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Stork Network births: The experience of puerperal women assisted by Obstetric Nursing in a Normal Delivery Center

Nascimentos da cegonha: experiência de puérperas assistidas pela enfermagem obstétrica em Centro de Parto Normal

Nacimientos de la Red Cigüeña: la experiencia de mujeres puérperas atendidas por el área de Enfermería Obstétrica en un Centro de Parto Normal

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Abstract: Objective: to analyze the perceptions and feelings of puerperal women about the experiences of delivery assisted by Obstetric Nursing in a Normal Delivery Center (*Centro de Parto Normal*, CPN), in the context of the Stork Network. **Method:** a qualitative, exploratory and descriptive research study, carried out with 14 puerperal women assisted in a CPN of northeastern *sertão*; the interviews took place from April to May 2018 and the material was discussed according to thematic content analysis. **Results:** the reports indicated welcoming assistance, with bond development and good delivery care practices. Misinformation regarding the role of Nursing at birth was revealed in the content. The puerperal women describe the physical structure available in the CPN as an environment of tranquility, comfort and privacy. **Conclusion:** the assistance provided by Obstetric Nursing in CPNs exerts a positive influence on the experiences of parturient women. In this context, humanized assistance in an appropriate place is indispensable for the process of giving birth to occur free of complications, providing safety, satisfaction and well-being.

Keywords: Obstetric nursing; Natural childbirth; Midwifery; Humanization of assistance; Women's health

Resumo: Objetivo: analisar as percepções e sentimentos de puérperas acerca das experiências do parto assistido pela enfermagem obstétrica em Centro de Parto Normal (CPN), no contexto da Rede Cegonha. **Método:** pesquisa qualitativa, exploratória e descritiva, realizada com 14 puérperas assistidas em CPN do sertão nordestino, as entrevistas ocorreram de abril a maio de 2018 e o material foi discutido segundo análise temática de conteúdo.

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Resultados: os relatos apontaram uma assistência acolhedora, com formação de vínculo e boas práticas de assistência ao parto. Uma desinformação em relação ao papel da enfermagem no nascimento revelou-se no conteúdo. As puérperas descrevem a estrutura física disponível no CPN como ambiente de tranquilidade, conforto e privacidade. **Conclusão:** a assistência prestada pela enfermagem obstétrica em CPNs influencia positivamente nas experiências de parturientes. Nesse contexto, uma assistência humanizada em local apropriado é indispensável para que o processo de parir transcorra sem complicações proporcionando segurança, satisfação e bem estar.
Descritores: Enfermagem obstétrica; Parto normal; Assistência ao parto; Humanização da assistência; Saúde da mulher

Resumen: **Objetivo:** analizar las percepciones y los sentimientos de mujeres puérperas acerca de las experiencias de parto asistido por el área de Enfermería Obstétrica en un Centro de Parto Normal (CPN), en el contexto de la Red Cigüeña. **Método:** investigación cualitativa, exploratoria y descriptiva, realizada con 14 mujeres puérperas atendidas en un CPN de la región noreste del *sertão*; las entrevistas tuvieron lugar de abril a mayo de 2018 y el material se discutió conforme al análisis temático de contenido. **Resultados:** los reportes indicaron atención acogedora, con establecimiento de vínculos y buenas prácticas de atención al parto. En el contenido se reveló cierta desinformación en relación con el rol de la Enfermería en el nacimiento. Las mujeres puérperas describieron la estructura física disponible en el CPN como un ambiente de tranquilidad, comodidad y privacidad. **Conclusión:** la atención prestada por el área de Enfermería Obstétrica en los CPN ejerce una influencia positiva sobre las experiencias de las parturientas. En este contexto, brindar atención humanizada en un lugar apropiado es indispensable para que el parto transcurra sin complicaciones proporcionando seguridad, satisfacción y bienestar.
Descriptores: Enfermería obstétrica; Parto normal; Partería; Humanización de la atención; Salud de la mujer

