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Childbirth experience of women in a maternity hospital signatory of the Adequate Childbirth Project: mixed study

Experiência de parto de mulheres em uma maternidade signatária do Projeto Parto Adequado: estudo misto

Experiencia de parto de mujeres en una maternidad signatorial del Proyecto Parto Adecuado: estudio mixto

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ABSTRACT

Objective: To understand the childbirth experience of women assisted in a maternity hospital signatory of the Adequate Childbirth Project.

Methodology: Mixed study, carried out in 2018. Applied the Free Word Association Test in 62 pregnant women and then conducted an open interview with 18 of them, then puerperal women, and, for analysis, the Central Nucleus Theory, Word Cloud, and thematic Categories, respectively.

Results: The predominant words revealed in the quantitative stage were: pain, wonderful, recovery, anxiety, and desires. The qualitative analysis is presented by thematic categories "Women's insecurities in the PPA model" and "New perspectives from experience in the PPA model".

Conclusions: The women's experiences demonstrated that the model favored the remodeling of childbirth care. However, they still experience pain, dissatisfaction, and lack of autonomy. The impossibility of choosing a trusted professional was a source of insecurity, and nurses had no voice in decisions and actions in care.

Keywords: Midwifery. Natural childbirth. Humanizing delivery. Patient satisfaction.

RESUMO

Objetivo: Compreender a experiência de parto de mulheres assistidas em maternidade signatária do Projeto Parto Adequado.

Metodologia: Estudo misto, realizado em 2018. Aplicado o Teste de Associação Livre de Palavras em 62 gestantes e depois realizado entrevista aberta com 18 delas, então puérperas, e, para análise a Teoria do Núcleo Central, Nuvem de Palavras e Categorias temáticas, respectivamente.

Resultados: As palavras de predomínio reveladas na etapa quantitativa foram: dor, maravilhoso, recuperação, ansiedade e desejos. A análise qualitativa está apresentada pelas categorias temáticas "Inseguranças da mulher no modelo PPA" e "Novas perspectivas a partir da experiência no modelo PPA".

Conclusões: As experiências das mulheres demonstraram que o modelo favoreceu a remodelagem da atenção ao parto. Entretanto, elas ainda vivenciam dor, insatisfação e falta de autonomia. A impossibilidade de escolha do profissional de confiança foi um gerador de insegurança, e as enfermeiras não tiveram voz nas decisões e ações no cuidado.

Palavras chaves: Tocologia. Parto normal. Parto humanizado. Satisfação do paciente.

RESUMEN

Objetivo: Comprender la experiencia de parto de mujeres asistidas en una maternidad signataria del Proyecto Parto Adecuado.

Metodología: Estudio mixto, realizado en 2018. La prueba de asociación libre de palabras se aplicó a 62 mujeres embarazadas y después se realizó una entrevista abierta con 18 de ellas, en ese momento ya puérperas y, para el análisis, la Teoría del Núcleo Central, la Nube de palabras y las Categorías Temáticas, respectivamente.

Resultados: Las palabras predominantes reveladas en la etapa cuantitativa fueron: dolor, maravilloso, recuperación, ansiedad y deseos. El análisis cualitativo se presenta por las categorías temáticas "Inseguridades de las mujeres en el modelo PPA" y "Nuevas perspectivas desde la experiencia en el modelo PPA".

Conclusiones: Las experiencias de las mujeres mostraron que el modelo favoreció la remodelación de la atención del parto. Sin embargo, todavía experimentan dolor, insatisfacción y falta de autonomía. La imposibilidad de elegir un profesional de confianza era una fuente de inseguridad, y las enfermeras no tenían voz en las decisiones y acciones en la atención.

Palabras claves: Partería. Parto normal. Parto humanizado. Satisfacción del paciente.

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INTRODUCTION

The delivery and childbirth care model is related to rights and damages when issues such as gender inequality, violence and medicalization of the female body in obstetric care emerge[1]. It also has an impact on negative health care indicators, with emphasis on the high rates of maternal and neonatal mortality, and Brazil ranks second in the world for cesarean sections, with levels well above those considered acceptable by the World Health Organization (WHO)[2–3]. In 2017, 56% of Brazilian deliveries were cesarean sections and, when looking at the private sector, this percentage reached the level of 86%[2] , rates that are distant from the 15% recommended by WHO[2–3].

