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Care technologies in normal delivery care: practices of nurses and obstetricians

Tecnologias do cuidado na assistência ao parto normal: práticas de enfermeiros e médicos obstetras

Tecnologías de atención en la asistencia al parto normal: prácticas de enfermeros y médicos obstetras

ABSTRACT

Objective: To analyze the care technologies used by nurses and obstetricians in normal delivery care. **Method:** Analytical and cross-sectional study conducted with 335 puerperal women in a reference maternity hospital. Data were analyzed using statistical inference, considering p-values < 0.05 statistically significant. **Results:** There was a higher prevalence and association between breastfeeding and free choice of position in deliveries cared for by a nurse; and with non-pharmacological methods for pain relief, episiotomy, oxytocin, verbal orders and supine position in deliveries cared for by a physician. In the final regression model, the higher chances of women having free choice in the position of giving birth, not having episiotomy and not having oxytocin administered remained associated with deliveries cared for by nurses. **Conclusion:** Care technologies capable of favoring women's autonomy and their individualities in normal delivery were associated with obstetric nurses, providing a respectful and safe care. **Descriptors:** Nursing Care; Obstetrics; Humanizing Delivery; Evidence-Based Practice.

RESUMO

Objetivo: Analisar as tecnologias do cuidado na assistência ao parto normal utilizadas por enfermeiros e médicos obstetras. **Método:** Estudo transversal analítico realizado com 335 puérperas de uma maternidade de referência. Os dados foram analisados mediante inferência estatística, considerando-se estatisticamente significantes os valores de p < 0,05. **Resultados:** Houve maior prevalência e associação da amamentação e livre escolha da posição nos partos assistidos por enfermeiro; e com métodos não farmacológicos para alívio da dor, episiotomia, ocitocina, ordens verbais e posição supina nos partos assistidos por profissional médico. No modelo final da regressão, permaneceram associadas aos partos auxiliados por enfermeiro as maiores chances de a mulher ter livre escolha na posição de parir, de não ser efetuada a episiotomia e não ser administrada ocitocina. **Conclusão:** Tecnologias do cuidado capazes de favorecer a autonomia da mulher e sua individualidade no parto normal foram associadas ao enfermeiro obstetra, oportunizando uma assistência respeitosa e segura.
Descritores: Cuidados de Enfermagem; Obstetrícia; Parto Humanizado; Prática Clínica Baseada em Evidências.

RESUMEN

Objetivo: Analizar las tecnologías de atención en la asistencia al parto normal utilizadas por enfermeros y médicos obstetras. **Método:** Estudio analítico transversal realizado con 335 puérperas de una maternidad de referencia. Los datos se analizaron mediante inferencia estadística, considerando estadísticamente significativos los valores de p < 0,05. **Resultados:** Hubo una mayor prevalencia y asociación de la lactancia materna y la libre elección de posición en los partos atendidos por enfermeros; y con los métodos no farmacológicos para el alivio del dolor, la episiotomía, la oxitocina, las órdenes verbales y la posición supina en los partos atendidos por profesionales médicos. En el modelo de regresión final, las mayores posibilidades de que la mujer tuviera libre elección en la posición del parto, de que no se le practicara una episiotomía y de que no se le administrara oxitocina siguieron estando asociadas a los partos asistidos por enfermeros. **Conclusión:** Las tecnologías de atención capaces de favorecer la autonomía de la mujer y su individualidad en el parto normal se asociaron al enfermero obstetra, permitiendo una asistencia respetable y segura.
Descriptores: Atención de enfermería; Obstetricia; Parto Humanizado; Práctica Clínica Basada en la Evidencia.

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INTRODUCTION

Over the years, delivery care has undergone changes, both in terms of the professionals' behavior and in the population's understanding of the topic [1]. Traditionally, parturition was a family episode centered on women, but it underwent changes under the influence of the onset of a biomedical and hospital-centric model, where the idea of medical protagonism was associated with the safety of the maternal-fetal binomial. In this context, normal delivery becomes a risk event that requires interventions [2].

Within this context, Brazil reveals a model for prepartum, delivery and postpartum care designed by the presence of excessive professional interference, sometimes provoking cases of obstetric violence [3]. According to the World Health Organization (WHO), this is defined as any disrespectful, dehumanized act, arising from negligence and mistreatment of the parturient woman and/or the newborn, which may be physical (such as the indiscriminate use of oxytocin, episiotomies, Kristeller maneuvers) or psychic (verbal insults, abuse of hierarchical relationship and speech restriction) [4].

