

Care humanization in an obstetric nursing residency program: possibilities and challenges

Humanização do cuidado em um programa de residência enfermagem obstétrica: possibilidades e desafios

Humanización de la atención en un programa de residencia de enfermería obstétrica: posibilidades y retos

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Abstract: Objective: to describe the possibilities and challenges faced by residents who experienced a National Residency Program in Obstetric Nursing, regarding childbirth humanization and puerperium. Method: a descriptive, exploratory study, with a qualitative approach, carried out with six nurses who have completed the residency program in obstetric nursing at a public university. A semi-structured interview was used for data collection, which was analyzed by the Content Analysis Technique, in the Thematic Analysis modality. Results: the residents' reflections, through the emerging categories, highlighted what they recognized as positive points for the implementation of childbirth and puerperium humanization: the obstetrics residency program coordination and tutoring team's support; the clear and objective interpersonal relationship with the entire multi-professional team; the institution's physical structure; however, they have also identified as negative points: their acceptance by coworkers in the workplace; the resistance offered by the multi-professional team and the patients; the institutional norms; and the interventionist culture. Conclusion: It is noted that the obstetric nursing residents still need to earn their place in maternity clinics in a more emphatic way, which will enable them greater autonomy, in order to put into practice the implementation of new strategies based on care humanization.

Keywords: Nursing students; Obstetric Nursing; Humanization of Assistance; Nursing; Obstetrics

Resumo: Objetivo: descrever as potencialidades e os desafios das residentes sobre a experiência vivenciada em um Programa Nacional de Residência em Enfermagem Obstétrica, no que se refere à humanização do parto e do puerpério. Método: estudo descritivo, exploratório, com abordagem qualitativa, realizado com seis enfermeiras egressas do curso de residência em enfermagem obstétrica de uma universidade pública. Para a coleta de dados, utilizou-se a entrevista semiestruturada, a qual foi analisada pela Técnica de Análise de Conteúdo, na modalidade Análise Temática. Resultados: das reflexões das residentes, por meio das categorias emergentes, pôde-se verificar que estas reconheciam como pontos positivos para a implementação da humanização do parto e do puerpério: o apoio da coordenação e da tutoria do curso de residência obstétrica; o relacionamento interpessoal claro e objetivo com toda a equipe multiprofissional; a estrutura física da Instituição; ao mesmo tempo, identificaram como pontos negativos: a conquista do ambiente; a resistência por parte da equipe multiprofissional e dos pacientes; as normas institucionais; e a cultura intervencionista. Conclusão: Percebe-se que as residentes em enfermagem obstétrica ainda necessitam conquistar seus espaços nas maternidades de maneira mais enfática, o que possibilitará maior autonomia, com vistas a colocar em prática a implementação de novas estratégias, fundamentadas na humanização do cuidado.

Palavras-chave: Estudantes de Enfermagem; Enfermagem Obstétrica; Humanização da Assistência; Enfermagem; Obstetrícia

Resumen: Objetivo: describir las potencialidades y desafíos de las residentes sobre la experiencia en un Programa Nacional de Residencia en Enfermería Obstétrica, referido a la humanización del parto y el puerperio. Método: estudio descriptivo, exploratorio con abordaje cualitativo, realizado con seis enfermeras egresadas de la carrera de residencia en enfermería obstétrica de una universidad pública. Para la recolección de datos se realizaron entrevistas semiestructuradas, las cuales fueron analizadas por la Técnica de Análisis de Contenido, en la modalidad de Análisis Temático. Resultados: a partir de las reflexiones de las residentes, a través de las categorías emergentes, se pudo constatar que reconocieron como puntos positivos para la implementación de la humanización del parto y el puerperio: el apoyo de la coordinación y tutoría del curso de residencia obstétrica; la relación interpersonal clara y objetiva con todo el equipo multidisciplinario; la estructura física de la Institución. Al mismo tiempo identificaron como puntos negativos: la conquista del medio ambiente; resistencia del equipo multidisciplinario y de las pacientes; normas institucionales; y la cultura intervencionista. Conclusión: Se advierte que los residentes de enfermería obstétrica aún necesitan conquistar sus espacios en las maternidades de manera más enfática, lo que les permitirá una mayor autonomía, con miras a poner en práctica la implementación de nuevas estrategias, basadas en la humanización del cuidado.

