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Satisfaction and dissatisfaction with normal birth from the care quality attributes standpoint

Satisfação e insatisfação no parto normal sob o enfoque dos atributos da qualidade da assistência

Satisfacción e insatisfacción en el parto normal bajo el enfoque de los atributos de la calidad de la asistencia

Diana da Silva Gonçalves[I]; Maria Aparecida Vasconcelos Moura[I]; Adriana Lenho de Figueiredo Pereira[II]; Ana Beatriz Azevedo Queiroz[I]; Clenilda Aparecida dos Santos[I]; Hugo Demésio Maia Torquato[I]

[I]Universidade Federal do Rio de Janeiro, Rio de Janeiro, RJ, Brazil; [II]Universidade do Estado do Rio de Janeiro, Rio de Janeiro, RJ, Brazil

ABSTRACT

Objective: to examine the attributes of birth care associated with childbearing women's satisfaction and dissatisfaction. **Method:** this qualitative study was conducted from October 2019 to January 2020 with 30 puerperal women at a maternity unit in the municipality of Rio de Janeiro, Brazil. The interviews were subjected to thematic content analysis and the quality structure frame of reference. The study was approved by the research ethics committee. **Results:** satisfaction with birth care was related to effective communication, respect for privacy, and autonomy with emotional support, which are convergent with a quality framework. Dissatisfaction was attributed to disrespectful professional behaviour, deficient infrastructure, and deficient service resources. **Final Considerations:** qualified listening, respectful and woman-centred care were crucial to participants' perceptions of quality. Dissatisfaction, meanwhile, was related to persistent shortcomings in the normal birth care system.
Descriptors: Nursing; Women's Health; Natural Childbirth; Quality of Health Care.

RESUMO

Objetivo: analisar os atributos da assistência ao parto normal relacionados com a satisfação e insatisfação na perspectiva de puérperas. **Método:** estudo qualitativo, com 30 puérperas, em maternidade do município do Rio de Janeiro, Brasil, realizada de outubro de 2019 a janeiro de 2020. As entrevistas foram submetidas à análise de conteúdo temática e referencial da estrutura da qualidade. Pesquisa aprovada por Comitê de Ética em Pesquisa. **Resultados:** a satisfação na assistência ao parto foi relacionada à comunicação eficaz, respeito à privacidade e autonomia com suporte emocional, convergentes com a estrutura da qualidade. A insatisfação foi atribuída à postura profissional desrespeitosa, à deficiência na infraestrutura e aos recursos no serviço. **Considerações finais:** escuta qualificada, assistência respeitosa e centrada na mulher foram basilares na qualidade percebida pelas participantes. Entretanto, a insatisfação foi relacionada à persistência de fragilidades na rede de atenção ao parto normal.
Descritores: Enfermagem; Saúde da Mulher; Parto Normal; Qualidade da Assistência à Saúde.

RESUMEN

Objetivo: analizar los atributos de asistencia al parto relacionados con la satisfacción y la insatisfacción en la perspectiva de puérperas. **Método:** estudio cualitativo junto a 30 puérperas en una maternidad de Rio de Janeiro, Brasil, realizado de octubre de 2019 a enero de 2020. Se analizaron las entrevistas por contenido temático y referencial de la estructura de calidad. El Comité de Ética en Investigación aprobó la investigación. **Resultados:** la satisfacción en la asistencia al parto estuvo relacionada con la comunicación eficaz, respecto a la privacidad y autonomía con apoyo emocional, convergentes con la estructura de la calidad. La insatisfacción se atribuyó a la postura profesional irrespetuosa, la deficiencia de infraestructura y a los recursos del servicio. **Consideraciones finales:** escucha cualificada, asistencia respetuosa y centrada en la mujer fueron fundamentales en la calidad que las participantes mencionaron. Sin embargo, la insatisfacción estuvo relacionada con la persistencia de fragilidades en la red de atención al parto normal.
Descriptores: Enfermería; Salud de la Mujer; Parto Normal; Calidad de la Atención de Salud.

INTRODUCTION

The quality of obstetric assistance is still a challenge in Brazil, given the finding of inadequate practices represented by the high C-section rate, which corresponded to 55.9% of the births in 2018, contrary to the 15% rate recommended by the World Health Organization (WHO)[1]. Similarly, routine episiotomy, Kristeller maneuver, deprivation of food and liquids, bed restraint, disrespect and mistreatment raise the perception of aggressive and unsatisfactory assistance among women[2-8].

