The role of the obstetric nurse: Non-invasive care technologies and pain relief in childbirth

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ABSTRACT

This article aims to describe the non-invasive care technologies used by obstetric nurses in the process of pain relief in the parturitive process. This is a narrative review of the literature carried out between January 2022 and October 2023. A search was conducted for articles published in the last 05 years in the Virtual Health Library (VHL). The interest in developing this work arose from the reflection on the role of the obstetric nurse and the importance of non-invasive technologies used in the parturitive process. The literature review, as a fundamental step for the study, allowed us to gather relevant theoretical information on the subject. The researched literature points to the technologies used by obstetric nurses, favoring the participation of women in the parturition process. The use of these technologies has marked the distinction of the obstetric nurse's practice in the obstetric field, because of which the role of the obstetric nurse in the qualification of care is evidenced, based on the principles of humanization and with the use, as a work tool, of non-invasive care technologies in the parturition process. In this sense, the woman's choice is respected and her protagonism in labor and birth is favored. Therefore, in the technologies used by these professionals, it is characterized by care based on the physiology and exercise of the woman's autonomy, rescuing childbirth as a physiological process.

Keywords: Obstetric Nursing, Labor, Nursing Care, Labor Pain.

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INTRODUCTION

The process of parturition is a relevant topic, which demands in-depth study and analysis, since it involves the lives of women, babies and families. For this reason, this issue has attracted increasing attention from civil society, health professionals and the legal field.

Historically, the monitoring of labor and delivery took place in the home environment, in which the woman was assisted by another woman, usually a midwife or a "groomer" of her trust, and supported by her family members. Midwifery is an art and historical practice, and for many years it was considered an activity exclusively for midwives, who were also responsible for taking care of women during pregnancy, labor, delivery and puerperium, in addition to the newborn1. Midwives were holders of empirical wisdom, shared and passed on from generation to generation by their mentors, associated with their own experience1.

Childbirth is a remarkable moment of relevance for society, as it is a means of maintaining human life; for the family, with the arrival of a new member, the fulfillment of cultural and social desires is fulfilled, as a human, biological and psychological experience. Especially with the process of hospitalization of labor and birth, the physiological act of giving birth came to be seen as pathological, favoring the technique and practices that were medicalized and centered on the hospital environment. In the twentieth century, more expressively after the Second World War, in the name of reducing the high rates of maternal and infant mortality, childbirth was institutionalized[2]. This process involved the advent of technology, contributing to the gradual departure of childbirth care from the home environment to the hospital environment, a process that affected not only obstetric care, but the entire health area3.

In this sense, the present study is justified by the interest in developing a reflection on the role of obstetric nurses in pain relief during labor and birth and the importance of the technologies used by these professionals. In this sense, the objective of this study is to describe the pain relief technologies used by nurses in parturition and the role of this professional.

HISTORICAL PERSPECTIVE AND LEGAL FRAMEWORK

In a historical temporal assessment, in Brazil, in 1998, the Ministry of Health (MS) officially recognized childbirth care by obstetric nurses in hospitals affiliated with the SUS and normalized the remuneration of these professionals. In 1999, as a defining framework for a new childbirth care policy, the Ministry of Health proposed the creation of Normal Birth Centers (BC), units that allow care for births of usual risk outside hospitals. Professional care during labor and birth, for women and newborns, is provided exclusively by obstetric nurses, and there is no need for the presence of medical professionals[4].

The obstetric nurse is a professional qualified to provide care for normal childbirth without

dystocia, with skills and competencies that provide technical and scientific safety supported by law, therefore, it is up to the obstetric nurse to understand all dimensions of the labor and birth process. Their professional training is based on ethical principles and scientific evidence, aimed at providing care using fewer interventions and adopting a more humanistic approach, with respect to the physiological processes and individualities of each woman[5]. The obstetric nurse seeks to ensure a healthy and iatrogenic-free delivery, with physical and emotional support, aiming at the well-being of the woman and newborn. This is because the act of caring begins with reproductive planning, going through prenatal care and continuing until the puerperium.

