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ORIGINAL ARTICLE

Strategies of nurse-midwives in relation to working conditions in maternity hospitals

Estratégias das enfermeiras obstétricas frente às condições de trabalho em maternidades

Estrategias de las enfermeras obstetrices frente a las condiciones de trabajo de maternidad

Manoel Luís Cardoso Vieira[I]
ORCID: 0000-0003-1614-5848

Juliana Amaral Prata[I]
ORCID: 0000-0003-1315-7595

Elias Barbosa de Oliveira[I]
ORCID: 0000-0001-5834-7312

Fernanda Alves Bittencourt Rodrigues[I]
ORCID: 0000-0001-9181-105X

Bárbara Christine Dantas Silva de Almeida[I]
ORCID: 0000-0002-4421-4516

Jane Márcia Progianti[I]
ORCID: 0000-0003-3843-5192

[I]*Universidade do Estado do Rio de Janeiro. Rio de Janeiro, Rio de Janeiro, Brazil.*

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Corresponding author:
Juliana Amaral Prata
E-mail: juaprata@gmail.com

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ABSTRACT

Objectives: to understand the working conditions and strategies adopted by nurse-midwives in maternity hospitals. **Methods:** a qualitative, descriptive, exploratory study with 20 nurse-midwives from public maternity hospitals in the city of Rio de Janeiro. Data were collected from June to September 2018 through semi-structured interviews, submitted to thematic content analysis and discussed in the light of the psychodynamics of work. **Results:** working conditions are inadequate due to poor infrastructure and resource deficit. Therefore, they develop defensive strategies to mitigate suffering, avoid destabilization of professional identity and minimize losses on care, through material purchase, lunch hour abdication, task reorganization and break implementation. **Final Considerations:** the strategies adopted hide work precariousness and suggest alienation of workers, evidencing the need to foster political awareness of this collective to promote concrete transformations in their work reality. **Descriptors:** Nurse Midwives; Work; Hospitals, Maternity; Nursing Care; Occupational Stress.

RESUMO

Objetivos: compreender as condições de trabalho e as estratégias adotadas pelas enfermeiras obstétricas nas maternidades. Métodos: estudo qualitativo, descritivo, exploratório, com 20 enfermeiras obstétricas de maternidades públicas do município do Rio de Janeiro. Os dados foram coletados de junho a setembro de 2018 através de entrevistas semiestruturadas, submetidos à análise temática de conteúdo e discutidos à luz da psicodinâmica do trabalho. **Resultados:** as condições laborais são inadequadas pela infraestrutura precária e pelo déficit de recursos. Diante disso, elaboram-se estratégias defensivas para mitigar o sofrimento, evitar a desestabilização da identidade profissional e minimizar os prejuízos sobre o cuidado, através da compra de materiais, abdicação do horário de almoço, reorganização das tarefas e implementação de pausas. **Considerações Finais:** as estratégias adotadas ocultam a precariedade do contexto do trabalho, sugerindo a alienação dessas trabalhadoras, evidenciando a necessidade de fomentar a consciência política deste coletivo, para promover transformações concretas em sua realidade laboral.
Descritores: Enfermeiras Obstétricas; Trabalho; Maternidades; Cuidados de Enfermagem; Estresse Ocupacional.

RESUMEN

Objetivos: conocer las condiciones laborales y las estrategias adoptadas por las enfermeras obstetrices en las maternidades. **Métodos:** estudio cualitativo, descriptivo, exploratorio con 20 matronas de maternidades públicas de la ciudad de Río de Janeiro. Los datos fueron recolectados de junio a septiembre de 2018 a través de entrevistas semiestructuradas, sometidas a análisis de contenido temático y discutidas a la luz de la psicodinámica del trabajo. **Resultados:** las condiciones de trabajo son inadecuadas debido a la precaria infraestructura y al déficit de recursos. Ante esto, se desarrollan estrategias defensivas para mitigar el sufrimiento, evitar desestabilizar la identidad profesional y minimizar el daño al cuidado, mediante la compra de materiales, abdicación de horas de almuerzo, reorganización de tareas e implementación de descansos. **Consideraciones Finales:** las estrategias adoptadas esconden la precariedad del contexto laboral, sugiriendo la alienación de estos trabajadores, destacando la necesidad de fomentar la conciencia política de este colectivo, para promover transformaciones concretas en su realidad laboral.
Descriptores: Enfermeras Obstetrices; Trabajo; Maternidades; Atención de Enfermería; Estrés Laboral.

