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MEANINGS AND EXPERIENCES OF WOMEN WHO EXPERIENCED THE HOSPITAL HUMANIZED BIRTH LABOR ASSISTED BY AN OBSTETRIC NURSE

SIGNIFICADOS E EXPERIÊNCIAS DE MULHERES QUE VIVENCIARAM O PARTO HUMANIZADO HOSPITALAR ASSISTIDO POR ENFERMEIRA OBSTÉTRICA

SIGNIFICADOS Y EXPERIENCIAS DE LAS MUJERES QUE EXPERIMENTARON EL PARTO HUMANIZADO DEL HOSPITAL ASISTIDAS POR UNA ENFERMERA OBSTÉTRICA

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Objective: understanding the meanings and experiences of women who experienced the process of hospital humanized birth labor assisted by an obstetric nurse and the motivation for this choice. Method: a qualitative study with 12 women, through semi-structured interviews, after 60 days of birth. Thematic content analysis guided data analysis. Results: four categories emerged: motivations for humanized hospital birth labor assisted by an obstetric nurse; experience and meanings attributed to childbirth; experience and meanings attributed to the participation of the partner and other people of the woman's choice; experience and meanings attributed to professionals. Final considerations: the experience of childbirth was considered unique, grandiose; a singular, fantastic, intense, exciting moment. Women felt respected, strong, victorious. Birth was the greatest experience of love, imbued with respect. The obstetric nurse transmitted peace, security and tranquility during childbirth, was a promoter of dialogue and respect, demonstrating knowledge, technical capacity and empathy.

Descriptors: Humanized Childbirth. Obstetric Childbirth. Obstetric Nurse. Nursing Care. Hospital.

Objetivo: compreender os significados e as experiências de mulheres que vivenciaram o processo de parto humanizado hospitalar assistido por enfermeira obstétrica e a motivação para essa escolha. Método: estudo qualitativo com 12 mulheres, por meio de entrevistas semiestruturadas, após 60 dias do parto. A análise temática de conteúdo guiou a análise dos dados. Resultados: emergiram quatro categorias: motivações para o parto humanizado hospitalar assistido

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por enfermeira obstétrica; experiência e significados atribuídos ao parto; experiência e significados atribuídos à participação do companheiro e outras pessoas da escolha da mulher; experiência e significados atribuídos aos profissionais. Considerações finais: a experiência do parto foi considerada única, grandiosa; um momento singular, fantástico, intenso, emocionante. As mulheres sentiram-se respeitadas, fortes, vitoriosas. O nascimento foi a maior experiência de amor, imbuído de respeito. A enfermeira obstétrica transmitiu paz, segurança e tranquilidade durante o parto, foi promotora de diálogo e respeito, demonstrando conhecimento, capacidade técnica e empatia.

Descritores: Parto Humanizado. Parto Obstétrico. Enfermeira Obstétrica. Cuidados de Enfermagem. Hospital.

Objetivo: entender los significados y experiencias de las mujeres que experimentaron el proceso de parto humanizado hospitalario asistidos por una enfermera obstétrica y la motivación para esta elección. Método: se trata de un estudio cualitativo con 12 mujeres, a través de entrevistas semiestructuradas, después de 60 días de parto. Análisis temático de contenido guio el análisis de datos. Resultados: surgieron cuatro categorías: motivaciones para el parto humanizado en el hospital asistido por una enfermera obstétrica; experiencia y significados atribuidos al parto; experiencia y significados atribuidos a la participación de la pareja y otras personas de la elección de la mujer; experiencia y significados atribuidos a los profesionales. Consideraciones finales: la experiencia del parto se consideró única, grandiosa; un momento singular, fantástico, intenso, emocionante. Las mujeres se sentían respetadas, fuertes, victoriosas. El nacimiento fue la mayor experiencia de amor, imbuido de respeto. La enfermera obstétrica transmitió paz, seguridad y tranquilidad durante el parto, fue una promotora del diálogo y el respeto, demostrando conocimiento, capacidad técnica y empatía.

Descriptores: Parto Humanizado. Parto Obstétrico. Enfermera Obstétrica. Cuidado de Enfermería. Hospital.

Introduction

In Brazil, with the expansion of medical care, childbirth was institutionalized to reduce maternal and infant mortality. This care contributed to the use of childbirth as a pathology that required intervention by a trained team, removing autonomy from the woman in the process of giving birth[1].

This redirection of birth care contributed to the increase in cesarean sections, placing Brazil as a global highlight, whose average of these procedures, per year, is 46.6% in public services and 85% in the private network[2-3]. It should be noted that the World Health Organization (WHO) recommends that the rate of cesarean sections considered ideal should be between 10 and 15% of births[4].

