deliver. A total disrespect (NUR2).*

*We have a very interventionist pediatric service, as well as obstetrics. We are focused on what a disease is, and not on what is a biological, on what is a normal event. If you let the baby come and stay there with the mother, I don't need to clean them, warm them up. They are already in skin-to-skin contact, they are already with their mother, they will have the right temperature, they will breathe (RES2).*

Due to the model of care centered on the doctor and the idea of hierarchy between professional categories, the performance of an interdisciplinary team is compromised and the presence of obstetric nurses is received with hostility by the medical team. However, there is great potential for obstetric nursing to transform the traditional model of care and to adapt childbirth care, gradually migrating to the humanized model. This paradigm shift has occurred because the training of this professional category is based on valorization of the woman's physiology in the pregnancy-puerperal cycle, while medical training remains centered on the pathologization of the female body.

*Here everything is in the doctor's hands. 'Ah, here we have a multidisciplinary team'. It's a lie. We don't. We have the doctor in charge of the pre-delivery. 'Ah, but there is an obstetric nurse'. But she's not there, in charge, together, she's not there working together. [...] That's the big question. Here it is doctor-centered (GOA2).*

*The medical team also had a difficult time accepting the presence of an obstetric nurse in the prepartum period. Not everyone liked the idea. I think it's because the doctors are afraid of losing their space, you know? [...] The obstetric nurses have a role very similar to ours [that of obstetricians] in normal deliveries. In fact, I have no doubt that their assistance is much better than ours in normal deliveries. Why? Because they are trained for the physiological birth. We are trained to see the pathology (RES2).*

The hierarchy in the health area is evidenced not only between professional categories, but

also within Medicine, between the attending physician and the resident physician. This work process hinders the possibilities of change in professional practice.

*As a resident, we have technical responsibility, because we are doctors. But I'm a medical specialist in training, so I owe my shift and everything I'm doing to the attending physician. I have to follow what they say, I have no other option. This is the biggest obstacle for me. [...] For me to do it differently, I need to survive this here, I have to finish this residency. So, I can't engage in a conflict with everyone, I can't impose what I believe, what anyone who is a fan of humanized childbirth believes. And then we get scared of subsequent retaliations, we get scared of several things and then we end up accepting what others want. [...] There are attendings who sometimes don't let you perform a certain procedure, either because they don't trust you or because they thought that what you did before was a little petulant (RES2).*

There is a technocratic, authoritarian and paternalistic conception by physicians about the care provided, not including the perspective of users in decision-making and getting them away from their condition of subject, their individuality and protagonism. The person being cared for is associated with a place of passivity. This view is even more present when associated with poverty, as there is an assumption that patients with low purchasing power have a limited repertoire to be involved in the process of choice and decision-making.

*I unfortunately see the health service going backwards. It looks like it's from the industrial era, it looks like we're tightening screws. But it is not! You need to look at that woman, pregnant woman, postpartum woman, newborn, father, you need to look at those people, understand their health needs and give them the care they deserve. They talk so much about individualization, that each person is unique and then you go to tighten screws (NUR2).*

*It's a problem the question of not discussing too much with the patient, you know? So things end up leaving a lot to be desired for them. We should work more together, so that the patients are safer, because they see the doctors discussing something among themselves that they don't need to know, you understand? And it's part of care, knowing about your diagnosis (NAT1).*

*We serve the population that has a slightly lower social level, that is not adequately prepared for a normal birth. They come here with the idea that if they pay, it will be a Caesarean section and if they don't pay, it will be a vaginal delivery. There*

*is little preparation regarding what a normal birth is (GOA1).*

### **Insufficient training to promote changes in health practice**

Inadequate, out-of-date conducts, without scientific basis and without uniformity, such as Caesarean sections without indication and episiotomy, are verified, being transmitted by the attending physicians to those undergoing training. It can be observed that this practice is related to a longer time since graduation and resistance to updating.