Ordinance No. 2,815 of May 29, 1998 of the Ministry of Health (MS), includes in the table of the Hospital Information System of the Unified Health System (SUS) the procedure "normal delivery without dystocia performed by an obstetric nurse" and its main purpose is to recognize the care provided by this professional category, in the context of humanization of childbirth. In addition, the Ministry of Health (MH) technically and financially promoted specialization courses in obstetric nursing because it noticed the small number of professionals working at the beginning of this century, even though it is estimated that the number of deliveries performed by these professionals is higher than that recorded in the SUS[6].

Nursing has its professional practice regulated by Law No. 7,498/86, Decree-Law No. 94,406/87, which also supports the professional practice of obstetric nurses. In this legislation, the nurse is privy to, among other functions, the direction of the nursing body that is part of the basic structure of the health institution, public or private, and the head of the service and nursing unit. In relation to obstetric care, the nurse provides nursing care to pregnant women, parturients, postpartum women and newborns; monitoring the evolution of labor; obstetric care in emergency situations and delivery without dystocia[7].

Technical knowledge, preparation and evidence-based practice are relevant for nurses to provide humanized care during labor. The obstetric nurse's practice is not limited to the delivery room, contemplating sexual and reproductive planning, working from the prenatal period to the puerperium. Its role encompasses welcoming women; the promotion, encouragement and support of breastfeeding; guidance and support for the exercise of women's autonomy and their sexual and reproductive rights, encouraging practices favorable to maternal and newborn health, in usual situations and/or in cases of complications8. The obstetric nurse does not replace the physician in high-risk pregnancies, as this is part of the multidisciplinary team, which in interdisciplinary work, provides singular care9.

Still in public policies in the area of women's health, in 2001 the Ministry of Health published the Manual Childbirth, Abortion and Puerperium – Humanized Assistance to Women. The publication defines the concept of humanization of care and defends a new perspective, in which the

care provided should be effectively beneficial, unnecessary interventions should be avoided, and maternal privacy and autonomy should be preserved[10].

The Federal Council of Nursing (COFEN) assigns to the obstetric nurse the competencies of welcoming women and assessing maternal and fetal obstetric clinical conditions. It includes, along with the promotion of the humanized care model for labor and birth, the offer of non-pharmacological methods of pain relief, the freedom to choose the position during childbirth, the immediate contact of mother and newborn, the preservation of perineal integrity, encouragement of exclusive breastfeeding until the newborn is 6 months old, as well as respect for the ethnic and cultural issues of women and their families11.

HUMANIZED ASSISTANCE

Qualified assistance during labor is essential for the best results to be achieved for the mother and the baby, both from a physical and emotional point of view. In order to achieve these goals, it is necessary that attitudes, measures and interventions adopted by care professionals are based on the best available evidence12.

The term "humanize" and its derivatives have acquired equally diverse meanings in different contexts. With regard to the phenomenon of childbirth, it refers to an attention that starts from the recognition of the fundamental rights of mothers and newborns and the right to appropriate technologies in care. This set of demands includes the right to choose a place, people and forms of care during childbirth; the preservation of the bodily integrity of mothers and babies; respect for childbirth as a highly personal, sexual and family experience; health care and emotional, social and material support in the pregnancy-puerperal cycle; Protection against abuse and neglect[13].

The humanization of childbirth care also implies, and mainly, that the professional's performance respects the aspects of physiology, without unnecessary interventions, recognizes the social and cultural aspects of labor and birth, and offers the necessary emotional support to the woman and her family, facilitating the formation of family affective bonds and the mother-baby-family bond[14]. The nursing care technologies employed by obstetric nurses contribute to the rescue of labor and delivery as a physiological event, preventing traumatic effects for the woman and her baby, thus the humanization of labor and birth has become a premise for some health institutions and professionals, who have come to understand the woman/parturient as the main subject in pregnancy. in childbirth, in the puerperium and in the care of the newborn, excluding ineffective obstetric routines and valuing the woman as the conductor of childbirth, attending to her in all dimensions and valuing the essential aspects of the human being[15].