Palabras clave: Estudiantes de enfermería; Enfermería obstétrica; Humanización de la asistencia; Enfermería; Obstetricia

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Introduction

The term "humanization", which has been used for about forty years, encompasses elements ranging from committed attention to the introduction of the human rights discourse to holistic assistance (1). It is important to emphasize that childbirth humanization can be understood as a genuinely natural and human event, with the purpose of promoting obstetric quality, in addition to guaranteeing the rights and medical care of the women in labor in an integral and individual manner, in order to contribute to the maternal dignity of the childbirth process (2).

During the first decades of the twentieth century, women's health was incorporated into national health policies, whereby programs were implemented to assist aspects related to pregnancy and childbirth. Thus, the Ministry of Health (MH) established the programmatic foundations of the Comprehensive Assistance to Women's Health Program (CAWHP), which introduced a new approach to public health policies, proposing a global approach to women's health in all phases of their life cycle, with the commitment of implementing health actions that contribute to guarantee women's human rights and reduce morbidity and mortality from preventable and avoidable causes (3).

In this light, the Ministry of Health created the Prenatal and Birth Humanization Program (PBHP) to improve CAWHP by emphasizing women's rights and proposing humanization as a strategy to improve the quality of care provided. The PBHP states that the main humanization strategy is to properly welcome pregnant women, from prenatal care to delivery and puerperium, based on the humanization of obstetric and neonatal care as a priority condition for the adequate follow-up of delivery and puerperium (4).

Childbirth has been institutionalized since the twentieth century, and it has become a medicalized process that is no longer a natural, private, and family process. It is in this context where women's protagonism is expropriated at the time of childbirth that the need to humanize that moment arises (1).

In this scenario, the Ministry of Health introduced the National Residency Program in Obstetric Nursing in 2012, in order to encourage higher education institutions to train nursing professionals to become obstetrics specialists. This action seeks to contribute to qualifying professionals, so as to enable the reduction of unnecessary obstetric interventions, which reflects directly on the improvement of the mother-child binomial health (5-6).

The qualification and commitment of health professionals are of utmost importance, especially obstetric nurses who will directly assist at the moment of pregnancy, delivery, birth, and puerperium, offering support and information needed by the mother and her family, in order to strengthen trust and thus enable an improvement in the quality of care provided and the mother-child and family bond (7).

This activity is upheld by the Federal Nursing Council (COFEN) Resolution nº 516/2016 that determines the Obstetric Nurse's competences, emphasizing a model of humanized assistance that seeks to ensure the integrality of the care provided within the Health Care Network (HCN), centered on women, childbirth, and birth, with the adoption of practices based on scientific evidence, such as: offering non-pharmacological methods for pain relief, freedom of position in childbirth, preservation of perineal integrity at the time of fetal expulsion; evaluation of labor evolution and maternal and fetal conditions, adopting appropriate technologies in the care and decision making processes, while considering women's autonomy and protagonism (8).

Therefore, the obstetric nurse's presence is considered an important part of the childbirth humanization process, being directly associated with the increase in the rates of normal childbirth, as well as with the increased use of good practices in childbirth care and the reduction of unnecessary obstetric interventions (6).

In light of the above, the objective of this study was to verify the possibilities and challenges found by the residents when developing the child delivery and birth humanization techniques in their assistance practice in a maternity ward in the State of Minas Gerais, where the National Residency Program in obstetric nursing is implemented.

Method

This is a qualitative, descriptive, exploratory study with six nurses who completed a National Residency Program in Obstetric Nursing and worked in a maternity ward in a city of Minas Gerais. These subjects were selected for this research since they composed the totality of a class enrolled in that program.

The residents were invited to participate in the study, being instructed on the research and its objectives, and subsequently, they were asked to sign the Informed Consent Term (ICT) to begin data collection. Then, a semi-structured interview was used, which was later recorded and transcribed. This interview was directed by a script, in which there is information from the researcher's profile and a guiding question, being applied from May to July, taking into consideration the respondents' understanding of the information, as well as the environment, in order to improve the information availability.

All the interviewees were identified with flower codenames during the organization and data analysis process, which were chosen by the participants themselves, thus guaranteeing the anonymity of the population studied.