*We still see some inappropriate behaviors, inadequate management of pregnant women, behaviors that are no longer carried out. Iatrogenics, you know? The indication for delivery is at 39 weeks of gestation, but it needs to be done at 37, out of fear, out of fear. [...] I prescribe a procedure and if the person doesn't like me, they come in the afternoon and change my conduct, so that's a problem, because the patient has no follow-up (GOA4).*

*We see that C-sections here are not performed due to actual indications. We see that the staff here is very insecure and ends up recommending a C-section for anything, for things that have no indication (RES2).*

*Professionals who graduated some time ago sometimes find it difficult to update their conducts. One of the negative points we face is the difficulty in standardizing the conducts. Everything that is new, everything that is unknown, generates anxiety (GOA6).*

*People inherit each other's knowledge and I feel that people here are very resistant to the new, to what is modern. Sometimes, we end up doing things because the boss has been doing this for I don't know how many years, so it's better to do it this way. I think there is this culture of propagating something that is not right (RES2).*

*Performing an episiotomy is not routine, but what I have noticed is that when a resident changes, it seems that it is necessary to have this class. Someone has to do it for them to learn, and then they do it (NUR2).*

*I know residents here who performed an episiotomy because of pressure from the attending physician who is with them, because they don't want to argue, because they feel kind of obligated to do it (RES2).*

It is acknowledged that the training is compromised, requiring constant updating and education, which is not always provided by the institution. For example, as related to labor analgesia, which is not taught in the assessed hospital,

either due to lack of knowledge of the anesthesiology to perform the technique correctly, or due to obstetrics, due to not knowing how to indicate analgesia or having difficulty in conducting the birth based on it. It is mentioned that the performance of practices that have been proven to be beneficial by health professionals would be facilitated by the existence of protocols and continuing education.

*There is a lot of talk about training, but there is no education, there is no teacher training to develop an activity (GOA2).*

*We don't just get carried away by learning here, we go outside of here, right? We go after the knowledge that we miss (RES4).*

*The residents are not taught how to perform analgesia for vaginal delivery, because we cannot teach, because our obstetrician does not ask, because the colleague obstetrician does not know or does not want to perform the SVB with the attending anesthesiologist (ANE1).*

*Here at our service we do not work with epidurals. The service also lacks the acknowledgement of the faculty in saying 'we don't know and we are going to find out, as this is important'. In fact, it is important for professionals who are graduating and much more important for the population that is cared for (NUR2).*

*A negative point would be the lack of a protocol and lack of labor analgesia. Far and away these are the biggest problems (GOA9).*

*There is a lack of trained employees in their sector and in their specialty. There is a lack of refresher courses, there is a lack of continuing education (RES3).*

## Discussion

The biomedical model still persists, with consequent unfavorable maternal and newborn indicators, including in hospitals linked to educational institutions, even after decades of implementation of public policies based on a comprehensive care model<sup>13-16</sup>. As shown in the results, in health services linked to educational institutions, not only outdated practices are carried out but they are also taught, consequently ending up perpetuating the conceptions and conducts that do not comply with the guidelines supported by scientific evidence. The Apice On Project is found precisely in these hospitals as a strategy for the incorporation of scientifically grounded contents and humanized practices aiming to have an impact on the training of future health profes-

sionals. However, there are challenges to its actual implementation.

Starting with the poor articulation between professionals and the management, generating a lack of cohesion between the proposals implemented in the institution and the actual daily practice. It is observed that the implementation of the Apice On Project in the assessed institution requires the establishment of a project to change the training of professionals and the creation of a plan agreed upon with the various actors involved in the actions to be developed by the project. But also, recognizing the challenges to be faced, and, above all, establishing a dialogue for the co-management of changes. Thus, locating and working reflexively and purposefully to overcome problems and resistances can be one of the ways for new projects to have a chance to become implemented.

It is recommended to invest in professional training processes and in Continuing Education in Health and in the co-management in health services, focused on the constant evaluation of the implementation of projects. Efforts should be directed towards the collective management of productive processes by health workers, with the collective sharing of planning and control of health practices, aiming at a deliberate, planned and reflexively performed work<sup>2</sup>. And, in addition to the importance of participatory management, it is necessary to extend efforts aimed at the adequate financing of SUS, seeking to envision effective changes in the care model<sup>10</sup>.