INTRODUCTION

In recent decades, neoliberalism has transformed the Unified Health System (SUS – *Sistema* Único *de Saúde*) by reducing the role State' role and restrictions in financing that have led to the scrapping of public institutions and emergence of flexible models for management of services and human resources. In this context, there is the care network expansion mainly through social organizations (SO), and the coexistence of different forms of labor relationship[1-5].

This conformation is associated with work precariousness at SUS, expressed in inadequate working conditions, in the multiplicity of employees' relationships with public administration and in the instability of some labor relations, which removes workers' autonomy and places them in situations of vulnerability concerning insecurity, intensification and discouragement[1-5].

In the context of delivery and birth care in SUS, this reality can be observed in the labor market of nurse-midwives in the city of Rio de Janeiro, for whom management through SO has expanded jobs, including new care units by Stork Network (*Rede Cegonha*) and the Rio de Janeiro Stork Program (*Programa Cegonha Carioca*). However, through forms of work organization that make labor relations more flexible, productivity and multifunctionality are required, resulting in labor intensification[1,5-9].

In this scenario, we add the technical division of nursing work, the specificities of management and care activities, sexual division, hierarchical and conflicting relationships, low salaries and accumulation of work relationships. These characteristics add complexity to nurse-midwives' work, undress the devaluation of this specialty in maternity hospitals and contribute to discouraging these workers[1,7-11].

It is considered that international guidelines and public health policies recognize nurse-midwives' work who, through a care process focused on relational skills and soft technology use, offer humanized and safe care that has contributed to changing a medicalized obstetric model, reducing interventional behavior adoption and increasing the degree of women's satisfaction[5,9,12-16].

Concerning these advances in qualification of obstetric care, greater government investments are needed to further improve maternal and neonatal outcomes through promotion and appreciation of nurse-midwives' work. In this regard, this study raises necessary reflections because, from the perspective of work, nurse-midwives are working under adverse working conditions, which produce suffering, sicken workers and create challenges for humanized care in SUS.

Therefore, this research is anchored in Cristophe Dejours' psychodynamics of work, which investigates individuals and their relationship with work organization (context, conditions and labor relations), taking care of the suffering resulting from workload intensification and defensive strategies used by workers to give a new meaning and overcome suffering arising from unstructured labor contexts[17].

From this perspective, work organization, which comprises work division (division and content of tasks, pace and time) and individuals division (power relations, responsibility, hierarchy, command and control), prescribes human activities and relationships for workers. This configuration mobilizes individuals' subjectivities, producing experiences of pleasure when organization allows transgression of the prescribed work, enabling a psychic structuring and expression of identity. If organization does not allow subversion of the prescribed by an individual, there are experiences of suffering and elaboration of defensive strategies in order to mitigate it[17-19].

OBJECTIVES

To understand the working conditions and strategies adopted by nurse-midwives in maternity hospitals.

METHODS

Ethical aspects

This study was approved by the Research Ethics Committee of *Universidade do Estado do Rio de Janeiro*. In compliance with the ethical and legal aspects of research with human beings, participants signed the Informed Consent Form (ICF). Their voluntary participation and anonymity maintenance have been explained to them. To this end, the letters NM have been adopted, for nurse-midwives, followed by Arabic numerals, representing the order of the interviews.

Type of study

This is a qualitative, descriptive and exploratory research that allows understanding the relationships and subjectivities of a phenomenon through reporting experiences and perceptions of all actors involved[20]. In this perspective, this study adopted the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Methodological procedures

Study setting

This study did not claim to focus on specific maternity hospitals. However, it is noteworthy that participants worked as nurse-midwives in seven of the twelve maternity hospitals in Rio de Janeiro, with different care profiles.

Study participants

The research was conducted with 20 nurse-midwives. Specialists in midwifery who worked in public maternity hospitals in the municipality of Rio de Janeiro for at least one year, who work on call and who have statutory and/or hired labor contracts (in Brazil, CLT) in these maternity hospitals have been included. Nurses who worked concomitantly in public and private maternity hospitals were excluded.

Snowball sample[21] was used to select participants, seeking seed participants through an intentional selection, by telephone contact with three midwifery students at a public higher education institution. This choice is due to the ease of the authors obtaining contacts with the coordination of this course.