The empirical material was reliably transcribed and subsequently submitted to Bardin Content Analysis, adopting the following steps: 1. pre-analysis; 2. material exploration, and 3. results treatment, categorization, and interpretation (9). The first phase was aimed at organizing and systematizing the collected data and ideas, doing what Bardin calls "floating reading", through which the points considered relevant for the understanding of the researched object were highlighted.

Subsequently, the analytical data description was carried out, highlighting the relevant parts of the collection. Thus, a more accurate study of the interviews was carried out, articulating them with the objectives and theoretical reference of the humanization policies regarding childbirth and puerperium of the Ministry of Health and World Health Organization, which were established for the research. The axes of analysis were established at that time. In the third instance, called interpretation, the data analysis was carried out in order to deepen the surveyed topic and define which speeches in the residents' interviews could be interpreted according to the analysis axes already established.

Therefore, successive readings of the produced material were carried out. The interviews were coded and analyzed according to the following steps: floating reading of each one of the answers and their ordering; vertical interpretation (situated interpretation of each resident) and horizontal interpretation (comparisons and contrasts between the data collected from the residents) and final analysis. The data obtained were discussed among themselves and confronted with the literature.

The research project was approved by the Research Ethics Committee of the Federal University of Alfenas, according to the legal opinion nº 975.752.

Results

Once the interviewed residents were characterized, it was possible to notice that they were in the adult age group, aged between 25 and 47, the prevailing age group being 25 to 27 years old. Regarding the time they worked as nurses, a predominance of three to four years of experience was observed, which means that they are recently graduated residents, while only one of them was more experienced than the others and has been working for 18 years. Concerning the time of service in obstetrics, it was found that two residents have only worked during the residency, i.e., for two years, and four residents have worked for over two years. Regarding the work regime, two residents work on a 12/36-hour shift schedule; one resident works 26 hours a week, and the other works as an hourly teacher at a nursing college in the field of women's health; as for the last two residents, one of them does not work at the moment and the other is enrolled in a *Stricto Sensu* Post-Graduation Program - master's level in the field of Maternal Infant Nursing.

When considering the "specialization" topic, it was noted that four of them did not pursue a specialization degree, and two professionals completed 360-hour specialization courses in the areas of Pedagogical Qualification in Professional Education in the Healthcare Sector: Nursing and Emergency, and Hospital Emergency. It should be noted that, in the contingent of those residents who have not completed their specialization programs, two of them are pursuing their academic master's degree in Nursing. Regarding their employment relationships, three residents have a single job, and they are hired by healthcare institutions under the Consolidation of Labor Laws (CLL) regime; and three of them are unemployed since they are not inserted into the labor market.

Concerning the kind of institution where they work at, two of them work for private institutions with lucrative purposes, and one works for a philanthropic institution; moreover, the questioning does not apply to the others, since they do not work at any healthcare institution. Among the three that have an employment relationship, only one of them dedicates 26 hours to teaching activities. Therefore, it is noted that there is an exclusively female population, where only one of the interviewees has any experience in the field prior to the residency program.

It is noteworthy that the analysis of empirical data, in order to express more vehemently the interviewees' statements, ensure the understanding of the constituent elements from their statements, as well as facilitate the availability of information, has brought forth two thematic categories, namely: "Possibilities unveiled by Obstetric Nursing residents for the implementation of childbirth and puerperium humanization" and "Challenges pointed out by Nursing residents for childbirth and puerperium humanization".

Category I: "Possibilities unveiled by Obstetric Nursing residents for the implementation of childbirth and puerperium humanization"

In this category, the residents' reflections recognized the following as positive points: the support provided by the coordination and tutoring team of the obstetrics residency program; the clear and objective interpersonal relationship with the entire multi-professional team; the

institution's physical structure; the availability of adequate resources; and the parturient's receptivity to humanized obstetric care.

Support from the coordination and tutoring team of the obstetrics residency program:

"I've found as a possibility, all the things that both the tutor and the coordinator of the residency program could do to make things easier for us, to defend, welcome and help us [...]. So, here at the University, they did their best to make the residency the best one ever, it was wonderful, it was amazing. We had an easy time, for sure, and I see it in a very positive way" (Daisy).

