DOI 10.18471/rbe.v35.42149 Original Article

PROMOTION OF FEMALE AUTONOMY DURING CHILDBIRTH: INTENTIONALITY OF THE ACTIONS OF HEALTH PROFESSIONALS

PROMOÇÃO DA AUTONOMIA FEMININA DURANTE O PROCESSO PARTURITIVO: INTENCIONALIDADE DAS AÇÕES DE PROFISSIONAIS DA SAÚDE

PROMOCIÓN DE LA AUTONOMÍA FEMENINA DURANTE EL PROCESO DE PARTURICIÓN: INTENCIONALIDAD DE LAS ACCIONES DE LOS PROFESIONALES SANITARIOS

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How to cite this article: Reis TLR, Honnef F, Padoin SMM, Alves VH, Souza IEO. Promotion of female autonomy during childbirth: intentionality of the actions of health professionals Rev baiana enferm. 2021;35:e42149.

Objective: to understand the intentionality of the actions of health professionals to promote female autonomy during assistance to labor and delivery. Method: qualitative research based on Alfred Schütz's social phenomenology, carried out with 17 professionals, in a university hospital in southern Brazil. The comprehensive analysis was based on the theoretical-methodological framework. Results: the intentionality of professional action was to ensure the best for the woman, the newborn, the professional and the health service during the process of labor and delivery; and to expect changes in professional performance towards a new paradigm. Conclusion: health professionals act towards achieving an outcome favorable to all involved and recognize the need for institutional and professional changes to qualify obstetric care, in order to promote women's autonomy in this context.

Descriptors: Women's Health. Childbirth. Personal Autonomy. Qualitative Research. Health Personnel.

Objetivo: compreender a intencionalidade das ações dos profissionais de saúde para promoção da autonomia feminina durante a assistência ao parto e nascimento. Método: pesquisa qualitativa fundamentada na fenomenologia social de Alfred Schütz, realizada com 17 profissionais, em hospital universitário no Sul do Brasil. A análise compreensiva foi guiada pelo referencial teórico-metodológico. Resultados: a intencionalidade do agir profissional foram: garantir o melhor para a mulher, o recém-nascido, o profissional e o serviço de saúde durante o processo

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de parto e nascimento; e ter expectativa de mudanças na atuação profissional em direção a um novo paradigma. Conclusão: os profissionais de saúde agem com a finalidade de alcançar um desfecho favorável a todos os envolvidos e reconhecem a necessidade de mudanças institucionais e dos profissionais para a qualificação da assistência obstétrica, para que se promova a autonomia da mulher nesse cenário.

Descritores: Saúde da Mulher. Parto. Autonomia Pessoal. Pesquisa Qualitativa. Pessoal de Saúde.

Objetivo: comprender la intencionalidad de las acciones de los profesionales sanitarios para promover la autonomía femenina durante el parto y la atención al parto. Método: investigación cualitativa basada en la fenomenología social de Alfred Schütz, llevada a cabo con 17 profesionales, en un hospital universitario en el sur de Brasil. El análisis comprehensivo se orientó por el marco teórico-metodológico. Resultados: la intención de la acción profesional era: garantizar lo mejor para la mujer, el recién nacido, el profesional y el servicio de salud durante el proceso de parto y nacimiento; y esperar cambios en el rendimiento profesional hacia un nuevo paradigma. Conclusión: los profesionales de la salud actúan con el propósito de lograr un resultado favorable a todos los involucrados y reconocer la necesidad de cambios institucionales y profesionales para calificar la atención obstétrica, con el fin de promover la autonomía de las mujeres en este escenario.

Descriptores: Salud de la Mujer. Parto. Autonomía Personal. Investigación Cualitativa. Personal de Salud.

