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RESEARCH

ASPECTS INVOLVED IN THE PROTAGONISM OF WOMEN IN LABOR AND CHILDBIRTH

ASPECTOS IMPLICADOS NO PROTAGONISMO DAS MULHERES NO TRABALHO DE PARTO E NO NASCIMENTO DO BEBÊ

ASPECTOS QUE INTERVIENEN EN EL PROTAGONISMO DE LA MUJER EN EL TRABAJO DE PARTO Y EL PARTO

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ABSTRACT

Objective: to understand the potentializing and limiting aspects of women's protagonism in labor and childbirth. **Methods**: qualitative research carried out in the maternal-infant unit of a Teaching Hospital. The study included 22 women admitted to the unit and 21 Nursing professionals. Data collection took place through semi-structured interviews. Data were subjected to thematic analysis. **Results**: aspects that enhance the protagonism of women were listed: attention, clarification of questions, respect for choices; and care based on scientific evidence. The aspects that limit the protagonism were lack of engagement of physicians in actions aimed at the humanization of childbirth; devaluation of women's speech; aggressive placements; and physical space constraints. **Final Considerations**: for women to be protagonists of childbirth and exercise their autonomy through conscious choices, prenatal health education is necessary. This education should include guidance on labor and the rights of pregnant women, conversations, and clarification of questions, in an empowerment process.

Keywords: Women; Parturition; Labor, Obstetric; Personal Autonomy; Empowerment.

RESUMO

***Objetivo**: compreender os aspectos potencializadores e limitantes do protagonismo das mulheres no trabalho de parto e no nascimento do bebê. **Métodos**: pesquisa qualitativa realizada na unidade materno-infantil de um Hospital Escola. Participaram do estudo 22 mulheres internadas na unidade e 21 profissionais de Enfermagem. A coleta de dados ocorreu por meio de entrevista semiestruturada. Os dados foram submetidos à análise temática. **Resultados**: elencaram-se como aspectos que potencializam o protagonismo das mulheres: atenção, esclarecimento de dúvidas, respeito às escolhas; e cuidado pautado em evidências científicas. Já os aspectos que limitam o protagonismo foram: falta de engajamento dos médicos nas ações direcionadas à humanização do parto; desvalorização da fala das mulheres; colocações agressivas; e restrições do espaço físico. **Considerações Finais:** para as mulheres serem protagonistas do parto e exercitarem sua autonomia por meio de escolhas conscientes, é necessária a realização de educação em saúde no pré-natal. Essa educação deve contemplar orientações sobre o trabalho de parto e os direitos da gestante, conversas e esclarecimentos de dúvidas, em um processo de empoderamento.*

***Palavras-chave:** Mulheres; Parto; Trabalho de Parto; Autonomia Pessoal; Empoderamento.*

RESUMEN

***Objetivo**: evaluar la eficacia de una actividad educativa online sobre lactancia materna para el Objetivo: comprender los aspectos potencializadores y limitantes del protagonismo de las mujeres en el trabajo de parto y nacimiento. **Métodos**: investigación cualitativa; realizada en la unidad maternoinfantil de un Hospital Escuela. Participaron 22 mujeres internas en la unidad y 21 profesionales de Enfermería. La recopilación de datos se realizó mediante entrevista semiestructurada. Los datos se sometieron a un análisis temático. **Resultados**: se eligieron como aspectos que potencializan el protagonismo de las mujeres: la atención, la aclaración de dudas, el respeto a las elecciones y el cuidado basado en pruebas científicas; aspectos que limitan el protagonismo: la falta de compromiso de los médicos en las acciones dirigidas a la humanización del parto, la desvalorización de la fe de las mujeres, las actitudes agresivas y las restricciones del espacio físico. **Consideraciones finales**: para que la mujer sea protagonista del parto, ejerciendo su autonomía a través de elecciones conscientes, es necesario realizar educación para la salud en el prenatal, orientándola sobre el parto y sus derechos y conversando y aclarando sus dudas en un proceso de empoderamiento.*

***Palabras clave:** Mujeres; Parto; Trabajo de Parto; Autonomía Personal; Empoderamiento.*

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INTRODUCTION

Childbirth is a physiological and social event that transcends the medical occurrence. For this reason, assistance should be centered on women's needs, considering their rights and their active participation in the parturition process.[1,2] However, these rights are not always respected, given the technical and technological interventions and the wide use of technology. cesarean section as a routine way of delivering a baby. Therefore, the current model of obstetric care is marked by the control and dispossession of women's bodies, making it impossible to exercise their autonomy and assume a leading role in childbirth.[3]

Briefly, Brazil has one of the highest rates of cesarean sections, which represents a true epidemic. In 2015, the country reached a rate of 55.5% of cesarean sections in the total number of deliveries performed. In the South region, the rate of 60.54% was reached; in the state of *Rio Grande do Sul*, this rate was 64.4%, contrary to the 15% of cesarean sections recommended by the World Health Organization (WHO).[4]