"[...] the tutoring that was very close by whenever we needed it, there was the University that was also very close by [...] And humanization was really an easy process and it was an incentive to us from the University in this regard, from the program itself, from the humanization process" (Lily).

Clear and objective interpersonal relationship with the whole multi-professional team:

"[...] collaborations with the nurses and some medics who granted us a lot of autonomy and freedom" (Rose).

" We had it easy right from the start because we had a collaboration with a specific medic, who encouraged us a lot to watch the deliveries since he had a lot of patients, we've always managed to learn a lot from this experience. The interactions with the nursing team and even with the medical team was always good, so I think it made it easier for us to get acquainted and grow in there" (Orchid).

"During all the residency period, we had an obstetric nurse who was our preceptor watching over us, so she had a different vision from the medical professional, who is highly interventionist, and views the childbirth process in a pathological way, while we view it in a physiological and more natural way. We had the obstetric nurse as an ally and this to be one of the positive points that helped us provided better care to patients" (Violet).

Institution's physical structure:

" I've found the potentialities in relation to the structure to be good [...]" (Daisy).

"[...] The institution's physical structure is wonderful, especially now after the renovation process has been concluded, so this was one of the factors that made it easier for us to provide a more humanized care because if you have a physical space that is helpful to you, it will also make providing better care easier for you" (Violet).

Adequate resources:

"The potentialities I've found were mostly in the form of the equipment that was available to us, I think it doesn't take too much to humanize childbirth, we need the ball the most, being the most expensive resource we've had [...]" (Rose).

Parturient's receptivity to humanized obstetric care:

"[...] The parturients' acceptance, they had a great desire to accept what we were proposing to them, they realized that it was effective, that the humanized care and respect were something different and new, they accepted it in a positive way" (Bromeliad).

"Another factor we can mention which makes things easier is that the population is becoming a little bit more acceptive, things are still difficult, but here we've found a big opening [...]" (Lily).

Category II: Challenges pointed out by Nursing residents for childbirth care and puerperium humanization

In accordance with what has been investigated by the participants regarding the challenges for the implementation of childbirth and puerperium humanization, it was identified that the residents recognized the following as negative points: earning their place in the workplace; the resistance offered by the multi-professional team, and the patients; the institutional norms; and the interventionist culture.

Earning their place in the workplace:

"Speaking of the Institution, the first challenge was that we came across great resistance in the beginning, but things improved later on [...] resistance from the nurses themselves, they were a little strange to our presence in the beginning" (Daisy).

"[...] as it was not part of the culture, as this humanization issue wasn't inserted into the medics and nurses' own conducts, we had some difficulty in instituting a non-pharmacological method, it was difficult to even offer it to women because these methods were viewed as unnecessary by the professionals and by the women themselves, just because it was not routine in that place" (Bromeliad).

"We've had a lot of difficulty dealing with medical professionals who weren't accepting our performance within the service, they didn't understand the importance of the obstetric nurse within the service, which ended up hindering a more humanized care, but even then we still tried to provide a more humanized care [...] a lot of times we were taken out of the labor room or the puerperium because our care was humanized and the medic didn't agree with it" (Violet).

"[...] I think we have to accept the fact that the problem with humanizing the process are the professionals themselves, they end up hindering and blocking the entire humanization process" (Lily).

The resistance offered by the multi-professional team and the patients:

"[...] unfortunately, we didn't receive the collaboration of all the nurses we came across [...] they were responsible for us, we couldn't do some things at times, because we didn't have this opening from the nurses themselves, so if they didn't allow it, we couldn't carry out the procedures and provide proper assistance" (Rose).

"[...] especially the sector coordinator, she offered clear resistance, we were welcome there, but she made it clear to us that there was a limit to everything we could do [...] we could act with the other preceptors watching over us, but not with her, we'd just watch whenever the coordinator was around" (Daisy).

"[...] in the end things were pretty bad, the preceptor made it crystal clear to us that we wouldn't be allowed to do anything on our own without her supervision, without her having done it first. Perhaps she was acting like that because our program was nearing its end. In one occasion, I bathed a newborn in a humanized manner by slowly bathing the baby in and out of the water, and I performed the humanized bathing technique really well, however, since I hadn't talked to her before bathing this baby, she ended up forbidding me to bathe babies, saying: 'no, you won't do it anymore from now on' [...]" (Daisy).