Women's satisfaction with the assistance provided during delivery is related to the adequacy of the care conditions, with the presence of the companion and with the perception of a leading role. However, the interventions

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Corresponding author: Diana da Silva Gonçalves. E-mail: enfdiana.goncalves@gmail.com
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intended to qualification of the assistance provided during delivery rarely include the pregnant woman's perspective about the experience. So that all pregnant women and newborns receive good quality assistance, the WHO established attributes regarding improvement of the delivery and birth process quality[9].

Satisfaction expresses the positive personal perception regarding the assistance received during delivery, evidencing professional practices and stances implemented with the patients. Previous expectations about delivery, access to obstetric care, and characteristics of the health system are multidimensional quality measures that show the parturient woman's perspective and make it possible to improve quality[10]. Dissatisfaction reveals the individual and unfavorable perspective about certain elements or absence of influencing factors in physical or emotional harms to the puerperal woman and/or the newborn[4,11].

The humanization of birth movement considers this period of women's reproductive life as a physiological event, promotes recovery of women's autonomy and their right to respectful assistance[12]. However, the quality of delivery assistance remains a critical issue on the maternal and newborn health agenda, with respect to meeting women's human rights, health outcomes, and costs of the services.

Despite the progress achieved in normal delivery assistance provided by qualified health professionals and in the minimum structural conditions of the health services in the last decades, obstetric assistance still needs to advance in quality to obtain successful and satisfactory results for women[1,4,13]. Considering this challenge, the current study was proposed, which aimed at analyzing the attributes of normal delivery assistance related to satisfaction and dissatisfaction from the perspective of puerperal women.

THEORETICAL FRAMEWORK

The theoretical framework is based on the quality framework proposed by the WHO[13], which defines the essential attributes of health services regarding available resources and delivery and birth assistance, centered on the woman, the newborn and the family, applicable to all maternity services. Use of these attributes enables strategic guidance to implement improvements and assessment of the quality of the assistance provided in health institutions[13]. The quality of delivery and birth assistance is the degree to which the health services provide care consistent with up-to-date scientific knowledge, valuing the parturient woman's preferences and wishes.

Care quality encompasses two intertwined dimensions of the process: care provision and experience (Figure 1). Care provision includes assistance practices based on scientific evidence, information systems, and a health system that allows referral to the different care levels. The second dimension is the care experience, which guided this research, contemplating effective communication to the parturient and to the family about the assistance provided; appreciation of expectations; and respect for the rights, in addition to the emotional support offered by the team[13].

The conceptual chart shown in Figure 1 provides the structure of care quality and the components of the assistance process, organized into eight domains that guide the evaluation and improvements[13].

The care experiences require effective communication between the professional and the pregnant woman to favor a positive experience during delivery. The health team should have readily available counseling skills and a positive attitude, and use simple, clear language to facilitate understanding and recognition of women's communication needs and preferences[13]. Interaction and a trusting relationship are necessary for a satisfactory assistance process in labor, as well as a favorable environment, with appropriate courses of action and in accordance with the client's expectations[2].

In addition to this attribute, respect and preservation of dignity becomes essential, which involves maintaining privacy, confidentiality and absence of mistreatment in the provision of care. Therefore, it is sought to motivate the pregnant women in making informed decisions and regarding clarifications about the courses of action and possible outcomes[13]. Emotional support is also an essential attribute for the centrality of care in parturient women, based on individual needs and on the possibility of favoring protagonism of the woman in labor, with encouragement for the presence of a companion of choice and the offer of adequate care, according to the organizational structure of each institution[13].

