ORIGINAL ARTICLE
Revista de Enfermagem do Centro-Oeste Mineiro
2021;11:e4139
DOI: http://doi.org/10.19175/recom.v11i0.4139
www.ufsj.edu.br/recom

Trajectory of women assisted in birth centers and their relationship with therapeutic choices

Trajetória de mulheres assistidas em centro de parto normal e sua relação com escolhas terapêuticas

Trayectoria de mujeres atendidas en centro de parto normal y su relación con las opciones terapéuticas

Débora Lucas Viana Gonçalves[1]
0000-0002-6072-1112

Síntia Nascimento dos Reis[1]
0000-0003-4235-5398

Luís Paulo Souza e Souza[2]
0000-0002-9801-4157

Kleyde Ventura de Souza[3]
0000-0002-0971-1701

[1] Hospital Sofia Feldman.
[2] Universidade Federal do Amazonas.
[3] Universidade Federal de Minas Gerais.

Autor correspondente:
Débora Lucas Viana Gonçalves
E-mail: deboralucasv@gmail.com

ABSTRACT

Purpose: To know about the trajectories of women assisted in Birth Centers and their relationship with their care choices during and after labor. **Method:** This is a qualitative research, done with in-depth interviews with 28 women in a Birth Center. **Results:** Two major categories emerged. First, the statements showed the trajectory taken for labor and labor, as well as choices in care influenced by individual experiences, family impressions and people living together. In the second category, the women recognized Birth Centers as a place of differentiated practices in care, offering coziness that resembles their home. **Conclusion:** Birth Centers and the qualification of obstetric nursing professionals are strategies to change the model of obstetric care and for women to (re)understand the care provided to them, enabling them to retell their stories in process of labor and labor.
Keywords: Humanized Labor; Natural Labor; Birth Centers; Midwifery; Obstetric Nursing.

RESUMO

Objetivo: Conhecer trajetórias de mulheres assistidas em Centro de Parto Normal e a relação com suas escolhas de cuidado no parto e nascimento. **Método:** Pesquisa qualitativa com 28 mulheres em um Centro de Parto Normal utilizando-se entrevistas em profundidade. **Resultados:** Emergiram duas grandes categorias. Na primeira, os depoimentos demonstraram o trajeto percorrido para o parto e nascimento e escolhas no cuidado influenciados pelas vivências individuais, impressões da família e pessoas do convívio social. Na segunda, as mulheres reconheceram o Centro de Parto Normal, como um local de práticas diferenciadas no cuidado, sendo um local de aconchego que se assemelha ao lar. **Conclusão:** Os Centros de Parto Normal e a qualificação dos profissionais da enfermagem obstétrica são estratégias para a mudança do modelo de atenção obstétrica e, também, para que as mulheres possam (res)significar o cuidado que lhes é prestado, possibilitando que recontem suas histórias no processo de parto e nascimento.
Palavras-chave: Parto Humanizado; Parto Normal; Centros de Assistência à Gravidez e ao Parto; Assistência ao Parto; Enfermagem Obstétrica.

RESUMEN

Objetivo: conocer las trayectorias de las mujeres atendidas en los Centros de Maternidad y su relación con sus opciones de cuidado durante y después del parto. **Método:** Se trata de una investigación cualitativa, realizada con entrevistas en profundidad a 28 mujeres en un Centro de Maternidad. **Resultados:** Surgieron dos categorías principales. En primer lugar, los enunciados muestran la trayectoria del trabajo y el trabajo, así como las opciones de cuidado influenciadas por las experiencias individuales, las impresiones familiares y las personas que conviven. En la segunda categoría, las mujeres reconocieron a los Centros de Maternidad como un lugar de prácticas diferenciadas en el cuidado, ofreciendo calidez que asemeja a su hogar. **Conclusión:** Los centros de maternidad y la capacitación de los profesionales de enfermería obstétrica son estrategias para cambiar el modelo de atención obstétrica y para que las mujeres (re) comprendan el cuidado que se les brinda, permitiéndoles volver a contar sus historias en el proceso de parto y parto.
Palabras clave: Parto Humanizado; Parto Normal; Centros de Asistencia al Embarazo y al Parto; Partería; Enfermería Obstétrica.

How to cite this article:

Gonçalves DLV, Reis SN, Souza LPS, et al. Trajectory of women assisted in birth centers and their relationship with therapeutic choices. Revista de Enfermagem do Centro-Oeste Mineiro. 2021;11:e4139. [Access_____]; Available in:_____. DOI: http://doi.org/10.19175/recom.v11i0.4139

INTRODUCTION

The trajectory of women in the healthcare network during pregnancy and in labor provides information about their motivation to search for specifics services and what they expect about healthcare procedures. In some countries as The United Kingdom, there are consolidated public politics concerning the planning of woman relating to the place of birth[1]. In these countries, women classified as at low risk of complication are allowed to plan their labor, at Freestanding Midwife Unit, or at Alongside Midwifery Unit, those managed by midwives or obstetric nurses, or even in obstetric units.[1]

In Brazil, one of the strategies applied to qualify obstetric care is the incentive scheme to create Birth Centers (BC), facilities that provide the development of good practices in labor and birth and the process of applying the woman-centered care. BC were created by Brazilian Health System (*SUS*) to assist women during pregnancy, labor and puerperium, as well as provide humanized care in normal labor without dystocia[2]. These facilities are led by obstetric nurses or midwives, from admission to discharge and aim to provide quality care, centered on the woman, the baby and the family, in addition to providing an environment with privacy and tranquility[3]

BC is characterized as a place with low added value, but with high profitability. It has a set of elements that allows the parturient woman and her companion an active and participative labor. Despite being implemented in 1999 in Brazil, the number of these establishments is small, in addition to the fact that women are unaware of this service, which develops practices that increase the satisfaction of parturients, restricted use of invasive procedures, presence of obstetric nursing, using scientific evidence based practices, thus differentiating from traditional obstetric care services [4].