In Brazil, the Ministry of Health (MoH) instituted the Prenatal and Birth Humanization Program (PBHP) in 2002, with the objective of guaranteeing women's rights of choice, reorganization of care and childbirth with minimal interventions. In 2011, it implemented the Stork Network to reduce neonatal mortality, also related to surgical births. In 2012, in the State of Paraná, the Paraná Mother Network was implemented, which aimed to ensure women the right to reproductive planning and humanized care for pregnancy, childbirth and the puerperium, and the child the right to safe birth with good practices and healthy growth and development[5].

In 2017, the Brazilian Ministry of Health published national guidelines for normal childbirth care, with the purpose of providing scientific, revised and updated information on the most common practices in childbirth care and care for women and newborns, with the aim of promoting, protecting and encouraging normal childbirth with reduction of unnecessary interventions and the consequent injuries of these interventions[6].

In 2018, the World Health Organization published recommendations Intrapartum care for a positive childbirth experience, which aimed to equip professionals for health care for labor, birth and care for the newborn, prioritizing the physiological process of the mother-baby dyad[7]. In this perspective, the Ministry of Health has encouraged the adoption of normal birth to boost its practice, as well as to make society and physicians aware of the importance of changes in childbirth care[6]. However, the unpreparedness

of health professionals has been dragging on for decades when the subject is humanized childbirth. This is due to the institutionalization of childbirth and the possession of childbirth as a medical act and no longer of women[1].

Obstetric nursing care in Brazil has shown advances, especially the reinsertion of Obstetric Nurse (ON) in the scenario of care to the puerperal pregnancy cycle, whose performance is based on good practices, aiming at care for a standard of normality, with guarantee of respect for the physiology of childbirth and birth; therefore, considered less interventionist[8] and more humanized. In this sense, humanization in the care of the parturient aims to improve the conditions of care for women, newborns and family[9] and is linked to the act of respecting the parturient's desire, whether in the choice of companion, in the position of giving birth, in the reduction of interventional conducts and in the attention to the physiology of childbirth[8,10].

According to the above, the question is: What are the meanings and experiences of women who have experienced the process of hospital humanized birth assisted by ON and what is the motivation of women to choose humanized birth in hospital? Therefore, the study aims to understand the meanings and experiences of women who experienced the process of hospital humanized birth assisted by ON, as well as the motivation of women for this choice.

Method

This is a qualitative, exploratory, descriptive study, with the participation of 12 women who experienced the process of hospital-assisted hospital humanized by the ON, in Cascavel (PR). In this municipality, during the study period, there were five hospital institutions of assistance to women in their process of parturition, four private and one public. The institution chosen as the study site was small, offered private care and authorized the hiring of ON by the woman for birth care, as well as allowing the presence of a companion of the woman's choice. In the other, childbirth was only assisted by obstetricians.

Inclusion criteria were having the woman experienced the process of labor and birth in an institution that allows the care of birth by ON not belonging to the functional condition of the institution; hospital birth was planned. The exclusion criterion was the woman to have had a cesarean section.

For data collection, the selection of participants was for convenience. The contact with the participants occurred after the data was provided by an ON team that promoted individualized care, without institutional ties. This team was the only team active in the municipality during the study period. Initially, telephone contact was made with the women to explain the research objectives. After accepting to participate in the study, individual interviews were conducted by a nursing student at home, guided by a semi-structured script submitted to a pilot test, lasting approximately 30 minutes, from January to August 2016, after reading and signing the Free and Informed Consent Term (FICT) by the women.

Data recording was by recording audios and field notations were performed after each interview. Transcripts of the interviews were not returned to the participants. The saturation phenomenon allowed to terminate data collection.

Data analysis occurred according to the principles of thematic content analysis[11], followed by the analytical steps: pre-analysis, exploration of the material, classification and treatment of the obtained results, and interpretation. The pre-analysis consisted of floating reading and constitution of the research corpus. In this phase, the units of record, the context units, the clippings, the form of categorization, the coding modality and the general theoretical concepts that guided the analysis were determined. In the exploration of the material, the codification occurred, in which the transformation of the raw data was performed to reach the core of the comprehension of the text. In the stage of treatment of the obtained results and interpretation, the data were submitted to analytical operations, which allowed to highlight

the information obtained. After this moment, the analyst proposed inferences and performed interpretations in the theoretical framework around theoretical dimensions, suggested by reading the material.

The study followed the ethical precepts of Resolution nº 466/2012 of the National Health Council of the Ministry of Health, with approval by the Ethics and Research Committee with Human Beings of the Universidade Estadual do Oeste do Paraná, Opinion nº 1,529,910. To guarantee anonymity, the participants were identified by the letter M, which represents a woman, followed by Arabic numbering according to the order of the interviews: M1, M2... M12.