Thus, the high number of cesarean sections in Brazil indicates the relevance of the current discussion on interventions in childbirth, especially in relation to the occurrence of unnecessary cesarean sections. In this sense, the cesarean section by choice emerges as a consequence of a medical and institutional culture that marked obstetric care, due to the occurrence of negative experiences, such as the absence of a companion, the delay in the time of admission and the absence of techniques for the relief of the pain. Such experiences correlate with the request for surgery, not being a real preference for women.[5]

In view of this, the WHO proposed the adoption of good practices in labor and birth care, encouraging the use of proven useful actions instead of harmful and/or ineffective ones. The WHO also recommended caution regarding practices based on little scientific evidence, discouraging inappropriately used ones. In addition to making it possible to rethink the obstetric model, good care practices during delivery and childbirth encourage respect for women's autonomy during childbirth and the rescue of her role.[6,7]

Respect for women's autonomy is closely related to guaranteeing their right to choose in the birth process, offering and ensuring an informed and conscious choice regarding the risks and benefits of their decisions. In other words, the instrumentalization of the woman is assumed so that she can, in fact, (re)assume the main role in the childbirth scenario, the role of protagonist.[7]

Therefore, being a protagonist entails exercising your power of reflection and decision throughout pregnancy, empowering yourself in such a way as to feel able to actively act in controlling the relationships of everything that involves the moment of childbirth and in the defense of your rights.[8] In this sense, researchers point out that the protagonism of women can minimize unnecessary interventions.[7]

However, a survey investigated what were the contributions of the Nursing team, during prenatal care, to encourage female empowerment in the natural parturition process. As a result, it was found that the strategies used did not offer enough knowledge for the exercise of female autonomy, due to the absence of a dialogue based on scientific evidence and reflections regarding the role of women.[9] In the opposite direction of this role, the number of of barriers to the execution of humanized actions in childbirth care in health services, such as inadequate physical structure and accommodation, reduced Nursing team, lack of material, overcrowding and lack of knowledge or awareness of professionals.[10]

Considering the challenges for the adoption of good practices in childbirth care and the humanization of childbirth care, this study seeks to answer the following question: What are the potentializing and limiting aspects of women's protagonism in labor and childbirth? birth of the baby?

OBJECTIVE

Understand the potentializing and limiting aspects in the role of women in labor and childbirth.

METHOD

The present study is a part of the macro-research entitled "Ambience of the maternal-infant unit: perception of users and Nursing professionals", which complied with Resolution 510/16 of the National Health Council of the Ministry of Health, directed at research involving human beings. The aforementioned macro-research was submitted to Plataforma Brasil for consideration by the Research Ethics Committee (REC), being approved by the Certificate of Ethical Presentation and Appreciation No. 08879619.3.0000.5316, Official Letter No. 3.219.877, on March 25, 2019. After being clarified about the rationale, endpoints, risks and benefits of the study, the participants expressed awareness and agreement to participate in the study, by signing the Free and Informed Consent Form (ICF). This qualitative research had an exploratory and descriptive character, using the Consolidated Criteria for

Reporting Qualitative Research (COREQ) instrument to guide its methodological construction.

The present research was carried out in the maternal and child unit of a Teaching Hospital (TH) located in the south of the country. In all, the research had 43 participants, 22 women hospitalized in the maternal-infant unit and 21 Nursing professionals working in this unit, constituting a convenience sample. In it, we sought to capture the perception of the different actors involved in the process of labor and childbirth in the hospital environment, in which the woman is seen as a client while the Nursing professionals are in the position of those who offer care. The number of participants was determined by data saturation: when new elements cease to emerge, it is inferred (even provisionally) that the internal logic of the object of study has been found, and therefore it is no longer necessary to continue with the collection.[11]

Inclusion criteria were: a) for women in the pregnancy-puerperal period: being over 18 years old; being hospitalized in the TH maternal and child unit; be clinically stable; communicate verbally in Portuguese; and consent to the dissemination of data in scientific circles; b) for Nursing professionals: being a nurse, Nursing technician or assistant; and to be working in the maternal-infant unit for at least six months. Following the exclusion criteria, there are: pregnant and puerperal women in clinical conditions that would make it impossible to carry out the interview; and Nursing professionals on vacation or sick leave during the data collection period. Also, three refusals to participate in the research were recorded, 2 from professionals and 1 from a hospitalized woman.

The women were approached during hospitalization, in the first half of 2019, according to days previously agreed with the nurse responsible for the sector. Nursing professionals were selected in the work unit itself through prior contact, and an invitation was made to participate in the study.

Data collection took place through semi-structured, single and recorded interviews, with an average duration of 12 minutes. It was guided by a script that explored information regarding the characterization of the participants. It was considered which aspects should be valued when aiming at the protagonism of pregnant and puerperal women hospitalized in the maternal and child unit, as well as which aspects the environment of this unit should provide to women so that they feel respected and have their opinion valued.