Thus, the sampling was constituted from these seed participants, which indicated other potential participants who, in

turn, appointed other new participants; thus, it was formed a non-probabilistic sample reference chain up to the saturation indicator, which was reached when five new participants started to repeat the contents already obtained in previous interviews, without adding new relevant information to the research[20].

Data collection and organization

Data collection took place from June to September 2018, through individual interviews, which enable researchers to establish a dialogue with interviewees, freely addressing an in-depth theme[20]. To this end, we used a semi-structured instrument containing closed questions about participants' characteristics and the following open-ended questions: how do you feel about your work? How do you perceive your working conditions? Which elements of your workplace are unfavorable and/or favorable to carrying out your activities? How do you act before these working conditions? What is the influence of these conditions on your health and care practices?

Through telephone contact with participants for clarification and invitation to participate in the research, interview dates were scheduled in common agreement among parties. They were performed by one of the authors of this study, a doctoral student at the time of data collection; interviewees occurred at participants' residence under appropriate conditions of convenience and privacy, providing the necessary spontaneity.

All interviews lasted an average of 60 minutes, being recorded in a digital device, without records of all expressions and feelings manifested. After transcription, this material was sent by email for content validation by participants.

It is noteworthy that three pilot interviews were conducted, which indicated the instrument's adequacy and, even though there was no need for alterations, these participants have not been included in the study. It is also punctuated that there were no refusals or losses of participants during this process, i.e., of the 23 participants selected, only the three who participated in the pilot test have been excluded.

Data analysis

In statement categorization, we used Bardin's thematic content analysis[22], whose findings were discussed in the light of the psychodynamics of work theoretical framework[17]. Without using any software, this process began with pre-analysis, followed by material exploration, to identify recording units, which were organized into units of meaning and regrouped into thematic units, which were submitted to inference and interpretation among authors, which allowed constructing the study categories entitled: "Inadequate working conditions of nurse-midwives: precarious infrastructure associated with a lack of material and human resources" and "Defense strategies adopted by nurse-midwives in before physical and mental work overloads".

RESULTS

Participants are female and between 25 and 34 years old. In relation to time passed after graduation, it has been more than three years for eighteen and less than two years for two. Regarding labor relationships, eleven have only one, five of which are statutory and six hired (under CLT regimen, the Consolidation of Labor Laws Decree Law 5452 (*Consolidação das Leis do Trabalho*, CLT) is the decree which governs labor relations in Brazil), nine of which accumulate two or three. Most of these workers develop their work activities in care and day service, in shifts of 12x60 hours, making a work day equal to or greater than sixty hours per week.

Inadequate working conditions of nurse-midwives: precarious infrastructure associated with a lack of material and human resources

This category showed that nurses' working conditions are inadequate due to precarious infrastructure, expressed in obsolete physical structure, equipment malfunction and lack of material resources in the workplace. These issues are inadequate working conditions that represent exposures to physical risks and interfere with care production, as recommended by the programmatic guidelines for humanization.

> *Physical structure is obsolete, it leaves a lot to be desired! For example, the bathroom is really bad! There is no shower, and those who do, the shower keeps breaking! You have to ask for maintenance all the time.* (NM5)

> *One thing that we fight a lot here is for a better physical structure! The boxes, the fact of having a bathroom and a shower for all patients* [...] *it is impossible, especially with a full house.* (NM9)

> *Here we work with few resources. We are able to apply some technological care resources based on evidence, but we lack birthing stool, Swiss ball* [...]. *Things that we don't have at the moment. So, this gets in the way a little.* (NM14)

> *It is an anti-hospital, it was prepared for this new model of humanization! So, for you to provide adequate assistance, based on humanization, it becomes much more complicated. Sometimes, one patient cannot stay in the bathroom for a long time because another wants to enter.* (NM15)

> *The room has been disabled due to the heat! We have been maintenance free for months and the air conditioners are all defective, complicated.* (NM20)

In addition to these aspects, which were also pointed out by NM4, NM11 and NM19, physical and psychological overloads of work resulting from the reduction in the number of nursing professionals, the increase in the demand for women for care and the demand for productivity by institutions. This work context, in most cases, leads to accumulation of tasks and/or functions and culminates in intensification of nurses' work in maternity hospitals, identified in the statements of fifteen participants.

