OBJECTIVE: to identify the care offered to women, under the watch of humanization in childbirth and puerperium, by nurses. Method: a descriptive, exploratory study with a qualitative approach, with six nurses, who graduated from the Residency Program in Obstetric Nursing at a public university. For the data collection, the interview was used. Then the data was analyzed by the Content Analysis Technique, in the Thematic Analysis modality. Results: it was verified the importance of the professional to offer respect and security through the qualified assistance, making all the possible orientations, so that the parturient feels comfortable and has autonomy when receiving the humanized obstetrical care, and, in this way, feels capable of going through The whole process of childbirth and puerperium in the best possible way. Conclusion: the residents achieved the humanized care recommended by the Ministry of Health (MH) and World Health Organization (WHO). But, despite all arguments about humanization, the predominance of the medicalization of childbirth was evident, hindering the comprehensiveness of humanized care. Descriptors: Students, Nursing; Obstetric Nursing; Humanization of Assistance.

ABSTRACT

THE CARE OF NURSES OF AN OBSTETRIC RESIDENCE PROGRAM UNDER THE SCOPE OF HUMANIZATION

OBJECTIVE: to identify the care offered to women, under the watch of humanization in childbirth and puerperium, by nurses. Method: a descriptive, exploratory study with a qualitative approach, with six nurses, who graduated from the Residency Program in Obstetric Nursing at a public university. For the data collection, the interview was used. Then the data was analyzed by the Content Analysis Technique, in the Thematic Analysis modality. Results: it was verified the importance of the professional to offer respect and security through the qualified assistance, making all the possible orientations, so that the parturient feels comfortable and has autonomy when receiving the humanized obstetrical care, and, in this way, feels capable of going through The whole process of childbirth and puerperium in the best possible way. Conclusion: the residents achieved the humanized care recommended by the Ministry of Health (MH) and World Health Organization (WHO). But, despite all arguments about humanization, the predominance of the medicalization of childbirth was evident, hindering the comprehensiveness of humanized care. Descriptors: Students, Nursing; Obstetric Nursing; Humanization of Assistance.
Humanization is associated with the transformation of the hospital culture, so that care is systematized to address the needs of women and their families; and, also, to make changes in the physical structure, remodeling the hospital space into a more comfortable and favorable environment for the establishment of humanized care practices. The importance of humanization in childbirth has been increasingly studied. In this sense, it is essential to emphasize that the humanization of obstetric care has been lost throughout history. Historically speaking, childbirth, as a natural event, made women share their own experiences and these were becoming familiar and accepting the maneuvers that facilitated the delivery, as well as having knowledge of pregnancy and puerperium with the experience imposed culturally.¹

In the nineteenth century, motherhood was increasingly being exalted, being the dominant discourse of the time. The increasing inclusion of the surgeon in the team collaborated for the medicalization of labor, adopting the position of dorsal decubitus to facilitate the work of the physician and the use of instruments. All of this new process contributed to the dehumanization of care, since there was no human relationship, there was a lack of personal and emotional contact, and the women lost the right to decide about their health and actions related to their own body.²

At the end of the 1990s in Brazil, the concept of humanization began to support the Humanization Program in Prenatal and Birth - PHPN, culminating with the National Humanization Policy - PNH. Thus, it is possible to understand the concept of humanization in two fundamental aspects: firstly, it is the duty of the health units to treat with dignity the woman, their relatives and the newborn, in an ethical and supportive way on the part of the health professionals and the organization of the institution, in order to generate a welcoming environment and to institute hospital routines in order to undo the traditional isolation determined to the woman.³

The humanization of childbirth care aims to be as natural as possible, within a relation of respect to the mother and child binomial, so that the women have the opportunity to manage their biological function through their mind and body, not to say that, the technological resources cannot be used in the limit moments.⁴

In this model of care, a minimum of intervention was recommended, in the delivery assistance, as advocated by the World Health Organization (WHO). If there is a need for intervention, the client needs to be explained to the client about her real need.⁵