Introduction

Delivery and the consequent arrival of a child can be memorable events in a woman's life. This moment, previously intimate and conducted at homes, has undergone several transformations over the years, with emphasis on changing the birth environment, from the home to the hospital.[1] After such a change, women began to be subjected to procedures assisted by health professionals, resulting in a decline in their autonomy in the process of giving birth.[2]

Inserted in a new context, society began to create a stereotyped image of the parturition process, almost always associating it with pain and suffering. Since then, the natural perception of delivery has been transformed into a pathological event, potentiating the introduction of interventions that seek the relief of pain and suffering and, in a certain way, contribute to the consolidation of a biomedical and hospital-centric model in assisting the parturient woman.[3]

Understanding the situation presented and aiming at the humanization of delivery and the change of the current obstetric care model, the World Health Organization (WHO) starts to discuss some of these procedures regarding its recommendations, scientific support and maternal health safety. That said, regulatory and health-care agencies have been trying to establish good practices for delivery and birth care. However, compared to the main developed countries, Brazil presents worrying indicators of maternal and child morbidity and mortality and it is believed that the care model adopted contributes to these data.[4]

Based on the Stork Network strategy, the Brazilian Ministry of Health endorses the scientific recommendations proposed by the WHO, including, among them, the establishment of Normal Delivery Centers, environments that aim to offer greater comfort, convenience and privacy to the parturient women during Pre-Delivery, Delivery and Puerperium. These structures are in line with a new obstetric care model, in an attempt to restore to women their autonomy at the time of delivery.[5]

The CPNs bring in their essence the natural perception of delivery, respecting the relationship between the mother-child binomial and rescuing the family figure through the presence of the companion in birth assistance. These are new services that can be constituted in hospital or out-of-hospital facilities, managed exclusively by Obstetric Nursing, which is also responsible for all assistance provided to women, enabling a reconquest of the parturient's autonomy and of a performance space for Obstetric Nursing with respect to the biomedical model.[6]

Despite the relevance of these facilities for delivery assistance, there is still lack of knowledge on the part of the population regarding the purposes and the importance of these new structures, as well as the assistance provided by the professionals who constitute them. Therefore, the following was established as research question: What are the perceptions and feelings of puerperal women involved in delivery care provided by Obstetric Nursing in a CPN?

Thus, the relevance of this research lies in the fact that it proposes elaborating scientific subsidies that aim to evaluate assistance models from theory to practice, enabling improvements in the assistance of the population and providing a rereading of professional practices; also emphasizing the need for new studies focused on the care interface and on women's satisfaction.[7]

In view of this, in an attempt to answer this question, the objective of the research was to analyze the perceptions and feelings of puerperal women about the experiences of delivery assisted by Obstetric Nursing in a CPN, in the context of the Stork Network.

Method

This is a field research with a qualitative approach of an exploratory and descriptive character,[8] which was carried out in an in-hospital CPN of northeastern *sertão.* Inaugurated in 2013, the CPN in question is located in the facilities of a Municipal Maternity Hospital and aims to provide low-complexity assistance to women in the Integrated Development Region (*Região Integrada do Desenvolvimento*, RIDE) of the lower basin of the São Francisco valley.

The study included 14 puerperal women assisted by Obstetric Nursing in the period from April to May 2018, selected by non-probabilistic sampling, and meeting the following inclusion criteria: being over 18 years old, being in the puerperium and in physical and psychological conditions to answer the questions asked. The exclusion criterion was the following: puerperal women who did not complete the interview.

The empirical material was obtained through individual approaches to the puerperal women in individualized wards of the CPN; in that same space, they were invited to participate in the interview. In order to guarantee the secrecy and privacy of the interviewees, the puerperal women were taken to a private location, in the same unit or in their individualized ward, in the

absence of their companion. Although informed about secrecy and confidentiality, five women refused to participate in the research, due to aversion to the use of the recorder.