The collection was carried out by a team composed of two Nursing students and a nurse with no connection with the researched unit. All were previously trained for this purpose. Data were collected in the examination room or in another room available at the time of the interview, in order to provide privacy to the women and Nursing professionals interviewed.

After transcribing the interviews in full, the Nvivo 11 software was used to organize and process the data, since it helps in the analysis of qualitative material, since it has tools for coding and storing texts.[12] It should be noted that the Anonymity of the participants was guaranteed, who were identified by the letters M, for "woman", and P, for "Nursing professionals", followed by Arabic numerals indicating the serial number of the interview.

Data were subjected to thematic analysis, seeking to find repeated patterns of meaning. Thus, a detailed and differentiated description of a specific theme or group of themes was possible.[13] From this process, the following themes emerged: i) aspects that enhance the protagonism of women in labor and birth; and ii) aspects that limit the role of women in labor and childbirth. Both themes had six recording units, which comprise the set of phrases relevant to the analysis of the themes. Subsequently, the results were discussed in the light of up-to-date studies relevant to the studied subject.

RESULTS

Sociodemographic characteristics of the participants

The study had the participation of 22 women, aged between 20 and 42 years, of which 14 were single, 7 married and 1 divorced. White race/color was predominant, with 17 women, while 4 self-declared black and 1 brown. With regard to education, 4 had incomplete Elementary School, 6 complete Elementary School, 1 incomplete High School, 9 complete High School and 2 complete Higher Education. Of the total number of participants, 13 women claimed to have a job and 9 were engaged in domestic activities at home.

Nursing workers are predominantly female, 20 women and 1 man, aged between 28 and 54 years, with the majority age group between 30 and 42 years. Of the total, 10 are nurses and 11 are Nursing technicians, whose time working in the maternity ward ranged between 1 and 15 years, with an average of three years of experience.

Aspects that enhance the protagonism of women in labor and birth

The women in the study point out that the professionals' concern with their health status, attention, being together, respect, clarifying doubts and affection in the

treatment make them feel valued. This provides a feeling of security during the hospitalization period.

> *We feel valued in here, everyone is very attentive* [...] *when they talk to us with affection, with respect, just like yesterday I was crying because I hadn't seen my baby, they came and calmed me down and they said I would see* [the baby] (M11).

> *Look, above all they respect us. For sometimes we arrive in a situation of pain and they understand and respect us. And they do their best too as there are a lot of people.* [...] *it is respect for people, for human beings* (M3).

> *They listen to me a lot, they listen to our questions, our complaints. The Nursing staff was always close by, asking how I was doing, despite the fact that it was a super quick childbirth, I felt welcomed* (M22).

For Nursing professionals, it is important to ratify women in their role as protagonists in childbirth, through words of encouragement and support. They also point out that it is necessary to respect individuality, as each woman will reach her potential in a unique way. Therefore, it is important to emphasize that there is no way to standardize care, since each woman, each body, has its needs and expression. Therefore, it is up to the professional to encourage them to exercise their role and make themselves available to help them in the childbirth process.

> *I think the important thing is for you to show her that she is capable; is to verbalize to her.* [...] *the way you approach it from pre-delivery, delivery and the puerperium, you have to show her that it depends on her, but that we are here to help. But that she is always ahead* [in every situation] (P7).

> *The most important thing is to say and show that she is capable of her way, soon the way that I think is best for her is not. The most important thing is to show her that she is capable, verbalize it. Sometimes, it's just a word of encouragement and she succeeds* (P16).

Assistance to women in the pregnancy-puerperal period requires constant professional updating, so that their practice is based on scientific evidence. In this way, it becomes possible to offer care and choice possibilities to women based on the best knowledge available so far.

> [...] *that our practices are based on evidence, although some professionals do not understand this. However, she can be grounded and knowledgeable, and we have a duty to offer her everything that we believe will benefit her and the baby, so that she has the opportunity to choose instead of us choosing for her* (P8).

As an ideal aspect to value and encourage the protagonism of women, professionals point out the need to offer actions recommended by the WHO and the Ministry of Health (MoH), understood as good practices in birth care. Such actions are: visit to the maternity ward; companion of free choice; suitable ambience; non-pharmacological methods for pain relief during labor; free movement and decision on the most comfortable position to give birth; availability of PDP room and bed (pre-delivery, delivery and post-delivery); labor monitoring; containment of unnecessary procedures; and minimization of separation between mother and child.

> *The ideal is what WHO brings to MoS, especially the parturient's privacy. So, an environment where she has privacy where she can have familiarity. That's the reason for the visits to maternity wards, so that they feel familiar with that environment. To know they have people they trust and they would like to be there* [for them]. *The law-based companionship. We also try the issue of penumbra to help the release of oxytocin, so that she feels at ease, so that she does not have external stimuli and can enter "childbirthland", as we say. Of course, we don't have PDP beds, which would be ideal, a room where the patient could be there during the pre-delivery, delivery, post-delivery, without having any interruption of the mother-baby bond, without having any external factor that influences that work childbirth, but they are ideal factors* (P20).

