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Original Article

Perceptions attributed by parturients about obstetric nurses' care in a normal birth center

Percepções atribuídas por parturientes sobre o cuidado de enfermeiras obstétricas em centro de parto normal

Percepciones atribuidas por las parturientas sobre el cuidado de enfermeras obstétricas en un centro de parto normal

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Abstract

Objective: to understand the perceptions of parturients regarding the obstetric nursing care during labor and birth in a Normal Delivery Center. **Method:** descriptive, exploratory study, of qualitative approach, with 15 puerperae who had care during labor and birth at the Haydeê Pereira Sena Normal Childbirth Center, metropolitan region of the state of Pará, Brazil. Semi-structured interviews were conducted, virtually, via the WhatsApp® application, in the video call function, from September to November 2020, after capturing the women who were discharged from the unit. Data were recorded using the SplendApps audio application, transcribed and submitted to thematic content analysis, with the support of the ATLAS.ti 8.0 software. **Results:** the welcoming and empathy during the humanization process was observed, as well as the use of non-invasive technologies of science-based obstetric nursing care. **Conclusion:** humanized care ensures respect, autonomy and empowerment, with the practice of obstetric nurses.
Descriptors: Nursing; Obstetric Nursing; Nursing Care; Humanizing Delivery; Humanization of Assistance

Resumo

Objetivo: compreender as percepções das parturientes quanto aos cuidados da enfermagem obstétrica no processo do parto e nascimento em Centro de Parto Normal. **Método:** estudo descritivo, exploratório, de abordagem qualitativa, com 15 puérperas que tiveram o cuidado no parto e nascimento no Centro de Parto Normal Haydeê Pereira Sena, região metropolitana do estado do Pará, Brasil. Realizou-se entrevista semiestruturada, por meio virtual, via aplicativo

WhatsApp®, na função de videochamada, de setembro a novembro de 2020, após captação das mulheres que receberam alta da unidade. Os dados foram gravados pelo áudio do aplicativo *SplendApps*, transcritos e submetidos à análise de conteúdo temática, com o suporte do *software* ATLAS.ti 8.0. **Resultados:** observaram-se o acolhimento e a empatia durante o processo da humanização, além da utilização de tecnologias não invasivas do cuidado da enfermagem obstétrica com base na ciência. **Conclusão:** cuidado humanizado garante respeito, autonomia e empoderamento, com a prática das enfermeiras obstétricas.
Descritores: Enfermagem; Enfermagem Obstétrica; Cuidados de Enfermagem; Parto Humanizado; Humanização da Assistência

Resumen

Objetivo: comprender las percepciones de las parturientas sobre el cuidado de enfermería obstétrica en el proceso de parto y nacimiento en un Centro de Parto Normal. **Método:** estudio descriptivo, exploratorio, con enfoque cualitativo, con 15 puérperas que fueron atendidas durante el trabajo de parto y el nacimiento en el Centro de Parto Normal Haydeê Pereira Sena, en la región metropolitana del estado de Pará, Brasil. Se realizó una entrevista semiestructurada, por medios virtuales, a través de la aplicación *WhatsApp®*, en la función de videollamada, de septiembre a noviembre de 2020, luego de captar a las mujeres que fueron dadas de alta de la unidad. Los datos fueron registrados utilizando el audio de la aplicación *SplendApps,* transcritos y sometidos al análisis de contenido temático, con el apoyo del *software* ATLAS.ti 8.0. **Resultados:** se observó la acogida y la empatía durante el proceso de humanización, además del uso de tecnologías no invasivas en el cuidado de enfermería obstétrica con base en la ciencia. **Conclusión:** el cuidado humanizado garantiza respeto, autonomía y empoderamiento, con la práctica de las enfermeras obstétricas.
Descriptores: Enfermería; Enfermería Obstétrica; Atención de Enfermería; Parto Humanizado; Humanización de la Atención

Introduction

Since the early 1990s, Brazil has experienced an epidemic of cesarean sections[1] and unnecessary procedures in the care of women during labor and birth, which gradually were introduced in this context, such as episiotomy, routine oxytocin, Kristeller maneuver and other interventions, in addition to the occurrence of situations of discrimination and prejudice in the assistance in health services in the performance of health professionals.[2-5] There is a preconized logic in obstetric care, with the interventionist model on the female body, which favors the numerous interventions in this care, disrespecting an assistance that ensures respect for women's choices.[6]

