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NORMAL BIRTH ASSISTED BY NURSE: EXPERIENCE AND SATISFACTION OF PUERPERALS

PARTO NORMAL ASSISTIDO POR ENFERMEIRA: EXPERIÊNCIA E SATISFAÇÃO DE PUÉRPERAS

PARTO NATURAL ASISTIDO POR ENFERMERA: EXPERIENCIA Y SATISFACCIÓN DE MADRES RECIENTES

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ABSTRACT

Objective: to describe the experience and satisfaction of women who had a normal delivery attended by a nurse. ***Method:*** descriptive, cross-sectional, quantitative approach, carried out in a maternity reference tertiary school, with 37 puerperal women. Data collected from the form, consult the cards of pregnant women and medical records of the puerperal women and adapted instrument of the Questionnaire of Experience and Satisfaction with Childbirth. ***Results:*** predominantly women with a mean of 23.6 years, stable marital relationship, complete secondary education, catholic, without own income, quite satisfied with their parturition process and with the quality of care received. ***Conclusion:*** the experience of normal delivery attended by a nurse was quite satisfactory for puerperal women. The nurse is recognized as a differentiated professional that provides physical and emotional support and helps in relaxation and coping with parturition. ***Descriptors:*** Natural Childbirth; Obstetric Nursing; Patient Satisfaction.

RESUMO

Objetivo: descrever a experiência e a satisfação de mulheres que tiveram parto normal assistido por enfermeira. ***Método:*** estudo descritivo, transversal, de abordagem quantitativa, realizado em uma maternidade escola terciária de referência, com 37 puérperas. Dados coletados a partir de formulário, consulta a cartões de gestante e prontuários das puérperas e instrumento adaptado do Questionário de Experiência e Satisfação com o Parto. ***Resultados:*** predominaram mulheres com média de 23,6 anos, relacionamento conjugal estável, Ensino Médio completo, católicas, sem renda própria, bastante satisfeitas com seu processo parturitivo e com a qualidade dos cuidados recebidos. ***Conclusão:*** a experiência do parto normal assistido por enfermeira foi bastante satisfatória para as puérperas. A enfermeira é reconhecida como profissional diferenciada que fornece apoio físico e emocional e auxilia no relaxamento e no enfrentamento da parturição. ***Descritores:*** Parto Normal; Enfermagem Obstétrica; Satisfação do Paciente.

RESUMEN

Objetivo: describir la experiencia y satisfacción de mujeres que tuvieron parto normal asistido por una enfermera. ***Método:*** estudio descriptivo, transversal, enfoque cuantitativo, realizado en una maternidad de la escuela de referencia terciaria, con 37 madres. Datos recogidos a partir de formulario, consulta a tarjetas de embarazadas, instrumento adaptado del cuestionario de experiencia y satisfacción del parto. ***Resultados:*** predominaron mujeres con un promedio de 23,6 años, relación marital estable, escolaridad completa, católica, sin renta propia, bastante satisfecha con su proceso de partitivo y con la calidad de la atención recibida. ***Conclusión:*** la experiencia de un parto natural asistido por enfermera fue bastante satisfactoria para las madres recientes. La enfermera es reconocida como distinguido profesional que ofrece apoyo emocional y físico y auxilia en la relajación y afrontamiento del parto. ***Descriptores:*** Parto Normal; Enfermería Obstétrica; Satisfacción del Paciente.

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INTRODUCTION

Labor, birth and birth are marked experiences in a woman's life and may be accompanied by the most diverse and contradictory feelings, depending on how they are lived and perceived individually. Because they are unforeseeable and unknown moments, they result in a mixture of expectations, worries, anxieties, hopes, fears and anxieties.[1]

Therefore, when assisting the parturient, the professionals involved in their care, besides offering attention based on technical and scientific knowledge, should seek to understand their perceptions and individualities, in order to offer a humanized assistance and to allow the active participation of women In the process of labor and birth so that it occurs as physiologically as possible.[2]

In this sense, worldwide obstetric care has undergone an intense period of reassessment of data and evidence and of re-signification of values and behaviors both in search of reduction of the maternal and child health, and of the qualification of the assistance offered.