Results

Regarding the sociodemographic characterization of women, 11 considered themselves white, 8 were between 30 and 34 years old, 9 were from the state of Paraná, 11 were married, 11 had completed higher education, and 9 had a family income higher than 5 minimum wages. Regarding the number of pregnancies, eight of the women had only one pregnancy, three women had two pregnancies and one of them, three pregnancies. Regarding the number of normal deliveries, ten women had a history of a normal birth and two women, two normal childbirths. Regarding the number of births per cesarean section, three women had experienced cesarean section before the birth in question.

Qualitative data will be presented in four categories, which are: Motivations for hospital humanized birth assisted by an obstetric nurse; Experience and meanings attributed to childbirth; Experience and meanings attributed to the participation of the partner and other people of the woman's choice; Experience and meanings attributed to professionals.

Motivations for humanized hospital birth assisted by an obstetric nurse

The participation of women in a support group for pregnant women, available in the municipality, with fortnightly meetings, favored the decision to humanely birth in a hospital environment. In this group, the pregnant women had access to lectures with health professionals, to reports of experience of other women and to scientific evidence, which provided knowledge and empowerment that favored the decision for humanized hospital childbirth.

> [...] *find out through a friend that there was a group that dealt with these issues, from reports of other women, and from there began to attend.* (M10).

In addition to participating in the group of pregnant women, women sought other information to strengthen decision-making for humanized hospital birth, such as access to scientific articles, documentaries, blogs, social networks, among others. These tools favored the building of knowledge for a conscious decision.

> *I started to inform myself, I started reading* [...] *hear reports from people who did different, who experienced both experiences* [...] *and that show that natural childbirth really has better satisfaction* [...] (M1).

> *Even before he was born I already knew I wanted humanized childbirth. The idea was kind of maturing* [...] *and I was sure of what I wanted from the moment I watched that film* [documentary]*, The Renaissance of Childbirth* [...] (M2).

The choice of women for the hospital environment to experience childbirth, perceived as a safety-promoting environment, was justified by the availability of immediate care in case of urgency or emergency, with physical structure, material and human resources available in the hospital.

> *I wanted to have all the possibilities in case of urgency* [...] *I lived in an apartment a little smaller than this* [...] *that did not have the proper structure* [...] *I thought ah, will that a premature birth happens or that I need ICU* [...] *and to have access to all the possibilities more easily.* (M10).

Primiparous participants were the majority in this study. Therefore, insecurity and fear of the unknown are notorious and conditioned the choice of the hospital environment because they have never gone through the birth process. Thus, the hospital environment conferred support, safety and consequently greater tranquility.

> *So, because it was the first* [pregnancy]*, I was insecure. And then, I thought, and the girls even told me, "you*

> *have to give birth where you feel safe." So, it wouldn't do me any good to have in my house if I were afraid* [...] *I felt safer in the hospital. At that moment, I did not feel safe here in my house* [...] *So, it was the first child, I didn't know what it was like, I didn't know if I was going to handle it, I didn't know if I was going to need an emergency, I didn't know anything about it.* (M7).

The family had an important influence on the woman's decision by the place of birth, some women considered and shared with family members and spouses the doubt about the option of the birth being home, which discouraged the home as a birth environment. Since the hospital environment was perceived as a safety promoter for the family, it was also perceived as safe by the woman when seeking the support of the family.

> *I considered winning at home, but then I was not encouraged by my family* [...] *I ended up having the hospital* [...] *My husband and my mother said no to the house. In case you could have a problem with the baby, you didn't have time to go to the hospital. They didn't touch it, and then I didn't want to take it alone.* (M12).

Some couples made the choice for hospital humanized birth without sharing the preference of the route of birth or consulting the opinion of family members, shielding themselves against the arguments and contrary ideas. It was the couple's choice.

> *And the decision, really, it was between me and my husband, right? Me and my husband! We closed and he said, "If you want, I'll back you up!" And so it was.* (M6).

Other couples who shared the desire for normal birth or sought the opinion of family or friends regarding vaginal birth were criticized and discouraged, and the option for vaginal birth was considered irresponsible, unsafe or suffering condition. Still, it was the couple's decision.

> *My husband's family* [...] *they saw humanized childbirth as a freshness* [...] *My sister-in-law, my husband's sister saw as irresponsible, because the C-section that is safe* [...] *my mother had insecurity, so did my sister. They didn't think I was going to make it, that I wasn't going to make it. Even a moment came, in the end, that I started to not comment on childbirth anymore.* (M7).

> *Friends, neighbors and acquaintances all discourage us* [...] *They said I was crazy. That to this day I'm the crazy, that the normal is you do a C-section, with anesthesia and not stay there in pain.* (M8).

