Esc Anna Nery 2022;26:e20210105

RESEARCH | PESQUISA

www.scielo.br/EAN

The perception of woman-centered care by nurse midwives in a normal birth center

A percepção do cuidado centrado na mulher por enfermeiras obstétricas num centro de parto normal

La percepción de los cuidados centrados en la mujer por parte de las enfermeras obstétricas de un Centro de Parto Normal

Tatianni de Nazaré Oliveira Jacob[1]
Diego Pereira Rodrigues[1]
Valdecyr Herdy Alves[2]
Elisângela da Silva Ferreira[1]
Márcia Simão Carneiro[1]
Lucia Helena Garcia Penna[3]
Vera Cristina Augusta Marques Bonazzi[4]

1. Universidade Federal do Pará, Centro de Ciências da Saúde, Faculdade de Enfermagem. Belém, PA, Brasil.

2. Universidade Federal Fluminense, Escola de Enfermagem Aurora de Afonso Costa, Programa de Pós-Graduação em Ciências do Cuidado em Saúde. Niterói, RJ, Brasil.

3. Universidade do Estado do Rio de Janeiro, Faculdade de Enfermagem. Rio de Janeiro, RJ, Brasil.

4. Hospital Sofia Feldman. Belo Horizonte, MG, Brasil.

Corresponding author:
Diego Pereira Rodrigues.
E-mail: diego.pereira.rodrigues@gmail.com

Submitted on 04/14/2021.
Accepted on 10/22/2021.

DOI:https://doi.org/10.1590/2177-9465-EAN-2021-0105

Abstract

Objective: To understand the perception of nurse-midwives' performance regarding the assistance provided to women admitted to a birth center. **Method:** This was a descriptive exploratory study with a qualitative approach and semi-structured interviews with 11 nurse-midwives from the Haydeê Pereira Sena Birth Center (Pará State, Brazil). The interviews were conducted using the WhatsApp application, via video calls, from September to November 2020 and recorded using the Cube ACR application. The interviews were later transcribed and submitted to content analysis in thematic mode using the ATLAS.ti 8.0 software. **Results:** The perception of care in obstetric nursing is based on humanizing prenatal care and care actions aligned with scientific evidence, physiology, and women's autonomy in obstetric care. **Conclusion:** Obstetric nursing focuses on humanization and is centered on the evidence of childbirth, which encourages redesigning obstetric care.

Keywords: Patient-centered care; Nursing care; Obstetric nursing; Humanization of assistance; Humanizing delivery.

Resumo

Objetivo: compreender a percepção da atuação das enfermeiras obstétricas em relação à assistência às mulheres atendidas em um Centro de Parto Normal. **Método:** estudo descritivo, exploratório e de abordagem qualitativa, com a realização de entrevistas semiestruturadas com 11 enfermeiras obstétricas do Centro de Parto Normal Haydeê Pereira Sena, Pará, Brasil. As entrevistas foram realizadas pelo aplicativo WhatsApp®, na função de videochamada e no período de setembro a novembro de 2020, com a gravação utilizando o aplicativo Cube ACR. Os áudios foram transcritos e submetidos à análise de conteúdo na modalidade temática, com o suporte do software ATLAS.ti 8.0. **Resultados:** a percepção do cuidado atribuído à enfermagem obstétrica se fundamenta no campo da humanização do pré-natal e nas ações de cuidado alinhadas às evidências científicas, fisiológicas e de autonomia da mulher no cuidado obstétrico. **Conclusão:** a enfermagem obstétrica possui como foco a humanização centrada nas evidências do parto, o que fomenta um redesenho da assistência obstétrica.

Palavras-chaves: Assistência centrada no paciente; Cuidados de enfermagem; Enfermagem obstétrica; Humanização da assistência; Parto humanizado.

Resumen

Objetivo: comprender la percepción de la actuación de las enfermeras obstétricas en relación a la asistencia a las mujeres atendidas en un Centro de Parto Normal. **Método:** estudio descriptivo, exploratorio y con abordaje cualitativo, con la realización de entrevistas semiestructuradas a 11 enfermeras obstétricas del Centro de Parto Normal Haydeê Pereira Sena, Pará, Brasil. Las entrevistas se realizaron utilizando la aplicación móvil WhatsApp®, en la función de videollamada y en el periodo de septiembre a noviembre de 2020, con grabación utilizando la aplicación móvil Cube ACR. Los audios fueron transcriptos y sometidos a análisis de contenido en modo temático, con el soporte del software ATLAS.ti 8.0. **Resultados:** la percepción del cuidado prestado en enfermería obstétrica se fundamenta en el campo de humanización del prenatal y de acciones de cuidado alineadas con la evidencia científica, fisiológicas y de autonomía de la mujer en el cuidado obstétrico. **Conclusión:** la enfermería obstétrica instituye su trabajo con un enfoque de humanización centrado en la evidencia del parto, lo que propicia un rediseño de la atención obstétrica.