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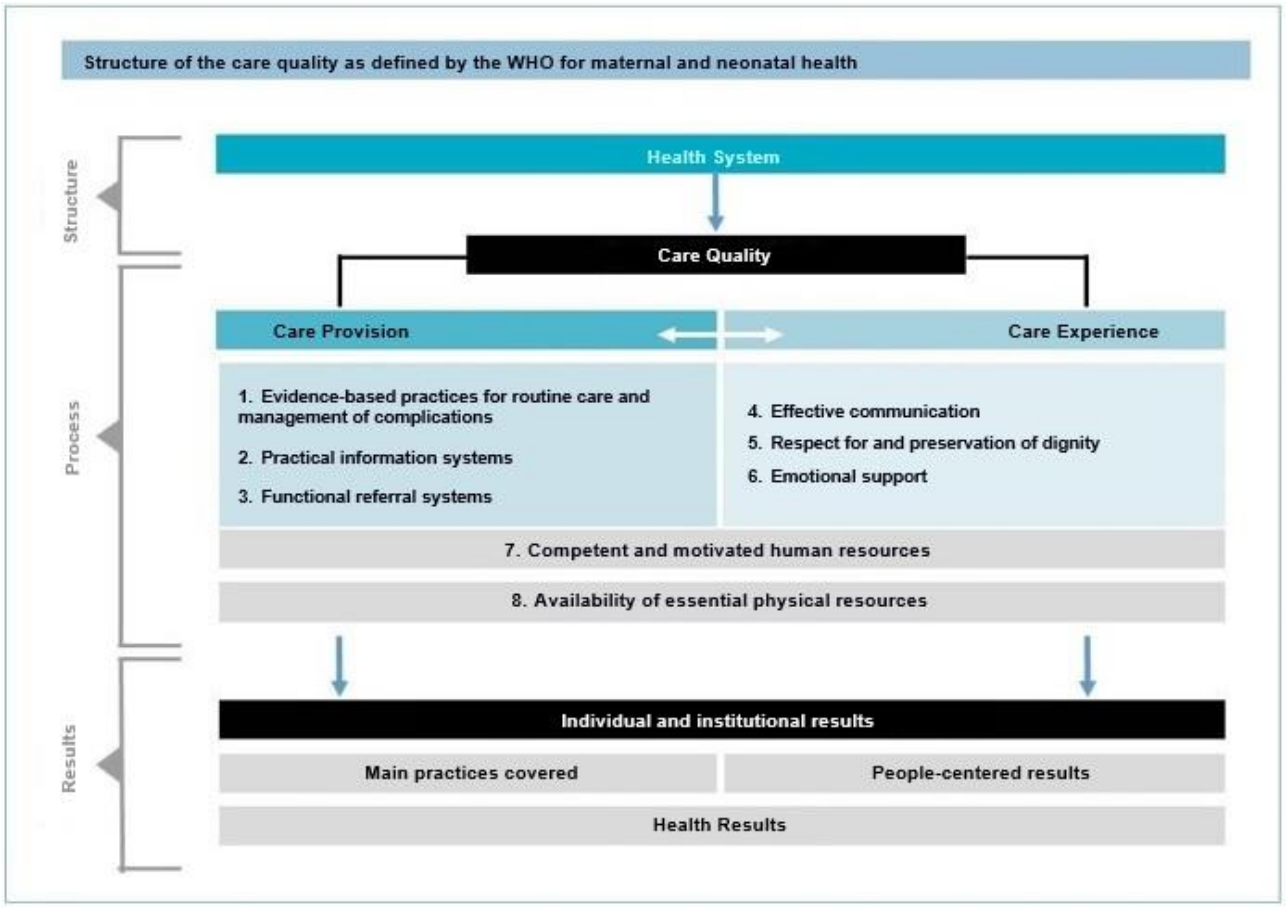

FIGURE 1: Structure of the Maternal and Neonatal Assistance Quality proposed by the WHO. Rio de Janeiro, RJ, Brazil, 2021.
Source: Adapted from the WHO: *Standards for improving quality of maternal and newborn care in health facilities* (2016).

METHOD

A qualitative and descriptive study conducted in a municipal maternity hospital from Rio de Janeiro, Brazil. The maternity hospital was selected because it is considered a reference in the implementation of delivery humanization practices by the municipal health management and for having an obstetric nurse to assist in normal delivery. The *Consolidated criteria for reporting qualitative research* (COREQ)[14] were adopted.

The study participants were 30 puerperal women who gave birth via normal deliveries, resulting from pregnancies classified as of usual risk. Selection of the participants occurred through the identification of obstetric characteristics in the medical records, identifying 48 eligible puerperal women who were invited individually in the Rooming-In (RI) sector, and were informed of the research objectives. Of this total, 30 puerperal women accepted to participate in the study and 18 rejected the invitation.

The inclusion criteria were puerperal women with usual obstetric risk classification, who had normal delivery assistance provided by obstetric nurses and physicians, and at least 24 hours postpartum. Those with limitations in verbal communication and with fetal death or preterm newborns as delivery outcomes were excluded.

The interviews were conducted by the main researcher, in a private room of the RI sector, from October 2019 to January 2020. They recorded with the aid of an MP3 device and lasted a mean of 45 minutes, being fully transcribed by the researcher herself.