The model of humanized care in parturition is an ideal that is increasingly becoming an experienced reality. To humanize is to provide quality care to the parturient through pain relief,

promotion of physical and emotional comfort, freedom of choice of her companion, and how she wishes to have her child, favoring positive experiences in a peaceful process16.

It should also be noted that, in article 2 of Ordinance No. 569, of June 1, 2000, it is described that every pregnant woman has the right to dignified and quality care during pregnancy, childbirth and puerperium, that is, for a long time there have been means to protect women, with the aim that they are respected and have their rights guaranteed17.

The birth plan is an important tool to stimulate the empowerment of pregnant women, favoring the woman's protagonism in her delivery. This is an educational instrument with high educational potential, which stimulates communication between the woman and the health team. The birth plan is a document that the woman can use to fill in her personal information and preferences for the experience of labor, delivery and immediate postpartum. This document gathers all the woman's wishes for the birth of the baby, from admission to discharge from the delivery service. This includes, for example, the choice of companion, positions and measures in an emergency situation18.

In summary, prenatal care, labor and delivery, and the right to informed choice are intertwined, ensuring that expectant mothers receive information and adequate support to make informed decisions about their health and that of their baby.

PAIN AT THE TIME OF CHILDBIRTH

The pain experienced by women during the parturition process is a subjective experience where different behaviors can be identified in relation to them, which vary according to culture and time. The fear of pain during childbirth is one of the main reasons that lead women to opt for cesarean section. Pain also results in a psychic response and reflects on physical actions. The pain that women feel during labor and delivery is individual and influenced by different factors[19].

Labor pain differs from other types of pain for several reasons, because it has an intermittent character, converging with uterine contraction, which gradually increases in duration and intensity until it reaches its peak. In the interval between contractions, there is often no pain, pressure, or discomfort, allowing the woman to relax, meditate, breathe deeply and often even sleep20. Pain during labor is a common symptom, which involves biological aspects such as uterine contractions, cervical dilation, fetal pressure, individual tolerance, and pain perception factors, which can be cognitive, environmental, and social. In addition, it is an important physiological aspect, responsible for triggering the release of endorphins and other endogenous substances also related to the feeling of pleasure and satisfaction during childbirth[21].

It can be seen that a person's painful experience is influenced by numerous factors, including previous experiences with pain, anxiety, culture, age, gender, and expectations. These factors can increase or decrease the perception of pain, according to the sociocultural and psycho-affective

context of the parturient. The pain threshold is the minimum stimulus to which a person reports pain, with tolerance being the maximum amount of pain a person can tolerate. The sensory experience of pain depends on the interaction between the nervous system and the environment. The processing of noxious stimuli and the resulting perception of pain involve the central and peripheral nervous systems[22]. Pain modulation is carried out by endogenous analgesic mechanisms, characterized by a pathway in which pain information travels through the nervous system to the brain. The pain-causing agent is detected by nociceptors, axons of nerve cells located in the spinal cord, which carry painful information from its peripheral origin to the central nervous system. The uterus, including the cervix, has sensory fibers that reach the spinal cord, accompany the sympathetic nerves, the cervical and pelvic uterus plexuses, which unite with the hypogastric nerve that passes through the round ligament of the uterus, receiving other branches of the labia majora from the anterior region of the abdomen and the rectal muscle. Following the iliac crest, joining the superior hypogastric plexus, entering the lumbar sympathetic chain and the lower lumbar thoracic chain, passing through the communicating branches and posterior roots of dorsal segments 11 and 12 and later through segments (T10 and L1)[19].