In this context, cesarean sections and obstetric interventions are a major risk for maternal and neonatal health. Therefore, Brazil aims to reduce, by the year 2030, the rate to 30 maternal deaths for every 100,000 live births (NV), in line with the Sustainable Development Goals (SDGs), as a global effort to eliminate maternal mortality from

preventable causes. It is noteworthy that the country has not reached the goal of the universal appeal of the United Nations, despite the decrease of 58% since 1990, when it obtained a maternal death rate of 60 per 100,000 NV in 2015, higher than those recorded in countries with less favorable socioeconomic conditions in Latin America, such as Cuba (39 per 100,000 NV), Costa Rica (25 per 100,000 NV) and Uruguay (15 per 100,000 NV),[4] and far from the rate of 12 maternal deaths per 100,000 NV in developed countries.[5] In this panorama, the state of Pará, Brazil, in 2019, presented a rate of 60 maternal deaths per 100,000 NV, in disagreement with the SDGs.[7]

Even with the increase in public policies by the Ministry of Health (MH), especially from the 2000s on, which culminated with the National Humanization Policy and the Stork Network strategy to change the Brazilian model of care, since the country has not achieved the goals for the transformation of the obstetric care model, with high rates of procedure in women's care during labor and birth, especially with unnecessary cesarean sections.[8-14]

These policies provide subsidies for transformation arising from the process of criticism of women's health care, delivery and birth; humanization as the center of professional actions; centrality of women in the care process; encouragement in the physiology of birth; practice based on scientific evidence; Obstetric Nursing (ON) as a driving category in this modification of reality.[12-14] Thus, the Normal Delivery Center (NDC) has demonstrated the effectiveness of this change and humanized care to ensure higher quality, satisfaction of women, with less risk of unnecessary interventions,[11-14] having the performance of the ON, within the scope of the NDC, based on the NDC Implementation and Qualification Guidelines, which were redefined by Ordinance No. 11, of January 7, 2015.[15]

The NDC is a service that increases the reorganization of obstetric services, favoring the necessary changes in maternal and neonatal indicators, with an incentive to normal birth, having the ON as a mediator of these transformations.[6] From this perspective, the performance of the ON, in the NDC, is supported by Law No. 7.498, of June 25, 1986 (Law of Professional Nursing Practice), and by the Resolutions of the Federal Council of Nursing No. 524/2016 and No. 672/2021.[12-14,16] In this way, ON becomes a fundamental component for breaking this model, whose practice is sustained on the guiding axis of change: humanization, a concept of nursing care.

Thus, giving voice to women about the care provided by ON at the NDC will allow for an understanding of the perceptions attributed by them to the care provided by Obstetric Nursing and the correlation with public health policies in the obstetric field. For the support of this transition model, it becomes necessary to expand the scopes of health policies, especially the meanings of care, with scientific advancement, and with the perspective of subsidizing the perceptions of women, companions, health professionals, and managers in this new sphere of action of the NDC, thus promoting differentiated care, which values humanization, respect, the right, freedom, safety, quality, and satisfaction of women.

The study aimed to understand the perceptions of parturients regarding the obstetric nursing care in the labor and birth process in a Normal Delivery Center.

Method

This is a descriptive, exploratory study, with a qualitative approach, with 15 women who delivered babies at the NDC Haydeê Pereira Sena, of the Municipal Health Secretariat of Castanhal, metropolitan region of the state of Pará, Brazil. The service was created on July 2, 2016, the only one in the Northern Region of the country. It aims to present a care directed to women at usual risk, with incentive to normal birth in the Unified Health System (UHS), in line with the scope of the Stork Network, with the purpose of transitioning the obstetric model and encouraging the ON to be a mediator of this transformation of reality.

The selection of participants was based on convenience among puerperae. The direction of the unit passed on the contacts of puerperae assisted during the months of May to August 2020. Then, the invitation was sent remotely, through the WhatsApp® application, to 20 women and, with the acceptance, the initial reception was performed, explaining the study, the objective, the data collection technique, the risks and benefits. Thus, the women responded positively and the eligibility criteria were applied: having age range above 18 years of age and vaginal delivery in NDC, between the months of May and August 2020. The exclusion criteria considered women who entered the NDC in the expulsive period, justifying the unfeasibility of the care offered in the health service.