Good obstetric practices and harm-free care, under the horizon of providing a positive childbirth experience, are the right of every woman[3], and are opposed to the negative outcomes noted above, which highlights the need for changes in the current models[2,4].

In this direction, in 2015, in response to the public civil lawsuits of the Federal Prosecution Service against the National Supplementary Health Agency (ANS) to the excessive number of caesarean sections practiced in the Brazilian supplemental health sector, it was launched the strategy named "Adequate Childbirth Project" (*Projeto Parto Adequado* - PPA), A cooperation between ANS, the Institute for Healthcare Improvement (IHI) and the *Hospital Israelita Albert Einstein* (HIAE), with support from the Ministry of Health (MS)[4–5].

The initiative is aimed at supporting the reorganization of the care model, to reduce the percentage of unnecessary cesarean sections and to increase the quality and safety of care for childbirth and delivery based on four fundamental pillars: governance, women's empowerment, monitoring of indicators and reorganization of the structure and processes in care[4–5].

Structured in phases, the PPA starts with the pilot phase, during the years 2015 and 2016, which included the participation of 35 hospitals and 19 health insurance operators, and demonstrated the project's viability, in addition to increasing the rate of normal birth from 21.5% to 38% in the participating hospitals. The second stage, the dissemination phase, began in 2017, and continues to date, with the participation of 137 hospitals and 65 health plan operators. And finally, the third phase, launched in 2019 with the slogan "Building a Movement for Health, Safety and Equity in Pregnancy and Childbirth", includes measures to promote the dissemination of strategies to improve the quality of care during childbirth and large-scale birth[4–5].

The present study intends to give voice to women who have experienced PPA with a view to pointing out the proposed care model, as well as reflections directed to care that promotes positive experiences in pregnancy, childbirth and postpartum for women and their families. The study was guided by the question: "How was the childbirth experience of women attended at a maternity hospital signatory of the Adequate Childbirth Project?". The objective was to understand the childbirth experience of women assisted in a maternity hospital signatory of the Adequate Childbirth Project in the interior of the state of São Paulo.

METHODOLOGY

This is a mixed study, developed from a first quantitative stage revealing indicators that were explored in the qualitative stage, followed by an association of the evidence of the phenomenon under study[6], in this case, the childbirth experience in signatory maternity hospital of the PPA.

The Free Word Association Test (TALP)[7], proposed by Abric, was selected for the first stage, and the qualitative exploratory research, for the second stage. The latter focuses on the exploration of meanings and senses that are part of an experience[8]. The theoretical and methodological frameworks that supported the second stage were, respectively, "Positive childbirth experience"[3] and "Thematic Content Analysis"[9].

The study took place in a single maternity hospital signatory of the PPA, located in a municipality in the interior of the state of São Paulo with an estimated population in 2018 of 76,864 inhabitants[10]. In 2018, there were 785 childbirths in the municipality, among which 381 (48.5%) were cesarean sections[11].

The choice of this institution was due to the fact that this maternity hospital was a pioneer of the PPA in the country, beginning the remodeling of the childbirth and delivery model in 2012 with the campaign "Campaign for the Best Childbirth" and then becoming a signatory of the PPA. At the time of data collection, this maternity hospital was experiencing the dissemination stage of the project referring to the second phase of the PPA initiative[5].

The maternity hospital listed in the study concentrates about 90% of childbirths in the municipality, receiving pregnant women from the supplementary network of the surrounding cities. Pregnant women at habitual risk, after 34 weeks, are referred to this maternity hospital for continuity of prenatal care until birth, while pregnant women classified as high risk are referred for follow-up and obstetric support in the neighboring city (counter-reference). Physically, the maternity hospital has 18 beds to attend to the usual risk pregnancies, and, during the study period, the obstetric team that accompanied the women during labor, delivery and the puerperium was composed by four obstetric nurses, an obstetrician, fifteen nursing technicians, approximately twenty obstetricians, ten pediatricians and five anesthesiologists, all of whom worked on a presential duty scale.

To participate in the first stage of the study, women met the following inclusion criteria: to be pregnant; to be in the first prenatal consultation at the institution signatory of the PPA; to be over 18 years old or emancipated and have a normal risk pregnancy. The exclusion criteria adopted were: impossibility of providing an understandable narrative and having a previous indication for cesarean section.