Introduction

The institutionalization of obstetric care changed the conceptions attributed to the birth process, as well as the behavior of professionals, parturients and family members. The qualification of care allowed for the reduction of negative maternal and neonatal outcomes[1]; however, by prioritizing the use of interventions and medical knowledge over the women's autonomy, it reinforces the distancing of the process from their intimate, family and private characters[1]. Considering the prevalence of actions based on a traditional obstetric care model[1-2], a study with 586 women indicated the maintenance of a technocratic and interventionist assistance[2].

Thus, actions should be reinforced to implement good birth care practices[3] and values for training new health professionals, in order to maintain the efforts initiated in the 1970s both globally and nationally to promote changes, which were internationally marked by the publication of a guide for a positive childbirth experience[4]. The recommendations indicate that professionals' actions have the potential to promote the protagonism of women in the obstetric setting and in the actualization of women's rights.

The protagonism involves the women's previous awareness about the care practices that will be used. Encouragement from the health team allows women to recognize childbirth as a natural and physiological process, as well as a participatory and conscious event that is protected by rights[3-5]. Thus, the promotion of women's protagonism and autonomy can provide benefits that extend to the newborn and the family[6-7].

It is therefore necessary to broaden the view about childbirth beyond biological aspects, contemplating women's rights and the establishment of an emancipatory attitude. The issue between the norm and the policy receives criticism because, despite the government initiatives established in laws, ordinances, pacts and programs within the Unified Health System (SUS, acronym in Portuguese) are not equally successful in the context of actions to guarantee women's rights[8].

Therefore, this study was based on the possibility of comprehensively analyzing human actions and their intentions, through hearing health professionals involved in obstetric care, to answer the following research question: What are their motivations in this context aiming at female autonomy?

In view of the above, the aim of this study was to understand the intentionality of the actions

of professionals to promote female autonomy during assistance to labor and delivery.

Method

This is a qualitative study with a phenomenological approach[9], based on Alfred Schütz's Social Phenomenology[9] as a theoretical-methodological support for understanding people's actions in the social world, considering the intersubjective relationships inscribed in their daily experiences. People perform actions consciously, as they are intentional and have meanings inscribed in the motivations. The actions result from experiences in the lifeworld (biographical situation and stock of knowledge), basing projects or intentions (reasons for) which can be apprehended[9]. For the writing of this study, the instrument called Consolidated Criteria for Reporting Qualitative Research (COREQ) was used for transparent and accurate research reports.

The study was developed in the obstetric center of a public reference hospital for tertiary care and integrated with SUS, in southern Brazil. The participants were 17 professionals, who met the following inclusion criteria: being a health professional directly involved in childbirth care. The exclusion criterion was to be absent from work activities during data collection (vacation, medical leave, or others). The professionals were approached in the service, in different shifts, which was when the objectives and clarifications of the research were explained. After the acceptance to participate in the research, the interview was developed individually in a reserved room in the obstetric center.

Data collection took place from April to May 2016 through phenomenological interviews[10], which were recorded. This approach has specific characteristics, such as empathy and intersubjectivity between the researcher and each participant, in order to understand their experiences and perceptions[10]. Open triggering questions were used, which allowed the professionals to spontaneously express their experiences, biographical situation and stock of knowledge. The questions were formulated based on Schütz's[9] theoretical framework and tested in the first interviews, allowing adjustments and adaptation to the research problem. The following questions were asked to the participants: "What do you have in mind when you assist women in labor and delivery?"; "Tell me about the actions that promote the exercise of women's autonomy that you perform in the assistance to labor and delivery?".

The analysis occurred concomitantly with the interviews, since it is necessary to recognize the convergence and sufficiency of meanings for the closure of data collection, demarcating the achievement of the objective[11]. Thus, there was no previous sample delimitation and this field stage was concluded in the 17th interview.

The data were organized based on the transcription of the interviews, followed by their reading and rereading. The analysis started for the identification of convergences and similarities or broader meanings, which indicated the actions and intentionalities (reasons for) of the action of assisting women in childbirth, with a view to female autonomy. Subsequently, they were separated and grouped according to the similarity of meanings. For the critical analysis, excerpts that represented the related significant aspects of the action (object of this study) were grouped together, making up the concrete categories with description of the actions and the corresponding intentions.