Palabras clave: Atención dirigida al paciente; Atención de enfermería; Enfermería obstétrica; Humanización de la atención; Parto humanizado.

INTRODUCTION

The different labor and birth care models in Brazil are points of criticism, especially considering the high maternal mortality rates that have remained unchanged since the 1990s[1]. In most Brazilian institutions, the obstetric care model is still focused on the parturition model, which brings a sense of intervention on the woman's body under the metaphorical perspective of the "body as a machine." Thus, at its core, this model has institutionalized authority in the biological field and is centered on the health professional, reverberating affirmatively to care practices that go against the human rights of women[2].

Unfortunately, the day-to-day care of women in labor and birth is still marked predominantly by intervention-oriented care. This can be evidenced by three phenomena: excessive practices such as episiotomy, amniotomy, the medicalization of the female body, and the Kristeller maneuver; the use of ineffective methods that include trichotomy and enemas; and the cesarean epidemic, especially in Brazil[3,4]. Data on cesarean sections in Latin American countries verify this, including the Dominican Republic (58.1%), Brazil (55%), Venezuela (52.4%), Chile (46.6%), Colombia (45.95%), Paraguay (45.9%), Ecuador (45.5%), Mexico (40.7%), and Cuba (40.4%) regarding this practice[5]. The World Health Organization (WHO) determines that countries should not exceed 10%, an important marker in health care quality[4].

Considering the context of the care, which is marked by inadequate structures of the maternal services and obstacles in accessing care networks, obstetric care has proven to be detrimental to perinatal health and aggravated by the cesarean section epidemic and unnecessary interventions. These facts present themselves negatively for women in the country and impede reaching the 2030 Sustainable Development Goals (SDGs) for better quality and reducing maternal health indicators, especially regarding obstetric conduct and maternal mortality[6].

The Stork Network (SN) was implemented in 2011[7,8]; it established guidelines to reorganize obstetric services and is a political, institutional, and methodological process of transforming the work process in child labor and birth. Moreover, the SN encourages the participation of obstetric nursing (ON) as an inducer for this change, with its practices anchored in humanizing care and focusing on the woman, the physiology of childbirth, her empowerment, discarding unnecessary practices, and employing science-based care to ensure greater safety, completeness, empathy, respect, and dignity[1,3,4].

Given this scenario, the role of nurse-midwives in the care provided to women is permeated by SN guidelines articulated with the humanization model[7,8]. Hence, it is important to shed more light on the perceptions of nurse-midwives considering their regionality and translate the cultural references that allow them to interpret and respond to different events and life situations in a birth center (BC) of Pará State.

The BC represents this structural policy initiative to ensure care decoupled from the hospital-centric model and centered on biological care. National and international policy guidelines in obstetric care are supported by the also acknowledging and inserting the ON in care, thereby enabling this care to be redesigned through the policy structure and in a real autonomy that is encouraged in ON care, with humanized childbirth[1,3,4,9].

The insertion of ON into the Unified Health System (SUS) and in the context of BC is anchored in Administrative decree No. 985, which was subsequently redefined by the new BC Implementation and Enabling Guidelines of Administrative Decree No. 11 as per the labor and birth standards of the SN[10].

Obstetric nursing plays an important role in women's care and has gained protagonism, especially in the BC after the establishment of the SN. Thus, the training of specialist nurses has been a recurring policy for a professional qualification within the SUS through the National Residency Program in Obstetric Nursing (PRONAENF). In fact, the Brazilian Ministry of Health (MOH) has advocated for, since 2012, the training of ON to act in women's health care in reproductive health, prenatal, labor, and birth, the puerperium, and family through the health policies[11].

With this incentive, the MOH has supported childbirth care to be performed by multidisciplinary teams with ON, a fundamental component to break the current technocratic model, by incentivizing humanization using safe practices based on scientific evidence, resulting in greater satisfaction and quality of obstetric care by reducing obstetric indicators and more instrumentalized childbirth[12].

The BC constitutes this critical political and identity framework of the humanizing movement, with the rescue of the woman and the ON as a mediator of this rupture of care in the field of birth by acknowledging birth centered on physiology and no longer on the biological aspect (disease). Notably, the obstetric nurse's performance must be in accordance with Law No. 7.498 (Law of Professional Nursing Practice)[9], they must assist normal birth without dystocia and be trained and qualified to provide a humanized, comprehensive, and safe care, thereby avoiding ongoing situations and practices of the current technocratic model that occur in maternity care[9,12].

Considering the role of nurse-midwives in the BC, the guiding question of this study was: what are the nurse midwives' perceptions of their performance in the care provided in the BC? Therefore, this study aimed to understand the perception of the performance of nurse-midwives regarding the care provided to women assisted in a birth center.