In the first stage of the study, all women (n=80) enrolled in the service throughout January 2018 were listed. In the first contact, before the prenatal consultation, in a private room, the pregnant women were invited to participate in the study and those who accepted signed the Free and Informed Consent Form (ICF). From the 80 women, five were under 18 years old and did not have emancipation, two gave birth before the first contact to invite them to the study, eight were excluded because they had a previous indication for cesarean section, two did not accept to participate and one was hearing impaired. The first stage, therefore, had a total of 62 pregnant women able and willing to participate.

For the first stage, it was adopted an instrument for sociodemographic and obstetric characterization of the participant, developed by the author herself. On the same day of application of the tool, the Free Word Association Test (TALP)[7] with the inductive term "Normal Childbirth" was also applied. Five evocations were requested for the participants, who then classified these evocations by degree of importance in an increasing way. The time to fulfill the instrument and collect the test was about 15 minutes.

The data from the application of the TALP were adjusted for synonyms or similarity of meanings. The OpenEvoc software[12] was used and, of 310 words, 38 corpus were reached, which were based on the proposal of Abric (1998) - Theory of the Central Nucleus, which interprets it in Central System and Peripheral System[7].

To start the second qualitative stage, the main author of the study tracked the 62 women who participated in the first stage through the maternity hospital birth book, in which all data on childbirths occurring in the maternity hospital are recorded. After 15 days of delivery, each woman was contacted through the WhatsApp® application or telephone in order to confirm the continuity of the research and propose the scheduling of a new meeting for the collection sequence.

For the qualitative stage, new inclusion criteria were listed: birth in the institution signatory of the PPA and women and children in adequate health conditions. In this stage, data collection took place until the theoretical saturation was reached, that is, the interviews ended when the information obtained from the participants would not provide new aspects in relation to the explored phenomenon[8]. This occurred after 18 women were interviewed. This step occurred during the months of March and April 2018.

On a date, time and place chosen by the woman, the interview started with the triggering question: "Tell me about how was your childbirth experience". During the conversation with the researcher, other questions were asked in an articulated way to the participant's narrative, in order to understand the integral aspects of the phenomenon exposed by her. All interviews were recorded on audio only once and lasted an average of 30 minutes. At the end, the interviews were transcribed in full, and it was decided to make small structural and grammatical corrections in the content, without changing, however, the meaning of what was expressed by the participant.

The data extracted from the interviews were treated with double methodological criteria. First, it was performed the Lexical Analysis - Word Cloud[13] of these data, and then they were analyzed using the Thematic Content Analysis[9]. For the lexical analysis and elaboration of the word cloud, it was used the software IRAMUTEQ (*Interface de R pour lês Analyses Multidimensionnelles de Textes et de Questionnaires*)[13].

The research was approved by the Human Research Ethics Committee, with a substantiated statement registered under number 2,409,121, and all women consented to the study by signing the Free and Informed Consent Term (ICF). In order to maintain the anonymity of the participants, their speeches were identified by the letter "P" (for participant) followed by an Arabic number translating the entry in the second stage of the study. As an example, "P3" would be the third woman interviewed in the second stage of the study.

RESULTS AND DISCUSSION

Among the 62 pregnant women who participated in the study, the average age was 32 years old, varying between 19 and 41 years old; 31 (50%) declared themselves white and 24 (38.7%) brown, and 30 (48.3%) were married. As for schooling, 7 (11.29%) did not complete elementary school, 10 (16.2%) did not finish high school, 29 (46.77%) completed high school and 16 (25.79%) entered in higher education. The majority of women (54.83%) had a family income between one and two minimum wages, 36 (58.06%) were multiparous, 27 (43.54%) did not plan the pregnancy and 48 (77.4%) started prenatal care in the first trimester of pregnancy; 34 (54.84%) progressed to normal delivery and 28 (45.16%) underwent cesarean sections.

