

CARE IN THE PARTURITION PROCESS FROM THE PERSPECTIVE OF NURSING PROFESSIONALS

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ABSTRACT

Objective: to reflect on nursing care for women undergoing parturition from the perspective of nursing professionals.

Method: this is a study with a qualitative approach based on Convergent Care Research. The participants were 36 nursing professionals, who developed assistance activities for women undergoing parturition in an Obstetric and Gynecological Surgical Center of a University Hospital in southern Brazil. For data collection, the convergence group discussion technique was used, through audio-recorded thematic workshops following the phases of the process called Four Rs (4Rs), from June to August 2017. The data were analyzed using the thematic analysis proposed by Creswell, supported by the Iramuteq software.

Results: five classes emerged: weaknesses/limitations in the parturition process; ambience and human resources in the parturition process; imposition of care and lack of privacy for women in the parturition process; process of being born: the understanding of nursing professionals; and contributions in the care process for a better birth.

Conclusion: the present study allowed understanding the relationships of the nursing care for women in the process of parturition, identifying the barriers and weaknesses in the care process, reflecting and discussing possibilities for the systematization of nursing care in the parturition process.

DESCRIPTORS: Obstetric nursing. Nursing care. Childbirth. Humanized childbirth. Labor. Qualitative research.

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CUIDADOS NO PROCESSO DE PARTURIÇÃO SOB A ÓTICA DOS PROFISSIONAIS DE ENFERMAGEM

RESUMO

Objetivo: refletir sobre os cuidados de enfermagem à mulher em processo de parturição sob a ótica dos profissionais de enfermagem.

Método: trata-se de um estudo com abordagem qualitativa baseado na Pesquisa Convergente Assistencial. Participaram 36 profissionais de enfermagem que desenvolviam atividades assistenciais às mulheres em processo de parturição em um Centro Cirúrgico Obstétrico e Ginecológico de um Hospital Universitário do Sul do Brasil. Para a coleta de dados utilizou-se da técnica de discussão em grupo de convergência, por meio de oficinas temáticas audiogravadas seguindo as fases do processo denominado Quatro Erres (4Rs), no período de junho a agosto de 2017. Os dados foram analisados mediante análise temática proposta por Creswell, apoiado pelo *software* Iramuteq.

Resultados: emergiram cinco classes: fragilidades/limitações no processo de parturição; ambiência e recursos humanos no processo de parturição; imposição de cuidados e ausência de privacidade da mulher em processo de parturição; processo de nascer: o entendimento dos profissionais de enfermagem; e contribuições no processo de cuidar para melhor nascer.

Conclusão: o presente estudo proporcionou compreender as relações dos cuidados de enfermagem à mulher em processo de parturição, identificar as barreiras e fragilidades no processo assistencial, refletir e discutir possibilidades para a sistematização dos cuidados de enfermagem no processo de parturição.

DESCRITORES: Enfermagem obstétrica. Cuidados de enfermagem. Parto. Parto humanizado. Trabalho de parto. Pesquisa qualitativa.

CUIDADOS EN EL PROCESO DE PARTO DESDE LA PERSPECTIVA DE LOS PROFESIONAIS DE ENFERMERÍA

RESUMEN

Objetivo: reflexionar sobre la atención de Enfermería brindada a la mujer en proceso de parto, desde la perspectiva de los profesionales de Enfermería.

Método: se trata de un estudio de enfoque cualitativo basado en la Investigación Convergente Asistencial. Participaron 36 profesionales de Enfermería que desarrollaban actividades asistenciales con mujeres en proceso de parto en un Centro Quirúrgico Obstétrico y Ginecológico de un Hospital Universitario del Sur de Brasil. Para recolectar los datos se utilizó la técnica de discusión en grupo de convergencia, por medio de talleres temáticos grabados en audio siguiendo las fases del proceso denominado Cuatro Erres (4Rs), en el período de junio a agosto de 2017. Los datos fueron analizados mediante el análisis temático propuesto por Creswell, con el respaldo del *software* Iramuteq.

Resultados: surgieron cinco clases: debilidades/limitaciones en el proceso de parto; ambiente y recursos humanos en el proceso de parto; imposición de cuidados y ausencia de privacidad de la mujer en proceso de parto; proceso de nacer: el entendimiento de los profesionales de Enfermería; y contribuciones en el proceso de la atención para un mejor nacimiento.

Conclusión: el presente estudio permitió comprender las relaciones de la atención de Enfermería brindada la mujer en proceso de parto, identificar los obstáculos y las debilidades en el proceso asistencial, y reflexionar y analizar posibilidades para sistematizar la atención de Enfermería en el proceso de parto.

DESCRIPTORES: Enfermería obstétrica. Atención de Enfermería. Parto. Parto humanizado. Trabajo de parto. Investigación cualitativa.