Even with an increasing demand for vaginal labor in SUS and in Supplementary Health, the percentage of this type of labor remains below the desired level, with an increase in cesarean sections and unnecessary obstetric interventions, which implies consequences for maternal and neonatal health, in terms of efficacy and effectiveness, use of health services and demand and supply arrangements in health systems [5]. Thus, BC appears as a care equipment, to assist in the reduction of cesarean rates, as it allows the reduction of obstetric interventions [6].

Knowledge about the contributions of this care tool will allow greater disclosure of its contributions to humanizing labor. It is necessary to know the trajectories of women who choose this service, understanding the need for change in the Brazilian obstetric model, establishing as a vision the need to accelerate progress towards Universal Health Coverage and the Sustainable Development Goals, ensuring the universal accessibility, availability, acceptability, quality and the effective cost of nursing and midwifery care for all, based on the needs of women and the population [4].

Understanding the meaning of care during labor and birth for women and how they perceive this care is important, since the meanings attributed at this moment contribute to determine future trajectories through the health service network, through the construction of their own convictions and experiences. Women deal with various dilemmas in their journey through the health network in search of the care that is most appropriate for them. To meet health needs during pregnancy, labor and the puerperium, they weave the itinerary within the health network, based on their convictions that are built throughout their lives; there is also the influence of information they receive, the quality of that information and the interactions they have with society[7-9]. Thus, knowing how these women access these services can facilitate the organization of the health care network, justifying the importance of knowing their therapeutic itineraries and trajectories.

Studies on therapeutic itineraries represent new possibilities for understanding behaviors and attitudes of people towards the search for care. Using the concept of an American researcher[10], psychiatrist and scholar of medical anthropology, this relationship of trajectories is demonstrated by the intercession between the popular and professional sectors. The folk sector, composed of the individual basis of each person, family and life experiences, social environment, community, it is the main determinant of the individual's choices. The professional sector is composed of formal, institutionalized health institutions, based on the scientific biomedical model and its professionals. Finally, the folk sector, non-professional or for professional, involves holistic care, covering body, mind, environment, morals and spirituality[10]. The model helps to understand the multiple factors that will determine the choices of these women and how the trajectories relate to the individual's desires, culture and society. Even though it is not a

disease context, women are able to describe their trajectories for labor and create meanings for them in their speech.

Considering cultural and social aspects, as well as the search for care, can provide a more complete view of how women, within a Birth Center, are relating to the health system and with what logic they are building their trajectory, making it possible to understand and propose care consistent with their real needs and expectations and convictions[9].

Thus, the aim of this study was to know the trajectories of women assisted in a Birth Center in Brazil and their relationship with the care choices during labor and birth.

METHODS

This is a descriptive study, with a qualitative approach, carried out with assisted women at the Birth Center *Centro de Parto Normal David Capistrano da Costa Filho* of Sofia Feldman Hospital (HSF), in Belo Horizonte, capital of the state of Minas Gerais, in the Southeast region of Brazil. The BC under study is peri-hospital, opened in 2001. Currently, it is the only one in the state in this modality and has a capacity to attend 150 low-risk births per month. The admission of women can be by free demand or by referral when the first appointment is made at the Sofia Feldman Hospital.

The identification of the participants took place from an existing database, composed of 209 mothers who gave birth at the BC, and was built for a larger research entitled: "Analysis of the care trajectories of pregnant women at usual risk and its implications for the quality of care obstetric and its impact on maternal and perinatal outcomes", linked to the Education through Work in Health Program (in Portuguese, *Programa de Educação pelo trabalho em Saúde*- PET) III – Cegonha Network (2012-2014), of Federal University of Minas Gerais. For the present study, women residing in the city of Belo Horizonte were intentionally selected, totaling 109 women. Among them, those who could be contacted by phone or through the address informed at the time of attendance at the BC and that agreed to participate in this phase of the research, in up to six attempts to contact and did not have disabilities that would impair their communication through speech were included. Thus, the final sample of this study was 28 women. Data collection took place from May to July 2014, using in-depth interviews with the following guiding question: *"Tell me about your search for care during the prenatal period, until your arrival at the maternity hospital and the birth of your child".* It is noteworthy that, prior to the final collection, an interview was carried out in order to test the interview script, with no need for changes in the instrument.

The interviews lasted an average of 7 (seven) minutes, the participating patients were in the postpartum interval between 3 (three) to 11 months. It is noteworthy that out of a total of 109, 81 did not participate in the study, due to unavailability of telephone contact. In addition, the pre-test interview was conducted with the first 3 (three) patients contacted from the final sample of 28 participants.

At the time of the interviews, which took place in the home of the participants, with women always accompanied by their child, was collected information that allowed the characterization of the studied population. The speeches were recorded and transcribed in full and, then, they were revised for the accuracy of the recordings by the researchers.

In this study, the concept of the health care system was used as a theoretical framework[10], which demonstrates a systemic articulation between the various elements linked to health, diseases and care, covering the attitude of the individual towards these situations and the factors that will determine therapeutic choices. In this way, we sought to understand the care consistent with the real needs of women, their expectations and convictions.