After applying these criteria, we contacted the participants to schedule the interview, according to their availability. The data collection process came to an end when the data were saturated,[17] when the meanings derived from the speeches of puerperae had the same thematic content in the meanings of the statements made, resulting in the comprehensiveness of the core of the phenomenon studied,[17] totaling 15 study participants. No approached participant refused to participate in the research and there was no need to extend the number of participants due to the established closure step.

It is mentioned that none of the participants knew about the personal objectives and characteristics of the interviewer, as well as there was no relational movement with the institutions to carry out the study. The selection of women in each scenario had no form of approach with the researcher, i.e., direct relationship (prior contact) with the women, because the descriptive process was carried out at the time of data collection, between September and November 2020, by the main researcher, through semi-structured interview, scheduled via application WhatsApp®, with the use of video calls and average duration of 40 minutes, the only data collection technique adopted.

This type of interview was used due to the imposition of the health emergency caused by the pandemic of the new coronavirus SARS-CoV-2. The interviews contemplated questions related to the profile of the women and the triggering questions were: how was the nursing care offered during the labor and birth process? How do you attribute this care offered?

The data obtained were recorded, using the SplendApps application to record the participants' voices, which was used as a resource to contribute to data transcription. After this process, they were transcribed in full by the main researcher and submitted to content analysis in the thematic modality,[18] with the support of the ATLAS.ti 8.0 software.

The main researcher holds a doctoral credential, with mastery of the interview technique, in addition to experience in applying it in other studies. Also, the main researcher and the research team had no personal or professional relationship with the institution, avoiding any conflict of interest.

The organization of the data began with the pre-analysis, with the perceptions described in the 15 interviews conducted, of which a floating reading of each one was performed, with the choice of relevant and representative elements. After this process,

we proceeded to the exploration of the material, in which coding interventions were made, relating the speeches of puerperae in order to categorize them.

In this step, the workability of the ATLAS.ti 8.0 was aimed at coding the excerpts of the statements in units of meaning, with the identification of the following meanings: support, reception, care, safety, non-invasive technologies, scientific evidence, physiology of birth, freedom, autonomy and protagonism, trust and expectation, uniqueness, integrality. And, in the final phase, the treatment of the results, interference and interpretation, so that they became significant and valid, with the presentation of the categories formulated.

Based on this analysis,[18] The meanings were the basis for the construction of the following thematic categories: 1) The support of nurse midwives in the normal delivery center: uniqueness and completeness; 2) The scientific care of nurse midwives: qualification in delivery and birth care; 3) The choice of the normal delivery center: the visibility of nurse midwives for a respectful delivery and female empowerment. The discussion of the categories was based on public policies in the field of labor and birth and on scientific evidence, focusing on the object of research.

The study was approved by the Research Ethics Committee of the Institute of Health Sciences of the Federal University of Pará (CEP-ICS/UFPA), on January 31, 2020, according to opinion No. 3,817,310, as provided in Resolution No. 466/2012 of the National Health Council (NHC). To preserve confidentiality, anonymity and reliability, the interviewees were identified by the letter (P) of puerperal women, followed by a numeric number, corresponding to the sequence of the interviews (P1, P2, P3, ..., P15), in addition to the guarantee of voluntary participation, through virtual signature, in Google Forms, of the Free and Informed Consent Term (FICT).

A standardized checklist, the Consolidated Criteria for Reporting Qualitative Research (COREQ), was used to help researchers report qualitative research information transparently and with quality.

Results

Of the 15 puerperal women interviewed, there was a predominance of 12 aged between 25 and 30 years old and three over 30 years old. All were in a stable union; nine

women had been in a relationship for more than five years, four women between three and five years, and two with less than three years. As for education, ten had completed high school, three had incomplete high school, and two had incomplete elementary school. Five had a formal job and the others were housewives.

Among the results, it was found that nursing care in the process of labor and birth was sustained in the humanization of assistance, with the welcoming and support in the NDC care. Moreover, it was verified in the statements the practice of obstetric nursing based on scientific evidence and the use of noninvasive technologies in the care offered by obstetric nursing.