INTRODUCTION

In the last two decades, women have been encouraged to have their babies in health facilities in much of the world, to ensure qualified assistance and timely referrals to the needs presented; however, the quality of care still does not guarantee the achievement of desired results and is below the ideal. The main reason is characterized by the predominant care model adopted, which is technocratic and interventionist, significantly interfering in the physiology of the delivery process.¹⁻²

Through guidelines,¹ the World Health Organization (WHO) has been seeking changes in the care model, which emphasize that care focused on the needs and expectations of women is as important as clinical care. Based on this understanding, the WHO recommends respecting women's values and choices, emotional support, and effective communication as essential components that should complement any clinical intervention.^{1,3}

A review that included 35 studies from 19 countries showed that most pregnant women want a positive birth experience, in which safety and psychosocial well-being are equally valued. Among which they included the birth of a healthy baby in a safe environment, with emotional support, and competent and reassuring professionals; they mostly wanted physiological labor and delivery, to maintain personal control through active decision-making, that is, protagonism, empowerment and autonomy in the process of delivery and birth.⁴

At the national level, actions based on the best scientific evidence were also developed with the intention of reducing the high rates of unnecessary interventions and making changes in the care model, which are expressed by the Ministry of Health (MoH), through the inclusion of care guidelines for normal births.⁵ When reviewing the public policies implemented over the past decades in relation to the current theme, there are important historical milestones for maternal and neonatal health, such as the implementation of *Rede Cegonha* and the Apice On project, which have the common objectives of humanized care, patient safety and the quality of maternal and neonatal care, with a view to good practices in delivery and birth care.

Although these efforts exist in order to improve all assistance to women in the parturition process, it is observed that it is necessary to sensitize health professionals to exercise care, dialogue, welcoming, and communication with the parturient to achieve ideal humanization. The active participation of nursing professionals in this process is important because, as members of the health team, in addition to technical-scientific knowledge, respect must be shown to women as unique beings, with desires and rights, in order to promote humanized care.⁶

Given the above, the formulation of public policies aimed at the performance of obstetric nursing in assistance for delivery and birth and the need to change to the model in obstetric care centered on women, the perspective on collaborative work between the team and care differentiated from each professional can be highlighted, in which each develops their skills and contributes differently, in order to guarantee continuity of care and ensure safe, efficient and satisfactory assistance to women.⁷

In this perspective, and in view of the experience lived by the first author in an Obstetric and Gynecological Surgical Center (*Centro Cirúrgico Obstétrico e Ginecológico*, CCOG), the concern arose about how the understanding of the parturition process perception by nursing professionals, either in relation to the care itself or to others aspects that permeate assistance and professional experience, with its positive and negative nuances, can contribute to overcoming contradictions in the obstetric scenario and result in a valuable reflection on changes in the obstetric care model, in order to guarantee humanized, safe assistance and quality. It is herein emphasized that the parturition process encompasses the act of giving birth and being born in itself and, in addition, all the emotional, human and cultural aspects that involve the woman and her family.⁵

Based on such arguments, this study aimed to reflect on nursing care for women in the parturition process from the perspective of nursing professionals.

METHOD

A study with a qualitative approach, based on the methodological framework of Convergent Care Research (CCR),⁸ carried out at a CCOG of a University Hospital in the Southern Region of Brazil, from June to August 2017. The research scenario is a large hospital, a state and regional reference for the most varied specialties, including Obstetrics. It is a hospital certified as Child Friendly, with adherence to *Rede Cegonha*, as well as to the Apice On Project.

The PCA methodological framework was chosen due to its embryonic and practical nature, with results of improvement and innovation in the context of nursing care, allowing for the approximation of care actions with research in the same physical and temporal space. CCR implementation takes place through four phases. The design phase, in which the research problem arises; the instrumentation phase, in which the research methodological procedures are elaborated; the search phase, with the development of skills and sensitivity for investigating and refining data; and the analysis phase, in which data are analyzed and interpreted simultaneously.⁸

Furthermore, it is a methodological framework that requires the researcher to be a health professional inserted in the field where the study takes place. At present, the first author has been a nurse in the sector for 9 years and identified the need for practical changes to improve care through research, using the concepts governed by CCR, in which communication was established through dialog by means of the workshops, expanding the researcher's initial purpose in relation to the need for practice, and articulating scientific research and care practice for the construction of the shared change.⁸

At first, the proposal was presented to the head and sectorial supervision with clarification about the importance of this study for the institution, for the professionals and for the parturient women. After the approval of the leadership, professionals belonging to the CCOG team were invited, in which 36 nursing professionals participated (nurses, technicians and nursing assistants). The inclusion criteria were the following: nursing professionals working in an obstetric center with direct and indirect action (responsible for other activities, such as transportation) to women in the parturition process; and the exclusion criteria were professionals who were on vacation, with certificates or licenses.

For data collection, the convergence group discussion technique was used, through thematic workshops following the process called Four Rs (4Rs), with its Phases of Recognition, Revelation, Redistribution and Rethinking.⁸ This allowed knowing the reality experienced by the group in relation to the care practice in the parturition process and provided the opportunity for reflection, discussion, sharing, and consensus among the group on nursing care for women during this process.

Four thematic workshops were held, with a mean duration of 60 minutes each, in the morning, afternoon and night shifts, in the premises of the CCOG, in order to reach all nursing professionals in the sector, totaling 39 meetings. All the workshops were conducted by the first author, recorded on audio, and had the Free and Informed Consent Term signed by all the participants. The workshops were repeated in more than one meeting so that all the professionals could participate, as they took place during working hours and by rotation, so that the service was not left unattended.