In this context, the possibilities and challenges that emerged with the proposal of humanization at childbirth had to increase the visibility of the role of nurses, that more radical changes occurred to the implementation and success of these proposals, since they require investments in the scope of training and performance of these professionals. Thus, it is still verified that, for this model to be reached, it will be necessary for the nurse to be committed to add to the component of care, educational and humanized interventions to women in the pregnancy-puerperal cycle. Nursing, through the reception, bonding, guidance and professional satisfaction, obtains a recognition and offer of new non-pharmacological techniques that guarantee a humanized delivery with the minimum of pain.⁶

Thus, with the focus on the humanization of the birth and delivery process, the Ministry of Health established the Ordinance MH/GM 2,815 of May 28, 1998, which includes, in the table of the Hospital Information System of UHS, the procedure “normal delivery without dystonia performed by obstetrician nurses” that has, as main goal, to recognize the assistance provided by this professional category.⁷ Since then, the work of these professionals has been encouraged by national health policies, including the Ministry of Health, has technically and financially encouraged the realization of specialization courses in Obstetric Nursing, due to the compatibility of this training with the contemporary tendencies of attention to gestation, childbirth and the puerperium, which is the humanized care itself. Consequently, obstetrician nurses are occupying greater spaces in care and gaining visibility, mainly, by the humanization of care in a qualified manner.⁸

Obstetric nurses are able to overcome the interventionist care model and develop noninvasive skills that are peculiar to this humanized and de-medically assisted model of care for the pregnancy-puerperal cycle. These are responsible for the cultural change for the realization of sensitive and humane care in the care of women who experience this process.¹

It is essential to prepare professionals before the implementation of the policies of humanization of childbirth, but it is also
essential to raise the awareness and constant training of obstetrical teams to validate this model.8

Therefore, the care of nurses of a National Obstetrical Nursing Residency Program was studied, under the guise of humanization, during the process of labor, birth and puerperium, in a hospital in a city of Minas Gerais.

OBJECTIVE

- To identify the care offered to women, under the watch of humanization in childbirth and puerperium, by nurses.

METHOD

A qualitative, descriptive, exploratory study, with six nurses (total number of students enrolled in the course), graduates of the Residency Program in Obstetric Nursing who cared for parturients and puerperas in a hospital in a city of Minas Gerais (MG), Brazil.

It was decided to research these subjects, with the purpose of knowing the experience of the care of the humanization applied in practice, in the development of the residence course. The residents were identified with flower codenames, chosen by the participants themselves, thus ensuring the anonymity of the study population.

For data collection, a semi-structured interview was used, which was recorded and transcribed later. It was directed by a roadmap for the interview, after a pilot test, in the pre-research phase, and it is shown that it establishes the profile of the respondents and a guiding question.

The interview was applied by the study's researcher from May to July 2015, trying to understand the information of the respondents, as well as to the environment, facilitating the availability of information.

In the process of data organization and analysis, all interviews were reliably transcribed, then, coded and analyzed.

In order to analyze the data from the open-ended questions, they were submitted to the Bardin Content Analysis and adopted the following steps: 1. pre-analysis; 2. exploration of the material and 3. treatment of results, categorization and interpretation9. The first phase was devoted to the organization and systematization of collected data and ideas, making what Bardin calls "floating reading", with which the points considered relevant for the understanding of the searched object were highlighted.

Then, the analytical description of the data was made, highlighting the relevant parts of the collection. A more detailed study of the interviews was carried out, articulating it with the objectives and the theoretical reference of the humanization policies to the delivery and puerperium of the Ministry of Health and World Health Organization, constituted for the research. At that moment, the axes of analysis were established. In the third moment, called interpretation, the data was analyzed, in order to deepen the researched topic and defining which lines, in the interviews of the residents, could be interpreted according to the axes of analysis already established.

