

Relational autonomy and humanized birth: the challenge of approaching desires and practices in the SUS

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Abstract: Rede Cegonha is a SUS assistance program that aims to decrease maternal and neonatal mortality through humanized and evidence-based obstetric practices. However, there still seems to be a gap between the desires of women at the time of delivery and what is offered by the care team. This study aims to unveil the limits of the woman's autonomy at the time of delivery in a hospital in the Rede Cegonha. The mothers answered open-ended questions in a personal interview and reported their birth experience. Content analysis was used to organize the speeches into categories of analysis. Fear of pain (which interferes with the woman's role), lack of dialogue with health professionals (perception of not being heard) and ignorance of the guidelines of Rede Cegonha appeared in the interviews as barriers to the significant experience of childbirth. For a real humanization experience, it is necessary to strengthen the dialogue between parturients and health team, to gather wishes and clinical protocols, as a way to affirm the autonomy of women in the face of childbirth.

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Introduction

Pregnancy, childbirth and the puerperium are natural events and related to female physiology and sexuality, but they were removed from the spectrum of care of groups of experienced women (midwives) and became the object of study, historically pathologized and medicalized, of gynecology-obstetrics (MAIA, 2010; MONTENEGRO; REZENDE FILHO, 2017). A relevant part of Western obstetrics bases its practice on technology and hospital care (DAVIS-FLOYD, 2003), anchors assistance in the figure of the doctor and performs practices that women describe as violent (FUNDAÇÃO PERSEU ABRAMO, 2010). The issues related to childbirth have a gender bias, which places parturients in a patriarchal, oppressive and domineering social reality (DODDS, 2000; DONCHIN, 2000).

The number of interventions in childbirth are contrary to scientific recommendations (BELIZÁN et al., 2018; DINIZ, 2005) and the wishes of a natural childbirth expressed by most women in national studies are ignored (DOMINGUES et al., 2014; LEAL et al., 2014). However, since the 1950s worldwide and in 1970 in Brazil, the number of people who critically oppose the hegemonic obstetric care model and advocate for the humanization of childbirth and birth has increased (RATTNER, 2009).

Amid these discussions, Rede Cegonha (RC) emerges in 2011 as a policy that aims to "implement a care network to ensure women the right to reproductive planning and humanized care for pregnancy, childbirth and the puerperium, as well as ensuring children the right to a safe birth and healthy growth and development" (BRASIL, 2011). It brings proposals that aim to reduce maternal and child mortality and improve the health of pregnant women in the country. By aligning assumptions based on scientific evidence (CAVALCANTI et al., 2013), it instituted the use of technologies and care consistent with international recommendations (WHO, 2018).

The obstetric practices proposed by the RC include the construction of a Birth Plan by the prenatal and pregnant women, non-pharmacological management of labor pain, vertical positions to give birth, immediate skin-to-skin contact with the baby and also the entry of new actors during birth assistance (BRASIL, 2011), as is the case of obstetric nursing, doulas and companions of the woman's choice.

SUS health professionals are invited to rethink routine clinical interventions, as well as those considered violent – episiotomy and Kristeller's maneuver¹ – in

addition to being encouraged to decrease cesarean rates. They are also invited to give new meaning to teamwork, with obstetric nursing being responsible for the integral care of healthy women in labor (BRASIL, 2011).

Periodic bulletins with specific indicators are sent to the Ministry of Health, to correct any deviations in assistance and to establish criteria for maintaining the financing (BRASIL, 2011). However, a purely quantitative assessment of assistance in RC, based only on indicators, can mask the obstacles to the reality of assistance. The conflicting practice scenarios show barriers in the implementation of teams that legitimize autonomous obstetric nurses as the front line of care (MAIA, 2010), an action considered essential to change the model of care for pregnant women and parturients (FUNDAÇÃO PERSEU ABRAMO, 2010; DINIZ et al., 2015). Users of services are also rarely questioned and heard in their own care demands, just as "humanized protocols" are applied without due critical reflection (MAIA, 2010).

National surveys demonstrate that satisfaction with childbirth takes, in short, the singularization of the experience (RATTNER, 2009; CARNEIRO, 2013a; TEIXEIRENSE; SANTOS, 2018), the perception of women's autonomy in making clinical decisions based on guidelines and the experience of a delivery free from obstetric violence (DINIZ; CHACHAM, 2006; ANDREZZO, 2016). In the publication of the World Health Organization (WHO, 2018), the parturient's satisfaction with care is also placed in equal importance with the other technical criteria of assistance in the pregnancy-puerperal cycle. These aspects can be interpreted as an attempt to bring technical success (compliance with updated protocols of good obstetric practices) closer to practical success (AYRES, 2007), as the parturient is given a voice, her subjectivity and her rights are considered, as well as the uniqueness of her feelings about childbirth.