> [...] *the team itself tries to provide maximum comfort in this sense, experiencing a better position, trying to make the decision on how They* [the women] *want to give birth, relaxation in the shower, a little warm water for them to relax, massage* (P5).

> *So, there's the companion, we explain the mechanism we have here like the shower, the pilates ball. We explain to them how pain relief works and they are enjoying it. They walk, they are no longer restricted to the bed. Of course, you have to see how the dilation is, we do the childbirthgram, see the FHR's* [fetal heart rate], *everything is right. See the conditions. If we can go to the shower, let's go to the shower, if we can make the ball too. And so, we explain all this and she says yes or no. I think this values their protagonism, for them to participate* (P17).

In addition, the women explained that respect and recognition of their choices regarding their bodies and

their sexual and reproductive health influenced the way they perceived their participation in the hospitalization process and in the decisions that permeate it. For healthcare professionals, respect for women's choices means empowering and recognizing them as protagonists of the childbirth, providing positive memories of this exquisite moment.

> *Anything they are going to do they ask if you [the healthcare professional] allow it, if you feel like it, it's not against your will, that in any procedure, in everything they ask for your authorization* (M7).

> *Respect what I wanted, my will, you know? That was interesting. The opinions I gave were valid. They didn't give any other opinion like that. They really made me feel at ease* (M3).

> *Working with women on empowerment in relation to childbirth, they choose the way they want and what they want to do. If they want to shower, if they want to walk, if they want to go to the ball, who should go with them? I think this protagonism has to be always encouraged, because it's a unique moment; they will never forget* (P2).

> *We have to be attentive to these details, even if it is urgent or not. She* [the parturiente] *has the right to be the protagonist of that moment; how it will be, who will enter, make their birth plan* (P14).

In this regard, women's empowerment is a reflection of how much the team feels empowered, how much the professional believes that the way he/she performs his/her work can be the differential in assisting women.

> *I really believe that if the team is empowered, it makes the women* [the parturientes] *to be empowered too. The team also believes, if I do my job this way it will make a difference for the woman* (P8).

> *All* [the professionals]*, at least the ones that assisted me, showed love for the profession. And I believe that, because they are valued, they are also able to pass this on to the patient* (M4).

Aspects that limit the role of women in labor and childbirth

The participants report that the physical space does not provide privacy for women, especially in the pre-delivery period. Although healthcare professionals pay attention to women's privacy during examinations, there is still a need for partitions between beds in order to minimize women's exposure and avoid embarrassment.

> *I think that labor room is really cool, what bothers me a bit is the functionality as it could have more privacy between the beds. Also, I don't know, I felt a little awkward in some situations, but everyone was really nice to me. But, I think that if there were divisions it would be very important* (M9).

> *What is complicated here is pre-delivery. It is a space that offers two beds, and when you put two mothers there, one constrains the other. One is pooping the other is vomiting. The husband of one cannot accompany that childbirth because he will pass by the door and see the other* [mother] *naked* (P4).

> *I think the pre-delivery needs to be improved, women have no space there and They are listening and watching each other* (P21).

According to the healthcare professionals, the space, in addition to interfering with women's privacy, intrinsically establishes a determined time for the woman to give birth, as there is a need to release the delivery room as soon as possible so that the unit's demand is met. In this way, both the woman and the professional are stressed to live the experience within an institutional time that dehumanizes and mechanizes labor and childbirth.

> [...] *you have to give birth soon to be able to make room* [for another woman]. *The woman does not have time to give birth in the best way; the way she had to be. I am from a time when women had their children at home with midwives and everything took longer. But, they had that time. Here they don't have it* [time] (P21).

> [...] *it's no use for us to have the experience, wanting to do it in her place. Of course, sometimes we make a mistake, because we want to have it done fast. Sometimes you* [the professional healthcare] *do it automatically* (P16).

In the present study, professionals point out that, specifically during labor, there is a lack of physician engagement in actions aimed at the humanization of childbirth. Aspects such as lack of recognition and respect for the birth plan elaborated by the woman are pointed out, such as her opting for non-pharmacological methods of pain relief and her free choice of the childbirth position, in addition to the lack of a welcoming environment. All of this limits women's protagonism and work relationships among healthcare professionals.

> *Listen to their wishes for these birth plans really come ready-made and most doctors don't even want to read them* (P2).

> *We have physicians on duty who encourage changing positions and not lying in lithotomy, not only lying on the back, walking, exercising and taking a shower. However, there are others who say: don't put it in the shower because it might be born in the bathroom. Don't tell her to walk as it will stimulate her* [to deliver]. *Don't put her on the ball* [pilates ball] *because the doctor doesn't like the ball* (P8).