The model of obstetric care prevalent in most Western countries, including Brazil, regards health as a problem, considering that life is full of risks and that pregnancies are potentially pathological, until proven otherwise, therefore, a medical problem.[3]

In this hospital-centric and technocratic model, childbirth and birth were marked by excessive interventions, unnecessary cesarean sections, isolation of the parturient, reduction of family participation, lack of privacy and disrespect for women's autonomy.[1]

Thus, although the benefits of technical-scientific advances in reducing maternal-fetal risks, in solving obstetric complications and in conducting high-risk pregnancies are undeniable, the indiscriminate use of interventional technologies, especially in pregnancies that are shown detrimental to the quality of obstetric care and awakened the attention of managers, professionals and social classes to the rescue of the humanization of childbirth.

In the last decades, this model has been identified as one of those responsible for the high rates of maternal and child mortality in several countries, being increasingly denounced by professionals and social movements articulated in favor of values brought by the notion of humanization of childbirth and birth care. [4]

In this context, the obstetrician nurse has shown herself to be a professional with differentiated care, while she has a delicate posture, respects the womanhood of the parturient, transmits security, gives women autonomy, allows the expression of pain and provides physical and emotional well-creating bond and being valued by pregnant women and their companions.[1]

In most developed countries, obstetric nurses and specialized midwives are responsible for providing low-risk childbirth care. Corroborating this, the WHO and the Brazilian Ministry of Health have recommended a greater participation of Obstetrical Nursing in order to improve normal delivery and to reduce cesarean rates, considering this professional category the most adequate to assist pregnancy and normal delivery, with better cost-effectiveness and safety, assessing risks and early detection of possible complications.[1,5]

In addition, studies show that satisfaction with childbirth is related to the expectation of the care to be received, the relationship developed with the professionals and their support in order to alleviate anxiety and allow the autonomy of the woman.[6] In this sense, it is important to emphasize that the obstetrician nurse is the professional who is more present in the follow-up of labor, working full time with the parturient.[5]

Considering the importance of evaluating Obstetric Nursing care in the context of the humanization of childbirth, it was intended to answer the following question: what is the degree of satisfaction with normal delivery in the view of the puerperal who had their deliveries attended by nurses In a maternity school of reference in the State of Ceará? Thus, this study aimed to describe the experience and satisfaction of women who had a normal delivery attended by a nurse.

METHOD

Descriptive, cross - sectional study of a quantitative approach carried out in a maternity reference tertiary school in the State of Ceará, from September to December 2015.

The study participants who had a normal delivery attended by a nurse at the time of collection and who were up to 48 hours postpartum, which corresponds to the approximate time of stay in the Joint Housing until all the exams necessary for discharge from the mother and baby, if there are no intercurrences. As inclusion criteria, there was: women who had a normal risk pregnancy and gave birth to term gestation. Exclusion

criteria included: women admitted to the Obstetric Center during the expulsive period; mothers of newborns with malformation discovered at birth and illiterate women.

The sample size was calculated by means of the average of normal deliveries assisted by a nurse in the year 2014, in the months corresponding to the collection period of the year 2015 (September to December), based on the records of the book of admissions of the Obstetric Center, defining a sample of 37 puerperae.

Socio-demographic and obstetrical data were collected through a form prepared by the researcher, containing 29 questions, as well as consultation of data recorded on pregnant women's cards and in women's records. In addition, an instrument adapted from the Questionnaire of Experience and Satisfaction with Childbirth (QESP) was used, using a total of 41 questions, with Likert-type questions, on a scale ranging from one to four ("no", "A little", " quite a lot" and "a lot").

The QESP is a self-report questionnaire, consisting of 104 questions regarding expectations, experiences, satisfaction and pain in labor, delivery and immediate postpartum, developed and validated in Portugal, which allows quantitative evaluation, of mothers' experience and satisfaction with childbirth. Some of the aspects addressed in the QESP are: use of relaxation and breathing methods for pain control; support of a companion (companion, family or friend); feeling of control of the situation; level of self-confidence; intensity of pain felt; emotions, fears and worries; level of knowledge about the events of labor, delivery and postpartum; satisfaction with the time it took each stage of the parturition process and the time that elapsed from birth to pick up on the baby; physical conditions of the institution; quality of care provided by health professionals.[7]

For the analysis of the data, descriptive statistical measures, averages and standard deviation of the quantitative variables were calculated, as well as absolute and relative frequencies of each variable. The data were tabulated and processed using the Statistical Package for Social Sciences - SPSS, version 20.0, and presented through tables, to facilitate the understanding of the results.