It is relevant to note that there was a dialogue between the results of the research, the theoretical framework of social phenomenology and the scientific evidence related to the theme under study. This triad allows for a contextualized and theoretically-based view of the phenomenon studied, and enables the researcher to guarantee the scientific validity, the subjective meaning of the action and the compatibility between the formulations of the researcher and the experiences of the common sense of social reality[12].

In the development of the study, ethical aspects were followed according to Resolution No. 466/2012 of the National Health Council, with approval by the Human Research Ethics Committee (REC) of the institution, according to Opinion No. 1.387.340 of January 12, 2016.

Results

The description of the participants will be presented by their biographical situation, as this aspect supported the understanding of the motivations of the actions. Among the aspects were their education, daily life and work relationships, as well as the stock of knowledge about female autonomy (Chart 1).

Chart 1 – Biographical situation and actions of professionals participating in the study with the intention of promoting women's autonomy. Santa Maria, Rio Grande do Sul, Brazil, 2016 (continued)

P	Biographical Situation	Actions to promote autonomy
P1	Nurse, 4 months of experience in the service, graduated in 2012, has a specialization degree.	*Sometimes I just stand close, quietly, to listen to her questions. It's a way of giving her autonomy, talking about what she is going to feel, what is going on and what is happening in her body. I tell them that they can walk, drink water and eat, and that they will stay in a bed with a companion.*
P2	Nurse, 6 months of experience in the service, graduated in 2013, has a PhD.	*I try to guide them about the labor. At the same time, I tell them that if they do not want something, they are free to say it. I explain that they are free to choose whether or not to drink water or eat, to move or to turn off the light.*
P3	Nurse, 12 months of experience in the service, graduated in 2005, no post-graduation.	*It is a matter of guidance, of letting them feel at ease. One concern I have is to ask what they think and what they want to do at that moment.*
P4	Nurse, 7 months of service, graduated in 2014, has a specialization degree.	*One of the actions I can highlight is to inform the woman. I think information is the first step towards autonomy [...] I provide guidance regarding the warm shower, ambulation, straddling a chair, the birthing ball, delivery positions, digital pelvic examination, the companion and the free nutrition.*
P5	Physician, 12 months of service, graduated in 2014, has a specialization degree.	*For a woman to have autonomy, she has to know what is going on. Explaining the risks, losses and benefits of everything [...] guiding about the possibility of walking or showering, the birthing ball or straddling a chair, stimulating the companion to give a back massage or to help in the psychological sense.*
P6	Physician, 10 months of service, graduated in 2011, has a master's degree.	*We must seek to respect women's autonomy and decide on what does not pose a risk to their lives. Clarifying on the possibilities, the risks and then we will see what she prefers.*
P7	Nursing technician, 19 months of experience in the service, graduated in 2008, no post-graduation.	*I tell women that the fact they are here does not mean they have to submit to what is imposed. I tell them that they are totally free* [...] *I also always try to leave the newborn with the mother in the first few minutes, not leaving them in that crib and causing traumas, aspirating, putting eye drops and many other things.*
P8	Nursing technician, 14 months of experience in the service, graduated in 2009, no post-graduation.	*We always guide and explain what can be done and how it can be done, but she is free to choose* [...] *I always tell them that they do not have to do anything against their will. It is their time to do what they think is best. When they can, of course.*
P9	Physician, 24 months of service, graduated in 2012, has a specialization degree.	*If there is no contraindication, you have to respect and work together. We try with the help of physiotherapy and nursing, putting them in the shower, doing some exercises on the ball, letting them walk for gravity to help* [...] *Nowadays, with the use of good practices, we try to be closer to the patients.*
P10	Nurse, 20 years of service, graduated in 1978, has a specialization degree.	*You make the patient active when you guide her, explaining about labor* [...]. *The basis of autonomy is to sit and explain. Every day we try to do something different, even with a paper that we put at the bed headboard with pictures of good practices.*