Accordingly, statistical data show that a quarter of Brazilian women who have experienced normal deliveries in hospital settings report having been victims of violence and/or mistreatment. Thus, given the context of obstetric violence delimited by a predominance of avoidable causes and high rates of unnecessary interventions, there is a need to reframe this reality by improving care for parturient women, which includes transformations in the care provided by health professionals [4].

It is known that most obstetric professionals have been trained in a traditional model of care, legitimized by the institutional culture of power, having their academic practices performed essentially on women's bodies, most of the time without their consent, disregarding the limits of ethics and respect [5].

Nevertheless, in general, medical obstetric training is more centered on interventionist practices, while that of the obstetric nurse (ON) adds to the humanization of care, rescuing delivery as a physiological event, as it uses care technologies and avoids unnecessary interventions, respecting women's wholeness and their privacy during the process of pregnancy and childbirth [6].

With a view to achieving the qualification of care and based on the insertion of good care practices in normal delivery, in 2011, the Brazilian Ministry of Health (MS, as per its Portuguese acronym) created the Stork Network strategy (*Rede Cegonha* in Portuguese), promoting the process of deconstruction of the interventionist model, in favor of the humanization of care [7].

This humanistic nature emphasized on respect acts positively in establishing a bond of trust between the mother and the health professional, promoting a satisfactory environment for care centered on the maternal-fetal binomial [2].

Therefore, obstetric care technologies consist of a set of practices and knowledge used in relation to women, understanding delivery as a natural and physiological process, prioritizing respect and maintenance of physical and psychological wholeness. They must be developed through non-invasive conducts, respecting the woman as the protagonist of the parturition [8].

In this context, the question is: What are the care technologies used in the practice of nurses and obstetricians in normal delivery care in the hospital setting? Answering this question is justified by the need to reflect and discuss about obstetric care technologies, in search of humanized and quality care for normal delivery that considers the guidelines envisaged by the Stork Network. Furthermore, the transforming potential of the obstetric nurse is glimpsed in the renewal of delivery as a natural, safe and respectful process. In light of the above, this research has the objective of analyzing the care technologies used by nurses and obstetricians in normal delivery care.

METHODS

Analytical and cross-sectional study, with a quantitative approach, outlined by the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) protocol. Data were collected between September 2018 and February 2019 in a public maternity hospital, reference in maternal and child care, in *Zona da Mata,* region located in the State of Pernambuco. The sample, composed of puerperal women, was calculated based on normal deliveries that took place in the maternity hospital in the year prior to the survey, totaling 2,603 births. Considering this information, the sample calculation formula for cross-sectional studies of a finite population was used, adopting a 95% confidence interval, 5%

margin of error and a critical value of 1.96. Thus, a sample of 335 puerperal women was obtained.

Women of any age group, of usual-risk pregnancy whose vaginal delivery took place in the maternity hospital, with a single fetus, cephalic, gestational age between 37 and 41 weeks, and who were referred to Rooming-in Setting, in the immediate postpartum period, were included. Puerperal women who manifested stillbirths or neonatal death were excluded; and those that had some cognitive and mental limitation, previously diagnosed, that made their verbal comprehension and expression difficult, making their participation impossible.

Face-to-face interviews were performed with the puerperal women during their stay in the rooming-in setting of the maternity hospital, and additional data were extracted from their and their newborns' medical records (use of partogram, infusion of uterotonics, child's weight and Apgar score). To that end, a questionnaire was used containing questions about sociodemographic characteristics, obstetric backgrounds and data on labor, delivery and postpartum, as well as about the woman's assessment of the received care.

The questionnaire was designed based on indicators from the Stork Network program; Brazilian Ministry of Health's national guidelines for normal delivery care [7]; and World Health Organization recommendations for a positive delivery experience [9].

Subsequently, the questionnaire was assessed by three specialists in the area of women's health for the adequacy of the items. A pilot test was conducted with five puerperal women to check the acceptability, clarity and understanding of the instrument's language. There was a need for further adjustments, and then this test of the statistical sample was discarded. A second pilot test proved the quality and acceptability of the instrument.