Having previous experience of obstetric violence or desire repressed by normal childbirth motivated women to seek and ensure that, in this next experience, the expectations of living a natural and humanized birth were met. It is noted that some women, in previous experiences, expressed a desire for normal birth, but were conditioned by the obstetrician to undergo cesarean section, and at the time, they wanted the new experience to be different. They emphasize that in the experience of the first pregnancy they were susceptible to accept the surgical intervention induced by the doctor, due to insecurity and fear of the unknown. Participants who did not experience repressed normal birth have this information based on reports from other women:

> *My first pregnancy I waited and searched... I went through four doctors behind normal childbirth* [...] *the fourth doctor, who said, "No, all right, I do. I'll take it. I'm going to deliver your normal birth." And when he arrived in the forty-five of the second half he put a gigantic pressure, like, "Your son is going to start to suffer, your son can die, and I don't know what," and we ran to a C-section. Because first child, we don't know, we don't know how it works. Hence the fear!* [...] *I started researching and found that my C-section had been totally unnecessary.* (M6).

According to statements, the obstetrician exerts influence on the decision of the woman and her partner/spouse in choosing the route of birth. The participants, when they realized the tendency of the obstetrician to lead to the thought of incapacity or impossibility for normal birth, chose to look for another professional who encouraged normal birth, and not the other way around.

> *At the first doctor I went to, he told me that he would deliver normal birth, but that he does it with anesthesia, all that conventional* [...] *I went on two consultations with him* [...] *And said* [...] *that humanized childbirth, of this business of the woman to be screaming and giving birth like crazy* [...] *it wasn't humanized childbirth.* (M1).

> *He* [doctor] *simply said that my baby had to be fit, that it couldn't be big, that I couldn't have high blood pressure* [...] *I noticed some signs that he, perhaps, would not birth this childbirth... Then, at my last appointment, he told me that I was getting too fat, that my baby was too big.* (M3).

Experience and meanings attributed to childbirth

The first stage of labor was experienced by the women at home, accompanied by ON the doula. The change of environment, from home to

hospital, occurred with cervical dilation of seven or more centimeters. However, some report that, with the change of environment, there was a reduction or stop in the progression of labor:

> *I woke up with contractions* [...] *they were already rhythmic; I already had three contractions in ten minutes. I was already in active labor* [...] *when she* [ON] *came to my house and said, "Wow, you're already six dilated." I was super well* [...] *it was not an unbearable pain* [...] *doing the exercises* [...] *time passed as if it were ten minutes* [...] *I knew I was there quite a while, but I had no idea how long I was there* [...] *I slept between contraction and another.* (M1).

> *I was already with seven dilation* [...] *was already in active work* [...] *And I do not know if it was this change from home to the hospital that gave a catch* [...] *dilate these last three finals were super long* [...] *Around about seven and a half, eight o'clock [in the morning] I was already seven. I dilated the ten were four in the afternoon* [...] *I do not know if it was my tiredness, anyway, but this exchange, sometimes of environment, makes the woman give a good regressed* [...] *At home there were seven quick... And the rest, the other three, were extremely stung.* (M2).

As for the experience of birth, women point out as unique, grandiose, a singular moment, fantastic, intense, exciting, difficult to size. Women felt respected, strong and victorious, as lionesses, for being able to give birth. The meaning of birth was signaled as the feeling of greatest love in the world, particularly when the woman receives the child in her arms, vigorous, strong, connected to her gaze. This condition overcomes the pain of labor, inherent to the experience of giving birth. This condition overcomes the pain of labor, inherent to the experience of giving birth. The women signaled good recovery:

> *For me it was a unique experience* [...] *It hurts yes, and I would do it all over again* [...] *Because it's like that song: "everything we suffer in a hug dissolve." Because it is the purest truth* [...] *The moment I grabbed him on my arm, I looked at him* [...] *I was forty weeks old, vigorous, strong, looking at me* [...] *It has no price, no price* [...] *Any pain goes away at that time.* (M3).

> *It was intense* [...] *a unique moment* [...] *A dream to have a normal birth, right? Because it's not like that these days, is it?* [...] *You be respected, you have that respect when your child is being born* [...] *you extremely feel a lioness, and you say, "My God, I did it!"* (M2).

> *It was fantastic. I never had a c-section to compare, but my recovery and my bond with my son were good* [...] *feeling of the greatest love in the world* [...] *we feel victorious for having succeeded.* (M8).

> *It was like this, the greatest experience of my life, every time we talk about it is exciting, because it was so important, I think so far I have not been able to scale what was that* [...] (M7).

The women declared respect for the natural time of birth and satisfaction in knowing that recommended practices were performed with the newborn, such as not being performed airway aspiration and application of eye drops; be the bath performed after 8 hours of birth:

> *Of all the benefits that a normal birth would bring to me and to my son* [...] *You're respecting his time and my time... It was very natural.* (M2).

> *Interventions on the child, you do not need to do an aspiration, eye drops* [...] *the bath was made only eight hours after he was born. So that vernix, which he was born, was moisturizing his little skin throughout that period.* (M9).