As a methodological framework for data analysis, thematic content analysis by Bardin[11] was used, seeking to identify the itineraries of women in the process of labor and birth, as well as the choices and strategies used by them in the search for care in this singular moment of their lives and the search for care in health services in the care network. The speeches allowed the elaboration of two great categories.

The research was approved by the Ethics Committees in Research with Human Beings of the Municipal Health Secretariat of Belo Horizonte (CAAE 13338713.9.0000.5132), of Belo Horizonte City Hall (number 381.882) and of Sofia Feldman Hospital (number 324.262). It is noteworthy that the recommendations of Resolution 466/2012 of the National Health Council and the signature of the Informed Consent were complied with. The names of the participants were replaced by

"Marias". The place of delivery of health services provided to patients was identified, according to their name in the SUS health service network, without mentioning their names, preserving anonymity.

RESULTS

Regarding the characterization of the women interviewed, the age ranged between 17 and 40 years. Most of them declared themselves married, brown, educated (complete high school) and multiparous. Regarding occupations, most of them declared to be "housewives".

The statements were grouped according to their similarity and made up two broad categories: 1) The (re)signification of women in the trajectory of chilbirth and birth based on women, family and community relations; 2) Women and the relationship with the health service network: the Birth Center as a powerful place for care and the realization of choices, which will be detailed and exemplified with the statements below. The debate / discussion of the meanings of each speech is reported in the Discussion section.

The (re)signification of women in the trajectory of labor and birth based on women, family and community relations

This category was elaborated based on the testimonies of women in relation to the trajectory taken for labor and birth and care choices influenced by individual experiences, family positioning and opinions of other people outside the family context. These are elements that will significantly influence the choices of trajectories at this point in their lives. According to the Health Care System model, it is from the individual, social and community spheres that will originate the main decisions about health care [10].

When the woman already has some perspective of what she wants, she travels her way in search of substantiating her convictions and achieving the expected care. Women reiterate their desire for natural, humanized labor. They are able to reflect on pain in labor and reinforce the conviction of a more physiological labor. This can be seen in the following statements:

"It was because I didn't want to get anesthesia, I didn't want it anyway, only if I really needed it, so there [the research hospital] I had this support, they [obstetric nurses] were going to help me regardless that I had it in my heart that would hurt , I know it hurts, so I liked it because of that, I chose it because of that, which is humanized labor. There was me, my mother, my husband, my brother. Everybody was there!". (Maria Aparecida)

"I thought: 'I want a normal delivery, but with analgesia'. I was very afraid of the pain of labor, he was born very naturally, very well, without any intervention. I made the birth plan, my birth plan was strictly followed, and the nurses who assisted me were wonderful, I never felt insecure". (Maria do Carmo)

Both the reports above and the following demonstrate that these women are restating their beliefs about what type of delivery and what care they want at that moment, enabling (re) significations in relation to labor. Therefore, they seek information that will support their desire for care:

"I tried to clear up my doubts [in relation to natural labor]. I was afraid of natural labor. I know it's better for health. It is way better. I didn't take any anesthesia to deliver. But I asked for it myself. It was my own choice". (Maria Aparecida)

"Because there [BC's referral hospital] has a normal delivery and I wanted it natural! I wanted a natural birth, I wanted it without any intervention. So, that's why it made me look there, because normal, being normal, you can give birth anywhere. I wanted a differentiator. I wanted it natural." (Maria Antônia)

"And I did not make an uninformed choice. On the contrary, I made a very well-informed choice". (Maria Helena)

"I always had it in my mind, since I was a child I always asked God, I want a natural birth, I spent my whole life imagining it. I never wanted to have a cesarean. In the first contractions, I went up the stairs, went down the stairs, I went to the shower, squatted, got up, all because I had already seen it on the internet, I had already been informed". (Maria de Lourdes)

Within the phrases of these women, some are highlighted: "what I want"; "I asked for it myself"; "It was my choice". Those expressions reveal their choices regarding the care they want. However, another aspect that appears as an influencer in the choices was the family, as observed in the statements:

"I had never been there [at the research hospital]. After my mother delivered my sister

there, I went to visit and I really liked it there ". (Maria da Penha)

"It was my choice; my cousin's godmother [said] that it was a good place, but I didn't know it, I went more because of that. My family already knew it and said: 'deliver there'. I said: 'oh, I'm going there' ". (Maria Rita)

"I chose it because my colleagues all said that there [the Birth Center] was good. My sister even had her boy there. I would always go there to visit, the second child arrived and I made my choice to go to the Birth Center". (Maria Aparecida)

As noted, labor becomes a family and community event, and the opinion of this social circle is important for the choices of these women. This is the sector that most influences and marks the emotions of women during pregnancy, labor and the puerperium. The support of this group is presented as fundamental for the affirmation of the convictions and directions for this rite in the lives of women. The approval of the family of these women's choices is a security. Some who had their convictions in relation to labor had to do all the work of arguing with their families, essential to sustain their choices of the trajectory to be taken.

"My husband is from a family that only gives birth through a cesarean section and I had to do a job to convince my husband to have a normal birth". (Maria Helena)

"I worked at a hospital, so I always knew the job [at the research hospital], I already knew it from the people who worked with me, I worked at a maternity hospital too. My mother, who did not know, she was very afraid, because unfortunately there are always people to speak badly, so I called her to go there [the research hospital] to visit, for her to know, because I already knew. We went there, the people from the ombudsman's officce received us and showed us the maternity ward and the Birth Center, which was my biggest interest. She [the interviewee's mother] was very calm, she liked it too much, she says good things (about the Hospital) now to everyone". (Maria Lúcia)

These women need to build their discourse in defense of what they believe and, therefore, seek quality information. There is a large and diverse movement in this search, mainly through social networks.