> *Sometimes, we try to leave the light off and leave only the light coming through the window because it's already good; but, sometimes, the medical residency side does not agree very much, there is friction in certain things like that, you know?* (P6).

Furthermore, women point out that the devaluation of their speeches and aggressive statements by professionals generate discomfort and inhibit their active participation in the parturition process.

> [...] *I went through the assessment, they put on a very urgent wristband as I was in labor and I stayed there in the hallway. I was feeling pain, but like I was calm, I didn't do any scandal; I endured the pain there alone. I told the girl: wouldn't it be good for me to go to the pre-delivery room? Because I just need to go to the shower for a bit. Then she said: no, because it's not time yet* (M9).

> [...] *there was a lady with the doctor who assisted the childbirth of my child. I have three other boys and then she asked the doctor how many births I had already and he said three, and then she said: Ah! But then you don't have to go. I meant that I would manage on my own, you know? At that moment there, meaning that if I had three, the fourth was easy. It bothered me a little. I stayed quiet all the time and did what I had to do* (M5).

In the present study, the interviewees point out that the fact that the unit is in a Teaching Hospital, whose care involves professionals and students, implies a greater number of people present at the birth. This ends up making it difficult to offer a space of privacy and a relationship of affinity between the woman and the professional, something so necessary for the expression of desires and decisions involving the birth of a child.

> *During my childbirth there were fifteen people watching. Fifteen! Most I think were students. I think that affects a lot* (M21).

> *We have to improve the number of people who participate in deliveries. I think they sometimes feel oppressed by so many professionals, students. Sometimes, in the room, which is a small space, she sees that many people around her, she feels some urges that maybe she won't tell us. But, if there is a smaller number, you introduce yourself, talk to her and follow the childbirth, there in the pre-delivery, after the delivery, she will have an affinity with us* (P17).

> *The delivery room is very individual, but when the mother has a baby you go in there and sometimes there are almost 20 people inside. You think it's interesting when you give birth to have 20 eyes looking at you, you know? But since this is a Teaching Hospital, then the gynecologist, a resident and a doctoral student, pediatrics, a resident and a doctoral student, sometimes the Nursing staff also assist, there is also the technician who is working, the nurse. So, I already told you that her individuality I can no longer respect* [...] (P4).

The professionals state that, during prenatal care, health education is necessary for the woman to be the protagonist of her birth, to be able to make conscious choices without having to delegate them to the professionals who assist them and, consequently, to be able to exercise her autonomy. This should happen both in individual consultations and in groups of pregnant women. Information about labor should be oriented and shared with women, talking about their rights and their questions, with a view to the process of female empowerment.

> [...] *her role I think cannot be taken into account only at the time of hospitalization. It must be worked on before pregnancy and even during the entire prenatal period, because they arrive here anxious or for some treatment for intercurrences or directly in labor. And a person in pain will not understand what their role is if I speak the first time. So, this must be worked on prenatally. They come here to visit the maternity ward and this is already an opportunity for them to be protagonists. They will know that they have other birthing positions, that they will not need to keep the light on, if they want they can ask to turn off the light, so they will ask for other birthing positions. So her protagonism is for us, professionals, to guide what she has the right and duty to request* (P8).

> [...] *I think there is no way we can make the woman the protagonist here in maternity only. She arrives and we say everything, because she will be sensitized, she will be worried, she will be anxious. So, during the prenatal period, she will be calmer, she is planning the childbirth, she is making decisions, this is her moment to become a protagonist* (P4).

> [...] *it depends on how she* [the parturiente] *understood the information that was given to her during pregnancy and even at the beginning of labor. If this information was clear and given her time to understand and assimilate. Often, women's insecurity makes them leave these decisions to others and not make them for*

> *themselves. The pregnant women's group or something like that to influence the ideas and to prepare her for labor and not leave her at the mercy of the ideas of other professionals* (P11).

> *Autonomy of the woman, that she is the protagonist of the childbirth, then it is not the doctor, it is not the nurse who does the childbirth, it is the woman and the baby. However, for that, we have many factors; has guidance during prenatal care. So, a strong prenatal care is needed, a prenatal care that empowers this woman so that she is aware of how the labor is going to be, what is going to happen, what are her rights, so I think it starts mainly with prenatal care* (P20).