Experience and meanings attributed to the participation of the partner and other people of the woman's choice

The participation of the partner with the woman in the experience of labor and birth was permeated with respect, affection, zeal, attention and availability. According to statements, at the time of birth, two beings (the woman and her companion) became one unit, united by and for the birth of a new being, loaded with multiple feelings, intense and deep. The experience of childbirth was of intense emotion and provided greater affection and respect among the couple.

> [...] *changed our life, changed the affection, the respect* [...] *I realized how much he belonged to that moment* [...] *he has participated in labor* [...] *I can't see us without that moment* [...] *To feel that emotion, that intensity, because there's nothing like it in this life...* [...] *he went into the shower together, he did massage together, he saw give birth* [...] *He and I got the baby together... So that's not how people talk... Ah, it's freshness, husband cut the cord, isn't it? For those who are immersed in that moment, it has a gigantic meaning.* (M7).

> *He [the husband] was there all the time: "what do you want me to do?"* [...] *Or, "What are we going to do now?" He was there* [...] *he stood by me, helped me, massaged. Even he who took* [the baby] *when he was born* [...] *already put in my lap and I lay down, I caught him; waited to stop pulsating the cord* [...] *and cut the cord.* (M11).

Regarding the participation of family members, most women chose their partner to accompany them in labor and birth. The mother, sister or friend were common choices to accompany

the woman along with her partner. However, whether in the current experience or in a previous one, the women pointed out that the presence of other people, besides the partner, can cause the feeling of invasion of privacy, in an intimate moment of the couple.

> *My husband went with me to the hospital, and then, after that, I met my sister and my mother. And the three of them participated all the time, from the moment I was admitted to the hospital, to the time the* [baby] *was born, they were the ones who accompanied me.* (M3).

> *My family was instilling a lot of privacy.* (M11).

> *I couldn't warn anyone, and I didn't want to. I'd rather be just us [wife and husband]* [...] *In the first humanized birth, I thought, "but why all this people in my birth?" Then I thought, "I didn't need all this."* [...] *Hence, in the second, I have already chosen no one* [but the husband]. (M12).

Experience and meanings attributed to professionals

The choice of professionals (physician and ON) for birth and birth care was previously performed, as well as the choice of doula. The ON and doula accompanied the women since pregnancy, with scheduled home visits, for guidance on the process of labor and birth, definition of the birth plan and clarification of doubts of the couple. However, it was in the experience of childbirth care that women perceived the different roles of the obstetrician, ON, doula and pediatrician, understanding the importance of each one's performance. These provided confidence and security, but the ON conveyed to women a sense of peace, security and tranquility during the process of giving birth.

> *The Birth Plan* [...] *I put options A, B and C; that the first was what happened to me, but the second was that if I needed another hospital, if I needed a cesarean section* [...] *I left everything in writing* [...] *A copy with the nurse, a copy with the doula.* (M7).

> *You begin to really understand what a nurse is, what a doula is, what a doctor is. No one takes the place of the other* [...] *From the moment I chose a team, I didn't just choose a nurse and a doula. I chose a nurse, a doula, a pediatrician and an obstetrician.* (M7).

> *The obstetric nurse's knowledge is impressive... It gives you a peace, a tranquility, a security* [...] *just the fact that she has this knowledge, of being so experienced in this, she gives you a tranquility* [...] *So this peace, this tranquility* [...] *is the best part of the obstetric nurse.* (M9).

Regarding the ON, it is noted, through the statements, that this professional constantly dialogues with the woman about the conditions in which the labor is, asks the woman's consent to perform any action or procedure, such as vaginal touch to evaluate the characteristics of the cervix and its dilation. He has knowledge and practical experience of maneuvers to correct dystocia or induce childbirth through natural techniques. This denotes, in addition to the technical capacity and knowledge, the respect and empathy present.

> *If I didn't have a team, I wouldn't have gotten my normal birth. The baby was fitted in a way that wasn't that simple* [...] *My birth was time consuming, I needed maneuvers* [...] *we did three maneuvers to fit him right in.* (M6).

> *I was already 41 weeks old, and the doctor would want to induce, and I didn't want to, so the obstetric nurse did a membrane detachment, and then in the early hours of the next day I went into labor.* (M4).

> *He was a little hard to get out, so the obstetric nurse offered me "oh, you want me to try to do a stunt?"* [...] *because it was already ten centimeters for more than an hour, and was not leaving, and then I said: "can do"* [...] *then she just tied a sheet like this on each leg, and then the doula pulled to one side, she pulled to the other, then gave two contractions, and he was born.* (M10).

The doula, in the performance of her occupation, was concerned with providing the well-being of women during labor (DL), reminding her of the need to eat, hydrate and rest to recharge her energies. To provide relief from contraction pain, he used the application of massages, use of shower bath, guidance and follow-up in performing exercises on the ball, encouraged the change of positions for comfort and pain relief. It offered emotional support, encouragement during labor, providing emotional, spiritual and physical well-being.