Thus, successive readings of the produced material were carried out. Subsequently, the interviews were coded and analyzed according to the following steps: floating reading of each one of the answers and ordering them; vertical interpretation (interpretation of each resident) and horizontal (comparisons and contrasts between the data collected from residents) and final analysis. Subsequently, the data obtained were discussed among themselves and compared with the literature.

The research project was submitted to the Brazil Platform, which was appreciated and approved by the Research Ethics Committee of the Federal University of Alfenas UNIFAL - MG, according to opinion no. 975.752, of December 17, 2014. All the study population signed the TCLE, Participate in the survey.

RESULTS AND DISCUSSION

Six residents of the Nursing Residency Program of the Ministry of Health of a Public University were interviewed. After the interviews, the data was organized to characterize the questioned population, as shown below:

The characteristics showed that the age varied between 25 and 47 years, predominating the age group between 25 and 27 years. Regarding the time spent in Nursing, a predominance of three to four years was obtained by the residents, that is, they are newly formed residents, whereas only one, with more experience has been active for 18 years. As for the time that they have worked in obstetric nursing, two worked only during the residence, which were two years, and four residents have been working for more than two years. Under the work regime, two work 12/36 hours, one carries out teaching for 26 hours a week and another does not work at the moment.

As for having attended or being enrolled in Post-Graduate courses, two have specialized in 360 hours and two are studying for a
master's degree. Regarding the Civil Status, the vast majority are single (four), one is married and one is judicially separated. Regarding employment relationships, three have only one and three do not have any, because they do not work. Regarding the form of contract in force in the health institution, three are in the CLT form and the other three of them the questioning does not apply, because they do not work in a Health Institution.

About the type of institution where they work, two work in private for-profit and one, in philanthropic; in the same way, the questioning does not apply to three, because they do not work in a health institution. Only one dedicates 26 hours to professional teaching activities.

There is an exclusively female population, with only one interviewee bringing experience to the area.

The categories were elaborated so that it was possible to express, more strongly, the statements of the interviewees, allowing to organize the material obtained, ensuring the understanding of the constituent elements from their lines, as well as facilitating the availability of the information.

Next, each of the thematic categories found in content analysis will be presented and discussed:

Humanized obstetrical care offered by resident nurses and facilitators of the promotion of autonomy and respect for women;

The non-pharmacological methods of pain as an alternative to a more natural assistance for the comfort of parturients;

Prevalence of the medicalization of childbirth: blockade in humanized obstetric care.

**Humanized obstetrical care offered by resident nurses and facilitators of autonomy and respect for women**

It can be seen that the residents, by their humanized care, gradually, conquered their space. In order to make the process more natural and humanized, respecting all its stages, Obstetric Nursing gradually, assumes its space, either by the quality of care provided or by the academic contribution and specializations.  

The humanization of care during the birthing-birth process mainly includes that the obstetrician nurse respects the aspects of the physiology of the woman, and it is essential that non-pharmacological pain relief be explored because they are safer and avoid the need for so many interventions. The importance of Nursing was highlighted, in the residents' speeches, as having a primordial role in the accomplishment of these care, providing the parturient pain relief and making the humanized childbirth, so that the woman can experience, in the best possible way, this singular moment that is the birth of her child.  

The evaluation of the interviews with the residents allowed us to identify that the humanization within the hospital context begins with the admission and acceptance of the woman, in the identification of the woman, seeking to apply the empathy and to pass all comfort and security so that, this woman's confidence can be won. One of the residents emphasizes the importance of the professional putting safety through qualified care, guiding that the pain that the woman is feeling is physiological and normal, so that they know and confess that they are able to go through the entire process of childbirth-Birth in the best possible way. In this way, there is recognition of the quality of these care of the resident professionals by the patients and want them to return.