The data were transcribed in full in a digital document, where, for the identification of each participant, the letters PE for Nursing Professional ("*Profissional de Enfermagem*" in Portuguese) were used followed by a number, in order to guarantee anonymity.

The first workshop characterized the Recognition Phase of the 4Rs process, in which the intragroup interaction started. It was primarily due to the realization of a group dynamics, which provided the opportunity for self-introduction and exposure of the satisfactions and dissatisfactions related to the work/care process. Subsequently, participatory dialog was established in relation to nursing care for women in the parturition process and expectations regarding the theme, respecting the differences of opinion of each member of the group. That workshop was worked on in nine meetings.

The second workshop, which took place in ten meetings, represented the Revelation Phase. Through the presentation of a video and the participatory dialog established in the previous workshop, key information was identified and reflection began regarding nursing care for women undergoing childbirth at the CCOG and how good practices in deliver and birth care were inserted in this scenario, reflecting on the convergent and divergent factors of such recommendation.

In the third workshop, held ten times, the Redistribution Phase was addressed. After the presentation of a video, the larger group was divided into smaller groups, to identify care that they considered important in the parturition process in relation to the theme discussed in previous workshops. Then, they were presented to the larger group, with all the care actions recorded, in which the same and/or similar care was grouped and, thus, all care was listed.

Held ten times, the Rethinking Phase was defined in the fourth and last workshop. Taking into account the participatory dialog, the discussions and group productions carried out in the previous workshops, and based on the scientific evidence in relation to the good practices of delivery and birth care, nursing care for women in the process of parturition was presented systematized, after considerations and changes made in consensus with the group.

The data were submitted to the thematic analysis proposed by the Creswell steps,⁹ which consisted of: organization and preparation of data for analysis; reading the data; detailed analysis with data coding; description of the data; analysis representation; and interpretation of the analysis. For the author, the analysis and interpretation of data is a mental process in which reflection takes place continuously in order to deeply extract the meaning of the data from the text.⁹

To support the coding of the data, the *Interface of R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (Iramuteq)¹⁰ software was used, in which the method of Descending Hierarchical Classification was employed, which aims to obtain classes of text segments with similar words at the same time and different from the text segments of the other classes. From the grouping of words that relate to each other, the software helps the data to be read so that the author more quickly identifies the thematic categories, called classes, referring to the object under study.¹⁰

The study was approved in 2017 by the Research Ethics Committee, according to the attributions set forth in Resolution 466/2012 of the National Health Council (*Conselho Nacional de Saúde*, CNS).

RESULTS

Data analysis resulted in five major classes: weaknesses/limitations in the parturition process; ambience and human resources in the parturition process; imposition of care and lack of privacy for women in the parturition process; process of being born: the understanding of nursing professionals; and contributions in the care process to better be born.

Weaknesses/Limitations in the parturition process

The reports of the nursing professionals in this class point out weaknesses/limitations in the parturition process, where the use of oxytocin has been shown to induce or accelerate labor, where unnecessary medicalization during labor can cause unwanted and negative outcomes, as shown by the speeches:

The patient is already in a lot of pain and they still ask to put oxytocin so that the delivery is faster (PE10).

The use of oxytocin, improper. Sometimes the patient has a lot of contractions but, because they want to advance the delivery, they introduce oxytocin (PE16).

This insistence on inducing labor unnecessarily also gets in the way. Often the patient is in excellent labor and, even so, they are given oxytocin. It complicates all labor (PE35).

The early admission of women during the parturition process proved to be another weakness mentioned by the nursing professionals, which generates anxiety about birth for both women and family members, according to the following statements:

Often they are admitted early and they didn't even need to [...] (PE35)

There is also the issue of hospitalizing very early, I don't know if it is due to insecurity or a social issue. From the moment they are admitted to have a child, they want to have the child. They don't understand that it can take a while. The family also puts pressure, because she was admitted to give birth they want her to give birth. So, I think they are hospitalized too soon (PE29).

Through the speeches, a limitation is perceived related to the assistance during the pregnancy cycle and that has great importance and contribution in the preparation of the woman and the relative for the moment of birth. Given the above, the lack of guidance in the prenatal care for this preparation causes insecurity and makes it difficult to care for women in the parturition process:

Explain everything beforehand, and it has to start from prenatal care (PE07).

The guidelines should happen since prenatal care, as they are not informed of their rights (PE12).

The patient is not ready for delivery. There would have to be preparation for delivery from prenatal (PE26).

Prenatal guidance is being very flawed. Many patients do not even know what the obstetric center is. The lack of guidance makes our care difficult (PE34).

The data in this category demonstrate factors that do not bring benefits to women undergoing parturition from the perspective of the nursing professionals, involving interventions and guidance in the parturition process.

Ambience and human resources in the parturition process

The discourse of the nursing professionals in this class encompassed the difficulties encountered in providing nursing care to women in the parturition process. One of the main difficulties evidenced by the statements is related to the physical structure, with restricted and inadequate physical space, reflecting on the woman's freedom of movement, and on maintaining adequate temperature and individuality:

Our pre-delivery environment is very ugly, congested, out of space and dark. The beds are awful (PE03).