The lexical analysis of the *corpus* formed from the evocations of the 62 participants in response to the inducing term "Normal Childbirth" revealed a mean of the evocation order of 3.0 and a mean frequency of 2 evocations, with a minimum frequency of 1. The "act of evoke" is about remembering something that is present in the subjects' subconscious[7]. Through the empirical data, it can be observed that, at the first contact of pregnant women with the inductive term

"Normal Childbirth", the elements of the Central System were "pain", "wonderful", "recovery", "anxiety", "wishes", "love" and "expectation"; the evocations "fear", "suffering", "best choice", "doubt", "good", "more natural", "ease" and "relief" formed the Peripheral System.

Based on paradigms, normal childbirth is represented by the participants as an unpredictable and obscure moment. In the active sensation of living and experiencing childbirth, the pregnant woman is immersed in a mixture and explosion of feelings. However, persuaded by personal and socio-cultural beliefs, the impact of changing the environment (now hospital) and the new prenatal care, they bring to light elements of a complex phenomenon, which is reaffirmed by observing the different terms evoked by the participants[14].

Still, the evocations: "anxiety", "expectation", "fear" and "suffering" allow us to reflect on how women feel in a passive position in relation to the health professional. In this sense, women's rights of choice and protagonism end up being infringed, leaving them almost speechless and with no decision power. Thus, cesarean section becomes a rule instead of a conscious choice based on the risks and benefits for maternal and child health[14].

It can be seen that, even before experiencing childbirth, pain is signified as an unfavorable element, in addition to being a socio-culturally pervaded topic, contradicting a positive and satisfactory experience for normal childbirth. Therefore, it is understood that the way the woman receives information and guidance on the gestational and parturitive process greatly interferes with expectations regarding childbirth and delivery, contributing or not to a positive experience of childbirth[15–17].

In this scenario, when discussing the woman's perspective on the reasons for her insecurity, many explain that their doubts are not clarified during pregnancy, which accentuates the distance between the functioning of their body and the physiological process of childbirth. This creates the metaphor of expropriation of the body itself and, when the experience of childbirth happens, it causes them to emanate reflections that go beyond a singular panorama[15,17].

In order to deepen the analysis, the qualitative stage started giving rise to the Word Cloud. The image was constructed with the interaction of words from the participants' interviews and, from their groupings, composed 175 different *corpus*. The word "pain", in the center, was the most mentioned, and counted as a frequency of 116 times, followed by the words "doctor" (95 times), "nurse" (88 times) and "baby" (87 times), shown in Figure 1.

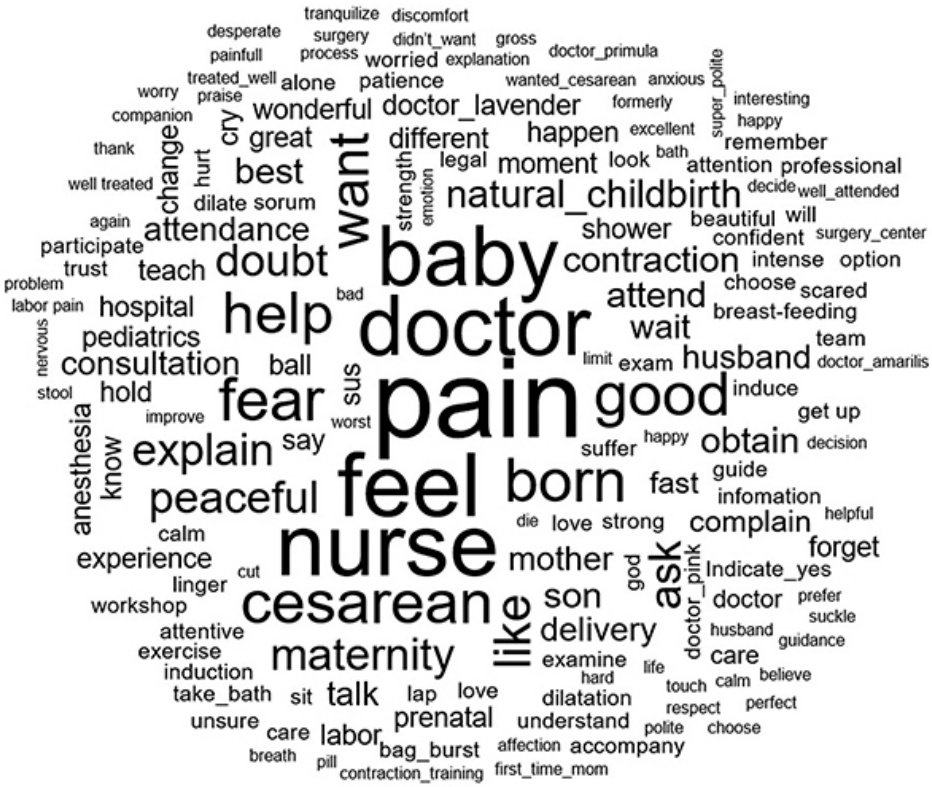

Figure 1 – Word Cloud
Source: Research data, 2020.