METHODOLOGY

This descriptive, exploratory, and qualitative study was conducted at the BC Haydeê Pereira Sena part of the Municipal Health Secretariat of Castanhal in Pará State, Brazil. The BC provides care to women in the pregnant-puerperal cycle with actions aimed at prenatal, labor/delivery, immediate puerperium, and the newborn (NB) within the SUS and according to the guidelines for the BC in the SN[10]. This obstetric care service was created on July 2, 2016, and it is the only BC in northern Brazil with over 700 deliveries since its implementation.

The participants were selected intentionally among the obstetric nurses of the BC. The researcher sought to identify in advance the main groups or conditions of individuals who may

contribute significantly to the objective of the study, with the selected individuals being required to have lived the experience[13]. Initially, the goals were explained, and the participants were invited to participate, totaling 11 obstetric nurses who met the following criterion: to act directly in the scope of labor and delivery. The exclusion criteria considered administrative or managerial positions. Data collection closure and establishing the number of study participants occurred by data saturation when the meanings derived from the obstetric nurses' speeches became convergent and there was a linkage between the meanings, leading to the understanding of the core of the studied phenomenon[14]. Notably, no participants dropped out of the study.

Prior to the health emergency caused by the COVID-19 pandemic, it was possible to hold meetings (interviews) without any recommendation of social distancing and restriction of other people in the services (e.g., the BC). As of Administrative Decree No. 65, restrictive measures focusing on social distancing were instituted. Thus, the participants were invited to participate via telephone, which was made available by the BC management and, later, through the WhatsApp application. A closer approach was made to explain the study and the importance of each participant's contribution and the risks and benefits of their testimonies. Then, the inclusion and exclusion criteria of the study were applied, and the interview with the participant was scheduled. In this stage of data collection, there was no previous contact of any kind with the participants.

This modality did not present any difficulties, and the participants felt calm and accessible in employing this tool for data collection as well as reconfiguring the process and instruments to be used in data collection, making it impossible to use the observation of the conducts adopted by the ONs due to the imposed mechanism of social distancing caused by COVID-19 pandemic. Prior to data collection, the researchers built the interview and applied it in the pilot study with three nurses to better align the tool and meet the study objective. The interviewer was trained before and during the pilot study by the main researcher (supervisor) to ensure the quality of the applicability of the interview process.

The interviewer collected data from September to November 2020 through scheduled meetings via WhatsApp video calls that lasted 50 min, on average. The interviews had a script that first contemplated the nurses' social/professional/academic profile, followed by the following question: "could you describe how you perceive the ON care, its autonomy, and the application of scientific evidence in the context of the BC?" The interviews occurred only between the participant and the interviewer without the presence of third parties, and this was guaranteed by the participant's statement when asked about the privacy of the interview.

The data obtained were recorded using the Cube ACR application to record the voice of the participants and transcribe the data. After this process, the main researcher fully transcribed the audios and submitted them to content analysis in the thematic modality using the ATLAS.ti 8.0 software[15].

Data organization began with pre-analysis of the meanings described in the 11 interviews, of which a floating reading of each one was performed, and the relevant and representative elements chosen. After this process, the material was explored, where coding interventions were made relating the obstetric nurses' speeches to categorize them[15]. In this step, the functionality of ATLAS.ti 8.0 aimed to code the excerpts of the statements in thematic units by identifying the following meanings: care, bonding, health orientation, scientific evidence, humanization, the centrality of physiology and the woman, and non-invasive technologies. In the final phase of organizing the results, interference, and interpretation, for them to be significant and valid, the following thematic categories were constructed: 1) the performance attributed by the obstetric nurses for a humanized practice in the BC in prenatal care; 2) scientific evidence as the central element in the care of the ON in the BC.

This study was approved by the Research Ethics Committee of the Institute of Health Sciences of the Federal University of Pará (CEP-ICS/UFPA), as provided in Resolution No. 466/2012 of the National Health Council. To preserve the confidentiality, anonymity, and reliability, the deponents were identified with the initial letters of the area (ON), followed by a numeric number corresponding to the sequence of the interviews (ON1, ON2, ON3,..., ON11), in addition to the guarantee of voluntary participation through the Informed Consent Form (ICF), which was virtually signed on Google Forms. The Consolidated Criteria for Reporting Qualitative Research (COREQ) was used for quality and transparency in reporting the conduct of the study.

RESULTS

All 11 participants were female, predominantly of white ethnicity (6), and 5 mixed-race participants. As for the time of training in ON, most participants had over 5 years, one had more than 10, and only one had less than 5 years of training. As for how long the obstetric nurses worked at the BC, 8 had over 3 years and 3 participants had less than 3 years of experience at the BC.