A previously tested semistructured script was used, and the pilot interviews were discarded. This script included objective and subjective questions about the sociodemographic profile, obstetric history and delivery assistance, concerning the assistance attributes involved in satisfaction and dissatisfaction with the care received.

The thematic content analysis technique[14] was used in the data analysis process. This technique aims at describing and interpreting the content of communications in general, such as the set of texts from the interviews, enabling understanding of the elements of meaning, manifests and regarding social phenomenon of interest.

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The analysis was performed in three sequential phases, namely: pre-analysis; exploration of the material and treatment of the results; inference and interpretation[14]. The coding and categorization stages took place based on words or expressions to attain the text's comprehension nucleus, moment in which the thematic categories emerged. Finally, treatment and interpretation of the results allowed highlighting the information and the analysis in the light of the quality attributes. The last two phases of the analysis had the supervision of two researchers that did not participate in data collection, in order to decide on any and all inconsistencies in the analysis.

The research protocol was approved by the Research Ethics Committee and respected the legislation pertinent to research studies on human beings. Anonymity was preserved, through identification of the interviewee ("E" for "*Entrevistada*" in Portuguese), followed by a numeral, according to the order in which the interviews were carried out, thus denoting the participants from E1 to E30.

RESULTS AND DISCUSSION

Of the 30 puerperal women participating in the study, the majority was aged between 20 and 34 years old (n=23), lived with their partners (n=22) and self-declared as brown- and black-skinned (n=11 and n=8, respectively). Regarding the schooling level, 13 puerperal women had complete High School and three had completed Higher Education. The other women had complete (n=9) and incomplete (n=4) Elementary Education. Most (n=18) of the puerperal women reported that normal delivery assistance was conducted by an obstetric nurse; the others, by a physician (n=3); and by both professionals (n=4); four of them could not specify the professional category.

The study categories are presented and discussed below.

Communication, leading role and welcoming: The presence of the care experience attributes in satisfaction regarding the assistance provided during normal delivery

In this category, it is evidenced that, from the point of view of quality attributes, the elements that corroborated satisfaction with the assistance received in normal delivery referred to professional behaviors and attitudes based on effective communication. This was identified as an attachment and interaction link between professionals, the parturient woman and the companion, resulting in a sensation of comfort, safety, trust and freedom for the parturient woman to express her needs and preferences[13].

> *The professionals were kind and careful, and they instructed my partner well. They made me feel comfortable and calm. The nurse was exceptional (...) she asked for my permission for the [vaginal] touch. (E14)*

> *I felt free to ask anything and I said what I wanted to say. The nurses were always encouraging, without imposing anything and putting themselves in the other's shoes, creating a bond. It was wonderful. (E25)*

As a communication tool, qualified listening promoted the sensation of professional zeal and availability to care for the pregnant women's needs. This relational technology has contributed to quality assistance, as it is anchored in scientific knowledge and technical skills, in agreement with the ministerial recommendations[12]. When used by obstetric nurses, they enable information exchange and encouragement of the pregnant woman's participation in the care-related decisions.

The professionals' communication made it easier for the pregnant women to participate in the assistance provided, with due observation and adoption of their needs, wished and choices as guiding elements. Centrality in the parturient women contributed to protagonism, for they felt responsible for conducting the delivery, experiencing empowerment and confidence, which exceeded the need for medical intervention. In this direction, assistance centered on the pregnant women was referenced as a characteristic of the "respect for and preservation of dignity" attribute, which provided a sensation of tranquility and welcoming.

Every woman and newborn has the right to receive respectful, dignified assistance during their hospital stay, which includes respect for privacy, confidentiality of information and absence of mistreatment. In addition, the care-related dynamics permeated by decision-making by the pregnant woman is indicated, based on clear information provided by the health care professionals[1].

The statements also show self-confidence in relation to the spontaneity and power for delivery, understood as a bodily, emotional and unique experience.

> *My satisfaction was being the center of that moment and the doctor not having imposed his will (...). I felt safe, welcomed and respected, it's the woman who gives birth and the professionals help in whatever necessary. (E15)*

> *The bath, standing up and using the ball made it easier (...) I was the protagonist of my delivery. They brought a stool, I put my hand in my vagina, felt the baby's head and pushed. It was an incredible moment. (E6)*

The bond established in the encounters with the professionals expressed a perception of welcoming, privacy and attention. An enriched experience due to the freedom of movement, position, access to the shower, birth stool and

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bobath ball, hard technologies of health assistance[15], used based on professional knowledge and skills, which valued the uniqueness of each parturient woman.