Semi-structured interviews were conducted, which were closed after theoretical saturation of the information. This stage included data collection for sociodemographic and obstetric characterization, in addition to guiding questions about the experiences of delivery assisted by obstetric nurses in a CPN. The women were directed to the following approaches: "Tell me how the experience of your delivery was"; "In your opinion, what is the role of the obstetric nurse in delivery care? Tell me a little about your experience of being assisted by an obstetric nurse at the time of delivery"; "Were you aware that this professional could deliver your baby? Tell me what was it that most marked the assistance provided by the nurse who delivered your child"; "Do you believe that the environment (the structure of the CPN) may have had a positive or negative influence on your delivery, how?"; "Were you satisfied with the delivery you had?" The interviews were recorded and lasted a mean of 30 minutes.

Analysis and discussion of the material was based on Thematic Content Analysis,[8] which describes it in three phases: pre-analysis, the stage in which the interviews were transcribed so that an organization of the data collected was obtained; exploration of the material phase, in which all the material was divided into similar groups always around the study context. In this method, it was sought to group the diverse information collected by organizing it into meaningful expressions or words based on this collected content. Finally, in the third phase, treatment and interpretation of the results, the data obtained were analyzed and interpreted so that they became meaningful and valid.[8] According to the interviews, the puerperal women were identified with the names of Greek Mythology Goddesses, guaranteeing their confidentiality and anonymity.

From this analysis, it became possible to group five categories, namely: Reception and welcoming in the obstetric practice; the Stork Network and good practices in delivery and birth

assistance; From the culture of the traditional obstetric model to the current experience; Role of Obstetric Nursing in the delivery scenario and, finally, Influence of the structure of the CPN in delivery care.

All the interviewees signed the Free and Informed Consent Form, and received a copy of it. This study was conducted in accordance with the ethical standards required (Resolution 466/2012 of the Ministry of Health), and approved by the Ethics and Research Committee of the Federal University of Vale do São Francisco, under opinion No. 2,548,096 on March 16th, 2018.

Results

A total of 14 puerperal women assisted by Obstetric Nursing in a CPN contributed to the research, aged between 18 and 29 years old and with a mean age of 23.5. Eight were primiparous and the other, multiparous. Nine women stated being from Bahia. As for schooling, complete high school predominated. Regarding their professions, the majority reported being housewives, although some reported being merchants, babysitters, fisherwomen and rural workers. Regarding marital status, seven married women and seven single women participated.

Reception and welcoming in the obstetric practice

This category addresses the main practices used in delivery care provided by Obstetric Nursing. The testimonies portray assistance in the light of welcoming and bonding, practices evaluated by the women as important for the moment, acting as therapy for pain relief. Simple practices were reported, such as guidance, affection, warmth and incentives.

> [...] *They received me very well* [the nurses]*, they helped me, said some things for me to do to relieve pain* [...] *and came here all the time to see how I was doing.* (Hera)

> [...] *they* [the nurses] *hugged me, wished me good luck, advised me* [...] *the girls were very attentive. I felt very welcomed.* (Atena)
> *They* [the nurses] *welcomed me* [...] *it was good.* (Hebe)
> [...] *People very dedicated to work who gave me a lot of attention and performed my delivery with great warmth.* [...] *she* [the nurse] *encouraged me, gave me a lot of strength and also courage, because there are people who are inhuman and they* [nurses] *are not.* (Hemera)

In this way, this category allowed us to understand that welcoming and humanization went hand in hand, and that light technologies were essential tools for a good welcoming and closer bonds.

Practices used in delivery and birth care

This category allowed for the grouping of testimonies referring to the performance of good practices in delivery and birth assistance recommended by the WHO and by the Brazilian Ministry of Health. The following were mentioned in the reports: encouragement to practice exercises for pain relief, guidance on breathing techniques, emotional guidance and support, conducting fetal monitoring by means of intermittent auscultation of cardiofetal beats (CFBs), and incentive to diet, as well as presence of a companion.

> [...] *I realized that I had this care, she guided me* [the nurse] *to do the ball exercises, the exercises on the little horse that is this device that helps too.* (Atena)
> [...] *every hour she* [the nurse] *comes to listen to the baby's little heart inside the belly* [...] *telling me to have a bath with hot water for the body to relax, bringing porridge to make me strong to be able to have the baby.* (Aurora)
> *She* [the nurse] *helped me a lot, if it weren't for her I don't know what would have become of me and of Julia* [baby]*. One was calming me down, and another teaching me how to breathe.* (Gaia)
> *Thanks to God the girls* [the nurses] *helped me a lot and my sister-in-law too who was accompanying me.* (Héstia)

Despite the reports pointing to assistance based on good practices, very few testimonies allowed identifying the use of practices considered inadequate, in the context of the Stork Network, especially in environments such as the CPNs, as was the case with the use of oxytocin to induce labor.