The performance attributed by the obstetric nurses for a humanized practice in the BC in prenatal care

Prenatal care in the BC starts at 30 weeks of gestation, with the basic health unit, and ends with the end of gestation, which can occur in the health unit (BC) with the usual risk or in high-risk maternity hospitals and with the indication of a puerperal consultation in the first week of the postpartum period. Thus, the woman has a line of care permeated by the entire pregnancy-puerperal cycle.

The work of the obstetric nurses of the BC pointed to prenatal care, which is necessary for women to have access to more effective and qualified evaluation and effective listening and creation of a bond (e.g., humanized practices), as encouraged by the structuring policy of the BC and SN, thus ensuring humanized care and autonomy for the woman:

> *My practice as a nurse in BC is very dynamic, specifically in the BC [...] I see that nurses perform prenatal consultation, monitor this woman in prenatal care [...] investigate possible*

changes in prenatal care, although all of my practice aims to look at prenatal care to have a birth aligned with humanization [...] we listen to her, her anguish, we create this bond that is totally necessary (ON1).

Following prenatal and childbirth at the BC, we already do humanized follow-up care to ensure patient safety. So, since prenatal care or when she first arrives in labor, this humanized follow-up is also done [...] we start talking, create a bond, and establish trust for her care (ON9).

The nurse-midwives pointed out that the educational process enables guidance to women and partners regarding pregnancy, labor, newborn care, and the puerperal period to establish bonds and trust with the woman and/or couple.

In my view, the conversations prepare this woman for this moment of birth, not only the woman, but we always focus and guide the woman to bring the person she chose to accompany her during the childbirth process, the guidance makes all the difference [...] this is how prenatal care makes the difference, this aggregation with everyone involved (ON2).

In the BC, we always orient ourselves; you see, we say that we don't deliver the woman; we inform the women that we assist the birth. So, with the guidance, we build confidence [...] fundamental for a woman to have confidence in herself to give birth [...] she is decided, they have the total capacity, knowledge is power, and we work this with health education (ON6).

Scientific evidence as a central element in ON care in the BC

The perception in the performance of the nurse-midwives pointed to care based on the physiology of birth and centered on scientific evidence, avoiding unnecessary interventions (e.g., episiotomy), where the BC receives zero indicators, as shown in the following dialogues:

Within the BC, our vision is assistance that ensures physiology [...] then, what we work with is assistance based on scientific evidence. Thus, our practices tend to be those that favor the most physiological birth possible [...] physiology and evidence go together in the BC (ON9).

We have a vision that recognizes the scientific evidence that we practice in care [...] in the BC, there are zero episiotomies, there have been deliveries of all forms, there have been many long expulsion deliveries, 4, 5, 6 hours of expulsion [...] these misaligned care practices [of the MOH] we do not do in the BC [...] our practice is aligned to knowledge (ON11).

In their practices, the nurse-midwives also pointed out the use of hands-off, favoring the process of natural parturition without unnecessary assistance techniques in the region of the perineum during the second period of labor with its implementation supported by scientific evidence and the humanization model.

We also use 'hands-off' delivery, so we don't manipulate the perineum for birth; we also don't use directed pulling, which I already told you about (ON4).

Then, during labor, let's say we arrive at the expulsion period and there comes the crowning baby that we 'hands off,' let it come (ON6).

The work in the BC pointed to the use of non-invasive technologies in ON care, such as the penumbra environment, massages, sprinkling and immersion baths, deambulation, Swiss ball, rebozo, acupuncture, aromatherapy, music therapy, and chromotherapy. These methods guide women toward a birth that ensures more comfort, safety, quality, and female autonomy.

I particularly perform acupuncture during labor in women assisted by me [...] when necessary and when they authorize it [...] We use chromotherapy with light or blue light, green light, aromatherapy with essential oils, everything based on research. Lavender will also relax, cinnamon can increase the contractions, or we use therapeutic tea (ON1).

Activities are done with them, massages guide the correct use of the Swiss ball, some walking exercises, offers environments in penumbra, teaches vocalizations for the expulsion period [...] The environment in penumbra is very important; they arrive more protected, evolve faster, it takes a little more work for us to see [...] parturition in the dark or in a penumbra with little light (ON4).

Thus, the care given by the obstetric nurses at the BC is about humanization and based on scientific evidence, thereby ensuring respect for the woman's autonomy.

DISCUSSION

The work of obstetric nurses establishes care focused on humanized prenatal care and with affective and active listening and creating a bond to provide better guidance (educational actions) about pregnancy, delivery, and birth, promoting a bond of trust between the ON and the woman. Moreover, the work of ON establishes humanization as a tool for action in prenatal care in the line of care established by the SN in the field of reproductive health.