The support of nurse midwives in the normal birth center: singularity and integrality

The women's perceptions regarding ON care were anchored in the welcoming and support during labor and delivery, configuring care aligned to the framework of humanization of care.

> *So, they provided all the care, all the time talking to me, all the time checking how my blood pressure was, my heartbeat, the baby's heartbeat, all the time super attentive. It was a delicate moment that I couldn't receive visitors, my daughter was born in the middle of the pandemic, she couldn't have all the structure that I imagined she would have, for example, no doula, no photographer, and I imagined all this, but I had the nurse with me.* (P1)
> *It was a very good experience I had at NDC, the welcome, since the beginning, they were super-human, they took care of me as if I were one of the family, or even better [...] welcome, which is a place of security, that I felt calm, even knowing I was going alone, I was calm, because I knew I would be very well welcomed*. (P3)

The care of women in the NDC was directed to empathy and singularity, obeying the precepts of humanization.

> *At the time of delivery, the nurses took my hand and said: everything is going to be fine, we are here, because they [nurses] saw that my greatest fear was that the baby would be born too late, and they passed this confidence to me and to my husband. I only have to thank God because they are professionals who love what they do, they are excellent at what they do, I can only praise them, because there were no negative points,*

> *in my point of view there weren't, there was great care for me and my baby*. (P2)
> *There they [nurses] are human, they care about us, the nurses care about what we want, this was very important, I had support, I was safe*. (P5)

Humanization is the foundation of obstetric nursing care in the field of labor and birth in the NDC allowing, from the welcome, support and empathy in this relationship of care.

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The perceptions of puerperae attributed to the care in the NDC were based on respect and the use of scientific evidence, with the use of non-invasive technologies in the care offered by obstetric nursing, such as the use of walking, penumbra, massages, music therapy, aspersion/hot bath, the Swiss ball.

> *Since the first moment, they [the nurses] always talked to me, gave me a lot of exercises, I walked, they put music on, calmed me down a lot, only positive things, wonderful, I was also on the ball [...] I was afraid, but they calmed me down, it was great, wonderful, since the massage that I never even thought that massage could relieve the contractions, these pains, they have a lot of knowledge*. (P4)
> *They oriented me, I understood, they spoke calmly to do exercises and get out of bed, because I was quiet with the light off, they said let's get up, put your body in motion, they kept doing massage, like really taking care, you know. And the baby was born at half past eleven at night and thank God everything went well, I believe because of their attention and the care they took from the time I arrived*. (P7)

The perceptions of puerperal women regarding the care provided by the obstetric nurses during labor and birth showed that they acted according to scientific evidence in the care of the newborn, using late clamping of the umbilical cord, skin-to-skin contact and breastfeeding in the first hour of life.

> *My aunt who was accompanying me cut the umbilical cord and as soon as he was born, he suckled and he stayed with me, this was his care to feel the warmth of his mother. This is important, it is rewarding, it is important to raise, to protect my son, I felt safe*. (P8)

> *They took me to the bed and went to evaluate, and while she was evaluating, the baby was on top of me, they took off my blouse to make skin contact, she stayed on top of me for at least twenty-five minutes, it was my husband who cut the cord. They did all the care in my presence and my husband's presence*. (P10)

It was observed that the care offered to women in the NDC by obstetric nursing was established in the scientific field, with the support of innovative practices, to change the obstetric model and consolidate humanization.

The choice of a normal birth center: the visibility of nurse midwives for a respectful birth and female empowerment

The testimonies of the puerperae reinforced the preference for assistance at the NDC, even if the participant had more favorable socioeconomic conditions, with complementary health insurance.

> *It is a delicate moment, I have health insurance, I could have gone to a place where there was a bigger structure, but for all the attention, all the work of the whole team, [...] We know that the situation of UHS is not the best, and we had health insurance, but we preferred to be there precisely for this service that was humanized, respecting the child's space and mine, the child's moment, our moment too*. (P11)
> *Certainly, I was very satisfied, it met my expectations, much more than I thought it would. Because it is UHS, we think that there will be someone in a bad mood to assist, but this does not exist, there is a patience that everyone has [...] that is unparalleled, there are people trained to work, even in private practice, we do not have all this offer of care, affection and attention that NDC has*. (P13)

The perceptions about care at the NDC were related to the valorization of care aligned with the physiology of parturition and inhibition of obstetric interventions.