> [...] *I exercised up to seven cm dilation, then I didn't want to do more because I couldn't take it anymore. Pain was very strong. Then, when it was nine, they* [the nurses] *induced it, put the serum for the girl to be born.* (Aurora)

Although the puerperal women are unaware of what the good practices of delivery and birth care are, it becomes evident when interpreting their reports, where there is, mostly, the adoption of practices based on scientific evidence in the light of recommendations from the Stork Network and the WHO by the Obstetric Nursing team of the CPN in question.

From the culture of the traditional obstetric model to the current experience

The testimonies address the participants' experiences, and their positive and negative impressions on the care model proposed by the CPN Obstetric Nursing team. In general, the reports point out marked and positive experiences of the assistance provided by Nursing, even in the face of distrust, generated by previous experiences or reports from others (blogs, colleagues and neighbors).

> [...] *I always heard someone talking badly, that they* [the nurses] *were going to do this, that they were going to do that, but no, it was all different.* (Têmis)
>
> [...] *I was surprised, because it came from those I least expected and it had a good result because we didn't expect it from her* [the nurse] *and she made a good delivery. Good assistance indeed.* (Electra)
>
> *I saw people complaining a lot on the blogs about here* [maternity] [...] *I thought I was going to feel the same, when I came here there was a room*

> *just for me, everything okay* [...] *I had never even expected to be here.* (Hemera)
> [...] *Although I didn't give birth in the delivery room* [...]*. From the beginning of my delivery to the end, until now it marked everything. It was great, for me it was great.* (Tálassa)

The search for a traditional obstetric model can still be observed in the testimonies of the assisted women, causing expectation regarding the performance of procedures and interventions currently discouraged. As every expectation can consequently be linked to frustration, the absence of expected practices led to the report of dissatisfaction of one of the assisted mothers.

> [...] *So, I just didn't like it very much because they* [the nurses] *kept looking and encouraging* [...] *they only touched when her head was already out and then I found it strange because there* [city where she gave birth to her previous son] *it's different from here, there they help put it out, like, they press the belly, they do something and here they don't.* (Afrodite)

In view of the puerperal women's testimonies, it is noted that, although the majority report satisfaction with the obstetric model based on scientific evidence, there is still some insecurity arising from lack of knowledge.

Role of Obstetric Nursing in the delivery scenario

Regarding the knowledge about the participation of Obstetric Nursing in the delivery scenario, lack of information regarding the role of this professional category in delivery and birth assistance was noticed in most of the statements. When the information was present in the reports, it took place at the maternity hospital itself or through the Nursing professionals in their social environment.

> [...] *I never knew that the nurse could do it, but I distrusted that she could.* (Febe)

> [...] *I didn't know, but then she* [the nurse] *did it.* (Aurora)
> [...] *I knew, because there in the pre-delivery she* [the nurse] *had already done other deliveries before mine.* (Iris)
> [...] *I have a friend that I made during my pregnancy that is an obstetric nurse.* (Atena)
> *Down there* [Obstetric Urgency] *they had commented that if it weren't the doctor, it would be the head nurse* [...]. *It was 100%, she's excellent.* (Artemis)

There is a need for greater engagement of the Nursing category to enhance and disseminate its attributions. Thus, it is understood that prenatal care is one of the most opportune moments for pregnant women to be educated about the professionals capable of providing assistance, since a well-informed woman will have greater discernment about who assisted her and, consequently less anguish and fears arising from information popularly pervaded both in relation to the professionals and about the physical facilities that will receive them.

Influence of the structure of the CPN in delivery care

According to the puerperal women, in general, the experiences were positive for providing tranquility, comfort and privacy, even being compared with private hospitals by some of them. This category also highlights the equipment and furniture that make up the structure, as it allowed the exercises recommended by Obstetric Nursing to be carried out.