In order to establish quality humanized care, the scientific literature ratifies the primary role of the ON in conducting activities directed at caring for women and families concerning prenatal care[16,17]. Hence, the work of obstetric nurses is permeated by humanization, which is an important strategy to ensure better

access to information. When the woman feels welcome, greater trust is established, generating a more meaningful relationship of affection. This relationship guarantees a better listening to the doubts and fears of the women, who are heard as a vital part of this care. It thus enables the creation of a greater bond, being supported both institutionally (by the BC) and by the assistance of the obstetric nurses, thus guaranteeing the primordial factors for quality prenatal care.

Therefore, the assistance given to women in prenatal care must be individualized and flexible, with emotional and continuous support, with the strengthening of the patient-professional bond, making them comfortable and guided as to their choices. By employing milestones established in the CR and acknowledging humanization, whose applicability is enabled by the structuring policy of the BC, with the ON, it is thus possible to redesign the model.

The ONs recognize the importance of prenatal consultations at the BC and that they should be conducted, concomitantly, at the basic health unit, as recommended by the SN, guaranteeing the first approach of pregnant women to the delivery site, with the intention of individualized attention to women, enhancing humanization and information to women.

By having information about their condition and actions directed to them, the women feel autonomous to make decisions about their delivery, sharing their decisions and assessments with the health professionals' regarding quality care and effectively enabling their rights as parturients[16,18].

The information provided during prenatal activities is an important link to ensure women's rights because an informed woman becomes empowered about her rights and the care provided in this context, thereby becoming able to prevent interventions on her body. Women's empowerment constitutes a greater autonomy regarding their choices in labor and birth, which directs the practice of humanized care by the BC, which provides value not only to the biological issue but also emotional, affective, social, cultural, and spiritual.

The educational actions implemented in the BC during prenatal care become a critical care practice and an example of strengthening women's citizenship. Health education establishes a multifactorial process in different spheres of care[18]. Scientific evidence shows that when education is employed and understood as an essential factor in prenatal care, the whole process is more efficient when actions on health conditions are operationalized and ensure their greater autonomy and empowerment, whose goal is to experience childbirth as a successful experience[4,9,19,20]. Given that health education in prenatal care shows positive and effective results, knowledge becomes power to transform their reality, with sharing among women, empowerment, and demystification of pain in childbirth - factors that contribute to engendering the BC as an essential strategy that values humanization[12].

Hence, the BC, together with health education and activities directed at prenatal care, sets up care to create a bond of trust and promote women's empowerment in the field of labor and birth. This bond is an essential factor in the BC, where the woman feels better informed, welcomed, and cared for with respect, empathy, and humanization. The bond is fundamental to establish the woman's confidence in her reproductive process and the care at the BC, where the ON is the mediator of this model.

The practice of obstetric nurses relates to the evolution of the scientific process and daily changes in obstetric care practices. In this context, scientific evidence communicates to obstetric nurses about their work process aligned with the scientific world, which resignifies their praxis. The work process of the obstetric nurses has a performance for the centrality of physiology and the woman regarding her freedom and autonomy and with the use of evidence (technologies employed and reviewed) in a direct interface with humanization.

The care practices assigned by the obstetric nurses at the BC meet the proven effective strategies in labor and delivery, as recommended by the WHO and the MOH[4,21], providing successful care that puts the woman's wishes in evidence and guided by practices based on scientific knowledge. This helps avoid unnecessary interventions and obsolete conducts, which contribute in an escalated way to the country's obstetric indicators (e.g., maternal mortality).

Episiotomy is one of the interventions that ON do not want to develop in their daily lives. Its practice aligns with scientific evidence that points to it harming women and that it should not be used routinely. This practice can cause several complications, including bleeding, edema, infection, dyspareunia, rectovaginal fistulas, and lesions that compromise the muscular, vascular, nervous, and epithelial tissues and should not be used because there is insufficient evidence to determine the indications[22,23]. Nonetheless, these practices have no basis in scientific evidence, although it is used by the model that values the intervention and is performed without the proper consent of women, damaging and disrespecting their rights.

When developing practices directed towards humanization, they should be centered in the field of physiology and scientific evidence. The nurse-midwives anchor their work process in using technologies aligned with humanization, enabling the BC to obtain zero indicators of this intervention, thus contributing to a non-interventionist model focused on a more natural birth. This aspect has similarities with other BCs, showing the zero rate of episiotomy[9,12]. Such qualification of obstetric care comes from the model that ensures this quality, respect for physiology, women's wishes, expectations, and shared autonomy between the ON and the woman.

Corroborating the aspect of preventing interventions, ON should humanize strategies in favor of the physiology of birth, such as the 'hands-off' technique to detach the baby's cephalic pole and avoid lacerations. This sphere of care is similar to another study carried out in the BC of the city of Rio de Janeiro, where the hands-off perineal technique was also not performed, acting physiologically to the detriment of scientific evidence[9,12], which shows a lower rate of episiotomy and unnecessary interventions to detach the cephalic pole. The BC resignifies the care for women

with these ON strategies, distancing itself from the conducts originated and linked to Brazilian maternity hospitals.