Chart 1 – Biographical situation and actions of professionals participating in the study with the intention of promoting women's autonomy. Santa Maria, Rio Grande do Sul, Brazil, 2016 (conclusion)

P	Biographical Situation	Actions to promote autonomy
P11	Physiotherapist, 1 month of service, graduated in 2015, has a specialization degree.	*The first thing is to inform on what I am going to do. I explain what my job is, the possibilities and ask if I can stay. If they authorize it, I start working; if they don't, I ask if they still want to hear my advices. From the moment she accepts my help, it is already her autonomy.*
P12	Physician, 3 years of service, graduated in 2010, no post-graduation.	*We encourage women to participate in labor, to believe that things will work out.*
P13	Nurse, 14 years of service, graduated in 2000, has a specialization degree.	*We help them to acquire knowledge, to ask questions. We act by guiding and being present. Sometimes you stand there, give her a back massage, take her hand so she knows someone is listening actively, listening to the complaint, listening to the crying. It helps them feel safer.*
P14	Nurse, 16 months of service, graduated in 2003, has a specialization degree.	*One of the main actions we perform are the guidances. So that they know about their rights, so they know they can say: "I want it this, I want that".*
P15	Nursing technician, 7 years of service, graduated in 2001, no post-graduation.	*We try to tell them they do not have to use oxytocin if they do not want to. We tell them they can walk, go to the bathroom, scream and do whatever they want.*
P16	Physician, 20 years of service, graduated in 1989, has a PhD.	*We encourage them to walk, to get on the ball, to shower, these more relaxing and stimulating things for labor. If they* [women] *want to stay in bed, it is their choice. But I always like to talk, to make the patient understand.*
P17	Physician, 21 years of service, graduated in 1990, has a specialization degree.	*We encourage the patient to walk, to get on the ball, to do exercises, etc. But if she does not want to do it, she does not have to. If she wants to lie down the whole time, she is going to lie down the whole time. No one is going to make her do anything against her will.*

Source: Created by the authors.

Key: P = Participant.

Each professional has specific purposes and objectives, which are rooted in the singular history of their lives and influence their motivations to perform actions that promote women's autonomy in labor and delivery. Thus, the objective syntheses of meanings of the actions from the participants' experiences were gathered and show the intentionality through the concrete categories of what was lived[9]. The professionals' intentions were "to ensure the best for the woman, the newborn, the professional and the health service during the process of labor and delivery"; and "to change the current obstetric care model".

To ensure the best for the woman, the newborn, the professional and the health service during the process of labor and delivery

With their actions, the professionals expect to encourage the women's active participation during birth and to contribute to making it a special moment full of good memories. They act to achieve the best for all social actors involved: the woman, the newborn, the professional and the health service.

> *My motivation is for them* [women] *to understand what is happening in their bodies and to have the right to choose what they want to do.* (P2).

> *Having a good first meeting, a beautiful moment.* (P6).

What motivates me is the outcome of that moment being a beautiful birth, in which she feels fulfilled as a woman and as a mother. (P10).

Making labor easier and helping them have a less painful delivery. (P8).

The only goal is to think about the well-being of her and the fetus [...] *we work in a way that is good for them and for us.* (P9).

Experiences and evidence show that natural birth is better for the patient and the baby. That the recovery is better and, in terms of costs for the hospital, it is a faster hospitalization. So, it is good for the whole group: mother, baby and hospital. (P12).

Intentionality to change the current obstetric care model

The intention to change the childbirth context is identified in the professionals' statements when they express the expectation of modifying the infrastructure for a welcoming and favorable space, with a view to implementing humanized practices based on scientific evidence, in addition to changes in professional performance towards a new care paradigm.

A change is necessary and, for that, we have to stop doing obstetrics without scientific evidence. (P4).