"I found out about it on the internet [research hospital], by indication [of a support group for pregnant women] as well, which is this support group for pregnant women, which encourages normal labor, and I read a lot on the internet." (Maria do Carmo)

"I really wanted to have a normal birth. I moved to Belo Horizonte a little while ago, it was at the beginning of last year, I was already pregnant. Then I started looking on the internet and found support groups [support groups for pregnant women; there I was guided, they sent me [the support group for pregnant women] to a midwife, the most famous obstetric nurse that there was there " (Maria Cristina)

Another talks about a "hegemonic discourse", as it influences choices of women, is related to the culture that women are "weak". It is embedded in the discourse of some professionals that propagates that culture in society. Another aspect expressed by the participant refers to the understanding that the type of labor that the woman will have is a matter of choice. (Maria)

"You don't convince anyone to have a normal birth. This is a choice, because if the woman wants to find in the literature, in common sense, twenty reasons for not having a normal birth, she finds it, fifty [reasons], she finds it. [Reasons] to have one, one cesarean section, she finds it. So, it's a choice". (Maria Helena)

Among the participants, some (re)signified the moment in which they lived, emphasizing difficulties, but, contrary to common sense, they managed to (re)signify their experiences with teachings for their own lives:

"I took the last drop of strength I had and did that strength, I was elastic! This child was born, it looked like the end of the World Cup! It is a unique experience for you to give birth to your child, and I am very proud to talk about it and it was hard! ". (Maria de Lourdes)

"That was it, we resignify things. It was a catharsis, it was a very crazy experience, it took me to meet my mammal nature, the lioness that exists inside me. Today, I say that I would choose this experience again ". (Maria Beatriz)

They feel more empowered as a woman, because care was offered to them, which strengthened their role in labor. In this way, allowing themselves to live a profound moment, such as labor, makes them create their own

convictions. Following are the speeches that confirm these statements:

"I even tell other people that 'is' pregnant that it was the only place I felt safe [research hospital]". (Maria Vitória)

"I think [BC] was a determining factor; I was very well looked after there. I know that my daughter was born, because I took a whole day to take care of her, with practices that would make her feel it was the right time for her come, that I was whole for her ". (Maria Helena)

Even women who did not know BC or were afraid of natural labor were able to reflect on the experience and deal with their fears. Based on their own experiences, they redo their convictions and desires.

"I gave birth to him not at the hospital, it was at the Delivery House. They gave me that option. At first I was a little afraid because I imagined something else. I got scared! I don't want natural labor. But, I mean, it was an experience that if I had to go through it again, I would go through it the same way, in the same place. It overcame everything " (Maria Alice)

"She asked me [health professional] if I wanted to go to the Delivery House to give birth. Then, as I didn't know, I asked 'what was the Delivery Housee?' She [health professional] said it was a natural birth, that it wouldn't have anesthesia, or anything. I said I wanted to go there". (Maria da Penha)

Women and the relationship with the health service network: the Birth Center as a powerful place for care and the realization of choices

This category was built based on the reports of women when they recognized the BC as a place of differentiated practices in nursing care during labor and birth.

In this study, it was noticed that these women do not always follow what is established by the health network, making routes according to their health needs, the degree of information they have and the influence of people from their social environment or not. In addition, these women have sought trajectories that are not covered in the health network. Women who had the option of having their children in the private health network have sought the Unified Health System (*SUS*), which is public, universal and free, as they recognize the possibility of health care, according to what they believe is the best for them and their babies.

"I already had a clear choice that I wanted to have a child [at the research hospital], because I'm not looking for hotels, I'm looking for quality care. I had to convince my husband, who went to see the private maternity hospitals. Finally, I spoke to him: 'so now we go there [at the research hospital], which is my choice.' And then, it was the place he liked most that he felt most welcomed ". (Maria Helena)

"I did all my prenatal care through SUS, because I think there are few public policies that we can trust with our eyes closed. But I made a point of giving priority to the issue of SUS and even because we were also in transition, we had no health insurance at the time. Do you know when you don't even consider another possibility? I didn't consider another possibility. [It was a] matter of reference and desire". (Maria Beatriz)

These women seek care in the SUS that meets their expectations, giving less value to aspects related to physical structure. Women have returned to the *SUS* and cite public policies in the field of obstetric care as a factor that qualifies quality and safety in labor. However, other statements demonstrate that the lack of waiting period, in private health plans, forces women to modify their trajectoryways in the health care network; they are creating alternatives to guarantee the expected care.