DISCUSSION

As for the aspects that enhance female protagonism, the women admitted to the maternal-infant unit indicated that they feel valued when professionals show concern for their health status, care, affection and respect, as well as when they clarify their doubts. Convergently, Nursing professionals affirm the importance of making themselves available to women to help them in the parturition process, respecting their protagonism and their individuality. Thus, it became evident that, in addition to the need to offer care based on technical-scientific knowledge, care for women in the pregnancy-puerperal period should include support practices, through respect for women's feelings and appreciation of their complaints. Psychological and emotional support is also necessary, promoting greater autonomy and protagonism.[3]

Ideally, professionals point out that, in order to value and encourage women's protagonism, it is imperative to offer actions recommended by the World Health Organization (WHO) and the Ministry of Health. Such actions are configured as good care practices during labor and childbirth. In this perspective, a research with the objective of evaluating the association between obstetric Nursing in the good practices of birth care and birth in maternity hospitals showed that the Nursing professional acts as a strategic agent in changing the interventionist care model, favoring the role of the woman as protagonist, helping and encouraging her to make her own decisions.[14]

In the present study, one of the professionals pointed out that women's empowerment is the reflection of an empowered team. This note is in line with the findings of researchers on the importance of Nursing in favor of autonomy and female protagonism. These findings indicate that the presence of a Nursing professional in birth care is associated with better results in labor, reducing unnecessary interventions - including cesarean sections - increasing women's satisfaction with the care received and presenting better perinatal results, with a prevailing desire of the woman.[9,15]

Adding to the above, a survey carried out with 13 obstetric nurses from a maternity hospital in Minas Gerais pointed out that institutional support is a facilitator for the performance of obstetric Nursing. In addition, managers were identified as important promoters of their work, through incentives and appreciation of work, which contributes to their autonomy and adoption of good practices.[16]

However, the findings of the present study showed that it is not enough for professionals to adopt good practices and offer the woman possibilities of choice so that she, in fact, exercises her autonomy and is the protagonist of the childbirth. It is imperative that, during prenatal care, she is prepared for this moment through health education activities. That is, female empowerment should be thought of as a result of these activities, providing opportunities to strengthen knowledge, participation and women's rights in decisions that permeate childbirth.[9]

The Ministry of Health recommends that prenatal care associate educational activities carried out individually and in groups, ensuring preparation for childbirth and the puerperium, clarifying doubts and allowing women to choose the type of childbirth, fully exercising their autonomy. Such activities consist of the main strategies for overcoming difficulties that manifest from hospitalization, such as pain, fear, suffering and loneliness.[17]

With regard to respect for women's choices at the time of childbirth, both women and professionals stated that the recognition of this right influences the perception of the moment experienced. For this reason, professionals pointed out the importance of recognizing these women as protagonists of childbirth, which provides positive memories of childbirth.

On the other hand, a survey aimed at identifying the perception of obstetricians who provide birth care in a humanized maternity hospital in southern Brazil pointed out that, when it comes to female autonomy and shared decision-making, in theory, doctors believe that every woman have the right to exercise their choice. However, when there is a difference of opinion, medical authority must be respected, based on the good outcome for the mother and baby.[18]

Over the years, the absence of female protagonism in childbirth and the birth of the baby has negatively influenced the experience of pregnant and postpartum women with motherhood. Currently, new understandings are required about the pregnancy-puerperal process.9 Thus, the results of the present study point to the need

for a professional update based on scientific evidence, so that it is possible to offer care and the possibilities of choice to the woman, having based on the best knowledge available to date.

However, the literature indicates that, in care, there is a lack of evidence-based knowledge and practices. In this way, the selection, interpretation and application of research results in practice increasingly become a challenge. This comes from the lack of exercise and learning of scientific research in professional training, whether at the undergraduate level or continuing education in service.[19]

With regard to the aspects that limit women's protagonism, the participants observe that the ambience of the mother-infant unit presents limitations to women's privacy, generating embarrassment and tension in the childbirth experience. Although the ambience alone does not change the work process, it can be used as a tool that contributes to changes through the co-production of spaces desired by professionals and users.[20] Thus, work areas, in addition to being functionally more suitable , will be able to provide pleasant living spaces from the global review of structural and organizational aspects of the institution, the professional-parturient relationship and the respect for the autonomy and the woman's right to choose.[21]

In general, the participants of this research indicated that the lack of engagement of physicians in actions aimed at the humanization of childbirth, as well as the devaluation of women's speech, inhibit female protagonism in the parturition process. Not infrequently, the woman's vulnerability is caused by fear and apprehension in the face of labor, causing the parturient to value the doctor's opinion more. It is based on the assumption that the doctor is the bearer of unique and absolute knowledge about the childbirth process, leading to withdrawal and subordination of the parturient to the professionals' choices.[15]

Another aspect listed as a limitation of protagonism is the fact that the maternity selected for the study is in a Teaching Hospital, whose care involves professionals and students. This reality involves a greater flow of people in the childbirth room, and may, therefore, inhibit women from expressing their wishes and their decisions regarding the birth of the baby. From a pedagogical point of view, the experiences of accompanying labor, childbirth and postpartum are significant in the training of nurses and physicians. It is a step that allows the student to relate theory to practice, facilitating the understanding of this phase in a woman's life. However, maternity hospitals must offer women a welcoming environment and create hospital routines that put an end to the traditional isolation imposed on women, determining a local flow according to the peculiarities and space of each unit. Nevertheless, the professionals and students involved must provide the best conditions and resources available so that the parturient feels welcomed and safe, acting in an ethical and supportive manner.[22]

The results of this study reinforce that assistance based on good practices in labor and birth care contributes to the appreciation of Nursing professionals. Therefore, there is the protagonism of the women who are under their care. Thus, the need for care to be aligned with to scientific evidence, so that women experience the pregnancy-puerperal period in a dignified and respectful way, but also so that Nursing consolidates its space as a protagonist in care.