The adrenocorticotropic hormone (ACTH), oxytocin and prostaglandins, act as a modulator, inhibitor and stimulant of pain, respectively, in any situation of stress, contraction or hypertonia of the sympathetic system can produce pain. Oxytocin and prostaglandins, as contraction hormones act together, estrogen, increases the concentration of prostaglandins causing the contraction of the endometrium and consequently the expulsion of the fetus. The presence and action of these substances are present continuously, in situations of synthetic oxytocin perfusion or use of drugs whose active ingredient is prostaglandin, the production of endorphins is inhibited, with an increase in the intensity of pain perception[20].

Pain influences the stimulation of oxytocin production, and it is conducive to avoiding pharmacological analgesia methods at the beginning of labor[23]. One of the mechanisms of oxytocin production at the beginning of labor occurs due to hormonal exchanges, the placenta and the stimulation of the cervix caused by active fetal movements.[20] Situations that stimulate a trigger in the release of hormones from the adrenaline family tend to stimulate the neocortex, inhibiting the labor process.

Another hormone of paramount importance is oxytocin, called the love hormone. The hormones secreted during childbirth originate in the archaic part of brain structures, such as the hypothalamus and pituitary gland. It can be stated that the behavior of mother and baby is under the influence of numerous hormones that are secreted during labor and delivery[23].

Labor is divided into four stages: the first stage begins with regular uterine contractility, effacement of the cervix, the beginning of the descent of the uterine cervix, and ends with complete

dilation of the cervix; the second stage begins with the complete dilation of the cervix and ends with the expulsion of the fetus; the third stage runs from the end of fetal expulsion to complete expulsion of the placenta and its membranes; The fourth stage takes place during the two hours after placental delivery, also called immediate puerperium[24].

Physiological childbirth refers to childbirth that can take place freely, without limiting the expression of the woman's behavior, without pharmacological procedures, or surgical interventions. In addition, it is a universal phenomenon that occurs among most women23. Women need to be understood as protagonists in their physiological processes, in the face of individual demands, with respect to the freedom to give birth. These factors contribute to women going through labor, reinforcing their importance and their central role in this process. In this context, the obstetric nurse has been the professional who presents the practice based on the use of non-invasive care technologies as a scientific, safe and favorable strategy.

NON-INVASIVE OBSTETRIC NURSING CARE TECHNOLOGIES

The non-pharmacological approach to labor and birth contributes to pain relief and the maintenance of the perception of personal control of the parturitive process, reducing discomfort and favoring a positive birth experience[12].

Obstetric nursing care technologies are defined as the set of techniques, procedures and knowledge used by nurses during their professional care relationship, understanding childbirth as a physiological process, respecting its nature, the bodily and psychic integrity of the women assisted26.

The use of these technologies by obstetric nurses marks the distinction of their practice in the obstetric field, thus being an important contribution to the full exercise of women's citizenship. The technologies used are non-invasive, encouraging women to be empowered to use their instinct at the time of childbirth27. During the labor period, pregnant women are encouraged to practice comfort, pain relief, anxiety and fear of childbirth, without the use of medications, and may use scientifically proven methods.

The main non-invasive obstetric nursing care technologies for pain relief in labor and delivery are: distraction and relaxation techniques, pelvic movements, ambulation, use of the ball, support bar, delivery stool, massage with vegetable oil, controlled breathing techniques, sprinkler bath, ambient music21. Below, more about some of the technologies used has been described.

Continuous support: it can be offered by a person of the pregnant woman's choice, such as her companion, for example, being this one's partner, mother or friend. The right to a companion is recognized by the Ministry of Health6. Scientific studies have shown that prenatal care and the parturition process, when performed with the presence of a companion, bring benefits and avoid problems to women's health. Women assisted by the Unified Health System (SUS) have the right to

choose a person they trust to be present in the delivery room and also during the postpartum period. The presence of a companion during childbirth and postpartum in SUS maternity hospitals is guaranteed by Law 11.108, of April 20056. The emotional support of a companion is important and effective, contributing to the labor and delivery process. It is necessary for the parturient to trust the people around her and to perceive the harmony between them. There needs to be understanding, patience, competence and respect for their rhythms and timings. Ongoing support can also be offered by the childbirth care health professional.