"Another challenge we've come across in providing more humane care was often the obstetric nurse herself, who at one point, single-handedly set us back to zero after all the progress we had made so far [...] so there were many humane care tasks we've been prevented from carrying out and whenever one of the tasks we were carrying out was going well, we'd be prevented from advancing in that task" (Violet).

" In my opinion, some professionals were immature because our care practices started to stand out, so I sensed their insecurity, a fear felt by the professionals who were there, that maybe this differential of ours, regarding the humanized care we were providing, could interfere with their work or something like that. Then, because of a specific obstetric nurse, we were set back light-years, everything that we had achieved so far was undone by her and things became even worse, then" (Violet).

"[...] as for the patients themselves, who viewed us just as students, they'd say things like: are you learning ON me? Am I your guinea pig?" (Rose).

Institutional norms:

"Another challenge we faced was with the hospital's own rules [...]" (Daisy).

" I believe the biggest challenge was the maternity system itself where we spent our residency" (Bromeliad).

"The challenges we faced were related to the hospital's routine and institutional rules" (Orchid).

Interventionist culture:

"Another challenge we've faced was the culture, an interventionist culture, in which employees think that anesthesia and post-surgery are less worse than labor pains when it comes to obstetrics. The problem stems from the interventionist culture that we've been experiencing since the 70/80s. The lack of incentive is yet another great challenge and it has to change, I've already mentioned how the residency was an incentive for this sort of change,

but I think we still need more incentive to change this Brazilian reality, the culture in which people don't accept humanization. When we talk about humanization, people believe we're talking about natural home birth or water birth, they don't realize we're talking about a form of care and assistance and they don't understand that procedures such as a cesarean section can be humanized, too, for instance. So I believe that this is mostly ignorance, it's not something people do out of sheer malice, but rather a lack of knowledge regarding these procedures which pose bigger challenges to the implementation of humanized practices, so I believe that professionals who have acquired the humanization role in their practice should go ahead and exercise the humanized care either way" (Daisy).

Discussion

The humanization refers to the process that starts in pre-partum, with actions focused on the newborn, the parturient, and the accompanying person, developed by a multi-professional team (10).

Regarding the "coordination and tutoring support of the obstetric residency program to the residents", it was found that the residents indicated this support as an important aid for the implementation of a more humanized and qualified assistance. These residents also acknowledge that the program has provided them a satisfactory theoretical and practical knowledge base, which has granted them the necessary skills and abilities to exercise their profession with excellence and safety.

From this perspective, one can learn how essential the support and incentive of a residency program in obstetrics is to make the care humanization in the gestation-puerperal cycle a reality through knowledge and practice. These findings were also found in a study (11) through which the findings elucidated that the residency program made it possible for the nurses to obtain a large contribution of practical experiences, proving to be an extremely important component for safety perception for the exercise of the specialty, particularly in normal childbirth care.

Regarding the "clear and objective interpersonal relationship with the whole multi-professional team", it is notable in the residents' speeches how valuable the collaboration they have established with the multi-professional team is, in particular with the medical professional, which promotes, in this way, their autonomy, as they have had greater freedom to participate in the childbirth processes alongside these professionals, which has helped them to learn from these experiences.

The preceptor nurses' support was also very enlightening, and they were able to introduce the residents to the service, who offered a different perspective from other professionals, being less interventionist, more physiological, and natural, thus favoring the humanized and holistic practice towards the pregnant/parturient/puerperal.

As the research points out, for the assistance provided to be effective, it is necessary that the nursing professional maintains a clear and objective interpersonal relationship with the entire multi-professional team, since the nurse is in constant contact with the client's care and thus linked to other health services. Moreover, the multi-professional format is able to achieve health promotion in a more qualified way (12). This information is in line with the results of a study, which demonstrates that multi-professional and interdisciplinary teamwork promotes the comprehension of the vast knowledge and practices through which actions converge and make teamwork possible (13). In this sense, integral actions in obstetric care presuppose the active

participation of its members and the conjunction of expertise in each area of knowledge in the execution of joint projects aimed at improving the quality of care during childbirth and puerperium.