Furthermore, as a limitation of the study, it is essential to register the impossibility of generalizing its results, since the research was carried out in a maternal-infant unit with specific characteristics, which contribute to the configuration of care at the local level. Another limitation is the fact that data collection took place at the place of care for women and where Nursing professionals work, which can sometimes discourage free expression about the phenomenon under study.

FINAL CONSIDERATIONS

The results point to aspects that enhance the protagonism of women in labor and birth, as well as aspects that limit this protagonism. For the women interviewed, the professionals' diligence, based on attitudes of attention, respect and clarification of questions, promotes a feeling of appreciation and security, enhancing their protagonism. For Nursing professionals, care for women in the mother-infant unit must be based on scientific evidence, which requires constant professional updating. In addition, it is essential to ratify the role of women as the protagonist of childbirth, through words of encouragement, supportive attitudes and respect for individualities.

It is noteworthy that, both for the women and for the professionals who participated in the study, respect for choices influences the way women perceive their participation in the parturition process and in the decisions that permeate them at that moment. For this reason, it is important that health education activities are developed during prenatal care to ensure women's empowerment, since shared knowledge can alleviate their fears and anxieties, as well as subsidize their choices. It is also constituted as a way of exercising their autonomy, so that, in fact, the woman can be the protagonist at the moment of childbirth, making choices, making decisions

and advocating in favor of her rights, without delegating this task to the professionals who assist her.

Among the aspects that limit the protagonism of women in labor and the birth of the baby, the lack of engagement of physicians in actions aimed at the humanization of childbirth, the devaluation of women's opinion and desire and the aggressive statements of professionals. Therefore, a review of practices is suggested, especially the relationship between health professionals and hospitalized women, so that their right to speak and choose about the parturition process is respected.

Furthermore, the physical space, by not offering a PDP room, interferes with privacy and intrinsically establishes a limited time for the woman to give birth, since she needs to free up the childbirth room due to the unit's demand. Furthermore, the high flow of professionals and students in the space makes it difficult to establish a relationship of affinity between the woman and the professional. This points to the need for an architectural readjustment of the unit, so that its space can contribute to raising awareness and consolidating good practices in childbirth and birth care, which reflect on the role of women.

REFERENCES

1. Mantilla MG, Di Marco MH. Reflexivity, autonomy and consent. An analysis of women's experiences in the search for a physiological birth in the City of Buenos Aires. Sex, Salud Soc [Internet]. 2020[cited 2021 Oct 26];35:260-82. Available from: https://doi.org/10.1590/1984-6487.sess.2020.35.13.a

2. Possati AB, Prates LA, Cremonese L, Scarton J, Alves CN, Ressel LB. Humanization of childbirth: meanings and perceptions of nurses. Esc Anna Nery Rev Enferm [Internet]. 2017[cited 2021 Oct 26];21(4):e20160366. Available from: https://doi.org/10.1590/2177-9465-EAN-2016-0366

3. Garcia-Torres OG, Ortega AF, Álvarez-Villaseñor AS. Perception of humanized childbirth in patients in the puerperium period. Rev Méd Inst Mex Seguro Soc [Internet]. 2020[cited 2021 Oct 26];58(3):258-64. Available from: https://doi.org/10.24875/RMIMSS.M20000029

4. Ministério da Saúde (BR). DATASUS. Tecnologia da Informação a Serviço do SUS. Sistema de Informação de Nascidos Vivos (SINASC) [Internet]. 2017[cited 2021 May 28]. Available from: http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sinasc/cnv/pnvuf.def

5. Zanardo GLP, Calderón M, Nadal AHR, Habigzang LF. Violência Obstétrica no Brasil: uma revisão narrativa. Psicol Soc. [Internet]. 2017[cited 2022 June 10];29:e15504. Available from: https://doi.org/10.1590/1807-0310/2017v29155043

6. Pereira SB, Diaz CMG, Backes MTS, Ferreira CLL, Backes DS. Good practices of labor and birth care from the perspective of health professionals. Rev Bras Enferm [Internet]. 2018[cited 2021 Oct 26];71(Suppl 3):1313-9. Available from: http://dx.doi.org/10.1590/0034-7167-2016-0661

7. Oliveira OS, Couto TM, Gomes NP, Campos LM, Lima KTRS, Barral FE. Best practices in the delivery process: conceptions from nurse midwives. Rev Bras Enferm [Internet]. 2019[cited 2021 Oct 26];72(2):455-62. Available from: http://dx.doi.org/10.1590/0034-7167-2018-0477