Another study demonstrated a reduction in lacerations and episiotomy in women with the implementation of the hands-off technique[24]. In their results, it was observed that only 2.7% of the hands-on group had trauma to the perineum compared to 47.7% of the hands-off group, and a 12.7% reduction in episiotomy for women with manipulation of the perineum compared to 5.7% of women who did not receive a manipulation[24].

The ON use non-pharmacological strategies for pain relief and integrative practices, such as massages, deambulation, Swiss ball, sprinkling and immersion bath, environment with penumbra, rebozo, acupuncture, aromatherapy, music therapy, and chromotherapy. All these strategies are supported by the benefits of physiological birth and contribute to perinatal quality and safety. The obstetric nurses' care is kept as a safe technology, providing benefits for preventing unnecessary interventions because they reinforce the naturalization of the physiological aspects of parturition, focused on the break of the hospital-centric and interventionist model.

In these strategies, similarities can be observed in the results of other studies on ON care in the BC[9,12], and the use of sprinkling bath, massage, Swiss ball, half-moon stool, aromatherapy, music therapy, free movement and/or walking, and penumbra with practices consistent with the model of humanization of childbirth have been reported[9]. In this sense, the use of non-pharmacological strategies to relieve pain in women's care aims to promote a more physiological and humanized process, being an integral part of the assistance provided in BC because the use of these strategies values the woman, decreases intervention, and shows the advancement of ON performance in the Brazilian care model[9,12]. These data corroborate the findings reported herein of the BC in Pará State; therefore, there is a similarity with non-pharmacological strategies for pain relief in ON care and are supported with the recommendations of the WHO and the MOH for safe and respectful care[4,9,12,20,25,26].

It is emphasized that there are similarities between the context of the obstetric nurses' performance and the use of non-invasive strategies of ON care in the BC, despite being from different regions of the country. Nevertheless, there is specificity within the BC in the context of the study, portraying the use of rebozo, acupuncture, and chromotherapy in labor and delivery assistance with the woman. Such care strategies are encouraged in daily care, but with the need to have a qualified professional to perform them[4,9,21]. Thus, the findings of the BC show that the use of these initiatives is positive as alternatives to transform obstetric care through the care of the obstetric nurse.

The structuring model of the BC enables the expansion of the practice of obstetric nurses; however, there are many challenges, especially regarding the autonomy of the ON and their performance in the BC because attempts are made to restrict their performance and rights. Obstetric nurses are qualified and skilled specialists with legal mechanisms for their work in the BC, not requiring the support of a medical professional for the care of usual risk, which is the public of the BC. It is necessary to expand this model and the role of the ON in favor of humanization, scientific evidence, obstetric and neonatal indicators, and women's autonomy and centrality.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The BC provides prenatal care, and the work of the ON makes assistance possible that has repercussions for humanization. Their work ensures the creation of bonds and trust, affective listening, and the use of health education strategies, enhancing singular and integral care.

The care assigned is based on scientific evidence, which supports the technologies employed in the daily life of the BC to avoid interventions in the woman's body while seeking a centrality in physiology. This acknowledges technologies such as more upright positions, 'hands-off' techniques, and non-invasive technologies in ON care, thus promoting greater women's autonomy and empowerment in addition to technologies in newborn care, such as timely clamping of the umbilical cord, stimulating skin-to-skin contact, and breastfeeding in the first hour of life.

These technologies of the work process sustain the care of the obstetric nurse at the BC, which is full of the scientific process and condition more qualified care, generating safety and satisfaction for the woman and their companion. In this sense, it is pivotal to expand to understand the care of the ON in the context of the BC, and this object must be expanded to the managers and users of the care service, the women, and their companion, thus potentiating the results of their performance in the BC and breaking with the hospital-centric and technocratic model of labor and birth.

This study was limited by the impossibility of using other data collection techniques with the observation of the conducts adopted during the monitoring performed with the woman in the labor and birth field due to the COVID-19 pandemic, which made it possible to redesign the study. In addition, the possible confirmation that the interview occurred without the participation of third parties (i.e., this privacy) may also be a limiting factor.

The contribution of this study consists in the possibility of the BC as a structuring policy for the ON's performance as a mediator of transformation in obstetric care, favoring humanization, evidence-based practice, in the protagonism, and respect of the woman and her family.

AUTHOR'S CONTRIBUTIONS

Study design: Tatianni de Nazaré Oliveira Jacob, Diego Pereira Rodrigues, and Valdecyr Herdy Alves.

Data production and collection: Tatianni de Nazaré Oliveira Jacob, Diego Pereira Rodrigues, Valdecyr Herdy Alves, Elisângela

da Silva Ferreira, Márcia Simão Carneiro, Lucia Helena Garcia Penna, and Vera Cristina Augusta Marques Bonazzi.