> *One thing that was also very important for me is that I had a lot of doubt if they would cut me in the vagina and there they don't do anything like that. I have seen several friends go through this situation of being cut, of having their bellies pushed, the baby pressed, forcing the woman to give birth when it was not time [...] I did have stitches, but it was natural, there was no intervention for that, it happened, my daughter came out, there was the cut in a natural way and they sewed it up*. (P14)
> *One thing that caught my attention is that they [nurses] perform the touch in the woman as a last resort, it is not something like arriving there*

> *and performing the touch immediately, like when we arrive at the hospital. In both the first and the second birth, they arrived and told us, look, I'm going to do the touch, and if it hurts, you tell us, they worry*. (P15)

The postpartum women presented perceptions about the process of empowerment and protagonism of women in labor and birth, encouraged by the obstetric nurses in the NDC for humanization.

> *I felt like the owner of my birth, I felt at ease, they said what I had to do and I tried to do it, because the way they give us is the way we find to be the owner of our own birth. I felt very comfortable, as much in the first, as in the second [...] I prepared some songs to listen to during the pain, I even prepared a dance, but there was no time, my first took longer, my daughter was very fast. But, I felt like the protagonist, I felt very comfortable, very well taken care of, and when you feel very well taken care of*. (P6)
>
> *I really felt their support, a question of encouragement, of showing that I can do it, I was a capable woman. It is very nice the question of empowerment, of one woman giving support to another woman, and this was the great energy that I felt. I did my part, because if it weren't for their guidance, they believed in me, in my capacity to have the baby, I wouldn't have this confidence in myself, I would think I couldn't do it, and I also remembered my grandparents, my mother, how much this strength of women exists in me, this will of women to accomplish*. (P9)

The protagonism and empowerment of women raised perceptions of the valorization in the context of obstetric nurses' care, aiming to offer assistance based on physiology and without unnecessary interventions.

Discussion

The study shows the perceptions attributed by parturients to the obstetric nursing care in the NDC, with the assistance process that supports a qualified, safe and respectful practice, in the exercise of ON, with the woman and her respective family members.[6,12] This practice is articulated and constituted as a philosophical framework of care in NDC, providing sustainability for the nursing professional's exercise, especially for ON, with scientific, welcoming, empathic, singular and integral assistance, with respect for all fields: biological, emotional, social and cultural, anchored in the Brazilian reproductive public policy, with the Stork Network strategy and the basic components of humanization.[8]

The humanization model is the connection that links the obstetric nursing care in the NDC, which goes beyond humanized behaviors13 and brings a philosophy of care,[14] which has repercussions on the methodical form of professional practice,[19] in the design of care and in the political sphere. Humanization is a political act to ensure better care and quality of care in NDC [11,14-15] and has the humanistic inspiration of the governing principles of the UHS, such as universality, integrality, equity and social participation, which modify aspects inherent in the Brazilian obstetric model.[19]

This political field of humanization is presented in the processes of management and work, guiding the institutional activity, with the appreciation of the subjective and social dimension of care and management practices. This process strengthens commitments and responsibility, transdisciplinary teamwork and group work, the use of information, communication, continuing education, and management spaces in the construction of autonomy and protagonism.[19]

Humanization in the conceptual sphere[19] is based on respect and appreciation of the human person, and aims to transform the institutional culture through the collective construction of ethical commitments and methods with health care and service management. It is the recognition of the field of subjectivity as a fundamental instance for a better understanding of the problems and the search for shared solutions, having autonomy, responsibility, and a solidary attitude as values derived from humanization.[19]

In this way, the implementation of the support and reception constitutes an act of rupture of the hegemonic model, the ON promotes a legitimate practice in the sphere of transforming the reality of parturition,[6,12,14] with support in the policy of the Stork Network strategy. This welcoming and the process of caring for women in the NDC, as demonstrated in the women's statements, are about a dignified, respectful, ethical care with the triad woman-baby-family, as a concept-method-policy[19] of ethical and solidary conducts for institutional transformation.[8-9,13]