In order to add representativeness to the figure and provide empirical convergence, the interviews were analyzed under the framework of content analysis through thematic categories. The analysis allowed the identification of two categories entitled: "Women's insecurities in the PPA model" and "New perspectives from the experience in the PPA model":

Women's insecurities in the PPA model

The category "Women's insecurities in the PPA model", is named as a feeling experienced by the woman's debut in the PPA strategy and by the process also observed during the prenatal period:

> *"[...]" I wanted (normal birth), but I was afraid, for working 9 years in another hospital and seeing some things that left me traumatized "[...]" (P 9)*
>
> *I had a very boring view, I thought I would be treated badly that at the time of delivery, no one would be patient with me "[...]" (P13)*
>
> *I had another view of what it was like "[...]" because of the things people talk about both normal birth and the cesarean section "[...]" (P15)*

Decentralized care, proposed by the PPA model, was not well understood and accepted by the participants:

> *Now it is the duty shift that makes [...] it should be who followed from the beginning. (P4)*
>
> *I know that there are all trained professionals there, but it is not the professional I chose, right, it was not my trusted professional [referring to the doctor]. "[...]" (P 9)*
>
> *"[...]"There is always a doctor, we identify more and that we would like to be with that doctor on the day of delivery, it is more for the sake of trust and such, and then, as there are several doctors, we were not sure who we were going to catch on the day "[...]" (P13)*

On the other hand, it was found with the reports a fragmented care process, sometimes disrespectful and verticalized, in which the woman is not heard and welcomed, in addition to having her right to choose suppressed:

> *I think that these consultations, each day with a different (physician), generates a lot of conflict, and whoever is in the middle is the pregnant woman who is already in such a delicate situation, psychological overexcited, is in the middle of this war, all with that emphasis to have a normal delivery, I think this is not a humanized delivery, it is a forced delivery "[...]"this is what I felt, all the time they say: 'no, you have the right to choose', in moments they said 'go, choose', 'no, you will do the normal, you can handle doing the normal' so this thing 'you can choose' for me is all farce.(P5)*
>
> *"[...]" I couldn't take it anymore staying there without knowing what was going to happen "[...]" (P8)*
>
> *"[...]" each one has a way of attend "[...]" (P16)*

Through what has been exposed so far, it is clear that being a hospital signatory of the PPA was not enough to guarantee positive experiences during pregnancy and childbirth, even with the perspective of changing the obstetric model offered. This may be due to the implementation of a model that is not consistent with the unique precepts or needs arising from women.

The centrality in the care of women, supported by global recommendations, is a way of raising awareness, acquiring knowledge and, consequently, obtaining freedom of choice for women, currently listed as a challenge for social mobilization and construction of public policies for a positive experience[2,15].

The woman brings with her representations about a model of birth that is determinant for psychosocial and cultural constructions. Currently, they are affected by a scenario with excessive cesarean sections, medicalized, conflicting and asymmetrical, which prevent them from being heard, a fact that limits their involvement, empowerment, immersion and understanding of themselves as protagonists of this act[1,15,17].

In this perspective, the speeches portray the biomedical paradox established, in contrast to the proposal of the PPA, in which, for the project, the decentralization of the medical figure is seen as a potentializing element for good experiences. However, for the participants, such decentralization was seen as a component that generates insecurity, that is, there is no possibility of choosing a reliable professional for continuous care.

The speeches suggest that this change in the centered medical model generated insecurity, since the bond with the medical professional who accompanied her for up to 34 weeks of gestation was broken and inserted her in a context created by the new PPA model, without her being able to do this transition internally and could feel safe in the face of the new team that would accompany her.