Data análisis: Tatianni de Nazaré Oliveira Jacob, Diego Pereira Rodrigues, Valdecyr Herdy Alves, Elisângela da Silva Ferreira, Márcia Simão Carneiro, Lucia Helena Garcia Penna, and Vera Cristina Augusta Marques Bonazzi.

Interpretation of the results: Tatianni de Nazaré Oliveira Jacob, and Diego Pereira Rodrigues.

Writing and critical review of the manuscript: Tatianni de Nazaré Oliveira Jacob, Diego Pereira Rodrigues, Valdecyr Herdy Alves, Elisângela da Silva Ferreira, Márcia Simão Carneiro, Lucia Helena Garcia Penna, and Vera Cristina Augusta Marques Bonazzi.

Approval of the final version of the manuscript: Tatianni de Nazaré Oliveira Jacob, Diego Pereira Rodrigues, Valdecyr Herdy Alves, Elisângela da Silva Ferreira, Márcia Simão Carneiro, Lucia Helena Garcia Penna, and Vera Cristina Augusta Marques Bonazzi.

Responsibility for all aspects of the content and integrity of the published article: Tatianni de Nazaré Oliveira Jacob, Diego Pereira Rodrigues, Valdecyr Herdy Alves, Elisângela da Silva Ferreira, Márcia Simão Carneiro, Lucia Helena Garcia Penna, and Vera Cristina Augusta Marques Bonazzi.

ASSOCIATED EDITOR

Stela Maris de Melo Padoin

SCIENTIFIC EDITOR

Ivone Evangelista Cabral

REFERENCES

1. Pereira RM, Fonseca GO, Pereira ACCC, Gonçalves GA, Mafra RA. Novas práticas de atenção ao parto e os desafios para a humanização da assistência nas regiões Sul e Sudeste do Brasil. Cien Saude Colet. 2018;23(11):3517-24. http://dx.doi.org/10.1590/1413-812320182311.07832016. PMid:30427425.
2. Palharini LA. Autonomia para quem? O discurso médico hegemônico sobre a violência obstétrica no Brasil. Cadernos Pagu. 2017;49(49):e174907. http://dx.doi.org/10.1590/18094449201700490007.
3. Lansky S, Souza KV, Peixoto ERM, Oliveira BJ, Diniz CSG, Vieira NF et al. Violência obstétrica: influência da Exposição Sentidos do Nascer na vivência das gestantes. Cien Saude Colet. 2019 ago;24(8):2811-24. http://dx.doi.org/10.1590/1413-81232018248.30102017. PMid:31389530.
4. World Health Organization. Recommendations: intrapartum care for a positive childbirth experience [Internet]. Genebra: WHO; 2018 [citado 2021 jan 12]. Disponível em: https://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/
5. Boerma T, Ronsmans C, Melesse DY, Barros AJD, Barros FC, Juan LMD et al. Global epidemiology of use of and disparities in caesarean sections. Lancet. 2018;392(10155):1341-8. http://dx.doi.org/10.1016/S0140-6736(18)31928-7. PMid:30322584.
6. Franchi JVO, Pelloso SM, Ferrari RAP, Cardelli AAM. Access to care during labor and delivery and safety to maternal health. Rev Lat Am Enfermagem. 2020;28:e3292. http://dx.doi.org/10.1590/1518-8345.3470.3292. PMid:32520244.
7. Amorim TS, Backes MTS, Santos EKA, Cunha KS, Collaço VS. Assistência obstétrica/neonatal: ampliação da prática clínica do enfermeiro na Atenção Primária. Acta Paul Enferm. 2019 ago;32(4):358-64. http://dx.doi.org/10.1590/1982-0194201900050.
8. Portaria nº 1.459 de 24 de junho de 2011 (BR). Institui, no âmbito do Sistema Único de Saúde - SUS - a Rede Cegonha. Diário Oficial da União [periódico na internet], Brasília (DF), 2011 [citado 2021 jan 12]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1459_24_06_2011.html
9. Duarte MR, Alves VH, Rodrigues DP, Marchiori GRS, Guerra JVV, Pimentel MM. Perception of obstetric nurses on the assistance to childbirth: reestablishing women's autonomy and empowerment. Rev Pesq Cuid Fundam Online. 2020;12:903-8. http://dx.doi.org/10.9789/2175-5361.rpcfo.v12.7927.
10. Portaria nº 11, de 7 de janeiro de 2015 (BR). Redefine as diretrizes para implantação e habilitação de Centro de Parto Normal (CPN), no âmbito do Sistema Único de Saúde (SUS), para o atendimento à mulher e ao recém-nascido no momento do parto e do nascimento, em conformidade com o Componente PARTO E NASCIMENTO da Rede Cegonha, e dispõe sobre os respectivos incentivos financeiros de investimento, custeio e custeio mensal. Diário Oficial da União [periódico na internet], Brasília (DF), 2015 [citado 2021 jan 12]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2015/prt0011_07_01_2015.html
11. Silva GF, Moura MAV, Martinez PA, Souza ÍEO, Queiroz ABA, Pereira ALF. A formação na modalidade residência em enfermagem obstétrica: uma análise hermenêutico-dialética. Esc Anna Nery. 2020;24(4):e20190387. http://dx.doi.org/10.1590/2177-9465-ean-2019-0387.
12. Duarte MR, Alves VH, Rodrigues DP, Souza KV, Pereira AV, Pimentel MM. Care technologies in obstetric nursing: contribution for the delivery and birth. Cogitare Enferm. 2019;24:e54164. http://dx.doi.org/10.5380/ce.v24i0.54164.
13. Teodoro IPP, Rebouças VCF, Thorne SE, Souza NKM, Brito LSA, Alencar AMPG. Interpretive description: a viable methodological approach for nursing research. Esc Anna Nery. 2017;22(3):e20170287. http://dx.doi.org/10.1590/2177-9465-ean-2017-0287.
14. Alcântara VCG, Silva RMCRA, Pereira ER, Silva DM, Flores IP. O trabalho no trânsito e a saúde dos motoristas de ônibus: estudo fenomenológico. Av Enferm. 2020;38(2):159-69. http://dx.doi.org/10.15446/av.enferm.v38n2.81874.
15. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2011.
16. Salimena AMO, Paula MBM, Souza IEO, Queiroz ABA, Amorim TV, Cardoso MCS. Trabalho de parto e o parto: compreensão de mulheres e desvelamento da solicitude como possibilidade assistencial. Rev Min Enferm. 2019;23:e-1201. http://dx.doi.org/10.5935/1415-2762.20190049.
17. Lira IMS, Melo SSS, Gouveia MTO, Feitosa VC, Guimarães TMM. Educational intervention to improve normal childbirth care. Enferm Glob. 2020;19(58):247-56. https://dx.doi.org/10.6018/eglobal.382581.
18. Reis TLR, Padoin SMM, Toebe TRP, Paula CC, Quadros JS. Autonomia feminina no processo de parto e nascimento: revisão integrativa da literatura. Rev Gaúcha Enferm. 2017;38(1):e64677. https://dx.doi.org/10.1590/1983-1447.2017.01.64677. PMid:28443976.
19. Oliveira EC, Barbosa SM, Melo SEP. A importância do acompanhamento pré-natal realizado por enfermeiros. Rev Científica FacMais [Internet]. 2016; [citado 2021 jan 12];7(3):24-38. Disponível em: https://revistacientifica.facmais.com.br/wp-content/uploads/2017/01/Artigo-02-A-import%C3%A2ncia-do-acompanhamento-pr%C3%A9-natal-realizado-por-enfermeiros.pdf
20. Progianti JM, Costa RF. Práticas educativas desenvolvidas por enfermeiras: repercussões sobre vivências de mulheres na gestação e no parto. Rev Bras Enferm. 2012;65(2):257-63. http://dx.doi.org/10.1590/S0034-71672012000200009. PMid:22911407.
21. Ministério da Saúde (BR). Diretrizes Nacionais de Assistência ao Parto Normal [Internet]. Brasília: Ministério da Saúde; 2017 [citado 2021 jan 12]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf

22. Santos RCS, Santos RG. Fatores relacionados com a prática da episiotomia no Brasil: revisão de literatura. Estaç Cient. 2016;6(2):43-52. http://dx.doi.org/10.18468/estcien.2016v6n2.p43-52.

23. Colégio Americano de Obstetras e Ginecologista. ACOG Practice Bulletin No. 198 Summary: Prevention and Management of Obstetric Lacerations at Vaginal Delivery. Obstet Gynecol. 2018;132(3):795-7. http://dx.doi.org/10.1097/AOG.0000000000002842. PMid:30134417.

24. Rezaei R, Saatsaz S, Chan YH, Nia HS. A comparison of the "hands-off" and "hands-on" methods to reduce perineal lacerations: a randomised clinical trial. J Obstet Gynaecol India. 2014;64(6):425-9. http://dx.doi.org/10.1097/10.1007/s13224-014-0535-2. PMID: 25489147.

25. Nogueira CLS, Modesto JPAN, Vieira F, Salge AKM, Castral TC. Utilização da bola suíça e banho de chuveiro para o alívio da dor no parto. Enferm Obstétr. [Internet]. 2017; [citado 2021 jan 12];4:e61. Disponível em: http://www.enfo.com.br/ojs/index.php/EnfObst/article/view/61/58

26. Silva MG, Shimo AKK. Influência da iluminação nas expressões emocionais de parturientes: ensaio clínico randomizado. Acta Paul Enferm. 2017 maio;30(3):217-26. http://dx.doi.org/10.1590/1982-0194201700034.