> *The issue of decreasing professionals is also very bad because the number of professionals decreased and demand increased.* [...] *so, we ended up with all the work and I'm accumulating service. Sometimes, I can't do my job on you* […] *the number of nurse-midwives and nursing technicians has been reduced.* (NM6)

They dun a lot for being a social organization! Once coordination is dunned, they dun us because they are afraid of resignation. There is pressure to assist more people. (E07)

We are often dunned because we are having less childbirth than the other institution. Dun is constant. (NM13)

Here there is a lot of pressure for productivity in assistance and stratification! […] *Stratification* [referring to the risk stratification recommended by the Ministry of Health] *has to be done in ten minutes! So, you have to follow this.* (NM20)

Defense strategies adopted by nurse-midwives before physical and mental overloads at work

This category revealed that, considering inadequate working conditions and physical and mental overloads, nurses develop defense strategies focused on problem-solving, such as buying materials by their own means, giving up, in whole or in part, the official lunch break, reorganizing tasks and implementing unofficial breaks for the nursing staff during work shift.

We buy materials, necessary equipment […] *not everything, of course, but we buy what we get and we divide the costs. So, we need Swiss balls, oils and aromas... then we chip in and buy* (NM4).

At times, we are unable to have a one-hour meal. You have to take less, otherwise the colleague will not eat or will have lunch much later. So, we always try to adapt, but it ends up overloading anyway. (NM12)

People are always supporting. We try to share more. We divide the tasks to reduce their workload. (NM17)

Our activity generates a lot of stress. So, we try our best to take it easy, but there are times when we can't. […] *during a shift, we were extremely tired, so even I said, "Sit there and relax and I'll go see the patients now".* (NM18)

My team is very close, everyone is there in the same boat. So, what can help the other helps. When one is sick, the other helps out. (NM19)

DISCUSSION

Infrastructure is an essential element for hospitals, as environments with spaces, furniture and material resources necessary for healthcare practice, with temperature, sound, lighting, synesthesia and color appropriate to the specificities of care, provide privacy, individuality and comfort; these elements translate into well-being for users and experiences of pleasure for workers[9,23-28]. On the other hand, an environment in dissonance with the recommended standards can generate dissatisfaction and weariness of workers in the performance of their work activities, shaping situations of suffering that negatively impact on the humanization, quality and safety of care[2,7,9,27-33].

From the perspective of the psychodynamics of work, working conditions integrate elements of infrastructure, support and administrative practices, which characterize the locus of production, involving physical and biological environments, anthropometric, hygiene and safety circumstances, instruments and equipment, symbolic material objects and organizational support. Thus, when the working conditions offered by an organization are precarious and do not accept workers' expectations and desires, experiences of suffering arise[34].

Such a deleterious configuration appears in the gaps between the prescribed work, such as the tasks set for a given work process and the real work as activities that are concretized in practice, considering workers' singularities and the material, organizational and/or social variables of the conditions of production[17]. In addition to the complexity of this relationship, within health care, prescribed work also incorporates normative and programmatic guidelines for public policies, the structuring of the care network, bioethical frameworks and legal provisions[7].

Therefore, the prescribed work interacts with workers' subjectivities and possibilities offered by working conditions, forming a real work that presents itself as adaptations of the prescribed before real work situations. Working conditions can provide experiences of pleasure when they allow psychic structuring and the expression of workers' identities, or they can determine experiences of suffering and interfere with the construction of identity, forms of sociability and self-esteem[17].

As seen in nurse-midwives' statements about the infrastructure of maternity hospitals, it is noted that obsolete physical structure, equipment malfunction and lack of material resources reveal precariousness at work. These working conditions elements that trigger suffering experiences, as it interferes with the development of a humanized care process and destabilizes workers' professional identities.

As a guideline of the Brazilian National Humanization Policy (*Política Nacional de Humanização*), ambience is defined as physical, social, professional and interpersonal relationships organized to provide healthy, welcoming and comfortable spaces that create meeting places between professionals, users and managers to improve conditions and processes of health work with a view to building human and resolving relationships[23-24].

From the perspective of obstetric services, the official recommendation for ambience runs through a hospital infrastructure that favors parturition and birth processes by adopting practices based on scientific evidence and implementing places for reception with risk stratification, rooming-in and rooms with pre-delivery, delivery and post-delivery (DDD) beds equipped with bathroom with boxes and shower[24]. It is also recommended that DDDs offer light, thermal and acoustic comfort, as well as providing areas for walking and equipment for relaxation, pain relief and encouraging the physiological evolution of labor, such as swiss ball, ling stairs, stool birthing, bathtub and/or hot water shower, among others[9,24-25].