It should also be emphasized that the testimonies listed by the residents in this category corroborate a survey in which the participants highlighted that the residency program made it possible for them to obtain new knowledge regarding other areas and allowed them to care for the patient in an integral manner, through multi-professional work (14).

As observed in the residents' speeches, they pointed out the preceptors' performance as a facilitator, since they are the professionals responsible for monitoring the residents' performance in their theoretical-practical activities. Therefore, they are of singular importance in the residents' insertion into the practice fields, being the mediators of relationships, conflicts, and existing clashes. The residents highlighted that the preceptor's presence in the internship field was extremely important to generate autonomy and to promote a safe assistential practice.

Hence, the preceptor must be the protagonist, due to the shared responsibility in the residents' training process. In this context, the pedagogical and scientific basis offered by preceptors is essential for the residents to be able to apply their knowledge in practice scenarios, thus modifying the care environment into a multi-learning space (15).

In addition, another research shows that the students' supervision in the units where they work contributes to these specialists' work intensification, inferring that it is an aspect related to the expansion of the qualification programs in Obstetric Nursing in public maternity hospitals. As a consequence of the stimulus provided by the permanent education and health policies of the SUS, it is worth mentioning that it is of utmost importance to share the teaching-learning process, based on reflections on practice, exchange of experiences, and re ("construction") of knowledge in health care scenarios (16).

Another possibility elucidated by the residents concerns the institution's physical structure, emphasizing that it helped them to successfully carry out the humanized assistance care. Corroborating such perspective, the study (17) highlights that adequate infrastructure is necessary to transform the hospital space into a more welcoming and favorable environment for the implementation of humanized assistance practices, which enables a better experience for women, such as the relaxation room.

Still, in relation to infrastructure, one resident listed the availability of "resources in the Institution" as a facilitator, since it is not necessary to have many resources to carry out the care in humanized assistance; it is only necessary for the Institution to organize itself for this purpose and offer the minimum indispensable resources for quality assistance.

These findings are in line with those observed in the survey, which found out that 40% of women reported a lack of resources during hospitalization, mainly personal items such as bedding and clothing (18).

Finally, another possibility mentioned by the residents was the "patients' receptivity to humanized obstetric care", since the way they respectfully promoted care was accepted in an entirely positive way by the patients.

In a study developed to analyze the care offered by obstetric nurses during labor and delivery from the point of view of the puerperal, an adjective highlighted by the parturients to the professional nurse was the companionship in the face of pain at delivery (19). The research shows that childbirth is a painful and difficult experience, which is culturally rooted in fear and negative psycho-emotional aspects. Therefore, this professional's activity is indispensable (20). Additionally, a study developed in Espinosa, Minas Gerais, Brazil, evidenced the parturients'

satisfaction with respectful and safe assistance, with qualified listening, effective orientation, and body care developed by nursing professionals (21).

In this context, it is highlighted that the essence of nursing care during childbirth in the perspective of humanization, consolidated in the technical-scientific knowledge, must be effective and solidary, permeated by respect, acceptance, appreciation, and individuality of the patient, with qualified listening of their health problems, always with a positive response and with the responsibility for their problem solving, which means safe care is provided.

In face of such considerations, it is understood that the above-mentioned possibilities allowed the residents to earn their space in the maternity ward, thus granting them autonomy and, consequently, evolution, meeting the expectations of quality training in obstetric nursing.

Among the challenges pointed out by the residents, earning their place in the workplace and the resistance offered by the multi-professional team are the ones that stand out the most. This reality was intensified at the beginning of the residency program, due to the great resistance offered by the professionals when installing the non-pharmacological methods for pain relief, since these were viewed as unnecessary within the maternity ward routine. As mentioned by one of the study participants, the other professionals' routine was different from what the residents believed to be the ideal for humanized assistance.

The resistance offered by some professionals, especially medics, has been verified in studies (22-23), finding that they do not allow good practices due to the presence of their concepts, values, beliefs, which are compatible with their formation, still intervening with unnecessary actions.

From this point of view, there is a lack of harmony and even understanding among the multidisciplinary health team and it is understood that the biomedical model still predominates, with the use of unnecessary interventions, which hinders nurses' work and eliminates their possibility of exercising their autonomy in the face of childbirth, with good practices. However, it is perceived that this is not constant, depending on the medical team, and it is necessary to remain respectful, with the scope of having a calm and propitious work environment to implement humanized care (24).