The dependent variable taken into account was the one associated with normal delivery care received from nurses or obstetricians; and, as independent variables, skin-to-skin contact, presence of a doula, non-pharmacological methods for pain relief, offering food, moving around, free choice of position at the time of delivery, vaginal touch, trichotomy, enema, directed pushing, Kristeller maneuver, episiotomy, prepartum oxytocin, verbal violence (shutting up), supine position during the expulsion period, breastfeeding in the first hour and partogram filled out in the medical record.

Data were analyzed using SPSS, version 23.0, using descriptive (absolute and relative frequencies and 95% confidence intervals of proportions) and inferential (Chi-Square test, Fisher's Exact test and the adjusted model for multiple logistic regression) statistics. In the multivariate analysis, adjustment for potential confounding effects was performed by logistic regression. In order to include the initial regression model, as a way to check the confounding variables, a significance of up to 20% ($p < 0.20$) was adopted, obtained in the bivariate analysis. In the end, variables with a p-value < 0.05 in the Wald test were considered significant for permanence in the adjusted model. The data entry method in all phases of the regression was the forced entry (enter). It is underlined that all variables were answered during the interview, so there was no loss of data or missing values due to lack of response from the participants.

The multicollinearity test, according to the Tolerance and VIF (Variance Inflation Factors) parameters, confirmed the absence of multicollinearity among the independent variables. The quality of the logistic regression adjustment was assessed by the Hosmer-Lemeshow test and Nagelkerke's R2. The fit of the final model was assessed by means of the area under the ROC curve.

The research followed the ethical recommendations, complying with the determinations of Resolutions 466/12 and 510/2016 of the National Health Council, and was approved by the Research Ethics Committee of the Federal University of Pernambuco (UFPE) (CAAE: 94050318.6.0000.5208).

RESULTS

In the sociodemographic profile of the women participating in the study, it was observed that they were mostly (69.9%) young adults (19 to 34 years old), self-reported brown skin color (68.4%), living with a partner (81.2%) and a low wage income (up to one minimum wage) (82.1%), according to Table 1.

Table 1 – Sociodemographic profile of the women in the study. Vitória de Santo Antão/PE, Brazil, 2020 (n = 335).

Variables	n	%	95% CI
Age (years)			
≤ 18	77	23.0	18.49 – 27.50
19 – 34	234	69.9	64.98 – 74.81
≥ 35	24	7.2	4.43 – 9.96
Self-reported skin color			
White	82	24.5	19.89 – 29.10
Black	22	06.6	03.94 – 09.25
Brown	229	68.4	63.42 – 73.37
Yellow	2	0.6	-0.22 – 1.42
Marital status			
With partner	272	81.2	77.01 – 85.38
Without partner	63	18.8	14.61 – 22.98
Educational level			
Illiterate	1	0.3	-0.28 – 0.88
Elementary school	164	49.0	43.64 – 54.35
High school	158	47.2	41.85 – 52.54
Higher education	12	3.6	1.60 – 5.59
Occupation			
With occupation	111	33.1	28.06 – 38.13
Without occupation	224	66.9	61.86 – 71.93
Family income (minimum wages*)			
≤ 1	275	82.1	77.99 – 86.20
1 to 2	50	14.9	11.08 – 18.71
> 2	10	3.0	1.17 – 4.82

Notes: *Minimum wage in the data collection period: R$ 998.00.

Source: Survey data, 2020.

As for obstetric and delivery information, 158 (47.2%) were primiparous and 182 (54.3%) delivered between 39 and 40 weeks of gestational age. It is noteworthy that only 15 (4.5%) women prepared the Birth Plan. Regarding the birth position, 319 (95.2%) women were in the supine position during the expulsive period. It was observed that 162 (48.4%) women were admitted to the maternity ward with a dilation less than/equal to 4 centimeters (Table 2).