In this regard, some authors[18], reflect that technology and its powers of persuasion have reinforced socioculturally that pregnancy, childbirth and delivery are unsafe and pathological events, and the need for medical intervention would be a way of guaranteeing security for these processes.

The prestige of the medical figure and his sociocultural knowledge narrows the doctor-patient relationship, making

it a relationship of trust, and the PPA model has difficulty in sustaining this discourse, causing unease and dissatisfaction on the part of some participants.

The permanency of the technocratic and biomedical model is eminent in the women's speeches, either due to the lexical prevalence and centrality of the word "doctor", revealed in the word cloud, or by the recurring speeches in the thematic category. The reputation of the on-call team is marginalized as poor assistance, fragmented and not shared, which is due to the fact that medical education is still based on procedures that depersonify women[1].

Thus, in order for insecurities to be re-signified and the care models such as those of the PPA to be recognized as better by women, it is necessary to uproot the centrality of the medical figure as the sole holder of power and to lead, in a shared way, the singular care, coming from multiprofessional teams, in which information and awareness for choosing the route of childbirth and the cares performed transcend the stereotypes of power created by society[1,14–15,18].

New perspectives from the experience in the PPA model

In the category "New perspectives from the experience in the PPA model", statements were observed that brought the benefits of an assertive informative support and welcoming efforts by the multiprofessional team, especially nursing, favoring positive experiences, the empowerment of women and the possibility of accepting the new assistance model proposed by the PPA:

> *"[...]" when they said it was humanized, I already liked it a lot, which it wasn't before, right? When they said I could choose things, I liked it. "[...]" (P7)*
>
> *I felt a lot of difference, much better, way much better, you feel more secure, you are freer "[...]" (P11)*
>
> *"[...]" they tried to explain the benefits of normal childbirth, which was what I was most afraid of, tried to show me the good side. "[...]" (P13)*

Still in this sense, the participants highlighted the efforts of welcoming and listening to the team formed by obstetric nurses and obstetricians, factors that favored the creation of bonds and care centered on the women's demands:

> *"[...]" there is a very nice nurse, it doesn't even look like the nurse, it seems like a friend you knew a long time ago, the girls are very polite and very friendly." (P6)*
>
> *"[...]" the nurses are exceptional, all of them, extremely incredible care, I think doctors should learn a little more from the nurses the care that a pregnant woman should have "[...]" (P5)*
>
> *"[...]" there are people who know how to deal with people, it was like she said to me I am not feeling your pain, but if you get stressed and worried about the other contraction, you will not be able to relax it is worse for you, then try to relax, breathe, so she calmed me down in an intelligent way "[...]" (P14)*

The informative support, in line with the good obstetric practices offered, favored the experimentation of labor in a more positive way, allowing a better view and understanding of the PPA:

> *"[...]" (the nurse) said that I could be comfortable, if I wanted to lie in bed, if I wanted to go to the shower again, if I wanted to stay on the ball. (P3)*
>
> *"[...]" everything that happened was very calm, explained very well and I left there very confident knowing what to do. (P2)*
>
> *"[...]" she helped me a lot, supported me a lot, recommended me a book and a documentary to watch, I watched it and I even bought the book and that's when I decided what I wanted, what I wanted, and it didn't matter the hour that came. "[...]" (P12)*
>
> *"[...]" she taught me to stay on the ball, stimulated childbirth enough, taught me a lot of exercise, taught almost everything, didn't know anything "[...]". (P17)*
>
> *"[...]" my husband's presence was very important because he helped me with everything, he was close to me, helped with childbirth, cut the cord, the doctor called him and he went there and helped me with everything, for me it was essential his presence. "[...]" (P1)*

The speeches above allowed us to identify that, when experiencing labor, women's feelings, and expectations regarding the PPA model changed. Much of this change was due to the informative and welcoming effort of the obstetric nurses and the obstetrician, who demonstrated a new concept of caring and being cared for, giving them greater protagonism and confidence in the parturition process.

In this perspective, the participants point out that the assistance to labor, delivery and postpartum, especially by the nursing team, favored a differentiated and singular relationship, experienced by the care and perception of quality

of care. When they appreciate this relational aspect, they demonstrate that care goes far beyond a personal process, being a paradoxical challenge guided by an inversion of values and ideals under the way of being born in Brazil, as well as in some scenarios across the country[14,17].