Ambience, Silence, Privacy, Darkness – For most women, an environment in the dim light or in the dim light is more conducive to relaxation. The childbirth environment should be comfortable for the parturient, favoring relaxation and undoing external distractions and sensory stimuli. A serene environment helps women to concentrate on themselves28. When the environment generates some kind of fear and anxiety, there is an increase in the secretion of adrenaline and possibly inhibition of labor.

Walking and Pelvic Movements - it is important for women to move freely and adopt positions that best suit them. Walking during labor increases the intensity of contractions (shortening labor), favors the blood flow that reaches the fetus through the placenta, being more abundant and reducing the perception of pain[27.] The freedom to move is very important, this means allowing the woman to walk, rock, perform a rotational movement with the hip, sit, lie down and get up whenever she wants, these being fundamental rights of women in the parturitive process.

Positioning – The position chosen by the woman during labor interferes physiologically and anatomically in this process. Some positions can increase blood flow to the uterus or can give more comfort. Choosing more comfortable positions tends to relieve fatigue, promoting greater comfort by activating circulation. In vertical positions, the contractions become more intense and with longer duration, favoring the effacement of the uterine cervix and the descent of the fetal presentation due to the force of gravity, with lower energy consumption of the parturient and improvement of cardiac output27. The squatting position is a position that favors the physiological process of childbirth, because the pelvis reaches maximum opening, added to the action of gravity and effective uterine contractions, which facilitates the descent of the fetus29. In the lateral position, contractions occur more intensely and shorter, a position that does not have the help of gravity, but can provide comfort and rest for the parturient27. The left lateral decubitus helps to reduce pressure on the inferior vena cava and abdominal aorta, improving blood supply and, consequently, oxygen supply to the baby29. The supine position promotes the compression of these vessels, which can lead to maternal hypotension, reduction of fetal heartbeat, as well as larger and shorter contractions. In this position, when the uterus is forced, it compresses the organs of the respiratory system and the inferior vena cava, which can cause the sensation of "shortness of breath" and hinder expulsive efforts. Widely

used in hospitals, its use promotes a longer expulsive period[27].

Warm sprinkler bath - labor in water becomes easier, more comfortable, and more efficient, due to the buoyancy or upward force of the water, reducing gravity, facilitating the variety of positions, minimizing the feeling of heaviness during contractions[29]. Warm water promotes comfort and relaxation and may reduce the need for pharmacological methods of pain relief30. With the heat of the water, there is a reduction in the secretion of adrenaline and relaxation of the muscles28.

Swiss Ball – consists of an inflatable rubber ball, used to relieve pain and discomfort in labor, as well as to favor its evolution. On the ball, the parturient can sit with the spine well aligned, being able to relax still or perform rotating movements (waddling). In addition to aiding in fetal descent, it also relieves pain. During contractions, the movements relieve tension, providing comfort between and during contractions, favoring the physiological process of birth31. The woman in the sitting position performs a pelvic balance, assisting in the descent and rotation of the fetus, providing a feeling of relaxation.

Delivery stool – its use aims at relaxation, increased dilation and reduction of pain, allows the parturient to sit, rest her feet on the floor and her arms on the bed, on her companion or professional who is accompanying the delivery. In this position, it is possible that the companion or the obstetric nurse massages the lumbar region of the parturient 31.

Wheelie – it is similar to a chair with an inverted seat, where the pregnant woman supports the chest and arms throwing the weight forward and relieving the back, widely used to help relieve pain, promote pelvic balance and the progress of labor31. During contractions, the parturient can also stay in this position to receive lumbar massage, in order to relax and relieve pain during labor.

Massage and Aromatherapy – the nerve impulses generated by massage in some regions of the body will compete with the pain messages being sent to the brain, reducing painful sensations. They are different nerve impulses, competing for the same receptors in the brain[32]. Aromatherapy is a therapeutic method in which the application of essential oils is used, these extracted through flowers, leaves, fruits, stems, seeds or roots. Aromas are reproduced by almost all ancient civilizations, being used through the use of essential oils, incense, perfumes and creams. When used in labor, it can bring benefits such as relieving painful sensations and progression of labor, reducing anxiety and fear, among others, making childbirth more comfortable and increasing the parturient's sense of well-being in such a remarkable and unique moment33.