> *The doula came* [at home] *and was accompanying me* [...] *contractions began to get pretty sore* [...] *I'd go to the shower, stay on the ball for a while, the doula would massage. The massage helped a lot* [...] *The doula was that most emotional part* [...] *"look, you need to eat, you need to take water, do you want to change position?"* [...] *It also gave a very great tranquility* [...] (M9).

> *The doula* [...] *she did massage* [...] *that back massage helped to slow down... about fifty percent of the pain* [...] *she taught relief techniques* [...] *Pilates ball, under the shower, which helped a lot to lessen the pain* [...] *if she needed it, she would come in with me* [...] *held my hand all the time* [...] *kept helping me all the time, with pain relief techniques and psychological help* [...] *that person*

> *who says you're going to make it, that it's going to be all right!* (M7).

It was identified that obstetric interventions not foreseen in the birth plan were experienced by the women. These were consulted and consented to the realization. However, the women contradicted the need, whose intervention meant frustration. Among the interventions, we highlight the potentiation of labor through intravenous infusion of synthetic oxytocin, artificial disruption of the amniotic sum, analgesia and episiotomy:

> *The only unnecessary thing I did was ask for the stock market break, but it was necessary for that moment because I was already very tired* [...] *Today, perhaps, I'd have patience, a little more. But only those who are in pain at that moment know how they are and what they can handle.* (M7).

> *I stayed three hours in that part of the expulsive* [...] *had to give a little oxytocin because the contraction was too spaced.* (M5).

> *Talking to me, my husband and the obstetric nurse, we decided to take analgesia, just to take some of the pain, because I was too tired. Analgesia was performed, and in a matter of half an hour, he was born* [...] *This procedure was asked if we authorized* [...] *It was quiet, other than this analgesia* [...] *Analgesia meant frustration. Of course, at the time it's a decision, and I told them that I was about to die, that I was tired, but so, today I say that if I had held on a little longer, would I not have succeeded?* (M9).

> *The doctor did an episiotomy, which I didn't want. But at the time, we, in birthland, let themselves be carried away* [...] *As the birth was a little more time consuming* [...] *If I could change, it would be quite different, I'd take that away.* (M4).

Discussion

It was the participation of women in a support group for pregnant women that made possible the knowledge about normal humanized childbirth and the approximation of the theme, fostering critical thinking, based on scientific evidence and shared among women. This phenomenon favored maternal empowerment, in which the pregnant woman and her family began to believe in the pregnant woman/parturient's body as a functional cog, until then discredited by the biomedical model, based on the medicalization of childbirth[12].

In this study, to strengthen decision making for humanized hospital birth, the information was reinforced by ON's skills in carrying out educational actions during pregnancy, centered on welcoming, creating a bond and promoting the feeling of security encouraged by the technical-political commitment that have[13]. It should be emphasized that, during prenatal consultations, ONs should share knowledge about physiology, types and positions of birth, use of noninvasive techniques for the progression of childbirth and pain relief, which allows the active participation of women in the planning of childbirth[1]. Condition confirmed by the statements.

The birth plan aims to facilitate the shared decision-making between women and professional(s) about individual preferences and desires for labor and birth. It provides obstetric care providers with important details about these decisions. In addition, women, when preparing the birth plan, can reflect on their values and choices regarding practices and interventions they do not want in childbirth, communicating them in advance to professionals[14-15].

The search for the hospital scenario for the experience of childbirth by the participants was mainly due to the need for women and families to feel safe. This finding is opposed to a study in which the participants did not identify with the logistics of care and associated the hospital environment with the state of illness, in which the birth process was understood as pathological, and, consequently, with the need for medicalization and intervention for the parturition process[12].

In this sense, it is necessary to recognize and value the physiological aspects of birth. To offer information and encourage the knowledge of women and families regarding this process and consequently respect the decisions regarding the scenario of birth chosen by them[1].

Regarding the influence of the family for the choice of type and environment of birth, the mothers are, after the partner, the ones chosen to accompany the birth. This is related to the knowledge and family beliefs transmitted by the experiences experienced, which influence the perception of the pregnant woman/parturient with regard mainly to the choice of the route of birth[16].

Women are constantly influenced about their opinions and decisions about their body, mainly due to the fear of putting their life and that of the baby in danger. It is intuited that fear comes from the technocratic model permeated by the biomedical system, characterized by the absence of close and respectful dialogue between doctor and woman/family, contributing to their vulnerability to the patterns propagated by interventionist common sense. In this perspective, women who receive advice from mothers, aunts, friends and neighbors from negative experiences, afraid to reproduce these experiences at the time of birth, seek to end the gestational process before going into labor[9].