> *I was very comfortable, I was alone in a room, there's a bathroom and everything.* [...] *I had the objects to do the exercises that helped me a lot.* (Iris)
> [...] *I'm feeling in a private hospital when it comes to the facilities, because I stayed in a room where there's a cabinet, there's a bed just for me, there's a bathroom, I have privacy.* (Atena)

> *I think it helped a lot, it's a very suitable place. Because there's the ball that helps a lot, there's the little horse, apart from their support* [the nurses] *who are always up there.* (Electra)
> [...] *I was alone in the room, all in silence, there the person is more concentrated to do the exercises and everything, there was no one in the room but me and my mother who was the companion.* (Aurora)

The reports demonstrate the puerperal women's satisfaction in relation to the physical facilities of the CPN and that the structural model adopted has shown to be effective in contributing to the guarantee of comfort and privacy, generating a feeling of well-being and collaborating for the good progress of labor.

Discussion

The assistance provided by Obstetric Nursing demonstrated in the results was mainly based on welcoming, which can be defined as the act or effect of receiving, an action and an attitude of inclusion. It is considered as one of the fundamental means for the humanization of the health services, not being reduced to just one space, but rather as an ethical posture that culminates in sharing knowledge and fears, and may be performed by any professional of the service, taking for themselves the responsibility of "sheltering and welcoming".[9]

A human reception combined with qualified listening and attentive to complaints, pains, fears and anxieties, in addition to keeping them oriented, allows for the understanding of the moment women are going through. In addition to that, considering their conditions as biopsychosocial subjects can culminate in the establishment of bonds among the actors involved and in respect for the principle of integrality of the Unified Health System (*Sistema Único de Saúde*, SUS).[10]

As the testimonies point out, the interpersonal relationship established by Obstetric Nursing and its comfort and pain relief actions used in all stages of delivery care makes the

environment more comfortable and peaceful for women, which can contribute for delivery to occur free of interventions. In this sense, the parturient women need to be welcomed and understood, treated in a unique way, always motivating them and giving them emotional support. The use of these practices is fundamental to prevent complications such as physical and/or psychological suffering for the parturient women.[11-13]

The assistance provided at the CPN in question shows that the use of light technologies implies the creation of a relationship among the subjects, in addition to being indispensable for the development of respectful practices in the process of giving birth and in the relationship between mother and baby, not being invasive to the physiology of the female body, to her mind or to her privacy. Health technologies are classified as: light, light-hard and hard, the last two concerning structured and protocolized knowledge and technological equipment that work together with an institution's organizational structures, machines, rules and routines, respectively.[14]

This establishment of a bond of trust with the Obstetric Nurse with a non-invasive character has great significance in the delivery experience due to the welcoming and attentive way in which assistance is provided. This allows the parturient woman herself to conduct her labor, being the main protagonist of this physiological event, in a way that the patients manage to perceive and report in the interviews.[14]

In contrast to this, the change in the delivery “address”, from home to hospital environments, brought along the passivity of the women. Practices such as the use of the dorsal decubitus adopted at the time of delivery, the use of collective rooms, as well as the medicalization of the female body and the use of unnecessary interventions culminated in the destitution of the woman's autonomy over her own body and, therefore, as they were performed naturally since the middle of the 16th century, it has become something cultural in society, depriving women of the right to full autonomy.[15]

In the meantime, births in hospital settings promoted an increase in the use of light-hard and hard technologies, with the aim of making delivery safer. However, women were exposed to potentially iatrogenic interventions, not supported by scientific evidence, in addition to not taking into account emotional, cultural and human factors in the process, having their effectiveness questioned.[4]

From the implementation of national humanization policies, it was possible to observe positive impacts in the delivery and birth scenario. These are strategies that are opposed to the technicist model, restoring autonomy to women. These policies seek to rescue the naturalness lost throughout the history of hospital care during delivery.[16]

Currently, the Brazilian Ministry of Health, through the Stork Network and anchored to the WHO recommendations, has launched the National Delivery Assistance Guidelines. According to the document, a series of practices make up the list of what are considered as "good practices in delivery care", such as encouragement to practice facilitating exercises, monitoring fetal well-being, offering an oral diet, respecting freedom of position, and presence of a companion of the woman's free choice, among others,[4,17] practices that were widely encouraged in the CPN where the study was conducted.