Rebozo - is a technique that uses a shawl to perform massages and assist in the movement of the pelvis, rhythmic, smooth and controlled movements can be performed, in order to promote muscle relaxation and ligaments of the lumbar and pelvic region. This care favors the descent of the fetal presentation and, when necessary, corrects cases of asynclitism, being contraindicated in the face of maternal discomfort, non-reassuring fetal heart rate, abnormal vaginal bleeding and risk of

cord prolapse or placental abruption[32].

Controlled breathing – Practicing slow, deep breathing can provide confidence in your ability to stay calm during labor. In turn, deep breathing contributes to the prevention of hyperventilation, and deep breathing can also be used as a strategy to relax29.

The obstetric nurse (OBE) plays a fundamental role in guiding women about the options available for pain relief and relaxation during labor and delivery. In this dialogue, this professional informs about the advantages and disadvantages and, together, there is the choice of the most favorable technologies for the woman, according to the needs and convictions of the woman, safeguarding maternal and fetal safety21.

METHODOLOGY

This is a narrative-type bibliographic research, carried out through the review of the reading, selection and registration of topics of interest for the research34. To carry out this research, the qualitative approach was chosen, as it seeks to understand the phenomena through their description and interpretation[35].

A literature review of articles published in the last five (5) years on the theme was carried out, seeking to answer questions on the subject, revealing ideals and practices related to the process.

To this end, a bibliographic survey was carried out in the Portuguese/Spanish languages, in the Virtual Health Library (VHL), using the databases LILACS (Latin American and Caribbean Literature in Health Sciences), IBECS (Spanish Bibliographic Index in Health Sciences), MEDLINE (International Literature in Health Sciences).

The search for articles was carried out using the following keywords: Obstetric Nursing; Labor, Nursing Care, Labor Pain. At first, the search was carried out with the use of a single descriptor or word, where a large number of articles to be worked on were found.

Chart 1: Quantitative distribution of the bibliographies found in the VHL through the individual descriptors.

DESCRIPTORS	LILACS	IBECS	MEDLINE
Nursing Obstetric	417	42	29
Labor	580	111	124
Assistance from Nursing	5252	1564	733
Labor Pain	166	733	31

Source: The author, 2023.

Subsequently, the search for descriptors was carried out in an associated way, so that the

articles could be closer to the theme addressed. In this way, the result is organized in table 2.

Chart 2: Quantitative distribution of the bibliographies found in the VHL through the associated descriptors.

DESCRIPTORS	LILACS	IBECS	MEDLINE
Enfermagem Obstétrica AND Trabalho de Parto	125	04	11
Enfermagem Obstétrica AND Trabalho de Parto AND Assistência de Enfermagem	93	04	09
Enfermagem Obstétrica AND Trabalho de Parto AND Assistência de Enfermagem AND Dor do Parto	24	01	00
Total	24	01	00

Source: The author, 2023.

By means of refinement, the articles were directed to the proposed theme, thus performing the pre-reading, which was done by examining the cover page or summary of the bibliography indexes and footnotes. With these elements, it was possible to have a global view of the text, as well as its usefulness for the research35. The next stage was then reached, which was the selection of the material related to the research. Selective reading is then carried out, which is deeper than pre-reading, as it allows the resumption of the same material with different purposes, in which the subjects that are related to the objective of the work were selected, thus forming the potential bibliography, adding up to a total of 13 articles.