Having previous experience of some type of obstetric violence or desire repressed by normal birth refers that democratic dialogue and the power of choice of women are not always respected in the hospital environment[12]. Because they are in this environment, they may undergo unwanted obstetric interventions, such as the surgical birth performed even before the woman goes into labor, triggering negative repercussions, such as premature birth and consequently the hospitalization of the newborn in a neonatal intensive care unit[17].

Despite appearing in the study, the autonomy of the woman as preserved, in some statements, they said they had opted for interventions that they did not want properly. Therefore, it can be inferred that there was interference by the circumstances of birth scene. It is important to point out that they were under the care of an ON group that was not related to the institution, a fact that, although it may have provided greater security in the face of the empathy process built during pregnancy, it does not always manage to prevent unwanted procedures.

The ONs that have institutional support through updated protocols and permanent education for decision-making see institutional support as a facilitator for the performance of obstetric nursing and the multidisciplinary team, contributing to their autonomy and adoption of good practices[8]; condition not always present in the reality of childbirth care.

There is a tendency on the part of some professionals to justify the interruption of pregnancy with surgical intervention, such as in cases of cord circular, size of the fetus and/or position in which it presents itself in the uterus. Contrary to scientific evidence, they stimulate cesarean section as a safer procedure, with fewer risks. This behavior cultivated among professionals instigates the fear of women and their families, weakening them by what is said, and indirectly offering the pseudo-opportunity of choice for the waiting for a natural birth. When mentioning the existence of risk, maternal and/or fetal, the woman, partner and family are persuaded and held accountable for the possible outcome, which, between the lines, can be negative. Preferring not to risk it, the pregnant woman and her partner end up opting for cesarean section, which, in most cases, does not present a real clinical indication to justify it[18]. Thus, the professional influences the decision of pregnant women, especially if he/she has greater affinity, safety and ability with a certain practice and/or specific type of birth[1].

In this study, the desire for natural birth and the empowerment of women led them to hire private and individualized assistance from ONs that have no institutional bond beyond the hospital service, also private, to ensure that the process of labor and birth in the hospital sphere are conducted by the principles of humanization of care. This is because institutional public and supplementary health services do not include the recommendations in force in obstetric practice[8].

About the participation of the partners in the experience of labor, it is evident that, when they perceive the proximity of the child's birth, they start to have interactive and empathic attitudes with the woman, apply non-pharmacological methods for pain relief, sensitize themselves to the parturition process experienced by the woman, expressing encouraging words, a condition that provides a quiet birth for both. Thus, the partner is affectively and emotionally connected to the parturient and the unarrived child[8,19-21].

It should be noted that the participation of the companion is recommended from the first

prenatal consultation, performing important functions about safety and support to women's choices. Some actions are cited as fundamental to help the parturient, such as calming, staying present, encouraging, giving strength, and providing support, comfort and physical and emotional well-being. Thus, it is important to guarantee the woman's right to have the companion of her choice in the process of parturition, which softens and facilitates the experience of motherhood[20-21].

In Brazil, although normal birth care due to ON is limited, there is consensus on the part of obstetricians that they have sensitivity, humanization, capacity and experience to successfully monitor deliveries, especially home births[1,10]. The ONs print on their performance, humanization and good practices of attention to labor and birth, with the adoption of positions facilitating for birth, low rate of perineal laceration and the need for perineorrhaphy, performance of late clamping of the umbilical cord, promotion of skin-to-skin contact and breastfeeding in the first hour of life, encouraging family participation, providing the rapid evolution of labor and birth with positive results for the mother and neonate, through careful, safe and quality care at all stages of the pregnancy-puerperal cycle[8,22].

Good practices are significantly more frequent in births assisted by ON, with a lower incidence of cesarean sections, in addition to less frequency of interventions, as observed in this study. This illustrates the benefit of collaborative work between ON and physicians when birth is assisted in the hospital environment[10]. This is confirmed when women who experience the experience of natural birth express satisfaction and little suffering, faster recovery, less pain after childbirth, victory in being able to give birth, added to the lower chances of complications, hemorrhages and infections and hospital discharge with a return to daily activities earlier[17].

The use of non-pharmacological methods such as hot bathing, massages, incentive for quiet breathing and perian exercises with Swiss ball are effective for pain relief. Reduce tension, relax the woman, leaving her calm and concentrated in labor, encouraging the adoption of vertical positions to provide greater cervical dilation and less use of analgesia instigate the increase of uterine contractions and the progression of fetal presentation, in addition to tending to maintain basal fetal heart rate and, consequently, the shorter time of exposure to interventions for the outcome of normal birth. These actions offer greater comfort, freedom and autonomy to women, thus stimulating normal birth[9,23].