This study is part of a larger study entitled Impact of the Satisfaction of Puerperas with Vaginal Delivery in Self-efficacy for Breastfeeding, whose project was approved by the Committee of Ethics in Research of the Maternity School Assis Chateaubriand, according to the opinion nº 657-290. Following the ethical and legal principles of the National Health Council Resolution 466/12 on research involving human beings, the data were collected with the consent of the women participants and after the signing of the Informed Consent Form, being guaranteed the anonymity and the confidentiality of all information, as well as the freedom to refuse to participate or withdraw from the study at any time without any harm or injury.[8]

RESULTS

The analysis of the socio-demographic data of the 37 women who took part in the study (table 1) showed that the age of the women ranged from 15 to 35 years, with a predominance of 15 to 21 years (48.7%) and a mean of 23.6 years old; 78.4% of them resided in Fortaleza, city in which the maternity research site is located; 83.8% were married or lived in stable union with their partner; and the majority (54.1%) were Catholic. The highest level of schooling among the puerperal women was high school, with 43.2% of them completing high school and 21.6%, incomplete. Most had no source of their own income, with 21.6% unemployed, 21.6% housewives and 16.2% students. Of those who had their own income, 29.7% were wage earners and 10.8% were self-employed.

Table 1. Socio-demographic data of puerperal women who had normal delivery attended by a nurse in a maternity reference tertiary school in the State of Ceará. Fortaleza (CE), Brazil, 2015.

Sociodemographic data	n	%
Age		
15 to 21 years	18	48.7
22 to 28 years	9	24.3
29 to 35 years	10	27
From		
Fortress	29	78.4
Other cities	8	21.6
marital status		
Married / stable marriage	31	83.8
Single	6	16.2
Religion		
Catholic	20	54.1
Protestant	11	29.7
Without religion	6	16.2
Education		
Incomplete elementary school	6	16.2
Complete primary education	6	16.2
Incomplete high school	8	21.6
Full High School	16	43.2
Incomplete higher education	1	2.7
Occupation		
No occupation	8	21.6
Student	6	16.2
From home	8	21.6
Autonomous	4	10.8
Salaried	11	29.7

Regarding reproductive personal history (table 2), at admission, 51.4% of the women were primiparous and 64.9% were nulliparous. Among the women who had previous deliveries (35.1%), all had at least one normal delivery; only 15.4% had, in addition to normal delivery, at least one previous cesarean section; and 84.6% breastfed their other children. Only 2.7% had a previous neonatal death and 18.9% had a previous abortion.

Table 2. Reproductive personal history of puerperal women who had normal delivery attended by a nurse in a maternity reference tertiary school in the State of Ceará. Fortaleza (CE), Brazil, 2015.

Reproductive Personal History	n	%
Gestations		
One	19	51.4
Two	11	29.7
Three	5	13.5
Four	2	5.4
Birthdays		
none	24	64.9
One	8	21.6
Two	3	8.1
Three	2	5.4
Vaginal discharge (n = 13)		
One	10	76.9
Two	2	15.4
Three	1	7.7
Abdominal deliveries (n = 2)		
One	1	50
Two	1	50
Previous breastfeeding (n = 13)		
Yes	11	84.6
No	2	15.4
Previous fetal / neonatal status		
none	36	97.3
One	1	2.7
Abortion		
none	30	81.1
One	7	18.9

Regarding the obstetrical data of puerperal women (table 3), all had prenatal care, with a predominance of six or more consultations, with a mean of seven antenatal consultations

(32.4%). All women were admitted to the Obstetric Center with some dilation. The majority (81.1%) did not use oxytocin in the first and/or second clinical period of delivery; only 2.7% used epidural analgesia; 75.7% had spontaneous rupture of the amniotic sac; and in only 8.1% the amniotic fluid was meconium - it is unknown whether in these cases meconium was fluid or thick.