Taking care of the temperature, because in the pre-delivery there is wind through the window, which doesn't close properly (PE08).

We know that the whole structure here is bad for monitoring this process. It is difficult, due to the structure, and with many patients in the same room (PE25).

Here in our service, I think that the structure is the most difficult thing (PE34).

The insufficient number of professionals was demonstrated as another difficulty evidenced by the statements, which does not guarantee the necessary care to be given to women in the parturition process, as follows:

I believe that the employee does what he can, but we lack time (PE03).

You barely talk to her, for lack of time. We don't have an exclusive time to be with the patient (PE04).

Sometimes we don't have time, we have to take medication, puncture, change, take her to the room (NP17).

In this class, the speeches of the professionals demonstrated that the physical structure and the inadequate quantity of the professionals involved in the care can have an impact on care that does not bring benefits to the woman and the companion in the parturition process, and thus contribute to care failures and, consequently, to an increase in adverse event (AE) rates.

Imposition of care and lack of privacy for women in the parturition process

The speeches referenced in this class focused on care that is often imposing, in which the will of the professionals prevailed and not of the woman, distancing humanization from the parturition process, as described below:

Sometimes we want to impose something in our own way, as we learn, and sometimes it is not the best for the patient. We should only help and we cannot impose [...] much is missing here for humanization (PE02).

Often we professionals do what we want. We think it is better for us and we set aside her wishes (PE07).

I think we do not offer humanization and, yes, we want to impose it (PE22).

In fact, the patient arrives and we already impose things (PE28).

Many professionals pointed out the exposure of women during the parturition process, in which privacy was not guaranteed, which caused discomfort:

We have to improve the privacy issue, which is very complicated here. We are unable to provide adequate privacy for each woman. I think the biggest discomfort that patients have today is privacy (PE20).

I think that here we have an excessive exposure of the patient and it is stressful for her (NP22).

Patients need privacy. Here, privacy is lacking, as there is the companion of one and of the other, all there together (PE33).

This class addressed the themes in relation to the absence of women's choices and the right to privacy in the parturition process, making it evident that the woman had not been a protagonist during this process and, even though her autonomy was not always respected by the professionals, which makes it difficult the empowerment of women and the evolution of labor.

Process of being born: the understanding of nursing professionals

The speeches analyzed in this class pointed out the perception of nursing professionals regarding their experience in relation to the parturition process, demonstrating the representativeness of this moment for women from the perspective of the professionals, as observed in the following statements:

Assist and receive this client in the best way, always putting yourself in her place. The patient always comes first. I think it's a special moment for women. Childbirth is her moment (PE01).

It is a unique moment for every woman. Each one must be cared for according to her moment. It is not caring for all them alike. Provide comfort to the patient, treat how I would like to be cared for and pay attention to their complaints (PE09).

It was also possible to highlight the professionals' point of view in relation to the factors they considered important in the parturition process, which involve attention, emotional care and security, among the factors necessary for the woman in the parturition process, as reported below:

Promoting a safe environment, as we need to guarantee this safety [...] it is a reserved moment for this woman (PE07).

Support, safety, mindfulness and morals are important (NP13).

It is comprehensive care for the mother and newborn, ensuring safety and comfort. May pregnancy and childbirth be a humanized, individualized and technically correct event. In addition to the technique, we need the holistic and humanized part (PE14).

In this class it was possible to identify the sensitivity of the nursing professionals in relation to the experience of women in the parturition process and pointed out important factors so that it occurs safely and brings benefits.

Contributions in the care process for a better birth

Through the speeches it was possible to highlight in this class the role of the companion as a resource for caring. The importance of the companion being guided so that he proceeds in an active way and that his participation in the process is beneficial was highlighted, as observed in the following statements:

The patient is also entitled to the companion of her choice [...] to teach the companion to assist in the parturition process [...]. If the companion is together, teach how to massage (PE12).

Facilitate the presence of the companion and, whenever possible, encourage care (PE20).

Guide the companion on the appropriate way to assist the patient in giving birth (PE30).

It also demonstrated care practices that can be performed by the professionals and that demonstrate through scientific evidence its benefits in the birth process, involving care based on guidance, stimulation, encouragement, and use of non-pharmacological technologies for pain relief, as shown in the following lines:

Direct the woman to the relaxing bath, put on the ball, horse. Talk to her a lot and explain what is happening (PE08).

[...] Forward to the relaxation bath. Do exercises on the horse, on the ball, explaining that it is to relax and for the good development of childbirth [...] to care (NP11).

Offer non-pharmacological methods for pain relief, guiding each one and its functions (PE30).

It appears that, in this class, the professionals pointed out important factors for assistance that helps women in the parturition process.