It would improve a lot if they had more engaged professionals and a better physical space. (P6).

I cannot change this alone. It depends on how the service is organized. (P9).

[...] *I would like to offer things I can't because the service does not work that way.* (P3).

Things are changing slowly, but we will get there. (P10).

[...] *Things cannot stay the way they are, it has always been like this.* (P14).

Thinking about women's autonomy in childbirth, there is a lot to improve [...] *you have to reinvent the wheel.* (P17).

There is a new way of thinking. I hope that things will get better and that women will have more freedom to express their wills. (P15).

Discussion

In the present study, one can infer that the professionals' stock of knowledge and biographical situation were guidelines for their actions in obstetric practice. Thus, the professional path of all study participants particularizes their social actions during health care, as they are in the world of social life, in intersubjective relationships, being signified and re-signified according to the type of relationship established with the other[9].

In order to promote female autonomy in labor and delivery, health professionals follow guidelines related to the birth process, such as the presence of the companion chosen by the woman, the different positions of the parturient in the first and second stages of labor, the use of non-pharmacological pain relief measures and less use of interventional practices without appropriate clinical and scientific indication. Such positive behaviors contribute to improve assistance in the birth process[3,13]. Furthermore, these behaviors converge with the recommendations from the World Health Organization (WHO)[4].

On the other hand, despite the short time since the professionals' education and the fact that humanization has gained space with the national guidelines of childbirth care, the understanding about the actions reveals aspects of professional training based on the technocratic and medicalized model[3,14]. Thus, in the interpretation of phenomenology[9], when professionals enter childbirth care they adopt a natural attitude and follow the codes received from professionals who already work in the service, which makes them act according to them, in line with the current obstetric care model.

The intention to do the best for all involved is mediated by the intersubjective face-to-face relationship, characterized by turning to the other and by proximity. In this relationship, they demonstrate their approximation with the women's expectations, especially when they intend to contribute to the experience of childbirth as a unique and special event, considering women as endowed with rights[9]. However, the conceptions about wellbeing are restricted to the clinical category, which is a reflection of the technocratic model; this is corroborated in a study that shows prescriptive and routine guidelines that are not individualized. Nevertheless, health professionals see communication as a means of ensuring care procedures were delivered[15].

Female satisfaction is an indirect way of evaluating the quality of obstetric care and is mainly associated with the provision of clear and useful information for the woman's needs in childbirth, with respect and availability of professionals, as well as with her participation in decisions[13,16]. For women and their families, the conception and provision of good quality services need to go beyond survival during childbirth and should give women the opportunity to participate actively in decisions about her health care, which this is closely linked to their empowerment[17].

Overcoming behaviors and conceptions restricted to biological aspects depends on public policies that act in changing childbirth care practices in health services, curricula and practice fields of undergraduate and specialization courses in Obstetrics and Neonatology[14]. The aim should be to work with students and obstetricians in the evaluation of the current model and its maternal and perinatal results, with the legitimacy of scientific evidence[14] as a support for this discussion, such as evidence from a systematic review that associates direct indicators of women's empowerment with indicators capturing maternal and child health outcomes[18].

The WHO[4] points out that all women, especially pregnant women, are entitled to the best outcomes of dignified and respectful care and to enjoy the best attainable standard of physical and mental health, including sexual and reproductive health. To this end, health systems should be organized and managed in a way that ensures women's human rights, taking responsibility for the way they are treated during childbirth and implementing clear policies and ethical standards.

The intention to promote changes in professional performance to change the obstetric care model is evidenced in the professionals' actions in this study, at the same time they aim to contemplate the current trend of humanizing care, which focuses on the rescue of female protagonism and autonomy, perceiving birth as a physiological event[19-20]. Thus, they act in the expectation of contributing in the future to the qualification of obstetric care, with a projected action, focusing on the goal to be achieved[9].