Among all the women, 5.4% underwent episiotomy at the time of delivery and 70.3% had lacerations - including women who had an episiotomy. Most lacerations (84.6%) were of first degree; 11.5% were of second degree; and 3.9% were of third grade. It is important to note that third degree laceration occurred in one of the women who underwent episiotomy. Of the women who had laceration, 84.6% needed suturing/episiorrhaphy.

Table 3. Obstetric data of puerperal women who had normal delivery attended by a nurse in a maternity reference tertiary school in the State of Ceará. Fortaleza (CE), Brazil, 2015.

Obstetric Data	n	%
Prenatal		
Yes	37	100
Number of queries		
Four	3	8.1
Five	3	8.1
Six	6	16.2
Seven	12	32.4
Eight	6	16.2
Nine	4	10.8
Ten	3	8.1
Dilation at admission		
Yes	37	100
Oxytocin in the 1st and / or 2nd clinical period of labor		
Yes	7	18.9
No	30	81.1
Analgesia		
Yes	1	2.7
No	36	97.3
Amniotic pouch rupture		
Spontaneous	28	75.7
Amniotomy	9	24.3
Appearance of amniotic fluid		
Of course	34	91.9
Meconial fluid	3	8.1
Episiotomy		
Yes	2	5.4
No	35	94.6
Laceration		
Yes	26	70.3
No	11	29.7
Degree of laceration (n = 26)		
First	22	84.6
Second	3	11.5
Third	1	3.9
Suture / episiorraphy (n = 26)		
Yes	22	84.6
No	4	15.4

Regarding the perinatal data (table 4), it was observed that, in 83.8% of deliveries, umbilical cord clamping was performed between one and three minutes after the baby's birth; The immediate skin-to-skin contact was performed in all deliveries, although there is no record of its duration; and the newborn's breastfeeding, in the first hour of life, occurred in 86.5% of deliveries. In relation to the Apgar score, 94.6% of the babies had Apgar of the first minute of life greater than or equal to seven, and all had the fifth-minute Apgar greater than or equal to seven. As for the weight of newborns, 89 , 2% of them weighed between 2,500 and 3,999g. It is worth mentioning that, in the delivery of babies weighing more than 4,000 g (5.4%), the laceration occurred was first degree, and suture was performed; and one of the mothers had a previous normal delivery, while the other had two previous normal deliveries.

Table 4. Perinatal data of normal births attended by a nurse in a maternity reference tertiary school in the State of Ceará. Fortaleza (CE), Brazil, 2015.

Perinatal data	n	
	n	%
Clamping of the umbilical cord		
<1 minute after childbirth	2	5.4
Between 1 and 3 minutes after birth	31	83.8
> 3 minutes after childbirth	4	10.8
Skin-to-skin contact mother-baby		
Yes	37	100
Breastfeeding in the 1st hour of life		
Yes	32	86.5
No	5	13.5
Apgar of the first minute of life		
Between 4 and 6	2	5.4
7 or more	35	94.6
Apgar of the 5th minute of life		
7 or more	37	100
Weight at birth		
<2,500g	2	5.4
Between 2,500g and 3,999g	33	89.2
Greater than or equal to 4,000g	2	5.4

When responding to the instrument adapted from the Questionnaire on Experience and Satisfaction with Childbirth (QESP), 48.6% of the women reported having used a lot of relaxation and breathing methods in labor and delivery (P) and 29.7 % Reported having used them only slightly. In addition, the majority of women reported having been able to relax a little during TP (54.1%) and P (45.9%), and 24.3% reported having relaxed a lot at both times.

Most of the women reported having received enough support from a companion (companion, family member or friend) in both PT and P, cited by 81.1% of postpartum women and postpartum (PP), this support was cited by 75.6% from them.

A significant portion of the women felt that they had the situation under control (59.4%) and felt confident (78.3%) especially after childbirth, although, in general, the majority reported at least some of these feelings as well during TP and P.