Thus, it is reinforced that it is necessary to organize the institutions in order to offer a welcoming environment, in which humanization prevails in the field of labor and birth,[13] as described in the participants' testimonies, that has a positive repercussion on the reduction of depersonalized and interventionist conduct indicators.[6,14] The support and welcoming

interlinks the concept of the humanization action line for the form of assistance (the form of care) and the political act, as a rupture in the obstetric model, with the ON.[20]

The women's perceptions, according to their statements, portray empathy and singularity in the care provided by the obstetric nurse at the NDC, which has repercussions on the way of caring, aiming at the essence of humanization and ethics, considering the spheres of the human being,[20] the biological, emotional, social, cultural and historical aspects of parturition.[8,12,14] The assistance at the NDC permeates the daily operationalization of the Stork Network strategy policy,[15] which potentiates real changes in the way of being and caring for women during labor and birth.

The NDC is a space that advocates much more than humanized procedures,[6,12] presents itself as an effective policy for the transformation of ON assistance,[14,20] contributing to changes in mortality indicators,[6,8,12,14-15,20] with the encouragement of natural childbirth and breaking the Brazilian logic of disrespect and violence in childbirth.

This establishes a unique connection between humanization and the development of the method, which allows the insertion of aspects of human thinking and acting on the care processes, in order to create legitimate spaces for sharing and transformation, as well as ethical principles in the organization of professional action, a fact that contributes to a respectful care, according to the statements of the women participants.[19-21]

This guiding principle of humanization allows the transformation of labor and birth assistance, in which it is observed that, in the researched NDC, the Non Invasive Technologies of Obstetric Nursing Care (NITONC) are operationalized, according to the women's statements.[22] These technologies constitute structured knowledge, developed and used by obstetric nurses, as a way to offer other possibilities for women to experience the birth process. In addition, they characterize changes in attitudes within the health model, to demedicalize childbirth and enhance the physiological aspects and scientific evidence.[22]

These technologies are used in the scientific field, for the adoption of practices in the direct care of women,[6,12,14,20] organization of the NDC and work process, in stimulating the parturients, through the application of resources, such as penumbra, walking, warm/hot bath, massages, stool, Swiss ball, music therapy.

Thus, women's perceptions translate into humanization,[8,13] with the technical use of these technologies, which are widely used in services, as a proposal to break disrespectful conducts and treatment of women, with the support of the scientific field, in which they are shown to be effective, welcoming, humanized, and promote pain relief, stress reduction, and ensure greater satisfaction of assistance.[12-15,20,22]

Humanization as a practice of NDC enables changes in knowledge and attitudes towards women's care, in which the ON assumes a supporting role and conceives to it the empowerment and centrality of assistance. Thus, the researched NDC presents a performance anchored in scientific evidence, because it uses the NITONC.[6,14,20-22] This care is established for traditional changes in the way of understanding the way of caring for the needs of parturients. When obstetric nursing encourages the development of these technologies, it connects the NDC care with the vision of the assistance offered. In this way, the NDC assistance makes the care more qualified, dignified, human and scientific.[14,21-23]

The practice of obstetric nursing is supported by the implementation and use of humanization in the conceptual, political, and practical fields,[19] since the institutionalization of the Stork Network strategy,[15] enabling the transformation of the institutional reality, with ON assistance based on scientific knowledge.[6,12-14] The best evidence is the foundation of the humanization method, based on effectiveness and safety. Thus, the perceptions of women regarding the care of the newborn permeate the late clamping of the umbilical cord, skin-to-skin contact, encouragement of breastfeeding in the first hour of life.

These techniques are used and scientifically established, effective and recommended by the WHO,[23] by the MH,[24] by institutions and professional associations. In this context, the scientific literature [6,8,12,14-15,20-24] recommends that late clamping of the umbilical cord should occur between the first and fifth minute or when the pulsation ceases; the encouragement of skin-to-skin contact, through orientation of the woman on the importance and benefits for creating a bond; and the support of breastfeeding in the baby's first hour of life, in order to reduce early weaning.[23-24]

Therefore, these practices in the field of humanization should be encouraged in the daily routine of obstetric care, as they show the real importance of ON in the qualified care of women and newborns in NDC.