Table 2 – Obstetric and birth profile of the women in the study. Vitória de Santo Antão/PE, Brazil, 2020 (n=335)

Variables	n	%	95% CI
Previous deliveries (Parity)			
Primiparous	158	47.2	41.85 – 52.54
2 previous deliveries	102	30.4	25.47 – 35.32
≥ 3 previous deliveries	75	22.4	17.93 – 26.86
Gestational Age (GA) at current delivery			
37 – 38 weeks	96	28.7	23.85 – 33.54
39 – 40 weeks	182	54.3	48.96 – 59.63
> 40 weeks	57	17.0	12.97 – 21.02
Prepared the birth plan			
Yes	15	04.5	02.28 – 06.71
No	320	95.5	93.28 – 97.71
Position of current delivery			
Supine	319	95.2	92.91 – 97.48
Non-supine	16	04.8	02.51 – 07.08
Free choice of position at the time of delivery			
Yes	139	41.5	36.22 – 46.77
No	196	58.5	53.22 – 63.77
Admission with dilation ≤ 4 cm			
Yes	162	48.4	43.04 – 53.75
No	173	51.6	46.24 – 56.95

Source: Survey data, 2020.

With regard to care technologies and obstetric interventions, the results were examined separately according to the professional category that cared for the delivery during the fetal birth period. Of the analyzed deliveries, 251 (74.9%) were cared for by a medical professional and 84 (25.1%) by ON (Table 3).

Still in Table 3, it was observed that 57 (22.7%) mothers whose deliveries obtained medical assistance reported having breastfed in the first hour postpartum, and only 86 (34.3%) chose the position at the time of giving birth. It is emphasized a major stimulus to skin-to-skin contact in the mother-child binomial (88.1%) and the encouragement of the parturient woman to move around (45.5%) by the ON professional.

Of the obstetric interventions, the trichotomy showed equivalent results in both professional classes, while the directed pushing was prevalent in the medical category, being performed in 207 (82.5%) deliveries.

Table 3 – Care technologies and interventions during normal delivery care. Vitória de Santo Antão/PE, Brazil, 2020 (n = 335)

Variables	Delivery cared for by		
	Obstetric nurses n (%)	Obstetrician (physicians) n (%)	p-value
Care Technologies			
Caregiver	80 (95.2)	222 (88.4)	0.071*
Presence of a doula	55 (21.9)	16 (19.0)	0.578*
Breastfeeding in the 1st hour	29 (34.5)	57 (22.7)	0.032*
Partogram filled out in the medical record	22 (26.2)	94 (37.5)	0.060*
Skin-to-skin contact	74 (88.1)	216 (86.1)	0.635*
Non-pharmacological methods for pain relief	54 (64.3)	199 (79.3)	0.006*
Offering food	30 (35.7)	104 (41.4)	0.354*
Moving around	34 (45.5)	113 (40.0)	0.468*
Free choice of position at the time of delivery	53 (63.1)	86 (34.3)	< 0.001*
Interventions			
Recurrent vaginal touches	80 (95.2)	244 (97.2)	0.478**
Trichotomy	01 (01.2)	03 (01.2)	1.000**
Enema	03 (03.6)	06 (02.4)	0.773**
Directed pushing	62 (73.8)	207 (82.5)	0.084*
Kristeller maneuvers	15 (17.9)	66 (26.3)	0.118*
Episiotomy	07 (08.3)	83 (33.1)	< 0.001*
Prepartum oxytocin	20 (23.8)	92 (36.7)	0.031*
Breaking the amniotic sac	02 (02.4)	16 (6.4)	0.160*
Verbal orders	08 (09.5)	50 (19.9)	0.029*
Supine position during the expulsion period	75 (89.3)	244 (97.2)	0.006**

Notes: *Chi-Square Test; **Fisher's Exact test.

Source: Survey data, 2020.

Regarding the women's assessment of the care received in the process of normal delivery, 265 (79.1%) felt safe and 298 (71.0%) affirmed that their expectations regarding the quality of professional care were met (Table 4).

Table 4 – Women's assessment of the care received during delivery care in the hospital setting. Vitória de Santo Antão/PE, Brazil, 2020 (n=335)

Variables	n	%	95% CI
Felt safe			
Yes	265	79.1	74.74 – 83.45
No	70	20.9	16.54 – 25.25
Met the expectations			
Yes	238	71.0	66.14 – 75.85
No	97	29.0	24.14 – 33.85

Source: Survey data, 2020.