"I found out I didn't even think about making an appointment at the health center or anything, because I had already accompanied my mother who gave birth in the private, so:" I'm going in the private ". I did it up to 6 months normally in private, but, until then, my plan did not cover labor, because of the waiting period. I started to see humanized labor, I started to do it at the health center, but there, the gynecologist was very difficult to have available time, and to do the exams it was too early for me". (Maria Antônia)

In the women's statement, the BC or the Delivery House is highlighted as a place of coziness that resembles the home; they refer to it as a familiar and safe environment. The place would be the concretization they wanted for the birth of their children and, therefore, they made the trajectory in search of this care, which would

strengthen them as the protagonist. The following statements confirm this statement:

"As a matter of attention, they [obstetric nurses] ask if there is any position that we find more pleasant. It goes on giving that cool emotional support ". (Maria Inês)

"I really liked it because I thought it was beautiful, cozy and was still serving hominy to newly born babies' mothers. The birthing center was the first option because it is cooler. It is a cozy environment, that kitchen, that table in the middle of the way, the service of all the people who received there and everything is very familiar and feels homemade". (Maria Cristina)

Some of these women reveal an immediate desire for BC for prior knowledge. Therefore, they made choices that would direct them to that place of birth. The direct and constant monitoring and care of obstetric nurses and a trained nursing team are also seen as an important aspect of BC. The following is one of the statements that portrays this care.

"So, I stayed in the room alone, just with them [nurses], then I felt a peace too, you know, there was pain, of course, but it was all naturally". (Maria Joana)

Many of these women did not know the BC as a place of birth and, currently, there is no formal reference in the health network for that place. Most of them, in order to be referred to the BC, women are evaluated first in the researched hospital. Some reports show fear of going to this place for fear of pain in labor; others were willing to go through the experience, as in the following statement:

"I had heard that when you go there [research hospital] they tried very hard for you to give birth in the Delivery House. But I didn't know what it was like until then. I went there, I went down, I liked it, my husband liked it too. Then we chose to deliver there ". (Maria Paula)

The approach of the professionals in relation to the BC makes a difference in the choice of these women, especially due to the clarifications regarding the care model recommended in this type of service. The direct and constant monitoring and care of obstetric nurses is also seen as an important aspect in the Delivery House.

"Liked it! Wow, great, very good! It is quiet there [BC], people respect us, [there was there] a very polite nurse". (Maria Aparecida)

"At the delivery house, the girl who stayed with me there, the nurse, guys, she was cute! And she was there all the time, measuring my pressure, talking to me. So, it gave me peace of mind, so I managed to have a normal birth because of that. Because I think that if I had stayed there, thrown, I wouldn't have been able to. Because you need a follow-up; you are in that affliction, that anxiety. The girl [nurse] who stayed with me was super calm, she calmed me down, talked to me, gave me a massage. Wow! It was very peaceful". (Maria Rita)

"It was an experience of a lot of love, a lot of affection, from people who had never seen me in my life, guys. I'm not talking about a sister of mine, a cousin of mine who would help me for sure, out of love and experience. I am talking about people who have never seen me before, who dedicated all the love they had there at the time, all the care they had there at the time with me, my daughter and my husband. I don't know if my friends, if my relatives, I don't know if they would give me the attention that the team gave me. I get emotional because it was this way, with this warmth that they received me ". (Maria Beatriz)

DISCUSSION

In order to enhance the discussion of the data and facilitate its understanding, this step was described according to the categories already presented. Thus, the data communicate with each other, converging on the objective of knowing the trajectory of women assisted in a BC and its relationship with the care choices during labor and birth.

The trajectory of these women demonstrates the search for care, influenced by their own convictions, construction of experiences and individual experiences, family, society, community. In addition to these factors, the search for holistic care and the service offerings of formal health institutions and their professionals are added. All of these elements interact with each other in a dynamic process that will influence women's choices in labor and birth, defining their trajectory in the health network. The health care system must be considered for the relationship between personal beliefs, social relationships and

cultural values with health promotion services. This complex and broad organic and living system is the one represented in the Health Care System model [10]. In the case of this study, highlighting the centrality of women regarding their experiences of giving birth and how the social and cultural dimensions can influence them, it is clear from them (re)significations of individual experiences, allowing a greater understanding of the context.

In this study, BC was revealed as a birthplace that allows the fulfillment of the desire to have continuous, safe, singular care, which respects the physiology of the woman's body, providing opportunities similar to other scenarios. In the United Kingdom, women are advised, from the prenatal period, on the possibilities of birthplaces. According to The National Institute for Health and Care Excellence (NICE), low-risk women have the opportunity to choose the place of birth [1]. In England, the decision regarding the place of birth is usually planned together with the family. Women are also instructed on how to configure low risk during pregnancy, receive detailed explanations about all types of birth place, are informed about research and statistics about the places, the possible complications that can happen and about the practices suitable for labor. They also have access to maternal and fetal results, in relation to each place of birth, so that they can discern the safety of their choices [12]. Therefore, they receive quality information that is part of their care decision-making process.

The BC is a place that carries a symbolic meaning of renewing obstetric practices, with its own and necessary paradigm for the transformation of the prevailing culture in institutions that provide labor assistance [11]. In some countries, Birth Centers led by midwives are birthplaces that would correspond to Normal Birth Centers in Brazil. Midwives are professionals dedicated to the care of women during pregnancy, labor and the puerperium and to the newborn, based on scientific evidence, in a philosophy of care that respects and guarantees direct care, similar to obstetric nurses or obstetricians, in Brazil.

In this study, yet, some women did not know the BC and were surprised by the care provided. Part of this lack of knowledge can be attributed to the lack of formal referral in the health network to the BC of this research. Women are admitted to the hospital, where, according to the risk, they are offered the possibility of going to BC. The relationship with this place of birth changes, when women already know it, from previous experiences or information. In this case, they themselves manifest, during the evaluation at the hospital, the desire to go to the BC.