This resistance was also pointed out by some residents in relation to a preceptor who made it clear that there was a limit between preceptor-resident, and that many times it did not allow them to practice humanized care unhindered. In one of the lines, the resident shows her indignation about how much they were prevented from advancing in their care, despite achieving positive results. This points out that such an attitude ends up hindering the continuous learning of humanized care, which makes it impossible to reach the final objective: the evolution of humanized obstetric care.

One of the residents, through her reports, claims that she once performed the humanized bath technique with a newborn. Due to the lack of communication, the preceptor prevented the resident from performing the technique other times, thus harming the Institution, the newborns, and the mothers, who could no longer receive this humanized assistance, which, according to the literature, is considered the most indicated procedure for the care of the underweight newborns (25).

Regarding this statement, a study (12) brings to light that there are conflicts of interest which are quite evident within the residency program, since these students are in the program to develop more elaborated technical skills and the health institution regards the resident as an effective professional, who has to be subordinated to preceptors, norms and routines, which, in this way, often prevents the humanized assistance from being applied.

It was possible to notice the existence of conflicts between preceptor-residents from the testimonies, due to the insecurity felt by these professionals that humanized care would have a distinctive result, and thus interfere in the maternity ward work and routine, which consequently hindered the implementation of humanized practices.

These findings corroborate the research (12), to the extent that they state that conflicts exist since people display differences in their values, interests, and particular affections. Additionally, nursing presents itself in a hierarchical context, in which, more than often, abuse of power occurs. Thus, the nurse must know how to lead a team and delegate attributions.

It is necessary to point out that this resistance was also offered by some patients, in the sense that the act of being a resident and being in training ends up generating a certain fear in the woman who receives the care because she faces the risk of a possible mistake, which is part of the learning process.

However, the study (25) draws attention to the qualification through the residency program, which contributes significantly to the sedimentation of knowledge acquired during graduation and allows the professional's growth in the articulation between the theoretical concepts learned and their employability in daily practice.

As a result, professionals trained in obstetric residency have expanded critical conditions, which allows a distinguished performance in the search for assistance completeness, whether in training other professionals in teaching activities or in professional practice.

The residents also pointed out the challenges faced by them with the Institution's rules, which prevented them from applying the humanized practices, due to a culture that was established there.

Faced with this challenge, it is clear that residency programs have been misused by health institutions as a way to supply human resources, making the resident nurse another professional in the service scale (12), i.e., he/she has to submit to the norms, without being able to put his/her humanized knowledge into practice, since, when employing such knowledge, he/she would be outside the context of institutional rules.

Finally, the interventionist culture, in which women are subjected to unnecessary interventions, was also pointed out as a challenge, since several myths regarding the delivery-birth process, passed down from generation to generation, such as the fear of pain in childbirth; the vaginal channel destruction (which would prevent women from having pleasurable sexual relations); the incentive to perform episiotomy or surgical delivery; and the fear of dying in childbirth.

People find it convenient to go to health institutions and submit to the biomedical model, despite all the arguments regarding humanization, because the predominance of technique and culture over procedures is considered normal. The population still lacks knowledge concerning humanization policies in the gestation-puerperal cycle, which generates difficulties due to the lack of dissemination, since there is no incentive to promote humanized practices under these circumstances.

The limitations of this study are that it is not possible to draw generalizations in relation to the data obtained from the reports submitted by the residents participating in the research, since this is a specific experience. Therefore, it is suggested that new studies be carried out on the subject, with larger populations and other outlines, in order to seek the implementation of strategies to assist women, with the aim of improving care, as a process based on humanization.

Final Considerations

The importance of the National Program of Residency in Obstetric Nursing in the maternity wards of the public health service is evident since obstetric nursing is of paramount importance to propagate the humanization in the care provided to the pregnant/parturient/puerperal woman, in order to provide quality, satisfactory and holistic care.

It is noted that the obstetric nursing residents still need to earn their place in the maternity wards in a more emphatic way, in order to attain greater autonomy, aimed at putting the implementation of new strategies based on care humanization into practice.

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