In the logistic regression model, it was inferred the *odds ratio* of good care practices in relation to delivery care on the part of nurses. It was observed that the chance of women having free choice in the position of giving birth was 2.971 higher in deliveries cared for by ON. Similarly, the *odds ratio* of not performing episiotomy and not being administered oxytocin in the prepartum period was 4.820 and 1.909, respectively, when delivery was cared for ON (Table 5).

The coefficient of determination of the model (Nagelkerke's R2) indicated that these factors included in the final regression model explain 18.4% of the occurrence of the investigated outcome (delivery care by obstetric nurses).

Table 5 – Factors associated with care during normal delivery in the hospital setting performed by obstetric nurses according to logistic regression. Vitória de Santo Antão/PE, Brazil, 2020

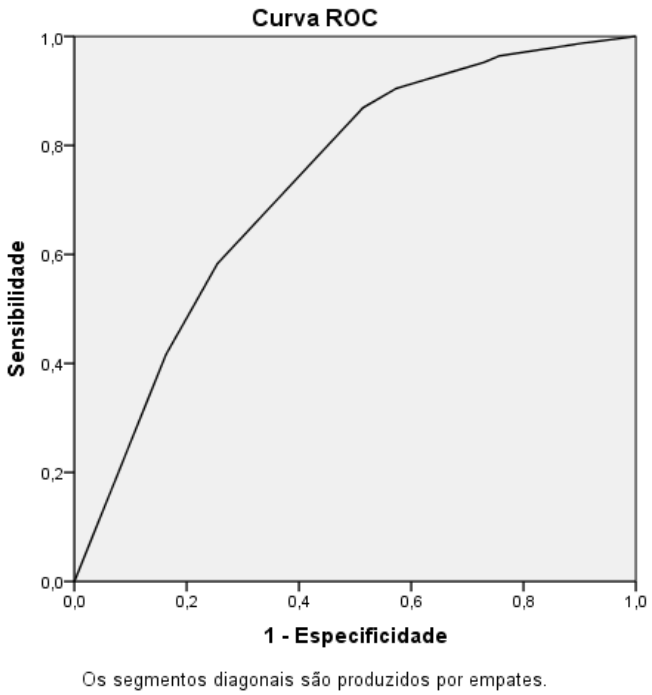
Variables	Adjusted *Odds Ratio* (OR)	CI (95%)	p-value*
Care Technologies			
Free choice of position at the time of delivery			
Yes	2.971	1.745 – 5.058	< 0.001
Interventions			
Episiotomy			
No	4.820	2.096 – 11.086	< 0.001
Prepartum oxytocin			
No	1.909	1.053 – 3.462	0.033

Notes: *Hosmer-Lemeshow test: p-value = 0.889; Nagelkerke's R^2 = 0.184.

Source: Survey data, 2020.

In the model, it is noted that the ROC curve (Figure 1) reveals an acceptable discrimination power (area 0.731, CI 0.673-0.789). In addition, the area comparison test was significant (p-value < 0.001), indicating that the use of the model has a relevant difference from the random estimation.

Figure 1 - ROC curve of factors associated with normal delivery care performed by nurses. Vitória de Santo Antão/PE, Brazil, 2020



Caption: Curva ROC = ROC Curve; Sensibilidade = Sensitivity; Especificidade = Specificity; Os segmentos diagonais são produzidos por empates = The diagonal segments are produced by draws.

Source: Survey data, 2020.

DISCUSSION

Surveys conducted in public maternity hospitals in Brazil show similarities with the sociodemographic profile found in the participants of this study. Comprehensively, women with a reproductive age between 15 and 40 years old are observed, self-reported brown, with a steady partner, educational level between elementary and high school and monthly income of up to two minimum wages [10,11]. Thus, it is noticed that the profile of Brazilian parturient women who go to a delivery in the public health care network is similar in most regions of the country.

The WHO encourages the creation of a letter of intent during prenatal care, called the Birth Plan, where the woman declares her aspirations for herself and her baby throughout the birth process, based on good obstetric practices [9]. Nevertheless, in this study, there was a low prevalence of women who prepared it.

Corroborating this, a study conducted with 11 puerperal women in Rio de Janeiro, Brazil, showed that, of these, only one claimed to know about the Birth Plan. Possibly, these data prove the lack of information on the part of women, little knowledge of the professional staff and low encouragement to develop this non-invasive technology in obstetric care [12].