DISCUSSION

The professionals identified important points for nursing care, involving resources for care that bring benefits in the process of delivery and birth and that can help women to experience this moment. But they also showed factors that interfere negatively. The use of inappropriate technologies and unnecessary interventions can contribute to negative outcomes throughout labor and delivery, a fact often determined by the care model adopted.¹

Medicalization in the parturition process indicated in the first class often leads to interferences in the physiological process of giving birth, although it can assist in dystocias.¹¹⁻¹² A study that interviewed more than 23,000 women showed that the use of oxytocytes to accelerate labor was a technique widely used in the public network.³ In this context, its improper use potentiates greater proportions of cesarean sections, in addition to other unsatisfactory outcomes for women and newborns (NBs), and should be used with caution and only when necessary.¹²

The use of unnecessary interventions can be related to the early admission of women, a fact evidenced in a study in Italy, in which women hospitalized in the latent phase had an increase in the proportion of cesarean sections, use of oxytocin, artificial rupture of membranes, instrumental delivery and analgesia, compared to women hospitalized in active labor.¹³ The same results were found in a research study conducted in the United States, in which it was evidenced that the hospitalization of women in active labor would result in a reduction of unnecessary interventions, lower risk, and significant savings per year for the country. In this context, the need for women and family members to receive early information related to the ideal time for hospitalization became evident.¹⁴

The importance of guidelines during prenatal care has as central aspect to prepare the woman and the relative in relation to the moment of birth and to allow them to make informed decisions based on the rights that are guaranteed to them.¹⁵ A number of studies show flaws in relation to the prenatal care guidelines for childbirth, in which, despite satisfactory coverage and proper filling of the prenatal card with adequate presentation at the time of admission, most women did not receive such guidelines, thus observing a gap between productivity and quality of care.¹⁵⁻¹⁶

In the United Kingdom, assistance to women during the puerperal pregnancy cycle is mostly performed by obstetric nurses, and a guide with guidelines has been published in partnership with the Royal College of Midwives and the British Institute of Human Rights to support the professionals, where information and guidelines are provided to women in relation to their rights and their relevance in the parturition process, allowing the professionals to provide quality assistance.¹⁷

In this context, the WHO approves the implementation of continuity of care models in health systems. This care model aims to provide pregnant women with respectful and individualized care, provided by professionals with clinical and interpersonal skills, including important information during pregnancy, in order to guarantee a positive maternal experience in the puerperal cycle.¹

Regarding the difficulties in the work process, it became evident that the physical structure is essential for humanized care and constitutes a fundamental element for the professional to be able to provide quality care.¹⁸ As highlighted by the WHO, the physical structure is so important as the provision of care to improve the quality of care for women in childbirth.¹ A qualitative review that included 67 studies conducted in 32 countries revealed that women and health professionals expressed that the improvement of the quality of the physical environment favors the promotion of respectful care in the maternity.¹⁹

However, studies in relation to the inadequate physical structure in the maternity hospitals have shown professionals' dissatisfaction, since it proved to be one of the barriers to the provision of care, which negatively interfered with humanized care, meeting the results of this study evidenced by the speeches of the professionals.^{18,20}

In the second class, the monitoring of the adequate number of professionals also stands out, making it possible to provide care that is essential for the implementation, application and support of the continuity of care model. According to the WHO, one of the main resource requirements for the care of women in childbirth is related to the sufficient number of qualified professionals to guarantee dignified and continuous care for all women.¹

The improvement of quality in the health system is determined, in addition to other factors, by the correct dimensioning of health care providers.¹⁹ An integrative review demonstrated the relationship between the dimensioning of nursing professionals and patient safety, in which work overload due to the inadequate number of qualified professionals consequently increases the AE rates, a fact that contributes to unsatisfactory results in the parturition process.²¹

Regarding the theme that gave rise to the category on the role, autonomy and privacy of women, it can be said that the use of good obstetric practices has been seeking the role of women. This occurs through welcoming with dignity, respect and through appropriate and unique care, thus being able to guarantee the autonomy of women in relation to their own delivery and making the process of being born a physiological event that guarantees family insertion.¹

A study shows that practices that guarantee the protagonism and autonomy of women are related to a differentiated assistance from what the traditional hospital environment brings us, in order to enable the integration of women in decision-making, respecting their needs, beliefs, values and desires, promoting their active participation.²²

Another positive factor is the possibility of verticalization during the parturition process, which guarantees women more active participation. In this context, the role of the obstetric nurse stands out, which contributes to the empowerment of women and to the reduction of unnecessary interventions, as evidenced in a systematic review of the Cochrane library.²³

Contrary to what was previously described, studies have shown practices that restrict the protagonism, autonomy and active participation of women in the parturition process. These are related to authoritarian practices in which there are asymmetrical relationships between the woman and the team, with imposing care, disrespect for the woman's wishes and needs. This generates failures in communication, causing lack of information, of consent on the part of the woman and negative feelings that hinder labor and delivery, being considered a violation of the rights of women in relation to the integrity of their body.^{3,22,24}

Privacy is still highlighted as highly relevant to humanization in the parturition process, corresponding to one of the human rights during and after childbirth, which fits within the main resource requirements for respectful maternal care.¹ Respect for privacy in delivery and birth care involves the protection of the woman's image and intimacy; however, it still needs to be stimulated, because the asymmetrical relationship between the woman and the team, unfavorable environment, and practices that do not guarantee benefits in the parturition process contradict the idea of humanization.^{22,24}