8. Nyang'au I, Asweto CO, Ouma P. Utilization of individual birth plan among women attending postnatal clinic at jaramogi oginga odinga teaching and referral hospital, Kisumu Kenya: a hospital-based survey. J Glob Health [Internet]. 2020[cited 2021 Oct 26];10(2):1-10. Available from: https://doi.org/10.52214/thecujgh.v10i2.6966

9. Jardim MJA, Silva AA, Fonseca LMB. The Nurse's Contributions in prenatal care towards achieving the pregnant women empowerment. Rev Pesqui Univ Fed Estado Rio J Online [Internet]. 2019[cited 2021 Oct 26];11:432-40. Available from: https://doi.org/10.9789/2175-5361.2019.v11i2.432-440

10. Cordeiro EL, Silva TM, Silva LSR, Veloso ACF, Pimentel RVT, Cabral MMO, et al. The humanization in the assistance to delivery and childbirth. Rev Enferm UFPE on line. 2018[cited 2021 Oct 26];12(8):2154-62. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/viewFile/236334/29730

11. Minayo MCS. Amostragem e Saturação em Pesquisa Qualitativa: consensos e controvérsias. Rev Pesqui Qualitativa [Internet]. 2017[cited 2021 Oct 26];5(7):1-12. Available from: https://editora.sepq.org.br/rpq/article/view/82/59

12. Guizzo B, Krziminski CO, Oliveira DLD. O software QSR NVIVO 2.0 na análise qualitativa de dados: ferramenta para a pesquisa em ciências humanas e da saúde. Rev Gaúch Enferm [Internet]. 2003[cited 2021 June 23];24(1):53-60. Available from: https://seer.ufrgs.br/rgenf/article/view/4437/2363

13. Rosa LS, Mackedanz LF. A análise temática como metodologia na pesquisa qualitativa em educação em ciências. Rev Atos Pesqui Educ. 2021[cited 2022 June 10];16:e8574. Available from: https://dx.doi.org/10.7867/1809-0354202116e8574

14. Silva TPR, Dumont-Pena E, Sousa AMM, Amorim T, Tavares LC, Nascimento DCP, et al. Obstetric Nursing in best practices of labor and delivery care. Rev Bras Enferm [Internet]. 2019[cited 2021 Oct 26];72(Suppl.3):235-42. Available from: https://doi.org/10.1590/0034-7167-2018-0561

15. Feitosa RMM, Pereira RD, Souza TJCP, Freitas RJM, Cabral SAR, Souza LFF. Factors that influence the choice of birth type regarding the perception of puerperal women. Rev Pesqui Univ Fed Estado Rio J Online [Internet]. 2017[cited 2021 Oct 26];9(3):717-26. Available from: https://doi.org/10.9789/2175-5361.2017.v9i3.717-726

16. Amorim T, Araújo ACM, Guimarães EMP, Diniz SCF, Gandra HM, Cândido MCRM. Percepção de enfermeiras obstetras sobre o modelo e prática assistencial em uma maternidade filantrópica. Rev Enferm UFSM [Internet]. 2019[cited 2022 June 10];9:1-17. Available from: https://doi.org/10.5902/2179769234868

17. Ministério da Saúde (BR). Diretrizes Nacionais de Assistência ao Parto Normal [Internet]. Brasília: MS; 2017[cited 2021 June 23]:51. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf

18. Sens MM, Stamm AMNF. Physicians' perception of obstetric or institutional violence in the subtle dimension of the human and physician-patient relationship. Interface (Botucatu) [Internet]. 2019[cited 2021 Oct 26];23:e180487. Available from: https://doi.org/10.1590/Interface.180487

19. Pereira RM, Fonseca GO, Pereira ACCC, Gonçalves GA, Mafra RA. Novas práticas de atenção ao parto e os desafios para a humanização da assistência nas regiões sul e sudeste do Brasil. Ciênc Saúde Colet [Internet]. 2018[cited 2022 June 10];23(11):3517-24. Available from: https://doi.org/10.1590/1413-812320182311.07832016

20. Ministério da Saúde (BR). Ambiência [Internet]. 2ª ed. Brasília: MS; 2010[cited 2021 June 23]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/ambiencia_2ed.pdf

21. Ferreira MC, Monteschio LVC, Teston EF, Oliveira L, Serafim D, Marcon SS. Perceptions of Nursing professionals about humanization of childbirth in a hospital environment. Rev RENE [Internet]. 2019[cited 2021 Oct 26];20:e41409. Available from: https://doi.org/10.15253/2175-6783.20192041409

22. Francisco MM, Andrade IAF, Siva LSR, Ferreira MC, Aymar DLFA, Simões EMS. Humanization of children's assistance: opinion of Nursing academic. Nursing (São Paulo) [Internet]. 2020[cited 2021 Oct 26];23(270):4897-908. Available from: https://doi.org/10.36489/nursing.2020v23i270p4897-4908