The women's reports confirm the proposals sustained for a BC, by expressing a recognition of this place as an environment of realization for what they wanted for labor: family, privacy, safety, coziness, continuous support that respects them in their singularities. The privacy offered is also a characteristic valued by these women, showing the intimate and familiar character of BC. They show characteristics of an environment and, in a way, of care that is distinguished from other birth spaces, such as traditional maternity services, especially those, still prevalent in Brazil, that, when the fragmented, hierarchical and marked by obstetric violence (OV) practice, affects women in different ways, reflecting inequities in assistance during labor and birth [13]. In this perspective, the expansion of BC, still in small numbers in Brazil, is an important strategy to overcome the current and hegemonic Brazilian obstetric model.

The constant care, affection, attention of the obstetric nurses and the BC team are highlighted in the statements. Safety in care and preparation is another characteristic attributed to BC professionals. Obstetric nurses affirm the importance of persisting in providing prudent and responsible care, in accordance with the principle of enforcing women's rights, meeting their health concerns and needs [14].

The care of obstetric nursing in a BC must be guided by the principles of humanization, ethics, in addition to the use of appropriate technologies. In a qualitative study conducted in Norway, women also pointed out that midwives spent time with them both in prenatal care and labor. This was extremely important to clarify doubts, as it allowed them to feel safe, confident and relaxed[15]. In the same study, it was highlighted that the continuous presence of midwives - preferably the same one - also promotes security and confidence to women, who, in this way, feel cared for[15].

The care of obstetric nursing must be based on scientific evidence and promote comfort, safety, satisfaction, as evidenced in the reports of these women. The care of midwives contributes to women having a natural birth and a positive experience. The strengthening of these women in labor allows for a positive outlook for long-term

health promotion[1]. The care model conducted by the obstetric nurse or obstetrician is based on the premise that pregnancy and labor are normal life events[16]. The care provided by these professionals includes monitoring the physical, emotional and spiritual well-being of the woman and her family during the pregnancy-puerperal cycle[16].

The care of obstetric nursing can stimulate the woman's autonomy so that she can exercise her right to give birth safely and with pleasure. This aspect demonstrates the political and emancipatory power of obstetric nursing care[16]. In this perspective, obstetric nursing in Brazil is in a historic moment and proves to be one of the agents of transformation of the model still in force, which requires, as a result, the training of human resources that meet these expectations. The assistance provided by obstetric nurses or obstetricians contributes to guarantee humanized assistance and to avoid unnecessary interventions[15], and can serve as a model for other institutions, especially hospital ones. The encouragement and creation of new care structures, such as Normal Labor Centers and the qualification of health professionals, especially obstetric nurses, midwives and the nursing team, are the safest way to change the obstetric care model in the country.

There is a mobilization of political actions in Brazil, in the discussion about changes in the Brazilian model of care to labor, with the adoption of practices and protocols based on scientific evidence, object of recent studies in the country[17-18]. In addition, women are questioning the formal health system and its professionals in care during the puerperal pregnancy cycle.

In this sense, the data also demonstrated how important it is to contribute to the construction of convictions, in relation to labor, through experiences already lived and adequate information. Some women make their trajectory, during pregnancy and labor, based on what they desire and not on what is regulated by the health network. Another observed result is the report of other women, of positive experiences in relation to the place of birth and delivery, promoting more security in the choices during this period. In a multicenter study carried out in Brazil, women who wished to have a vaginal delivery expressed this desire, because they believed that this type of delivery is more physiological, natural and they would have a faster recovery[19]. Such beliefs corroborate those mentioned in the women's reports of the research in relation to the wishes about labor.

At the moment of birth, the most fundamental care is started, to maintain and accompany the life of the mother and the child who has just been born[20]. Being cared for, taking care of oneself and caring are conjugations that involve important life passages, which constitutes the indispensable need for care. For birth, knowledge was generated, creating habits in society with cultural characteristics, immersed in symbolic representations, often impregnated with rites[16], thus requiring questions about the instituted. Therefore, in care centered on women, family, social and cultural contexts must also be considered in order to meet health needs more fully[19].

The rationalization of science excluded empirical knowledge from the practice of caring during birth. The empirical knowledge used in care started to be seen as superstitious, and the understanding of labor as a rite of passage started to be ignored, devalued.

The loss of this type of knowledge in the practice of caring has brought serious harm to women, removing care from its symbolic meaning. The practice of caring is an art of absolute interest. Women have resumed the search for their protagonism in labor, in which they and their family actively participate in the care surrounding this event[21].

The presented results showed a search for information and knowledge during the gestation period. Women reported several ways to acquire information: women's groups, fairs, the internet, among others. The movements of women and Non-Governmental Organizations (NGOs) appear as powerful mechanisms of information and knowledge in the return of women as an active participant in their care during labor[22,23]. In this study, women extolled the movements that were part of the trajectory of some of them. All of these initiatives demonstrate that women are mobilizing, and one of the important characteristics of these movements is the healthy and democratic exchange of knowledge and experiences between them[24].

In the results of this study, it has been shown a demand for women to have their birth at *SUS*, even those who have private health insurance, because they believe that there they will be met in their expectations of care during labor. Society in

general and women in particular must relearn to take their place in the field of care and, thus, resume as a protagonist in the health system[8]. The professional sector must listen to health users and try to understand their care concerns[10].

Another observed result is the positive experiences, in relation to the place of birth and labor, promoting more security in the choices during this period. Therefore, the incentive and the creation of new assistance structures, such as the BC and the qualification of health professionals, in particular, of obstetric nursing professionals, are strategies for changing the model of obstetric care in the country and, also, for women, who can, thus, give a new meaning to the care provided to them, allowing them to retell their stories during labor and birth[24].