A systematic review that addresses qualitative evidence related to factors that facilitate and hinder assistance in delivery and birth showed that privacy is highly valued by women, but it is often not appreciated in institutions, due to the lack of respect and cultural sensitivity, arrogant attitudes, and mainly due to the lack of private wards.²

The process of being born is an event of extreme anxiety and pain in the life of women, in which care permeates factors in addition to assistance, in order to achieve humanization. In this context, Nursing is a science with a central point in human beings and in their countless everyday relationships, in which it is necessary to perceive and recognize unusual aspects that present themselves in different degrees of complexity in the provision of care.²⁵

A study showed that most nursing professionals recognized the fundamental role they have during the entire parturition process, helping, and favoring the autonomy of women and their active participation.²⁶ However, a systematic review study showed that, upon arriving at an institution, often experienced delays in the provision of care, in which communication failures were evident.²

Women aim to have a positive experience in the parturition process and, among the factors for its attainment, assistance, emotional care and safety are included.¹ For women in labor, the assistance given during this process by the nursing professionals has great relevance, because it involves the ability to communicate, which enables the creation of bonds and support and, in addition to establishing a symmetrical relationship between the woman and the team, it also provides trust, safety and satisfaction.²²

In a study that included 16 countries and more than 15,000 women, it was evidenced that emotional support, comfort measures, and information during the parturition process increased the possibility of spontaneous delivery and reduced the need for unnecessary interventions with drug therapies, contributing to shorter labor time, thus promoting a satisfactory parturition process.²⁷

With regard to contributions to the care process for a better birth, the companion is a provider of continuous support to women in the parturition process. This should be the exclusive choice of the woman and efforts should not be measured to encourage and implement this resource in the provision of care, including respecting the desire of women who prefer not to have them present, despite being a proven beneficial practice.¹

A systematic review by Cochrane, which provided data from 17 countries, including Brazil, and involving almost 16,000 women, showed that continued support by the woman's chosen companion can improve the results for women and newborns, including less time in the duration of labor, reduction of caesarean sections, instrumental delivery and need for analgesia, in addition to improving the experience in the parturition process.²⁷

In a synthesis of qualitative evidence, it was demonstrated that the presence of the companion during the parturition process helps to relieve pain through touch and alternative techniques, in promoting self-esteem, self-confidence, and also guarantees respect for customs and traditions, thus providing an improvement in the quality of care provided to women.²⁸

Despite these premises, the lack of adequate facilities, with limited spaces, becomes a barrier to implement the presence of the companion and, in some cases, the presence of female companionship is imposed, which generates anxiety in many women and infringes the woman's right to choose.^{2,28}

One of the most important factors for women in the parturition process is pain relief. Non-pharmacological methods are gradually being valued and inserted in the care practice in hospital institutions, guaranteeing fewer interventions, which corroborates with satisfactory results for the well-being of women.¹

A study in Spain sought, by means of comparison, to describe the differences in obstetric results and women's satisfaction in relation to the biomedical model and the humanized model in delivery and birth care; in the humanized model, the offer of non-pharmacological methods, emotional and psychological support, guidance and information was guaranteed, thus promoting the active participation of women in decision-making, and constituted the model with the best results in assisting women and newborns.²⁹

Therefore, the participation of nursing professionals in assisting women in the parturition process is decisive, as it contributes to guaranteeing humanized care, attention to the perspectives of women and families, and also allows for the use of non-pharmacological methods to relieve pain, providing satisfaction and safety.³⁰

Despite the benefits of non-pharmacological methods, a number of studies indicate that unfavorable practices are still part of the assistance provided to women in delivery and birth in some institutions, and that the lack of support, guidance and information increases anxiety, hinders the process of being born, and results in negative outcomes.³⁰

Among the limitations of this study, there is a shortage of nursing staff, which made it difficult to carry out workshops during off-hours. Thus, the meetings took place during office hours, with stipulated time and with rotation of professionals, so that patients did not spend too much time without the available team. Despite this, the large number of workshops generated a large and rich material to be analyzed, which provides subsidies for changes in the care reality of women in the parturition process, in view of the professionals' experience in daily care.

As this study was carried out in a public service, fully served by the Unified Health System, and with its nuances, it is suggested that other scenarios, notably private services, can be investigated so that different realities are known to Nursing, in order to increasingly develop and provide better care to the population in focus.

CONCLUSION

The present study allowed us to reflect on the relationships of nursing care to women in the parturition process and to identify challenges inserted in the care practice. In this process, nursing professionals play a fundamental role in guaranteeing individuality and comprehensive care for women, in a way that converges with good practices in delivery and birth care based on scientific evidence, so that they take place safely and with quality.

The results of this study demonstrate the sensitivity of the nursing professionals towards the humanization of the parturition process, evidenced by the reports that deal with a complex moment for women who experience it and permeated by determining factors so that it occurs safely, bringing benefits to the woman and for it to become a positive experience.

However, factors that, from the perspective of the nursing professionals, have somehow not brought benefits to women in the parturition process have been evidenced, involving forms of care, inadequate structure, scarce human resources, unnecessary interventions and guidelines. The statements showed that professional attitudes still relegate the autonomy and protagonism of women, hindering the process of humanization and the development of good obstetric practices.