Such transformations have been anchored in scientific evidence that encourages humanized assistance and that composes a series of actions that stand out in an effective reception, a quality listening and a relationship of trust, with plausible changes in the social context and representativeness of normal childbirth noticed in the speeches above[2,15].

These improvements in care have been encouraged by WHO since the 1980s. In 2018, through the "WHO Recommendations: intrapartum care for a positive childbirth experience", the importance of participation and inclusion in the health teams of non-medical professionals was reinforced. Such professionals are qualified for excellent care, with the purpose of enabling better childbirth experiences, with the reduction of unnecessary interventions seen even in biomedical models. Such recommendations, based on singular, multidimensional, integrated and multiprofessional care, have been shown to be effective when viewing favorable perinatal health indicators[19].

It can be seen, through the data coming from the word cloud and the speeches, that the nursing team has the unique action of guiding and influencing changes in the obstetric scenario. However, within the model and in Brazil, there is still the challenge of the performance of obstetric nursing in assistance to childbirth and delivery. Even being part of a multidisciplinary team, the role of the obstetric nurse and the midwife is still below expectations and recommended by WHO. The obstetric nursing team, especially in the national scenario, has its potential for autonomy of continuous care and educational resources throughout the gestational and parturitive process reduced, remaining to them, in most cases, the monitoring of labor, not less important, but it also proves to be challenging and without incentive[3–4].

A study[4] points out that only in 27% of vaginal births there are records of the performance of Brazilian obstetric nursing as the technician responsible, even though this performance is on the rise in the public sector. On the other hand, in the private sector, this performance is almost nonexistent.

In 2019, the International Confederation of Midwives (ICM) released a worldwide document updating the practices and skills of obstetric nurses and midwives. The document encourages the professional's autonomy for reproductive, gestational, parturitive and puerperal care, punctuating integrative competences, such as diagnosis, action, intervention, and emergency actions for women's health, as well as participation in the teaching of new professionals and in the development of scientific evidence. Such initiatives are important, as they add values of changes in scenarios and in birth contexts[20].

This study contributes to both practice and science by identifying, in the context of a maternity that is a signatory of the PPA strategy, the experiences of women who have given birth in this model. In general, it is evident that such experiences occurred in a tenuous way between (un)satisfaction, (in)security and (dis)trust.

It is worth remembering that these experiences have undergone constant changes, both in the projections that the participants brought with them and in the historical, cultural, and social context, as well as in the relationship established with health professionals.

CONCLUSIONS

Although the PPA has in its principles to transform the current model of childbirth care, the statements of the women in this study show a care scenario still linked to the health-disease process, with a discreet leadership of midwives and obstetrical nurses and a low valuation of female autonomy and positive experiences for women and families.

Considering the impacts of the childbirth experience on identity and social roles, women's physical and mental health, it is imperative that the current model be transposed and that strategies such as the PPA increasingly involve users in monitoring the quality of care. It is up to us, researchers and professionals, that the desires, opinions and choices of women are welcomed and directed in the light of the best clinical evidence of care.

In addition, obstetricians and obstetric nurses must be considered key parts for the transformation of obstetric care due to the ability to overcome the conception of childbirth only as a biological event and to improve the choice of women. There is a growing body of evidence indicating that continuous care led by these professionals is particularly suitable for healthy women, as it tends to be more focused on woman and the family, a factor of great relevance in women's satisfaction with childbirth.

Finally, it is essential to raise society's awareness of the fact that women and children alive are not enough, but that, in addition, they need to be healthy and have positive experiences of this process, which is so impactful in the life of the human being.

It is recommended that other studies be conducted in this care scenario, so that the gaps mentioned above are further explored, as well as innovative strategies proposed to promote a safe and positive childbirth experience for women and their families.

Study limitations

The research, by its nature, is subject to certain limitations. Thus, this study had as limitations the evaluation of a single PPA unit specific to a region and the loss of participants throughout the process (a fact expected in scientific studies that involve more than one stage of data collection). Although the qualitative characteristic of the methodology does not allow us to extrapolate the results, it supports us in reflecting the problem in the specific context and can still serve as a basis for new quantitative studies on the perceptions about obstetric care through the current models.

However, we believe that the results indicated may contribute to the development of new studies on the experience of childbirth and the quality of care for women.

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