To the detriment of these results, it is important to point out that, in the city where the study was conducted, one of the great Brazilian capitals, a maternity hospital built since 2009, with the potential to function as a BC, for meeting requirements proposed by the World Health Organization (WHO) and by the Ministry of Health (*MS*), keeps its doors closed, despite all the benefits that this type of service can offer: improvement of perinatal indicators; reference place for a model of care and professional training, among others. These justifications have not been sufficient to put health equipment into operation - with a reduced number in a country that has three million births / year and high rates of unnecessary cesarean sections[25].

In this perspective, the necessary creation and strengthening of spaces such as BC is placed on screen, which, due to their philosophy, bring renewed care practices, with the inclusion of women as protagonists in the process of giving birth, one of the ways to overcome the obstetric model Brazilian, which, although with recognized advances, there is much to be done in it[26].

The data resulting from the remaining interviews will certainly reveal new and diversified narratives and grammars of the disease(s) that will highlight the centrality of individuals and their social and cultural position in the various dimensions related to the experience of the disease.

The important thing is to create a space, for new practices and care, both for health professionals and for users / clients, in the construction of more comprehensive therapeutic projects that can overcome the dichotomy of the hegemonic biomedical model. Practices / care would resize their limits, including the user / client as an active subject in their care and as a protagonist in their illness process.

FINAL CONSIDERATIONS

The present study sought to learn about the trajectories of women assisted in a normal birth center (BC) and the relationship with their care choices during labor and birth. In this sense, the two categories presented here act in complementarity in demonstrating how women signify the care received in a BC, the expanded view on the organization of the health care system, relating the construction of individual convictions with the use of health services. It is urgent to understand the health system, in order to adapt it to the real health needs of the population, through the sensitivity of how it is organized and how the search for care of a population is configured.

Women have their family, society and community organized under a cultural symbolism, which is the stronghold of the first choice for care. The testimonies presented reinforce the family and social character of labor and birth, in addition to revealing how women are acting for their return to protagonism in labor. Women's movements, on social media and with politics, have favored this process. Women have realized what would be the best type of care for them. Only women as active social actors will be able to change the labor environment, and this movement is already underway. In this scenario, the BC stood out as a place of care capable of offering assistance, according to the real desires of these women, standing out as a place of coziness, family, safety, in which their needs are fully met.

Following the purpose of reaching an understanding of the meaning of care, during labor and birth for women and how they perceive this care, it can be said that the BC proved to be a place that promotes good practices in labor and birth, and obstetric nursing has assured guarantee of such practices. The continuous and safe care given by the professional in this area has provided positive experiences in relation to labor. The network view and sensitive listening of women can predict a lot about the type of care that should be given to them.

This study was limited to one institution. Further studies are recommended, using the theoretical framework presented, considering that it is a little explored framework, although that strongly helps in the understanding of the factors

that determine the choice of care by the subjects in health services and how their trajectories (with their influences) influence that choice. Finally, there is a need for further studies in environments such as BC, as knowing the contributions of this tool, based on nursing care in the view of women, will enable the dissemination and development of humanized actions in labor, health policies and current guidelines, seeking to change the obstetric model.

REFERENCES

1 - National Institute for Health and Care National Institute for Health and Care Excellence (NICE). Intrapartum care for healthy women and babies. Reino Unido: Nice; 2014 [citado em 14 dez 2020]. Disponível em: https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and-babies-pdf-35109866447557

2 - Brasil. Ministério da Saúde. Portaria nº 985, de 5 de agosto de 1999. Cria o Centro de Parto Normal (CPN) no âmbito do Sistema Único de Saúde (SUS). Brasília: Ministério da Saúde; 1999 [citado em 14 dez 2020]. Disponível em: http://www.cvs.saude.sp.gov.br/zip/Portaria%20GM%20MS%20n%C2%BA%20985,%20de%2005ago99.pdf

3 - Brasil. Ministério da Saúde. Portaria nº 11, de 7 de janeiro de 2015. Redefine as diretrizes para implantação e habilitação de Centro de Parto Normal (CPN), no âmbito do Sistema Único de Saúde (SUS), para o atendimento à mulher e ao recém-nascido no momento do parto e do nascimento, em conformidade com o Componente Parto e Nascimento da Rede Cegonha, e dispõe sobre os respectivos incentivos financeiros de investimento, custeio e custeio mensal. Brasília: Ministério da Saúde; 2015 [citado em 14 dez 2020]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2015/prt0011_07_01_2015.html

4 - Mamede MV. Força de trabalho da enfermagem e obstetrícia e os novos Objetivos de Desenvolvimento Sustentável (2016-2030). Rev Rene 2017 [citado em 14 dez 2020]; 18(6):710-11. Disponível em: http://periodicos.ufc.br/rene/article/view/31068/71659

5 - Entringer AP, Pinto M, Dias MAB, Gomes MASM. Análise de custo-efetividade do parto vaginal espontâneo e da cesariana eletiva para gestantes de risco habitual no Sistema Único de Saúde. Cad Saúde Pública 2018 [citado em 14 dez. 2020]; 34(5):1-15. Disponível em: https://www.scielo.br/pdf/csp/v34n5/1678-4464-csp-34-05-e00022517.pdf

6 - Garcia LV, Teles JM, Bonilha ALL. O centro de parto normal e sua contribuição para atenção obstétrica e neonatal no Brasil. REAS 2017 [citado em 14 dez 2020]; 7:356-63. Disponivel em: http://hdl.handle.net/10183/170557