In this context, they pointed out care that they considered important and that can help women in the parturition process, being observed by the statements that this care involves non-pharmacological technologies to assist in pain relief and ensure satisfactory results throughout the process of delivery and birth. Guidelines, stimulation, encouragement and support were also considered as primary care, thus favoring a humanized delivery process and the development of good practices in delivery and birth care.

REFERENCES

1. World Health Organization (WHO). Sexual and reproductive health. WHO recommendations: intrapartum care for a positive childbirth experience [Internet]. Geneva (CH): WHO; 2018 [cited 2018 Jun 30]. Available from: <http://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf>
2. Bohren MA, Hunter EC, Munthe-Kaas HM, Souza JP, Vogel JP, Gülmezoglu AM. Facilitators and barriers to facility-based delivery in low and middle-income countries: a qualitative evidence synthesis. *Reprod Health* [Internet]. 2014 [cited 2018 June 30];11(1):71. Available from: <https://doi.org/10.1186/1742-4755-11-71>
3. Leal MC, Pereira APE, Domingues RMSM, Theme Filha MM, Dias MAB, Nakamura-Pereira M, et al. Obstetric interventions during labor and childbirth in Brazilian low-risk women. *Cad Saúde Pública* [Internet]. 2014 [cited 2018 June 30];30(Suppl 1):S1-S16. Available from: <https://doi.org/10.1590/0102-311X00151513>
4. Downe S., Finlayson K, Oladapo O, Bonet M, Gülmezoglu AM. What matters to women during childbirth: a systematic qualitative review. *PloS one* [Internet]. 2018 [cited 2018 June 30];13(4):e0194906. Available from: <https://doi.org/10.1371/journal.pone.0197791>
5. Ministério da Saúde (BR), Departamento de Gestão e Incorporação de Tecnologias em Saúde. Diretrizes nacionais de assistência ao parto normal: versão resumida. Brasília, DF(BR): MS; 2017 [cited 2018 Mar 20]. Available from: http://bvsmms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf
6. Camacho KG, Progianti JM. A transformação da prática obstétrica das enfermeiras na assistência ao parto humanizado. *Rev Eletr Enf* [Internet]. 2013 [cited 2018 Apr 14];15(3):648-55. Available from: <https://doi.org/10.5216/ree.v15i3.18588>
7. Vogt SE, Silva KS, Dias MAB. Comparison of childbirth care models in public hospitals, Brazil. *Rev Saúde Pública* [Internet]. 2014 [cited 2018 Apr 14];48(2):304-13. Available from: <https://doi.org/10.1590/S0034-8910.2014048004633>
8. Trentini M, Paim L, Silva DMGV. Pesquisa Convergente-Assistencial – PCA: delineamento provocador de mudanças nas práticas de saúde. Porto Alegre, RS(BR): Moriá; 2014.
9. Creswell JW. Investigação qualitativa e projeto de pesquisa: escolhendo entre cinco abordagens. 3th ed. Porto Alegre, RS(BR): Penso; 2014.
10. Camargo BV, Justo AM. Tutorial para uso do software IRAMUTEQ (Interfacede R pour lês Analyses Multidimensionelles de Textes et de Questionnaires). Florianópolis, SC(BR): UFSC; 2018 [cited 2019 Aug 10]. Available from: <http://iramuteq.org/documentation/fichiers/tutoriel-portugais-22-11-2018>
11. World Health Organization (WHO). Recommendations for augmentation of labour: highlights and key messages from World Health Organization's 2014 global recommendations [Internet]. Geneva(CH): WHO; 2015 [cited 2018 June 30]. Available from: <http://apps.who.int/iris/handle/10665/174001>
12. Hidalgo-Lopezosa P, Hidalgo-Maestre M, Rodríguez-Borrego M. Labor stimulation with oxytocin: effects on obstetrical and neonatal outcomes. *Rev Latino-Am Enfermagem* [Internet]. 2016 [cited 2018 Aug 30];24:e2744. Available from: <https://doi.org/10.1590/1518-8345.0765.2744>
13. Rota A, Antolini L, Colciago E, Nespoli A, Borrelli SE, Fumagalli S. Timing of hospital admission in labour: latent versus active phase, mode of birth and intrapartum interventions. A correlational study. *Women and Birth* [Internet]. 2018 [cited 2018 Aug 30];31(4):313-8. Available from: <https://doi.org/10.1016/j.wombi.2017.10.001>