Considering these official recommendations, ambience inadequacy in maternity hospitals is perceived, as participants consider that the obsolete physical plant does not favor caring with respect to privacy and promoting comfort to women, since it does not include bathrooms with individualized boxes and showers with hot water. Moreover, recurrent malfunctioning of air conditioners exposes professionals and users to physical risks due to high ambient temperatures. Lack of institutional availability of specific instruments used by nurse-midwives hinders providing

humanized care with a minimum of intervention and prevents the expression of their identity referents in the workplace.

In the humanized care process characteristic of nurse-midwives, swiss ball, stool birthing and essential oils are some of the material resources necessary to use Non-Invasive Technologies in Midwifery Care (TNICEO); TNICEO are conceptualized as techniques, procedures and knowledge that contribute to the physiological progression of parturition, encourage female autonomy, promote well-being and reduce unnecessary interventions[13-14,35-36]. In addition to these contributions, TNICEO are referential identities that generate belonging, confer distinctions on the care of nurse-midwives and create representations of a humanized care model that allow recognizing these specialists among other health professionals[13,36].

Within the scope of international guidelines and Brazilian public policies, these specialists are recognized as strategic agents to promote humanized practices in childbirth and birth care services, through TNICEO[7,13]. Thus, when work organization does not provide the necessary instruments for using these technologies, devaluation and institutional non-recognition of nurse-midwives' work is evident; recognition is a symbolic retribution resulting from workers' contributions to an institution, resulting from the meanings and values attributed to their activities[17].

From this perspective, it is possible to infer that the working conditions mentioned by participants encourage experiences of suffering. Lack of important instruments for using TNICEO destabilizes their identity referents and adds psychic burden to work by depriving symbolic material objects that give meaning to their practices, reinforce their professional identity and provide the social valorization of midwifery.

As another element related to working conditions in maternity hospitals and which also produces experiences of suffering, work intensification was evidenced, expressed in participants' statements through a work overload resulting from the reduced number of nursing professionals, the increased demand for women for service and institutional dun for productivity.

In recent decades, the world of work has been reconfiguring itself from the neoliberal determinations of flexibility and rationalization of work organization, associated with requirements of qualification, versatility and multifunctionality. Thus, labor force exploitation and despoiling, often in precarious conditions and with fragile bonds, together with the weakening of collective capacity to mobilize workers, are fundamental to meet the demands of productive processes under the auspices of the capital[1-4].

As a result of this situation, there are changes in the content, nature and meaning of work that start to add pressure for increased productivity and performance, culminating in intensifying work or increasing the degree of work intensity, which is expressed in extension of working hours, tasks performed at an intense pace and with strict control, accumulation of functions, flexibility and variable remuneration[1-4,9,11,37].

Such characteristics attributed to labor are present in health work organization. However, nursing is the staff most affected, because, in addition to frequent accumulation of work relationships due to low wages, its activities include shortage of workers and wear and tear related to the complexity and heterogeneity of occupational activities in the hospital; these activities are configured as an overload for adding a greater load of material and immaterial work[1,6-9,29-30,38].

It is assumed that work should be a source of pleasure and professional fulfillment; however, in adverse conditions and labor intensification, there is a greater chance that work will be a source of stress, frustration, depersonalization and discouragement, compromising the functional and moral capacity of workers, as well as the quality of health care[1-2,4,6-9].

Therefore, it was found that participants are immersed in inadequate working conditions that conform to experiences of creative suffering, which is characterized by using the potential for reframing work through changes congruent with the desire of workers to resist destabilization at work. At the same time, some participants reveal experiences of pathogenic suffering; such suffering occurs when workers' internal and external resources are exhausted to meet the demands of a strict work organization, in which space of freedom is limited[19].

Considering the precarious environment and work overload, nurse-midwives use practical intelligence, which consists of using their own resources and using inventive capacity; they also used cooperation, which represents ways of acting in groups to face suffering at work through the development of predominantly collective defense strategies; they contribute to cohesion at work, as they are developed by a group of workers to withstand work organization's adversities[18-19].