It is important to address the respect that should be had with the patient during all stages of the parturition process. Let them choose the preferred position for each moment, the exercises they want to accomplish, what they want to do in this unique moment. Let it be "owning its own body", giving it all autonomy. This is essential for respect to be created, and, thus, there is the bond between the professional-patient and also with the family. All these notes are noted in the speeches, as explained below:

**The humanized care that I sought to apply was an empathetic welcome, it was to pass on patient security, confidence, to awaken in her that my desire to be part of that moment as an aid, as a support, and thus depositing in her the confidence that she is capable. And I've always used that term: your pain is normal, it's a physiological pain, this pain is not a problem, it's okay, it's a pain of well, it's a normal pain. Then it seemed to comfort him. [...] So they could talk: I can trust that person, that person is here with me. So much so that some of them asked: are you coming back? Are you coming tomorrow? Understood? So, I feel that I have made a difference in the issue of humanization. (Daisy)**

**Let her choose a little bit and be her owner, not only in the exercises she will perform but in the choice of position, who wants to stay with her, how she wants to stay. (Lily)**

**As a form of humanization, I believe it was the respect of the woman during childbirth**
The care of nurses of an obstetric...

The involvement of the family member in this process of labor, not only the creation of the bond, but also involve the family member or partner in this process. (Violet)

The patient's free choice companion represents a bond with her home environment, leaving a comfortable presence, physical contact, dividing fear and anxiety, to positively, stimulate, the patient in difficult times. Thus, the interviewees showed the importance of the interaction of the companion also with the care, for example, of them to do the massage technique if the patient wanted, thus, involving them in this process. In this sense, it can be seen that the study residents are thus identified as responsible for making the companion proposal a reality.13

It was also evidenced, in the interviews on the experience of the practice of skin-to-skin contact, according to Ordinance No. 371, of May 7, 2014, art. 4, that determines the immediate and continuous skin-to-skin contact, placing the infant on the abdomen or chest of the mother, according to their wishes, on the stomach and covering it with a warm, dry covering, in which the ambient temperature should be Around 26 degrees to avoid heat loss14, as shown below:

The promotion of skin-to-skin contact with the RN, that we got a lot too. (Orchid)

Skin-to-skin contact, creates an excellent environment for the newborn to adapt to extrauterine life, as it calms the baby and the mother who are in tune; Helps stabilize blood, heart rate and breathing of the child; Reduces the crying and stress of the newborn, with less energy losses, and keeps the baby warm by the mother's heat transmission, and is considered a potential resource for the promotion of early breastfeeding.15

Nursing enables the initiation of contact and help the woman in this first recognition of the mother-child binomial, providing more security and freedom for the woman to request help, whenever necessary. Thus, skin-to-skin contact was a humanized practice that the interviewees were able to promote during their stay.15

It was verified that another Obstetric Nursing care that the residents were able to implement was the late clamping of the umbilical cord, as commented lower:

The late section of the umbilical cord timely, we got it too. (Pink)

This practice is seen positively when evidence of iron levels in the child is strongly induced by total body volume of iron at birth, and the timing of umbilical cord clamping can affect the volume of blood transferred from the placenta to the newborn and, consequently, the total volume of iron. Late clamping, compared to immediate clamping, contributes to higher hemoglobin concentration and lower incidence of anemia at four months of life and higher iron stores at six months.16

Another, successful care provided by the residents, was the promotion of breastfeeding in the first hour, and also to assist postpartum women who had difficulties, an act recommended by the World Health Organization (WHO) and corresponds to Step 4 of the Baby-friendly Hospital Initiative (BFHI), Which is interpreted as: putting the newborn (NB) in skin-to-skin contact with their mothers immediately after delivery for, at least, one hour and encouraging mothers to recognize when their babies are ready to be breastfed. This care was also understood as an expressive practice of humanization carried out by residents:

Stimulate breastfeeding, when they had difficulty, sometimes the RN did not pick up right away and we could do some pretty cool work as well. (Orchid)

 [...] The first hour after childbirth we tried to promote breastfeeding. (Lily)

This study shows that this is one of the priority strategies for the promotion, protection and support of breastfeeding in Brazil and is based on the ability of newborns to interact with their mothers in the first minutes of life. This contact is essential for the establishment of the mother-child bond, thus increasing the duration of breastfeeding:
the prevalence of breastfeeding in hospitals; and the reduction of neonatal mortality.16