14. Tilden EL, Lee VR, Allen AJ, Griffin EE, Caughey AB. Cost-effectiveness analysis of latent versus active labor hospital admission for medically low-risk, term women. *Birth* [Internet]. 2015 [cited 2018 Aug 30];42(3):219-26. Available from: <https://doi.org/10.1111/birt.12179>
15. Gonçalves MF, Teixeira EMB, Silva MAS, Corsi NM, Ferrari RAP, Pelloso SM, et al. Prenatal care: preparation for childbirth in primary health care in the south of Brazil. *Rev. Gaúcha Enferm* [Internet]. 2017 [cited 2018 Aug 30];38(3):e0063. Available from: <https://doi.org/10.1590/1983-1447.2017.03.2016-0063>
16. Viellas EF, Domingues RMSM, Dias MAB, Gama SGN, Theme Filha MM, Costa JV, et al. Prenatal care in Brazil. *Cad Saúde Pública* [Internet]. 2014 [cited 2018 Aug 30];30(1):S85-S100. Available from: <https://doi.org/10.1590/0102-311X00126013>
17. The British Institute of Human Rights (BIHR) et al. *Midwifery and human rights: a practitioner's guide*. Queen Mary University of London. 2016 [cited 2018 Aug 30]. Available from: <https://www.bihhr.org.uk/handlers/download.ashx?idmf=6677278e-0773-4ab8-8fc1-69d935ea7116>
18. Feijão LBV, Boeckmann LMM, Melo MC. Conhecimento de enfermeiras residentes acerca das boas práticas na atenção ao parto. *Enferm Foco* [Internet]. 2017 [cited 2018 Aug 30];8(3). Available from: <https://doi.org/10.21675/2357-707X.2017.v8.n3.1318>
19. Shakibazadeh E, Namadian M, Bohren MA, Vogel JP, Rashidian A, Pileggi VN, Souza JP. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. *BJOG: An Intern J Obstet Gynaecol* [Internet]. 2018 [cited 2018 Aug 30];125(8):932-42. Available from: <https://doi.org/10.1111/1471-0528.15015>
20. Dodou HD, Sousa AASD, Barbosa EMG, Rodrigues DP. Sala de parto: condições de trabalho e humanização da assistência. *Cad Saúde Coletiva* [Internet]. 2017 [cited 2018 June 30];25:332-8. Available from: <https://doi.org/10.1590/1414-462x201700030082>
21. Lima EM, Oliveira TA, Siqueira CL, Silva AF. Segurança na assistência de enfermagem: uma revisão integrativa. *Enferm Rev* [Internet]. 2016 [cited 2018 Aug 30];19(2):262-81. Available from: <http://periodicos.pucminas.br/index.php/enfermagemrevista/article/view/13164/10306>
22. Ferreira LMS, Santos ADF, Bezerra IMP, Alves DA, Damasceno SS, Kerntopf MR, Lemos ICS. Assistência de enfermagem durante o trabalho de parto e parto: a percepção da mulher. *Rev Cubana Enferm* [Internet]. 2017 [cited 2018 June 30];33(2). Available from: <http://revenfermeria.sld.cu/index.php/enf/article/view/1102/263>
23. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Db Syst Rev* [Internet]. 2016 [cited 2018 Aug 30];4:CD004667. Available from: <https://doi.org/10.1002/14651858.CD004667.pub5>
24. Biondi HSilva, Barlem ELD, Pinho EC, Tavares DH, Kerber NPC, Tomaschewski-Barlem JGer. Moral Suffering in Assistance to Childbirth: Situations Present in the Work of Nurses of Obstetric Centers and Maternities. *Texto Contexto Enferm* [Internet]. 2019 [cited 2019 Aug 10];28:e20180052. Available from: <https://doi.org/10.1590/1980-265x-tce-2018-0052>
25. Ramos WMA, Aguiar BGC, Conrad D, Pinto CB, Mussumeci PA. Contribution of obstetric nurse in good practices of childbirth and birth assistance. *Rev Pesqui Cuid Fundam.* [Internet]. 2018 [cited 2018 June 30];10(1):173-9. Available from: <https://doi.org/10.9789/2175-5361.2018.v10i1.173-179>
26. Braga TDL, Santos SCC. Parto humanizado sob a ótica da equipe de enfermagem do Hospital da Mulher Mãe Luzia. *Rev Eletr Estácio Saúde* [Internet]. 2017 [cited 2018 Aug 30];6(1):20-34. Available from: <http://revistapuca.estacio.br/index.php/saudesantacatarina/article/viewFile/3641/1563>
27. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. *Cochrane Db Syst Rev* [Internet]. 2017 [cited 2018 June 30];7:CD003766. Available from: <https://doi.org/10.1002/14651858.CD003766.pub6>

28. Bohren MA, Munthe-Kaas H, Berger BO, Allanson EE, Tunçalp Ö. Perceptions and experiences of labour companionship: a qualitative evidence synthesis. *Cochrane Db Syst Rev* [Internet]. 2019 [cited 2019 Aug 10];3:CD012449. Available from: <https://doi.org/10.1002/14651858.CD012449.pub2>
29. Ferrer MBC, Jordana MC, Meseguer CB, García CC, Roche MEM. Comparative study analysing women's childbirth satisfaction and obstetric outcomes across two different models of maternity care. *BMJ Open* [Internet]. 2016 [cited 2018 Aug 30];6(8):e011362. Available from: <https://doi.org/10.1136/bmjopen-2016-011362>
30. Sousa AMM, Souza KV, Rezende EM, Martins EF, Campos D, Lansky S. Practices in childbirth care in maternity with inclusion of obstetric nurses in Belo Horizonte, Minas Gerais. *Esc. Anna Nery* [Internet]. 2016 [cited 2018 June 30];20(2):324-31. Available from: <https://doi.org/10.5935/1414-8145.20160044>

NOTES

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CONFLICT OF INTEREST

There is no conflict of interest.

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