In addition to fostering the women's empowerment and the search for autonomy in the delivery scenario, the Birth Plan is correlated with positive rates of the use of other care technologies, such as skin-to-skin contact, choice of the birth position, free intake of liquids and food, late clamping of the umbilical cord and non-accomplishment of trichotomy and enema [9,13].

Delivery comprises four clinical periods: dilation, birth, discharge and Greenberg [14]. It is common sense that information associated with medical care is essential from the second stage of delivery onwards, even with normal clinical and obstetric parameters. This point of view gains strength when associating it as a probable event of clinical complications.

It was found that some analyzed deliveries had their outcomes recorded by physicians, even though the ON conducted some deliveries during the period before birth, which may justify some study results. The clinical practice of delivery care in Brazil is still centered on the medical professional; however, obstetric nursing emerges as a profession centered on the promotion of good care practices and humanized delivery [8].

It is recommended the inclusion of nurses in the care of low-risk delivery, since they are present in numerous phases of women's life, from consultations in adolescence to the climacteric period, also remaining present throughout their pregnancy-puerperal cycle. Nursing work is premised on respecting the physiology of birth, which provides an adequate reception, influencing the reduction of interventions, as well as favoring women's satisfaction about the received care [6].

During labor and delivery, the presence of a caregiver is a non-invasive care technology that promotes pain relief, as it provides support and reduces maternal anxiety [15]. A study conducted in the southern region of the country shows that most women (51.7%) had a caregiver during labor, but few stayed with him/her during delivery (39.4%) [16]. In the current study, there was greater encouragement on the part of obstetric nurses about this practice.

It is worth emphasizing that monitored women experience reduced labor time and spontaneous vaginal deliveries [15]. Moreover, those who receive continuous support are less likely to undergo cesarean section or to have instrumental vaginal deliveries, with regional analgesia [17]. Accordingly, it is essential to highlight the need for this practice to be carried out by all categories of professionals working in obstetric procedures, in order to ensure this right.

The encouragement of breastfeeding in the first hour was quite prevalent in the nursing category. Both the WHO and the MS portray skin-to-skin contact between mother and child as a fundamental element in the immediate postpartum period, as the newborn learns to suck effectively, is warmed up and receives colostrum, which counts as the first childhood immunization, while that the bond with the mother is strengthened, promoting positive results in his/her development [7-9].

It is noteworthy that breastfeeding provides better quality of life for families, considering that children get sick less, decreasing the number of hospital admissions and the use of medication for the treatment of pathologies. This results in a good family relationship and a consequent reduction in hospital expenses [7-9].

It can be observed that non-pharmacological methods constitute an option to replace analgesia during labor and to advise parturient women to deal with their pain complaints. Among the most widespread, one can

mention: breathing techniques, hydrotherapy (immersion and/or aspersion baths), massage, use of the Swiss ball, auriculotherapy, miniature horses and music therapy [18].

In an analysis of neuroendocrine parameters, it was found that aspersion bath promotes tranquility and stress control, as it decreases cortisol release and increases norepinephrine secretion. In turn, the Swiss ball promotes a reduction in the perception of pain and favors well-being, associated with the increased release of endorphins [19].

Many Brazilian maternity hospitals do not offer women freedom of choice regarding their position during delivery. In the current study, in less than half of the deliveries cared for by physicians, the mother was allowed to choose the position of giving birth. At times, the way in which delivery beds are structured leads the parturient woman to assume a lithotomy position, which is understood as a classic for birth, denoting lack of encouragement and little knowledge on the part of women about their rights.

Moreover, the position of the parturient woman during delivery is highlighted according to advances in research. It is proven that giving birth in a supine position harms both the woman and the fetus during delivery, as it is related to genital trauma, compromised maternal-fetal blood supply (due to the chance of compression of the abdominal portion of the aorta artery and inferior vena cava), in addition to hindering pelvic mobilization, preventing the baby's passage[20].

In this study, most participants whose births were cared for by physicians gave birth in the supine position, pointing to a deficit in the implementation of this care technology, associated with a lack of knowledge on the topic on the part of parturient women.

Conversely, a study conducted in a maternity hospital in Rio de Janeiro showed a frequency of 75.0% of deliveries in non-supine positions, most of which were cared for by obstetric nurses. This information raises the relevance of Nursing in the parturition process through the efforts of professionals to change the context of obstetric practices [21].