Regarding pain, the majority of puerperal (67.5%) recall PT and P as quite painful, and this intensity of pain decreased postpartum (27%). The feeling of fear was also more evident during TP and P, so that after delivery, 70.3% of the puerperal said they did not feel it. Conversely, during PT and P, most of the puerperal reported feeling no or little pleasure or satisfaction, whereas, after delivery, 54% referred significantly to the feeling of pleasure or satisfaction.

In terms of knowledge, the frequency of responses appeared well distributed among the alternatives. Nevertheless, in general, most women reported having at least a little knowledge about the events of the parturitive process, although a considerable number of them reported having no knowledge of TP (29.7%), P (37.8%) and PP (27%).

Concerning their state of health in PT and P, women also had varied and balanced responses to each other. After childbirth, on the other hand, this concern tended to decrease, while 54.1% of them denied having worried about their health thereafter.

Concerning the health concern of the baby, this occurred during PT (56.7%) and P (54%) in most of the women, decreasing soon after birth (35.1%). In addition, 86.5% of the women stated that they were very satisfied with the time they took to deliver the baby after delivery, and 91.9% reported having been able to take advantage of the first time they were with them.

Regarding the duration of the labor and delivery, 48.6% and 62.1% of the puerperae reported being very satisfied with the time it took TP and P, respectively. In addition, the majority reported being very satisfied with the way TP (78.3%), P (81%) and PP (86.4%) were given; And for 78.3% of them, the physical conditions of maternity corresponded to their expectations. Finally, the great majority of women were very satisfied with the quality of care provided by health professionals who attended both in labor (91.9%), in childbirth (97.3%) and in post-childbirth (94.6%).

DISCUSSION

The socio-demographic profile of the participating women corresponds to what is observed in other Brazilian studies. A study carried out in Salvador drew the profile of 449 puerperal women attended by the Unified

Health System and observed that women with an average age of 24.8 years, married or in stable union, were predominant, with approximately ten to 12 years of study and without Remuneration.[9]

Regarding the obstetric profile of the women, a recent study, carried out with 424 puerperal women attended at two public maternity hospitals in São Paulo, showed the predominance of primigravidae, nulliparous until the moment of admission, with no previous history of abortion and who underwent prenatal, With more than six queries, which resembles the profile found in this study. On the other hand, there is divergence related to the occurrence of episiotomy in 46.2% of the deliveries analyzed in the study from São Paulo, against 5.4% in this study. It is worth mentioning that in these maternity hospitals in São Paulo, births are attended only by the medical professionals of the Obstetric Center, not including nurses in childbirth care.[10]

A study conducted in Vietnam found that lack of training on how to minimize women's suffering at birth and how to maintain intact perineum was the biggest hurdle reported by obstetricians (56.5%) and midwives (36.7%), To reduce the rate of episiotomy. In addition, rooted practices, which disregard current evidence, make it even more difficult to change behavior, which reinforces the need for updating, training and confidence in the success of vaginal delivery without unnecessary interventions.[11]

In this study, preterm births without synthetic oxytocin and spontaneous rupture of the amniotic pouch predominated, evidencing the minimization of interventions by the nurses responsible for parturient care. On the other hand, an important study in Brazil found that oxytocin infusion and amniotomy were widely used to accelerate labor and occurred in about 40% of women at normal risk, being more frequent in women of the public sector. Lower levels of schooling, which demonstrates the need for improvements in Brazilian obstetric care.[12]

A carioca study, that analyzed data from 1665 normal births attended by obstetrician nurses, observed that in 49.6% of deliveries, occasional perineal laceration occurred, with first degree laceration (67.3%), followed by laceration of the second degree (31, 2%) and third degree (1.5%). [13] This data resembles those of this study, in which first-degree lacerations (84.6%) prevailed.