Table 3: Total articles used in the formation of the Potential Bibliography

DESCRIPTORS	LILACS	IBECS	MEDLINE	TOTAL
Obstetric Nursing; Childbirth Pain; Labor and Delivery; Nursing Care **Nursing**	**12**	**01**	**00**	**13**

The articles obtained were numbered according to the year of publication, in ascending order and analyzed in a descriptive manner, guided by the objectives proposed here. In possession of the articles in full, we opted for the analytical reading. The purpose of this stage was to organize and summarize the information contained in the sources in order to obtain answers to the research problem[35]. Finally, the construction stage was reached, through interpretative reading, in which the reader interacts with the text and leaves his passive position of receiver of the message, becoming a builder of new knowledge.[34th]

Table 4: Selected articles from the Potential Bibliography

1- Non-invasive care technologies used by obstetric nurses: therapeutic contributions. (Port/ESP – 2022)
2 - Use of non-pharmacological methods of pain relief in normal childbirth. (Port. 2021)
3 - Coexistence and prevalence of obstetric interventions: analysis of childbirth care models in public and private maternity hospitals in Belo Horizonte. (Port/Esp – 2021)
4 - Women's expectations and (dis)satisfaction with normal childbirth care Hospital: perspectives for quality. (Port/ESP – 2021)
5 - Obstetric nurses in the parturition process: women's perception. (Port/ESP – 2020)
Maternal and perinatal parameters after non-pharmacological interventions: a trial randomized controlled trial. (Port/ESP – 2020)
7 - Care practices in habitual risk deliveries attended by nurses Obstetric. (Port - 2020)
8 - Care technologies for pain relief in parturition. (Port/English – 2020)
9 - Obstetric nurses' performance in habitual risk childbirth: a care guide. (Port – 2019)
10 - Obstetric violence: an integrative review. (Port – 2019)
11 - Analysis of maternal and neonatal outcomes associated with the interventions performed during labor of low-cost nulliparous women. (Port – 2019)

12 - Effectiveness of non-pharmacological procedures for pain relief Parturients: contributions to obstetric nursing. (Port/ING – 2019)
13 - Contributions of Obstetric Nursing to Good Practices in Labor and vaginal delivery. (Port – 2019)

RESULTS AND DISCUSSION

From the interpretative analysis of the data extracted from the 13 articles read in full, it was identified that the articles address the importance of humanization in parturient care; the role of the obstetric nurse in the parturition process as a care differential and the non-invasive technologies used in nursing care for pain relief in the parturitive process.

THE HUMANIZATION OF PARTURITION CARE

In the contextualization presented by the authors of the texts, it was possible to verify that in order to humanize care, the nursing team needs to be available to provide comprehensive care to the parturient. It was found that, although humanization is widely discussed, in some institutions it is still possible to find practices related to the biomedical model, performed by the nursing team, which is characterized by technocratic care, where actions are very fragmented and individualized. In order to change this reality, it is necessary to be involved and open to the process of updating care practices, towards comprehensive care with appreciation of the individuality of each assisted woman.

It was observed that the humanization of care for women consists of welcoming the parturient, respecting her individuality, offering a safe environment, providing the opportunity for the presence of a companion of the woman's choice and avoiding harmful interventions, rejecting the use of harmful technologies, rescuing childbirth as a physiological process. It is worth noting that in the proposals for the humanization of childbirth care, professionals are engaged in comprehensive care and assistance, respecting women's choices, recognizing them as protagonists of labor and birth. It is necessary to recognize the vulnerability of women in the process of labor and birth, in which varied feelings can emerge and beyond the sensation of pain. At this moment, pain is understood not only as a universal manifestation of an organic process, but also as a symbolic construction that varies according to the sociocultural context and the subjectivity of the woman. Women must be cared for considering their uniqueness and with respect, and for this to occur, professionals have to engage in this purpose, which is to humanize care.

THE ROLE OF THE OBSTETRIC NURSE IN PRE-DELIVERY AND DELIVERY, AS A DIFFERENTIAL OF CARE.

It was evidenced that the care provided by the obstetric nurse is specialized and constantly

undergoes improvement with a view to sensitive and attentive care, based on technical and scientific competence. However, these professionals face challenges in their daily practice, providing challenges for their performance.