Professional availability in a dynamics of subjectivity appreciation stands out, aimed at meeting the parturient woman's needs and wishes, which goes beyond routine practices and institutional norms[16].

These elements, together with light technologies in health, that is, those that are materialized in human relationships, in the way of implementing and managing care and services[15], emerged as characteristics of the respect and preservation of dignity attribute, which made it possible to meet the needs and preferences in the delivery. Practices favorable to the parturient woman's autonomy proposes comfortable, safe positions and pain relief, meeting the perceptions of parturient women in São Paulo[17,18], Minas Gerais[19] and Rio de Janeiro[20], as well as in the international context, such as in Italy[21], Australia[22] and the Netherlands[23].

It is therefore verified that these low-cost technologies, when implemented by competent professionals, are compatible with the subjective perceptions of most participants, which implied satisfaction and a positive experience of normal hospital delivery.

Qualified delivery assistance requires recognition of the birth process as a physiological and natural event, anchored in the therapeutic professional-parturient-companion bond established. In this perspective, the individual needs for the promotion of personalized assistance that favors the pregnant woman's satisfaction are identified.[24,25].

> *They helped me by saying: 'push' and they gave guidance for my husband to participate; and during the delivery, I was able to drink water and eat. It was very good. (E23)*
>
> *(...) I gave birth on the stool, the professionals were patient, they were around me and my husband was behind me; I felt protected, respected and safe. There was quality in the Service, professionalism and care.. (E29)*

Emotional support sensitive to the pregnant woman's needs fostered a sensation of self-confidence and trust in the competence of the professionals assisting her. This attribute motivated and encouraged free movement, the adoption of comfortable positions, food and liquid intake, provision of pain relief and comfort, as well as it favored the parturient woman's autonomy[2]; an approach that contributes to better delivery experiences, adherence to postpartum care, lower costs to the health care system, reduced maternal mortality, and promotion of improved quality of assistance[26,27].

Satisfaction was commonly associated with communication, interaction and involvement of the parturient woman and companion in the assistance provided, through clear information and promotion of an environment with reduction of sound and light stimuli. Shared decisions[12], fulfillment of the expectations and the preferences associated with "respect" converged with the results of a systematic review[27].

The current obstetric context in Brazil is characterized by a hybrid model, in which the humanized and technocratic paradigms coexist[28]. In this sense, through contrasting reports, dissatisfaction with the assistance received was evidenced given the absence of the quality attributes.

The dissatisfaction experience given non-adequacy of the quality attributes reconfigured as obstetric violence

This category evidenced the absence of quality attributes as an intervening factor in the dissatisfaction with the assistance received during delivery. This perception was described from the disrespectful professional attitude, weaknesses in communication, material resources and poor institutional infrastructure.

Ineffective communication between the health professionals, parturient woman and companion resulted in concern and a sensation of unattended assistance.

> *Some professionals who examine, observe and leave without saying anything; others just keep staring, sometimes with a frown on their faces and a bit rude. (E7)*
>
> *Assistance was very bad. I already arrived in pain to have the baby, but there was no one to support me (...). I felt as if I was trash because no one is caring about anything. (E17)*
>
> *The obstetrician asked where I came from, I said: from a private maternity hospital. She said: Why did you come here from a great maternity hospital? (...) The obstetricians were annoying, they were there judging me. That was bad, it blocked me. It was another service for them, but for me, a unique moment. (E19)*

The speeches made it evident that these participants felt vulnerable in face of lack of communication, absence of welcoming and undervaluation of demands. Exposure of concerns and clarifications was made impossible, which limited informed decision-making and the exercise of autonomy. Questions and judgments about the choice of the delivery locus were identified as discouraging and disrespectful; a situation that, according to the WHO, characterizes disrespectful, abusive and negligent assistance, unfavorable to the delivery experience[13].

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Hypermedicalization of the female body during labor, described by these parturient women, expressed characteristics of obstetric violence, a reflection of gender violence, a phenomenon that marks the violation of women's human rights, a reality inserted in the cultural and social power structure, which appropriates the natural female processes and places them in a position of passivity reflected in the health services[29].