7 - Reis TLR, Padoin SMM, Toebe TFP, Paula CC, Quadros JS. Autonomia feminina no processo de parto e nascimento: Revisão integrativa da literatura. Rev Gaúcha Enferm. 2017 [citado em 14 dez. 2020]; 38(1):1-8. Disponível em: https://www.scielo.br/pdf/rgenf/v38n1/0102-6933-rgenf-1983-144720170164677.pdf

8 - Martins CA, Mattos DV, Santos HFL. Autonomia da mulher no processo parturitivo. Rev Enferm UFPE 2016 [citado em 14 dez 2020]; 10(12):4509-16. Disponível em: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/download/11517/13403

9 - Ferreira LS, Santos AF, Bezerra IP, Alves DA, Damasceno SS, Figueiredo ME, et al. Assistência de enfermagem durante o trabalho de parto e parto: A percepção da mulher. Rev Cuba Enferm. 2017 [citado em 14 dez 2020]; 33(2). Disponível en: http://www.revenfermeria.sld.cu/index.php/enf/article/view/1102

10 - Kleinman A. Concepts and a model for the comparison of medical systems as cultural systems. Soc Sci Med. 1978;12(2B):85-95. DOI: 10.1016/0160-7987(78)90014-5

11 - Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2011.

12 - Coxon K. Birth place decisions: Information for women and partners on planning where to give birth. 2014 [citado em 14 dez 2020]. Disponível em: https://kclpure.kcl.ac.uk/portal/files/33242518/Birth_place_decision_support_Generic_2_.pdf

13 - Lansky S, Souza KV, Morais ER, Oliveira BF, Diniz S, Viera NF, et al. Violência obstétrica:

Influência da Exposição Sentidos do Nascer na vivência das gestantes. Cien Saude Coletiva 2018;24(8):2811-24. DOI: 10.1590/1413-81232018248.30102017

14 - Dahlberg U, Persen J, Skogås AK, Selboe ST, Torvik HM, Aune I. How can midwives promote a normal birth and a positive birth experience? The experience of first-time Norwegian mothers. Sex Reprod Healthc. 2016;7:2-7. DOI: 10.1016/j.srhc.2015.08.001

15 - Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev. 2016;28(4):CD004667. DOI: 10.1002/14651858.CD004667.pub5

16 - Vargens OMC, Silva ACV, Progianti JM. Contribuição de enfermeiras obstétricas para consolidação do parto humanizado em maternidades no Rio de Janeiro-Brasil. Esc Anna Nery 2017;21(1):1-8. DOI: 10.5935/1414-8145.20170015

17 - Carmo Leal MC. Parto e nascimento no Brasil: Um cenário em processo de mudança. Cad Saúde Pública 2018 [citado em 14 dez 2020]; 34(5):1-3. Disponível em: https://www.scielo.br/pdf/csp/v34n5/1678-4464-csp-34-05-e00063818.pdf

18 - 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. Cien Saude Coletiva 2018;23(11):3517-24. DOI: 10.1590/1413-812320182311.07832016

19 - Oliveira VJ, Penna CMM. Cada parto é uma história: Processo de escolha da via de parto. Rev Bras Enferm. 2018;71(supl 3):1228-36. DOI: 10.1590/0034-7167-2016-0497

20 - Tostes NA, Seidl EMF. Expectativas de gestantes sobre o parto e suas percepções acerca da preparação para o parto. Temas Psicol. 2016;24(2):681-93. DOI: 10.9788/TP2016.2-15

21 - Mouta RJO, Silva TMA, Melo PTS, Lopes NS, Moreira VA. Plano de parto como estratégia de empoderamento feminino. Rev Baiana Enferm. 2017;31(4):1-10. DOI: 10.18471/rbe.v31i4.20275

22 - Carvalho SS, Cerqueira RFN. Influência do pré natal na escolha do tipo de parto: Revisão de literatura. Rev Aten Saúde 2020;18(63):120-8. DOI: 10.13037/ras.vol18n63.6315

23 - Santos FSR, Souza PA, LanskI S, Oliveira BJ, Matozinhos FP, Abreu ALN, Souza KV, et al. Os significados e sentidos do plano de parto para as mulheres que participaram da Exposição Sentidos do Nascer. Cad Saúde Pública 2019;35(6):1-11. DOI: 10.1590/0102-311x00143718

24 - Pinheiro GQ, Silva Júnior AP, Giotto AC. O processo de parto: A importância do enfermeiro no parto humanizado. Rev Inic Cient Ext. 2019 [citado em 19 mar 2021]; 2(4):190-5. Disponível em: https://revistasfacesa.senaaires.com.br/index.php/iniciacao-cientifica/article/view/255

25 - Oliveira M, Elias EA, Oliveira SR. Mulher e parto: Significados da violência obstétrica e a abordagem de enfermagem. Rev Enferm UFPE 2020;14:e243996 DOI: 10.5205/1981-8963.2020.243996

26 - Serres WP, Pieszak GM, Gomes GC, Prates LA, Rodrigues AP. Vivências de mulheres com o parto domiciliar: resgate por meio da história oral. Rev Enferm UFSM 2020;10(51):1-18. DOI: 10.5902/217976923484

Note: This document is part of the Master Degree's Dissertation report presented to the Postgraduation Course in Nursing of the School of Nursing of the Federal University of Minas Gerais.

Recebido em: 07/12/2020

Aprovado em: 23/03/2021