Actions with such intentionality are supported by the Brazilian Ministry of Health (BMH) through the recommendation of evidence-based strategies[21-22]. Humanization is understood as the valorization of the different social actors involved in health processes, emphasizing autonomy and their protagonism. It presupposes changes in the care model for an assistance based on sexual and reproductive rights, democratization of work relationships and strengthening the performance of the multidisciplinary team[22].

Furthermore, the health professionals' intentional actions with a view to changing the current obstetric model are also inscribed in their social relations, especially in professionals with different academic backgrounds and points of view. There is also discussion about the situation in Brazil, in which despite the need for changes seeking to value obstetric care, the model based on the principles of humanization cannot be effectively instituted due to the superimposition of medical knowledge, which is based on a biomedical model. The typical characteristics of this assistance should not be inflexible; they must be continuously restructured and motivating new social actions[5-6,15].

When projecting the action, the professionals anticipate a behavior, in which the possibilities of doing so are directly linked to the present lived[9], mainly in relation to the scientific evidence that emerges from the movement for the humanization of childbirth[4]. Despite the recognition of the need to change the current obstetric care model, the promotion of female autonomy is limited to the possibilities of choosing care practices previously determined by protocols and routines of the service.

Evidencing the challenge of humanizing obstetric care for health professionals, institutions, and society, several possible strategies run into the predominant care model, which is focused on the physician, the use of interventions and the low valuation of psychosocial aspects of labor and delivery. However, states and cities are gradually

adhering to ministerial recommendations, which are reinforced by the Stork Network program (Rede Cegonha, in Portuguese), and receiving financial incentives to adapt infrastructures and assistance processes[19,21].

In addition to the quantitative expansion of the services, the multidisciplinary team qualifies the assistance to pregnancy, labor and delivery. The inclusion of obstetric nurses is strategic and prioritized, which enables (re)directing and sensitizing the multidisciplinary team[24]. Studies indicate successful experiences in the reconfiguration of health practices since their inclusion, thus allowing the identification of the commitment of these professionals to the quality of care and to the principles of humanization, good practices and safety in labor and delivery [21,25].

Moreover, humanizing health care also means breaking with the biological paradigm, disregarding the perception of the individual as an object of intervention, in the name of an expanded view of the human being with their needs, feelings and biological, social, cultural and economic conditions. This will be possible by resizing the roles and powers of the social actors involved in the labor and delivery context, giving women their right to be mothers with dignity and safety; such reality is still a challenge for all professionals, such as health promoters.

An important limitation of this study is that it sought to portray the local reality of a teaching hospital that is a reference for high-risk deliveries, whose characteristics are the focus on the training process and obstetric interventions. Therefore, there is no intention to generalize the results.

Conclusion

The study allowed understanding that health professionals act aiming to achieve a favorable outcome for all involved: woman, newborn, health professional and service. They are guided by a training anchored in the technocratic obstetric care model, and sometimes they present a perception that is restricted to biological and physiological aspects of childbirth. There is still a path to be followed to expand the implementation of actions that contemplate the promotion of women's autonomy with a view to strengthening the counter-hegemonic field for the effective guarantee of rights. The results also indicate the need to strengthen the field of assistance approaches based on good childbirth care practices and guidelines of the BMH and the WHO.

Collaborations:

1 – conception, design, analysis and interpretation of data: Thamiza Laureany da Rosa dos Reis, Fernanda Honnef and Stela Maris de Mello Padoin;

2 – writing of the article and relevant critical review of the intellectual content: Thamiza Laureany da Rosa dos Reis, Fernanda Honnef, Stela Maris de Mello Padoin, Valdecyr Herdy Alves and Ívis Emília de Oliveira Souza;

3 – final approval of the version to be published: Thamiza Laureany da Rosa dos Reis, Fernanda Honnef, Stela Maris de Mello Padoin, Valdecyr Herdy Alves and Ívis Emília de Oliveira Souza.

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Received: October 22, 2020

Approved: February 1, 2021

Published: April 27, 2021