Thus, buying some instruments to use TNICEO is a collective defense strategy designed to prevent inappropriate working conditions from destabilizing nurse-midwives' professional identities, manifested in humanized care, and to minimize the impacts of this context on maternity care. On the other hand, total or partial abstention from the right to lunch, reorganization of tasks and implementation of unofficial breaks for the nursing staff during work shift are collective defense strategies that aim to alleviate the effects of physical and psychological overload of nurses' work, as well as mitigate pathogenic suffering before an adverse work reality.

Although these defensive strategies are collective, they do not produce effective changes in working conditions, nor do they represent an organization of nurse-midwives to fight for their rights at work. Such finding refers to the idea of voluntary servitude, in which workers, despite being aware of submission to the prescribed, submit themselves to the trade's rules, by alienation or due to management using fear, covering up serious organizational and structural problems that affect the their dignity and well-being at work[39-40].

It is worth mentioning that the world of work's current configuration is potentially harmful to workers' health, since restrictions on investments in human resources and infrastructure add uncertainties, dissatisfactions, occupational stress and suffering.[29-30,38]. Such issues promote imbalances that are expressed through anguish, frustration, sadness, stress, tachycardia, tension headache, lack of concentration and creativity, depression, low productivity, musculoskeletal pain, tiredness, progressive exhaustion and exhaustion[2,27]. Some of these excruciating changes in health were reflected in participants' statements, showing that working conditions generate experiences of pathogenic suffering that materialize in illness caused by work.

This research found that the defensive strategies used by nurse-midwives are not directed to cope with inadequate work conditions in maternity hospitals. However, they pervade the

feeling of belonging and cohesion of these workers, functioning as efficient collective resources to minimize tiredness, stress and overloads resulting from an unworthy occupational context, with precarious ambience, intensification and demand for productivity, which induce isolation destabilization of professional identity, suffering and illness of workers.

It is noteworthy that the findings of this study are supported by international research that addresses the working conditions of nursing professionals in different countries, correlating them with suffering, illness and job dissatisfaction[29-33,38]. In this regard, nurse-midwives and midwives who work in work ambiance with security, necessary resources and good interpersonal relationships, combined with salaries and decent work hours, have higher degrees of job satisfaction, with positive impacts on their health and qualification of obstetric care[29-33,38,41].

Study limitations

Considering the depth and diversity of the data found, it appears that the non-use of software for analysis of the 20 interviews carried out can be considered a limitation, as it would be an efficient resource for data organization and interpretation, which confers reliability to the process of building analytical categories in qualitative research.

Contributions to nursing, health and public policies

The reflections of this study give rise to a new way of thinking about nursing education. Maternity hospitals in Rio de Janeiro are settings for practical training of nurses and nurse-midwives, who are immersed in inadequate working conditions. Therefore, it is necessary to direct efforts to minimize the distance between the prescribed and the real. The coexistence of students with a precarious context of nursing work can harm the constitution of future nurses' or experts' profiles, as well as interfere with the process of building professional identity, with the potential for discouragement in relation to the profession.

A precarious work in SUS can jeopardize the advancement of government initiatives aimed at qualifying health care for women and humanizing care; this study showed, predominantly, experiences of suffering among nurse-midwives who work at maternity hospitals. Such finding can trigger the evasion of these experts to other assistance scenarios, especially when work organization does not provide decent working conditions and demands productivity from workers.

FINAL CONSIDERATIONS

Nurse-midwives' workplace shows signs of precariousness, as inadequate working conditions mobilize the practical intelligence and cooperation of workers, so that they develop defense strategies to face overloads and minimize suffering. However, the nature of these mechanisms suggests their alienation, since their actions do not promote concrete changes in their work reality and, at the same time, hide their work's precariousness.

In order to break with a configuration that maintains a continuous cycle of precariousness, this study showed the importance of fostering political awareness for organization of this group of workers, in order to fight for decent working conditions. Furthermore, it also sparked reflections on the effects of this overview on nursing education and public policies for women's health care. It was emphasized that mismatch problem-solving between prescribed and real work is necessary for building workers aware of their struggles and with dispositions to claim the valorization of their work, to strengthen a humanized model and, at the same time, to face the world of work's neoliberal logic.

Thus, this study points to the need to conduct further research on the work of nurse-midwives in other care settings and in the context of maternity hospitals in other administrative spheres and in other states. It also aims to deepen discussions about the importance of decent working conditions regarding facilities, human resources, material and technological inputs, which provide experiences of pleasure and promote well-being for carrying out work of inestimable social value, like nursing.

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