Aiming to reduce maternal and child mortality, the Stork Network acts as a strategy that is organized in four aspects: prenatal, delivery and birth, puerperium, and comprehensive health care for the child, in addition to the logistic system that surrounds the previous aspects. In order to guarantee access, welcoming and resoluteness, it works on the operationalization of already existing policies based on funding and attention focused on the physical structure of maternity hospitals and the training of health professionals to comply with good delivery care practices.[18]

Also regarding the Stork Network, which seeks a reduction in the medicalization of birth, the non-pharmacological methods of pain relief during labor deserve to be highlighted because,

in addition to being mostly effective, they reduce the use of analgesic drugs and oxytocin in the patients. Taking into account that this pain is the result of sociological, psychological and obstetric mechanisms, the interventions must go beyond medications. Such methods include body massages, baths, breathing techniques and active walking, in addition to physical and emotional support, strategies reported by the women who participated in the study.

Despite the clarity of the recommendations based on scientific evidence, there are often reports of the use of practices that are considered harmful and should be eliminated. These categories comprise techniques with the use of the Kristeller's maneuver (pressure on the upper part of the uterus), the use of amniotomy, episiotomy and routine oxytocin, enema and trichotomy, in addition to perineal massage. The routine use of oxytocin, an example reported by the puerperal women, reduces labor time and can generate hyperstimulation of the uterus, causing increased pain and even tachysystole. When used unnecessarily, it is considered a harmful practice.[4,17] Of these practices, only one report brought the use of oxytocin, demonstrating that this method is not routinely used in the CPN.

From the experience reported by the women about care, it is perceived that, although there was predominance in the satisfaction regarding the services provided by Obstetric Nursing, strong cultural issues arising from a traditional model are still imbued in the women's feelings. Practices currently considered as obstetric violence are requested by the women due to lack of knowledge or misinformation. It is necessary to give voice to these experiences and bring information to the women in order to improve the assistance provided.[20]

The practices considered as obstetric violence in the hospital setting can take on several faces, ranging from verbal aggression and humiliation to negligence and physical violence, such as Kristeller's maneuver, for example. The most common forms of violence during delivery are the following: refusal of admission to the maternity ward; preventing the entry of a companion; actions that interfere with the woman's body causing harms or pain, such as administration of

oxytocin to accelerate labor in a routine manner; excess of touch examinations and performed by several people, forced fasting, episiotomy and immobilization, among others,[21] which were not identified in this study.

Furthermore, any action or act, verbal or not, that brings up negative feelings in the parturient, such as anguish, fear, vulnerability and inferiority, is considered as obstetric violence. Such practices have become common to women because they are performed excessively. Thus, empowering and offering knowledge to the women is effective in combating these practices, and related actions must be developed and practiced.[21]

In the study, it was possible to observe that some women are still distressed regarding the place where they are going to give birth; this fear comes from negative information about such place. The WHO acknowledges the situation in relation to negative news about the place and the service on blogs and brings clarification to the pregnant women as a means of reducing this fear.[22]

The hegemonic hospital structures in Brazil are considered unfamiliar environments, which have the power of important decisions under the control of the professional. When and how delivery will take place, whether or not a companion is allowed, and the use of practices that are not always agreed upon by the women, in addition to having their privacy and autonomy stolen by the technocratic care model, are examples of these decisions.[23]

The CPNs were created from Ordinance No. 985/GM of the Ministry of Health, on August 5th, 1999.[24] They have the objective of making the place of delivery assistance similar to a home environment, providing the presence of a companion of the woman's free choice, and considering her the protagonist of the moment. In addition to that, they favor a better relationship between the team and the client, making it possible to make respectful decisions during labor and delivery.[13]