It is verified that the infrastructure is insufficient and maintains the environment of the technocratic model, that is, it does not correspond to the recommendations of the RC and the Apice On Project, which indicate the need for adequate technology in the care provided to the parturient, in order to allow the woman to experience labor and childbirth as a natural process. This scenario ends up being amplified by the breakdown of the network. The Primary Care, which is responsible for low-risk prenatal care and guidance on pregnancy, childbirth and the puerperium, cannot meet all these demands. Thus, there is a disarticulation in the referrals, in addition to the overload of the tertiary service, as observed in the analyzed institution, in which part of the demands could have been avoided or carried out in other places.

A crucial point to overcome the traditional model of care is the inclusion of obstetric nurses in the delivery and childbirth care; however, the lack of understanding of their professional



competencies makes this process a difficult one<sup>17</sup>. This practice is favored by the care centered on the physician, corroborating the permanence of the hierarchy among health professionals and the ineffectiveness of the interdisciplinary team. It is necessary to work with the professionals' resistance to change, when considering the health needs reported and perceived by pregnant and postpartum women and sharing the decision-making.

Moreover, it is also necessary to understand that gender violence is an important challenge for the humanization of childbirth<sup>18</sup>. It is established through alienation arising from the patriarchal relationships reproduced by health professionals, who, in turn, normalize the disregard for the dignity of women undergoing painful and iatrogenic situations at the time of childbirth<sup>19</sup>. However, it is also necessary to develop questions arising from the work process, as childbirth care contains the phenomenon of patriarchy, but this should not be superimposed on the relationships produced by work.

Thus, the focus of the implementation of humanized care should be the working process, which is where changes are consolidated<sup>4</sup>. Work overload, vulnerability and emotional fatigue lead health workers to exhaustion, illnesses and the consequent perpetuation of biomedical practices. The reflexive, self-conscious and creative nature of work must be reinforced and the scientific-technological production itself must be developed under social control, indispensable for the subjects' control over work and necessary for overcoming alienation<sup>2</sup>.

The growing social medicalization must also be questioned, so that subjects can build themselves as conscious protagonists, through the politicization of the determinations of the processes that generate suffering in society, developing a life dimension that has a more complete meaning. Therefore, the concept of humanization is associated with the inclusion of all individuals involved in the processes, through greater access to services of better quality and resolution, comprehensive care, democratic opening to professionals, with the objective of emancipation<sup>1</sup>.

## Conclusion

The analysis of the challenges experienced in the implantation and implementation of the Apice On Project in a large hospital in Brazil, allows us to infer that despite the project claims re-

garding an obstetric and neonatal model based on humanized care and scientific evidence, the biomedical care model, an ineffective management of the health work conduct and insufficient training to promote changes in health practice still persist.

Democratic and participatory management in services and the initial training of professionals are crucial to strengthen the humanized model. In particular, the training of obstetric nurses, as it joins philosophical aspects based on the respect for the physiology of childbirth, on the protagonism of women and on individualized care. Regarding the teaching practices and professional attitudes, Permanent Education in Health can be a strategy for reflection, reconstruction and transformation of care processes. It is precisely in hospitals linked to educational institutions that the Apice On Project is developed, making the debate about professional-teachers a vital one, who ultimately become a model for the future practice of students in training.

Based on this finding, Permanent Education in Health should be incorporated as a strategy for reflection and reconstruction of health practices. It is an ally to enhance the implementation and expansion of these tools, so that a transformation of the working process and the provided care can actually take place, in line with the humanization of labor and childbirth.

It is understood that there is a study limitation, as it was carried out in only one hospital institution. The perspective of care in Primary Health Care, together with the teams of the Family Health Strategy and Basic Health Units, could contribute to creating an overview of how the Stork Network, which includes the Apice On Project, has been constituted in different services. Therefore, it is necessary to expand the investigation to other scenarios.

## Collaborations

BCS Capelanes, KTA Rezende and MPS Santos participated in the study conception, design, analysis and interpretation of data, writing of the manuscript and approval of the version to be published. MQ Chirelli participated in the analysis and interpretation of data, writing of the manuscript and approval of the final version.

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