The work of these professionals is based on the knowledge of the physiology of labor and birth, recognizing and valuing the social and cultural aspects of childbirth. The obstetric nurse has the responsibility to recognize the parturient's situations and condition, using active listening as care tools. Obstetric nurses should develop critical and reflective reasoning about their actions so that they can act effectively in the promotion of care, so that the proposed strategies are successfully achieved, favoring a pleasurable, positive birth experience. It was verified through the listed texts that the care provided by the obstetric nurse in physiological childbirth presents an essential differential of care, as it contemplates the woman in her integrality, different from the biomedical model. The obstetric nurse has been working in accordance with the new guidelines of the World Health Organization and the Ministry of Health, developing humanized care practices in favor of physiological delivery.

THE NON-INVASIVE TECHNOLOGIES USED BY THE OBSTETRIC NURSE IN LABOR FOR PAIN RELIEF.

Non-invasive technologies for obstetric nursing care are based on the humanistic model of care, which are mainly characterized by non-invasion and respect for women's autonomy and privacy.

It was verified, when analyzing this category, that the non-invasive technologies used by obstetric nurses favor the rescue of physiological childbirth, since it favors the empowerment of women for decision-making, favoring a more natural and satisfactory experience. Care technologies are said to be non-invasive because they offer women the right to use them or not. The objective of the use of these technologies is for the woman herself to have the freedom of choice in her labor, being the protagonist of her process, and the obstetric nurse contributes to this process. Therefore, it is necessary that this professional is able to provide physical and emotional support to the parturient, through non-invasive technologies such as, for example, relaxation techniques, stimulation of ambulation, favoring the use of water through immersion or sprinkler baths, the participation of a companion of the parturient's choice, and a pleasant environment. The articles show that technologies can be used in an associated way, such as: bathing, ambulation, pelvic movements, massage and the participation of the companion, always respecting the woman's opinion. The birth environment should be conducive so that the parturient can relax, perceive her needs and with the minimum of external distractions and sensory stimulation.

The term care technologies was defined as "all the techniques, procedures, and knowledge used by the obstetric nurse during the patient care process. When it comes to obstetric care, the use of

care technologies brings childbirth closer to a natural, pleasurable and interactive phenomenon between mother and baby.

FINAL THOUGHTS

There is a growing social movement for the humanization of parturition care in Brazil, with the purpose of respecting the physiology of childbirth and the role of women in this process. In view of the objective delimited in the process of carrying out this research, the professional training of obstetric nurses in the process of humanization is essential, with this the need for personal and institutional attitudes is evident, which seek to raise awareness that this professional has technical skills, knowledge and legal anchorage to qualify care, in the principles of humanization. The results obtained in the present study are subsidies for reflections on the parturition process, as well as for the role of the obstetric nurse and the care strategies based on humanization by these professionals.

It should be noted that in recent years, childbirth care in Brazil has been a subject present in militancy in the obstetric scene, by women and professionals engaged in feminist movements, causing the theme to reach an effervescence in the academic environment, in government agencies and in social networks. Thus, emphasis is placed on discussions such as: obstetric violence, high rates of cesarean sections and the challenges faced by obstetric nurses in the exercise of their profession. This study demonstrated aspects related to fundamental human rights, such as the dignity of the human person, the patient's autonomy and the duty to inform.

It is hoped that this study will contribute to the visibility of the importance of professional training, with a view to updating and improving the care provided, based on scientific knowledge combined with welcoming and respect for the uniqueness of the assisted woman. The use of non-invasive care technologies favors the participation of women during pregnancy, labor and birth, knowing the changes in their body, with decision-making based on guidance, clarification and encouragement of participation. Finally, although the hegemonic physician-centered model is the most recurrent in Brazil in an interventionist and often traumatic scenario for women, the care provided by obstetric nurses has enabled improvements and favorable changes for the obstetric area. This is because their care is based on good obstetric practices, scientific evidence, welcoming, theoretical, practical and legal frameworks that anchor the practice of obstetric nurses.

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