In this way, the CPN also aims to offer intimacy and privacy so that moments with warm baths, walks and exercises are encouraged, in order to favor the physiological evolution of labor.[25] It is important to mention that, according to the WHO, the obstetric nurse is the most appropriate professional to assist pregnancy and normal delivery in this scenario.[22]

However, despite the satisfaction with the service, most of the women interviewed reported not knowing the role of the obstetrical nurse (ON) in that service. Nevertheless, the professional has legal support in his/her duties, having a specialization in Obstetrics; this is a professional able to conduct deliveries in light of Federal Law 7,498/198: law of professional practice.[26] ONs are able to provide assistance to normal delivery without dystocia using practices based on scientific evidence, as recommended by the WHO.[22] Their performance in the CPNs and/or delivery centers is regulated by Resolution No. 478/2015 of the Federal Nursing Council, which delimits their competences in such scope.[27]

Although the performance of the ON is duly regulated, this practice is still not very expressive, an aspect evidenced by the testimonies of the women who participated in the study. Such speeches are anchored to the panorama that composes the transition movement of the delivery assistance model. The data presented, coming from the users' speeches, indicate that the performance of Obstetric Nursing is welcome. However, there is an urgent need for insertion and dissemination of their competences, enabling the broadening of women's understanding of their role since, according to the scientific evidence, this professional qualifies assistance when acting from the perspective of the medicalization of the female body and humanization of delivery.[22,28] In accordance with legal protection, the WHO recommends greater involvement of Obstetric Nursing in low-risk delivery care, considering its training focused on care and not on intervention, being defined as professionals with more availability to meet the parturient women's needs, since this relationship is built by means of affective bonds and trust, both well defined. The aforementioned determined that the puerperal women

participating in this study describe this professional as having scientific technical competence after being assisted, even with previous lack of knowledge of their role.[29]

Thus, the Nursing professional must act in such a way as to promote the rescue of delivery as a physiological event, aiming at the integrality and individuality of each parturient woman.[29] However, the insertion and recognition of the profession in this scenario requires breaking social and institutional paradigms, as it demands managerial commitment, since there will be opposition from the sectors interested in maintaining the current technocratic model, as it is believed that full expansion of the autonomy of Obstetric Nursing can take place through a new care model, based on knowledge and competences.[30]

This study had some limitations and barriers, which must be described. It was possible to identify a demand below the installed capacity of the CPN since, during the collection period, the few rooms available were in operation, making it difficult for patients to access the place. In addition, there was aversion by the women to the recorder, even after the study's secrecy and confidentiality issues had been clarified, which led to the refusal of five puerperal women to participate in the research.

Conclusion

The analysis of the testimonies showed that the mothers expressed positive perceptions regarding the experience of delivery assisted by Obstetric Nursing in the CPN, part of which is related to welcoming assistance, based on guidance, emotional support and bonding. In addition to that, significant feelings arising from professional conducts were evidenced in the content of the interviews, such as: stimulating exercises for pain relief, fetal monitoring, encouraging oral diet, and presence of a companion, practices based on scientific evidence and recommended by the Stork Network and by the WHO.

It was possible to verify that, although the impressions related to the assistance provided proved to be positive, lack of knowledge about the duties of the Obstetric Nurse was evidenced, as well as about the structure of the CPN, and even about the obstetric model centered on their needs. Also in the context of the Stork Network, it was possible to conclude that the structure of the CPN provided privacy, comfort and tranquility – essential elements for the process of giving birth to occur smoothly, generating feelings of safety and well-being, and providing sensations such as welcoming and bonding.

It is believed that the results of this research may contribute to the practice of the health professionals, especially Obstetric Nursing and its care model, allowing the patients' views on their care to be understood and, from that, shaping their practice. In addition to that, this study contributes to spreading knowledge about the duties of Obstetric Nursing, since such profession and its role proved to be unknown in the results herein described.

In addition, this study serves as a subsidy for teaching and research, taking it as a basis for analyzing the care model, from theory to practice and inciting new research studies, extension and health education projects, expanding scientific knowledge beyond the walls of the universities, disseminating to the population the attributions and the importance of Obstetric Nursing and facilities such as the CPN.

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