Regarding obstetric interventions, episiotomy, prepartum oxytocin, verbal violence and supine position reached a significant percentage for the category made up of obstetricians. Incision made in the vaginal orifice with the objective of accelerating the fetus' passage, episiotomy is still widely performed, despite having a direct relationship with maternal morbidities in the postpartum period, due to predisposing hemorrhages, puerperal infections, dyspareunia and vaginal prolapse [2].

Consolidating, data from the national survey 'Born in Brazil' (*'Nascer no Brasil'* in Portuguese), encompassing 23,940 puerperal women, indicated that episiotomy was performed in 53.5% of women [22]. This procedure is sometimes performed without any prior consent of the parturient woman, constituting physical and psychological obstetric violence that, in addition to perpetuating an interventionist and technocratic model in obstetric care, has been associated with consequences such as iatrogenic effects, increased maternal and infant morbidity, hemorrhage and maternal infection [21].

Prepartum oxytocin infusion, although not recommended by the WHO, is a common practice in Brazilian maternity hospitals, with a view to accelerating uterine contractions. Nonetheless, it is known that this routine procedure hinders the freedom of position and walking of parturient women. In addition, a study conducted in Salvador/BA observed that this technique was feared by women, since it intensifies discomfort and pain [23].

Obstetric violence is shown by negligence in care, physical, psychological and/or verbal attacks. A study conducted in Tocantins revealed dissatisfaction on the part of puerperal women with the received care due to lack of listening, trivialization of pain, devaluation of the woman's speech, as well as insensitivity on the part of professionals [24].

The moment of giving birth in the life of a woman and her family is of immeasurable significance. Delivery is a gradual event, which requires time and patience on the part of the obstetricians who take part in this process, considering that it causes changes not only in the body, but also in the woman's emotional side.

Concerning the assessment of women in relation to the care received during normal delivery care, a study shows satisfaction rates from good to excellent in 77.7% of deliveries, with reports of Kristeller maneuvers and lack of access to non-pharmacological methods for pain relief (82.4%) [22]. Research conducted in Teresina/PI revealed good quality of care from the perspective of puerperal women, even with reports of excessive touches, use of oxytocin and lack of information [12].

It is underlined that many women do not have the necessary knowledge to detect harmful and unnecessary practices in delivery care in the hospital setting, and sometimes do not identify the suffered obstetric violence. Nonetheless, the research result indicated fewer routine interventions (oxytocin and episiotomy) in the care provided by the ON, with respect to the evolution of delivery [25].

Based on the above, it is emphasized that shared and interdisciplinary care is essential for the rescue of quality care, resuming delivery care in a model based on the principles of humanization, in order to enable the exercise of a safe and respectful practice.

CONCLUSION

When analyzing the care technologies used in normal delivery care, it was observed a higher chance of women having free choice as to the position of giving birth in deliveries cared for by an obstetric nurse. The chance of not performing an episiotomy and not being administered oxytocin in the prepartum period was also higher in deliveries cared for by an obstetric nurse. Therefore, care technologies capable of favoring women's autonomy and their individuality in normal delivery were associated with the obstetric nurse, providing opportunities for respectful and safe care.

Even being marked by unnecessary interventions, many women reported safety and had their expectations met regarding the received professional care, showing a lack of knowledge about the delivery care based on scientific evidence.

Finally, it is reinforced the need for a collaborative model of care centered on the woman, with a view to achieving satisfactory levels of quality in normal delivery care in the hospital setting. It is important to infer that the care plan must dialogue with the woman's choices and consider her uniqueness in such a way as to provide respectful care throughout the cycle of pregnancy, birth and puerperium.

The findings of this research have the potential to assist in the improvement of care and in the discussion of variables that affect the quality of care and the safety of delivery, in order to instigate the need to expand the use of good obstetric practices in health services, raising the women's protagonism in the parturition scenario.

As limitations, one can include the use of a cross-sectional model, which makes it impossible to identify cause-and-effect relationships among the explored variables. It is also pointed out that data collection, carried out through consultations of medical records, may compromise the discussion of some variables predicted by the study due to the incomplete filling out of some information. Accordingly, it is evident the need for studies that understand the health care process from the professionals' point of view and the observation of the provided care.

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