Regarding the Nursing orientations, it can be seen that the residents prioritized to carry out the guidelines from the first moment, clarifying all the doubts that arose, as much as the physiology of their organism would be reacting at all times, as to clarify any and all procedure that was carried out, always explaining in advance, for that woman not to be unprepared, as shown below:

We performed the procedures as smoothly as possible. Because most of the patients we took were completely unprepared, had a prenatal care without knowing what was going on inside it and what was going to happen. (Daisy)

Within the humanized care, I believe it is whatever the woman in the parturient lived better this moment, so, at first, I believe that it is the orientations, the clarifications, of each moment that she was living, as that her body could be reacting and then To offer her some means so that she could experience that moment perhaps with greater control of her own body, with more control of her own pain. (Bromeliad)

The care, I think the basics of obstetrics, care, humanization comes based on what we will tell her what we are doing, explain to her every procedure starting there in admission until what will happen, because I think the great knot of obstetrics nowadays is women being afraid of the uncertain and what the background tells them, the obstetric history of how it happened. (Lily)

In one of the statements, the interviewee reports that the women arrived in the institution completely unprepared, without having the necessary guidelines during prenatal care. So, the residents had an important role to make such orientations throughout the process.

The implementation of educational actions, during all stages of the pregnancy-puerperal process, is very important, but it is during the prenatal period that the woman would have to be better oriented so that the process takes place in a positive way, thus, having fewer risks of complications in the puerperium and more successful in breastfeeding.19

Moreover, in another interview, it was verified that the resident speaks of women's fear of what will happen, because of what has already been told to them, and so it is necessary to give more emphasis to the importance of the guidelines throughout this process.

It can also be perceived that the relationship between humanization and Nursing care exists and it is up to each professional to be truly present in the reality of their care, as shown below:

The Nursing care I think encompasses all this, not only a ball exercise, a bath, but the way to deal with the patient, the care, contact and knowledge too, because I think humanized care only comes from the moment That we have science and not just care, so I think caring is very easy, Nursing has to go beyond caring, caring is an art, but it has to be based on science. (Lily)

And it is necessary to capture care in its broadest sense, which is how to be, how to express oneself, how to relate oneself, with others and with all. These issues that must be discussed and reflected among all nurses who seek to apply the principles of humanization.20

In analyzing the care taken from the content analysis of interviews, unfortunately, it is noted that these have been offered, basically in the period of prepartum and childbirth. So, the puerperium still remains almost no one, since it was approached with assistance only in two moments, in skin-to-skin contact and in breastfeeding, quite subtly and by few residents.

Therefore, in order to have a humanized care in the best possible way, it is cru, applies this knowledge to help women achieve a comprehensive health promotion Quality of life.20

♦ The non-pharmacological methods of pain as an alternative to a more natural assistance for the comfort of parturients

When analyzing the interviews of the residents regarding the non-pharmacological methods of pain relief, one can see that they were able to perform them within the limits allowed to them in the institution. Some care they managed to implement, acquiring resources such as the Swiss ball, acquired by the university, or else performed some care improvised.

It was emphasized, in the speeches, to perform the care with the minimum of possible interventions. This action is strengthened by verifying that non-pharmacological care has been praised as a strategy to replace the possible use of anesthetics and analgesics during labor. In this way, the multidisciplinary health team should reflect the extent to which an intervention is really necessary.11 Some notes were made on the interventions performed. These are mentioned below:

Exercise on the ball, do some exercises with them, lumbar massage, the sprinkler bath. We managed to implement the Swiss ball in the hospital, because until then it had not.
Respect for the choice of position during labor should be free to be able to wander and take whatever position she wants. (Pink)

In labor, all that is possible within the institution, the wandering, the massage, whatever she chose, offered her shower, however she wanted, whatever time she wanted. [...] This is all according to their will. [...] We used the combination of the Swiss ball together with the massage. (Orchid)