With regard to the perinatal data of nurse-delivered deliveries analyzed in this study, the prevalence of newborns with good vitality (Apgar score greater than or equal to seven in the first and fifth minutes of life) and adequate weight for gestational age (Between 2,500 g and 4,000 g), considering term pregnancies, is similar to what is observed in public maternity hospitals in the Southeastern part of the country.[10]

The nurses responsible for attending the births studied, recognizing the importance of skin-to-skin contact, facilitated their performance in all deliveries, which enabled breastfeeding of the vast majority of newborns in the first hour of life. Skin-to-skin contact, performed immediately after delivery, in addition to increasing maternal-infant interaction, contributes to the reduction of the third clinical period of delivery, decreases the risk of postpartum haemorrhage, prevents neonatal hypothermia and promotes successful breastfeeding early maternal mortality.[14]

Childbirth is a natural event strongly stigmatized by modern cultural values that associate the idea of suffering and modification of women's sexuality. However, when accompanied and enlightened, the experience of childbirth can become a moment of recognition of the autonomy and the feminine self-esteem. Obstetric Nursing, acting directly and integrally with pregnant women, parturients and puerperal, plays a fundamental role in the significance of childbirth and birth for the woman.

Among the actions of the nurse obstetrician, we have used non-pharmacological methods for pain relief, which aim, to reduce the stress experienced at that time. Stress is an adaptive and defense biological mechanism that elevates adrenaline levels in the blood, which inhibits the release of endogenous oxytocin, making it difficult to evolve labor.[15]

In this study, most women used some relaxation and breathing method and were able to relax at least a little during labor and delivery. In a study carried out in a public hospital in the State of São Paulo, puerperal reported that support, bathing, walking and walking helped reduce pain and improve delivery. However, it is important for the pregnant woman to be informed about pharmacological and non-pharmacological methods for pain relief and to participate in the decision to use them or not.[2]

In the maternity ward studied, most of the women had enough support from a companion - companion, family member or friend - in labor and delivery and in the puerperium. A survey carried out in 59 health care services that provided care in Santa Catarina showed

that, although the majority of services allow the presence of the companion throughout the parturition process, 23.7% allow the companion in the vaginal delivery room only sometimes And 15.3% do not allow it, which is an expressive number, considering that having an accompanying person is a right of the woman protected by Law 11,108 / 2005.16 The support of the Nursing team and the head of Nursing were the factors that facilitated the insertion of the companion in the services, while the inadequacy of the physical conditions and the non-acceptance of the doctors were cited as the greatest difficulties to this practice.[17]

For the Nursing team, the presence of the companion is also a fundamental care, since the team recognizes that their support gives the woman the feeling of tranquility, confidence and security. Even so, it is noticed that there is also the need for support and preparation of some companions so that they can contribute, in an appropriate way, to that moment.[18]

The feeling of control under the situation and the confidence of the women studied was more present after the birth. This is due to the fact that women's feelings tend to be masked by the feeling of relief after birth and by the happiness reactions of having a child and seeing them healthy and/or having no complications during childbirth.[2]

Participants in this study reported pain in labor and delivery, with significant decrease after birth. Many women are surprised by the intensity of the pain, perceiving it as growing, but ending the baby's birth.[2] Research that evaluated the satisfaction of puerperal according to the type of delivery also observed that satisfaction with the intensity of the pain experienced in a normal birth was greater after the baby's birth.[19]

It is important to recognize that some factors can increase the perception of pain, such as: fear, stress, tension, fatigue, cold, hunger, loneliness, social and affective helplessness, lack of knowledge about the events of childbirth and strange environment.[15] In this context, in a study about the perception of puerperal about how quality care should be, women reported that the pain of childbirth appears as something very strong and difficult to overcome and, therefore, they needed more care and understanding of the professionals towards the doubts and their unpreparedness at that moment.[20]

Fear, anxiety and worries, especially regarding the child's well-being, arise during gestation and tend to increase with the onset of labor, especially, when the woman has negative memories of previous births. With the onset of labor, these feelings may be exacerbated by pain; for fear of not controlling; not having the assistance of the team; of physical damage, such as episiotomy; or to discover problems with the newborn, such as malformations. These feelings, however, usually disappear after childbirth, so that the puerperal are amazed at the birth of the child and report that the childbirth was good and that they forgot the pain.[2]

Regarding the knowledge, although the majority of postpartum women in this study reported having at least a little knowledge about the events of labor and delivery and had performed six or more prenatal consultations, approximately one-third of them reported not having such knowledge. This is a worrying fact that raises the question about the quality of prenatal consultations and how empowered women come and go.