The possibility of giving birth in a quality service, such as NDC, contributes to women, including those with more favorable socioeconomic conditions, having access to supplementary health care when seeking NDC. This welcoming space establishes a more respectful assistance, in addition to the distancing from the traditional obstetric model, so that women do not go through negative experiences in labor and birth assistance, as described in the statements. Thus, the distance from unnecessary interventions allows the NDC to be a welcoming and constructive environment for the full experience of parturition, with a focus on humanization and naturalization of the female body.

Delivery and birth care has been undergoing important changes in recent decades, both nationally and internationally. Thus, these changes can promote changes in practice, standardize and standardize the most common techniques used in childbirth care, in addition to reducing the variability of conduct among professionals in the process of childbirth care and reduce unnecessary interventions.[6,8-15,20-24] Women's perceptions of NDC show it to be an important space for the reduction/elimination of disrespectful conducts in the daily life of parturition.

The NDC, with the action of the ON, potentializes conducts aligned to the physiology of parturition, according to the testimonies of the women participants, with the reduction of unnecessary interventions, such as episiotomy, Kristeller maneuver, unnecessary touches, in addition to cesarean sections.[8-14,20-24] These interventions are not in the daily care routine of the NDC. This fact contributes to women seeking the service, so that a natural/physiological care, the singularity, in the distinct biological, emotional, social, historical and cultural fields of women, aligned to the conceptual aspect of humanization.[19]

In this scenario, the conceptual sphere of humanization[19] is about respecting the woman's protagonism as a social subject, considering her individuality, particularity, and singularity. The humanized model[6,8,12-13,20] emphasizes the welcoming, respect, empathy, effective communication, conducts based on physiology and scientific evidence, among other care practices in the conceptual, methodical, political and practical operational field of humanization,[19] these perceptions being attributed important milestones in the fields of humanization.[20]

The statements are in line with the results of studies,[6,12,14] in which the parturient woman is a value in itself, being configured as central care, showing a growing change in behavior and attitudes to value effective care in the humanization model of labor and birth.[6,12,14] Therefore, human care represents a link to female protagonism, thus recognizing the respect and appreciation for singularity and subjectivity.[20-24]

In this context, the encouragement of NDC ON's with the protagonism of childbirth translates into the valorization of a care with the field of ethics and social subjects for the transformation of the institutional reality. Therefore, humanization enhances this collective sphere of transformation. That said, the women's perceptions value the empowerment, with a feeling of capacity of the birth experienced, in which they feel safer with the encouragement of the obstetric nurses. NDC guarantees care that recognizes the woman as a social, cultural, and historical figure, allowing the full experience of perceptions arising from labor and birth.

Despite the above, the study has limitations, since it was promoted from a particular reality of the scenario involved that did not allow relationships and generalization, not obtaining the totality of women in the service.

The perceptions attributed to the care offered by the NO allowed the identification of a singular and integral assistance, with respect for the woman and her family. Thus, it is reiterated that the NDC space is configured as a link to ensure a respectful birth, with the application of practices supported by scientific evidence.

Conclusion

The perceptions attributed by puerperae to the assistance in NDC permeate a practice aligned with the dimensions of humanization. The ON strengthens the know-how in reproductive health, by articulating the guidelines of humanization in labor and birth care, for a real change in the logic of birth. Obstetric nursing promotes a care that breaks with the predominant model of care in obstetrics.

The Stork Network strategy has enabled a new redesign of care for women and newborns in the context of NDC. The ON, in the management of care, are organized in the welcoming, support, and empathy, in order to value aspects beyond the biological, considering the uniqueness and particularity of each woman.

The daily practice of ON is supported by the application of science as a guide to safe and quality care. This assistance goes through the practical field of humanization, with the use of NITONC, which allows the body and physiology to be valued, thus optimizing the autonomy and empowerment of women. These facts contribute to the reduction of unnecessary interventions, aligned with possible better maternal and neonatal outcomes.

The women's perceptions reaffirmed the humanized model and the care of the obstetric nurses. This appreciation allows strengthening the transition of conceptual, political, methodical, and practical changes in the daily life of obstetric care. These perceptions are intertwined with human care as a policy, objectified in the practice of humanized, qualified, respectful and safe care.

Expanding the implementation and qualification of NDC in Brazil becomes essential and urgent for changing the interventionist model of obstetric care, with possible contributions to reducing unnecessary interventions and respect for women's choices.

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