[...] Another caution I observe is the minimum of possible interventions. [...] We had no way of offering all non-pharmacological methods, but, with what we had implanted and what we did not improvise. So, we used the ball, massage technique, the bath, the music we got to put on when some of them accepted. (Violet)

The care provided by the interviewees was: exercise on the Swiss ball, sprinkler, massage, assisted walking, music therapy. The benefits of these uses are mentioned:

The use of the Swiss ball promotes the stretching and active exercises of circumference, anteversion and pelvic retroversion, which favors the more active participation and the overall relaxation of the woman, thus, leaving the process of parturition calmer and serving as support for other techniques, such as, massage and a shower. [22]

As for the spray bath, it promotes the relief of the painful sensation, relaxing and favoring the comfort of the woman. Regarding lumbar massage, they report that it is effective in helping to reduce the intensity of pain during labor. [22]

As for ambulation, the vertical position has been used and preferred since antiquity to allow less pain throughout the parturition stages. Decreases time, improves uterine contractility and offers more comfort to women, as well as ensuring maternal-fetal-placental changes longer, thus reducing the risk of fetal distress. [23]

On the use of music as a humanized care, it awakens feelings of tranquility and calm, which helps in relaxation and pain relief. [24]

With this experience, it is possible to perceive, in the speeches, how essential respect for the woman in the birth-process is essential, always leaving them free to choose which method of pain relief feels safe and comfortable to perform, according to their will and your time.

♦ Prevalence of the medicalization of childbirth: blockade in humanized obstetric care

It was noticed, however, that, during the residence in the hospital area, there is still an interventionist culture clearly, the medicalization of childbirth. The preceptors are the obstetrician nurses, but, the patient is admitted to the care of the medical professional, and, from these, it was evident in the speeches that there is still a lack of integration with the resident nurses, since the work should be multiprofessional, with the same focus is a humanized and qualified care. However, what is perceived is that only a doctor has more proximity to the residents and shares a little more of the philosophy of the humanization of childbirth and puerperium, but, even though it is a great incentive and have offered great support to the Residency Program, it still maintains medicinal and conservative practices:

At the time of delivery, no, at the time of delivery it still remains in the traditional mode. [...] The issue of childbirth unfortunately without being lithotomy yet not, but the contact with the RN yes. (Pink)

And as for the doctor, it was quiet, we had a great support from an obstetrician who practically hugged us. (Daisy)

The free position is only during labor, during birth we could not offer different positions for her, only during labor as she wanted to stay we always oriented the best positions, but it was her choice as she wanted to stay. (Orchid)

Even though there is enough scientific evidence for changes in the traditional medical model of childbirth care, demedicalizing it causes a loss of power, since most obstetrician physicians see deliveries as risky situations, requiring medical follow-up. However, the humanization of the parturition process is a challenge that the medical professional needs to overcome in order to modify the routine of assistance to low-risk births, acting only in the field of obstetric pathology. [25]

CONCLUSION

It is possible to perceive that the residents, by their humanized care, gradually conquered their space, and this was due to their knowledge based on science and put into practice when they tried to fight for the effectiveness of the humanization policies, and, thus, to make a Quality assistance. Residents were able to carry out many of the humanized care advocated by the Ministry of Health (MS) and the Muldial Health Organization (WHO), among them, the creation of the link with the patient from the moment of their reception, through empathy and respect, always prioritizing their
autonomy, making all the necessary guidelines, so that, the residents also conquered the women and they felt safe and comfortable.

The non-pharmacological methods for labor pain relief that they were able to perform were: Swiss ball exercise; sprinkler bath; massage; assisted walking; music therapy; also managed the presence of the companion; skin-to-skin contact; delayed clamping of the umbilical cord, and to promote breastfeeding in the first hour.

By experiencing the establishment's routine, it was perceived to be different from what the residents believed would be ideal for humanization, as it was not within the interventionist cultural standards of health professionals. It was concluded that, despite all arguments about humanization, the predominance of the medicalization of childbirth was evident, hindering the integrity of humanized care.

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