The lack of knowledge resulting from the lack of orientation or insufficient guidance during prenatal care hinders parturition by the woman because she fears the unknown. It is important for the woman to be informed about labor, delivery and puerperium during her gestation. At the moment of hospitalization, the guidelines given by the professionals should be only reinforcements of the knowledge already acquired, since the woman will be in a delicate, anxious and painful moment, and the information given will not be absorbed in its totality, nor with such clarity.[18] In addition, they should also be informed about good practices in childbirth care, appropriate obstetrical care and the benefits of vaginal delivery so that they are prepared to conduct their delivery actively.[12]

Most of the participants in this survey were satisfied with the time it took for labor, delivery and the time it took them to get the baby for the first time. It is known that the duration of labor depends on personal characteristics, so that the more the woman feels positive and prepared for delivery, the faster she will tend to be perceived by her. On the other hand, when associated with anxiety, fear and uncontrollable pain, the evolution of labor may seem time-consuming and traumatic, even though it is within the normal norms of normality.[2] Hence the importance of having a professional who goes beyond the clinic and act to reduce women's anxiety and provide relaxation and pain control.

The majority of postpartum women in this study were very satisfied with the way they went through labor, delivery and postpartum,

and almost all of them expressed satisfaction with the quality of care provided by health professionals.

A study, that sought to understand the significance of parturients attributed to the process of giving birth attended by an obstetrician nurse in the hospital context, revealed that the puerperal recognize that this professional is more sensitive and develops a relationship of identity with the woman; transmits security and self-confidence, granting autonomy to the parturient; is more receptive and available to provide guidance and physical and emotional support, in addition to promoting care that stimulates the bond between mother and child, such as touching the baby's head during birth and allowing the mother to stay in touch with the child and to breastfeed soon after birth.[1]

However, an Australian study reinforces that in obstetric care, a number of aspects need to be considered, since women's satisfaction is closely related to factors that vary between each case / woman / team, such as: care given by the team; personal characteristics of the professionals; active listening to women's needs; provision of information and clarification of doubts, in addition to women's autonomy and participation in decision-making.[21]

CONCLUSION

It was found that the experience of women with nurse-assisted delivery was quite satisfactory for them. Although the pain was reported as being of great intensity during labor and delivery, it is perceived that the Nursing activity as a caregiver, that is involved in providing physical and emotional support to the parturient, was fundamental to assist in the relaxation and coping of this So unique and delicate a moment as the birth of a child.

Obstetric nursing care, has sought to adapt to the current recommendations, with more humanized, less interventionist practices that allow habitual childbirth to occur in the most natural way possible, with the active participation of the woman, as well as has obtained satisfactory perinatal results, with the birth of babies with good vitality and satisfied mothers.

However, the lack of knowledge with which women arrive in the maternity ward requires professionals to be more careful in order to transmit safety and confidence to the parturients and to enable them to experience childbirth as protagonists, recognizing their autonomy over their own body. In addition, this care requires even greater attention when it is considered that the professional must know how to recognize the moments that are conducive to the provision of information and guidance, given the pains and the range of contradictory feelings and sensations that the woman experiences at the moment .

As limitations of the study, the fact that the research site is a reference tertiary maternity of the State, often goes through periods of overcrowding and, in several situations, the nurses act including assisting deliveries of women who arrive in an expulsive period, it is not possible to offer Nursing care during labor, as well as, occasionally, in the absence of the obstetrician, assist women with high-risk pregnancies. In addition, because it is a maternity school, the Obstetric Center has the participation of obstetrician doctors and nurses, Medical and Nursing residents, undergraduate students in Medicine and Nursing, as well as Obstetric Nursing specialists, overcrowding of maternity hospitals to the large number of people to assist in childbirth and the bureaucratic work inherent in the Nursing service, the number of women with habitual risk gestations assisted by a nurse during labor and delivery was considered small, making it difficult to collect of the data.

This study does not exhaust the topic and serves as a starting point to understand what aspects can positively or negatively influence satisfaction with normal delivery, to evaluate the quality of prenatal consultations and to identify what actions can be developed to provide a Increasingly qualified and humanized obstetric care in Brazil.

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