Parturients who experienced normal birth and surgical birth report that physiological birth is painful, however, pain is tolerable. These emphasize normal birth as a satisfactory experience, minimizing the memory of pain after the baby's birth, in addition to postpartum recovery being better than in cesarean section, in which initially there is no pain, however, in the postoperative period, with the passage of anesthesia, persistent pain may occur. Moreover, in the puerperium, the woman is limited in terms of her movements, presenting the implications of healing time and the discomfort of the suture[17].

Women highlight and value the role of ON during the pregnancy-puerperal cycle, as they show empathy for their needs, particularly in the process of parturition, providing information pertinent to the moment and respecting women's autonomy. In this context, ON is seen as committed and qualified to encourage and rescue vaginal birth[17].

ONs are promoters of care according to individual needs, focusing on integrative actions and methods that favor fewer interventions and without interference in the physiology of childbirth. Well-being and comfort are ensured, especially autonomy and control in labor and childbirth. Communication between nurse and parturient is one of the factors that contributes to the constitution of trust and safety, which favors humanization, the progress of childbirth and reassures women[13].

The ONs welcome the woman in a welcoming and affectionate way, stimulate body movement and relaxation exercises, favoring their protagonism and empowerment. According to the experience of humanized childbirth

assisted by ON, the strengthening of the internal potentials of women is identified for making their own decisions, which refers to the respect and recognition of their right to make choices[24].

The work of the doula is also perceived by the puerperal women as an adjuvant to remain calm, active and focused on reducing the sensation of pain and discomfort in labor and childbirth[11]. This is characterized as a work of light technology and subjective basis whose work instruments are empathy and patience and has as main objective to be available and at the service of women, helping to promote physical and emotional well-being. With the presence of the doula, the woman can break the cycle pain - fear - tension, making childbirth a positive and affectionate moment with successful experiences that also favor the role, autonomy and empowerment of the parturient, reflecting on satisfactory experiences in labor, childbirth and postpartum, in which the experience of childbirth will be remembered with joy and visualized as a healthy and pleasurable physiological event[9].

In this sense, the doula meets the needs of women due to the availability of time and the commitment to provide emotional and physical support, without the concern to identify pathologies and/or dystocia[9]. However, it is worth mentioning that the assistance of on cannot be replaced by that of the doula, nor does the presence of the companion replace her work, since they have different skills and functions about birth care[12-13,21]. Thus, it is possible to highlight the need for joint work when the pregnant woman requests assistance provided by on and doula[12-13].

The frustrations experienced by women regarding the use of pharmacological measures for pain relief, the performance of episiotomy and amniotomy elucidate the obstacles to effect good practices in the hospital environment[25]. Every time the woman is submitted to invasive procedures, she loses some fraction of her role in the process of parturition. Parturient, family and professional inserted in the biomedical model end up not opposing the technocratic system, because giving birth naturally configures resistance to medicalization and control of the woman's body[3].

The investigation of the subject is considered as a limitation of this study through reports of women assisted by ONs hired by them and their families, external to the institutional staff. In this aspect, it is recommended to study with women who have experienced births in institutions that privilege the care of ON as part of the local professional body, to identify satisfaction, as well as the meanings attributed to this experience.

Final considerations

The participation of women in a support group for pregnant women, access to up-to-date information, reports of experience of other women, the perception of safety in the hospital environment (most women were primiparous), the influence of the family, as well as previous experience of obstetric violence or desire repressed by normal birth guide the motivation of women for the choice of humanized hospital birth, assisted by ON hired by the woman.

The women described the experience of childbirth as unique, grandiose, a unique moment, fantastic, intense, exciting and difficult to size. Above all, they felt strong and victorious. Birth was meant as the greatest experience of love, imbued with respect.

The doula was concerned about the physical and emotional well-being of the woman during labor, providing pain relief through non-pharmacological measures. The participation of the partner, permeated with affection, zeal, attention and availability provided greater affection among the couple. ON conveyed to women a sense of peace, security and tranquility during the birth process; she was a promoter of dialogue in each phase of labor, demonstrating, in addition to knowledge and technical capacity, empathy for women.

Based on the results obtained in this study and as a contribution to maternal health, it is recommended, from the perspective of the parturient, that the environments related to the care of women, in the scenario of labor and

birth, can count on the performance of ON. In this aspect, the presence of the companion as a participatory subject of this process is reinforced, given the benefits provided in view of the meanings of childbirth, expressed by the women in this study, in which they recall with pleasure their experience in giving birth.

Collaborations:

1 – conception, design, analysis and interpretation of data: Maria Aparecida Baggio and Fernanda de Castro Pereira;

2 – writing of the article and relevant critical review of the intellectual content: Maria Aparecida Baggio, Maycon Hoffmann Cheffer, Gicelle Galvan Machineski and Alessandra Crystian Engles dos Reis;

3 – final approval of the version to be published: Maria Aparecida Baggio and Maycon Hoffmann Cheffer.

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