Although harmful, this assistance standard is still recurrent, as reported by parturient women from maternity hospitals in Brazil[30] and other countries[31,32] in surveys, which interferes in the search for delivery assistance and in the low expectations in subsequent deliveries[33].

The limitations of the service infrastructure and of the obstetric care network were also pointed out as influencing the feeling of insecurity, fear, uneasiness, frustration and discomfort.

> *I was in the shower the whole time and the water went into the room, which made it quite hard, so I didn't like it. I think that the environment for women's health should be more of a priority. (E6)*
>
> *It was three hours of pain, doubts and uncertainty (...), and I grasped the bars and tried to sit on the floor, but it was dirty. The bathroom was in bad conditions, due to the strike, all expectations collapsed. (E19)*

Lack of support from the obstetric team gave rise to a sensation of distress, discomfort and lack of assistance, at a time in which they felt abandoned and weak due to the absence of pain relief or support for free positioning. The restrictions imposed on this sensitive moment confronted the parturient woman's expectations for delivery in an adequate environment and assistance received in precarious conditions.

These participants reported weaknesses in the infrastructure of the health service, which subjected them to unfavorable conditions during labor, given the SUS crisis. The political and economic situation manifested in the three spheres of the federal, state and municipal government poses a challenge to managers in the organization of institutions in the face of financial restraint and precariousness of the health system. This situation hinders operationalization of the public policies for women's health and the qualification of normal delivery assistance[34].

> *(...) They gave me the serum, said that pain would get better, but it didn't happen (...). I asked for a C-section, but they said no, because I had a passage. When the baby was coming out, my mother called the team, they came running and almost didn't grab my daughter. An awful experience, I suffered a lot. (E11)*
>
> *I think there should be less [vaginal] touch because it's very uncomfortable. (E20)*
>
> *I gave birth lying with my legs wide open and on the bed holding on to the bars. It was uncomfortable, I felt cramps, but I had no choice (...). They didn't do anything to relief pain, they didn't care much. (E27)*

Dissatisfaction with movement restriction, frequent vaginal touching, and absence of the professional team during the expulsion period evidence the interventionist and technocratic assistance that is still recurrent in the country[21,35]; an assistance standard that generated dissatisfaction with the limitation and exclusion of possible decisions, as well as the report by women from maternity hospitals in different regions of Brazil[36], evidencing a harmful and dissatisfactory paradigm, from the women's perspective. In this direction, rejection of unnecessary interventions and the search for respectful delivery assistance, especially in out-of-hospital settings, have been a gradually increasing phenomenon required by women[37].

In addition, these behaviors increase the risk for pain during delivery, discourage the experience of normal delivery, favor sleep disturbances, mood and appetite changes, family planning for fewer children, impaired bonding with the newborn, the decision not to talk about the delivery experience, fear of normal delivery, and identification of the C-section as an alternative to feel safe[11]. These consequences are characterized by situations of institutional violence.

The participants mentioned negligent, reckless and disrespectful professional attitudes, as well as inappropriate use of invasive procedures and assistance technologies for maternal health care in the hospital spaces. These practices devalue the woman as a person, making her a mere object of assistance and without consideration for the feeling of pain arising from these practices and from the inadequate physical and structural conditions in the service.

Study limitations

The study limitations were due to its development in a single maternity hospital, to the collection of information in the assistance scenario, and to the fact that it included a particular group of puerperal women, which precludes generalization of the results herein presented to other assistance scenarios, at the municipal and national levels.

FINAL CONSIDERATIONS

The elements that comprised satisfaction with the assistance received in normal delivery converged with the quality attributes related to the *care experience*, such as *effective communication, respect and preservation of dignity,*

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and emotional support, described by qualified listening and promotion of the parturient woman's leading role, in a comfortable environment with integration of the companion during delivery.

Although advances in obstetric assistance progressively promote improvements and the achievement of satisfaction with the assistance received, the need for qualification in delivery assistance is still evident, as inefficient communication, disrespect, lack of emotional support and weaknesses in material and human resources caused concern, and sensations of distress, contempt, frustration and dissatisfaction. Violation of the parturient woman's rights and dignity evidenced the complex relationship between the characteristics of the health system and the professional practices and attitudes regarding the delivery experience.

The potentialities and challenges in the qualification of normal hospital delivery assistance in the Unified Health System (*Sistema Único de Saúde*, SUS) were presented, in the face of the inconsistency of quality attributes and persistence of elements that disqualified the assistance provided, from the parturient women's perspective.

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