Conceptually, autonomy is recognized in Western societies as a central moral and political value. Being autonomous means acting for motives, reasons or one's own values and making choices for oneself based on reflections (CHRISTMAN, 2018). The concept arises, initially, in the midst of political and moral theories that sought to equip modern citizens (usually white men and owners) with a set of rights. Among these rights was the right to resist coercion (CAMPBELL, 2017).

In bioethics, the principle of respect for personal autonomy has been one of the main principles guiding medical practices since the 1970s, when Beauchamp and

Childress (2001) defended that “the autonomous individual acts freely according to a self-chosen plan, analogous to the way an independent government manages its territories and establishes its policies”.

Feminist theorists have criticized this view of autonomy that guides bioethics and sought to develop a concept that takes into account the subjective experiences and the interconnections between individuals, especially with regard to women's decisions. For Stoljar (2018), the view of principlist bioethics does not sufficiently take into account the fact that individuals are socially intertwined with each other and that their relationships are permeated by practices of domination and oppression. Such practices must be considered when it is intended to follow the decision logic of women in relation to themselves and their bodies (STOLJAR, 2018). Authors argue that the focus only on the patient's situation and their critical reflection process is fundamentally individualistic, which makes it inadequate in the case of women, commonly positioned in situations of subjection (DODDS, 2000; DONCHIN, 2000).

An alternative model of autonomy then begins to gain momentum: Relational Autonomy (RA). According to this model, individuals are fundamentally involved in a wide network of relationships and the activities involved in the exercise of autonomy (such as reflecting, planning, choosing, deciding) "are social activities that often involve others or are done in different ways that are subject to the influence of our relationships and social context "(DIVE; NEWSON, 2018). As stated by Zirbel (2016, p. 172): “[...] the model of relational autonomy emphasizes the need to think of autonomy as a human characteristic that involves creativity, desires and imagination as well as reflection and rationality”.

RA is a competence that comprises a set of different skills and abilities developed in a network of relationships, which, in turn, is necessary for the formation and development of the ability to think and act (MEYERS, 1987, 2005). Other authors add that it is a competence that can be developed to varying degrees: “If the autonomy competence comprises a set of skills that can be more or less developed, exercised and coordinated, it makes sense to think of *autonomy as a matter of degree*” (MACKENZIE; STOLJAR, 2000).

Meyers also distinguishes between what would be programmatic autonomy (linked to individual life plans) and episodic autonomy (applied to particular situations). In

the latter case, the individual often ponders his own desires and the possibilities of action existing in the midst of an oppressive reality (MEYERS, 1989; 2000).

When dealing with childbirth, we are faced with the possibility of exercising an episodic autonomy that occurs when, in a given situation, the person asks themselves what they can do about it and what they really want to do, only then, after internal deliberation, they execute a decision.

When thinking about autonomy as relational, it is also possible to distinguish between perspectives of a weaker type and a stronger type (DONCHIN, 2000). In a medical or health care context, these two dimensions of autonomy are evident in the doctor-patient relationship, with all the complexities of power and communication involved. The same can be said of the patient's relationship with his social environment, which affects their choices in various ways.

The woman's way of life and baggage of experiences, within her social, cultural, racial environment, etc. is considered by feminist theorists, as the things which create the substratum for reflection and for informed decisions (or not) of women who face ethical dilemmas or concrete challenging situations. When thinking about a woman's autonomy, it is necessary to take into account that we are facing an individual with a capacity that develops linked to her environment, reaching varying degrees and manifesting sometimes stronger, sometimes weaker, depending on the situation, the context and the people involved in the situation (FRIEDMAN, 2003; MEYERS, 2005).

Relational Autonomy is the analytical category that guides this research and helps to think about health and care services from the demands of the individual, amid the ethical, cultural and scientific boundaries imposed at the time of delivery. It allows us to think of ways to strengthen the subjectivity and the protagonism of women at the time of delivery (CARNEIRO, 2013). Although it recognizes the importance of social, racial, and interpersonal relationships as factors that shape and modify the construction and expression of the autonomy of the women interviewed, this cutting was not actively sought or developed in this investigation.

The research focused on the subject of the parturient's autonomy to verify what happens in the practice of a public hospital at the time of delivery. This article aims, in addition to describing the research results, to initiate a discussion about RA and its intersection with humanized practices in SUS.

Methodological route

The field research was carried out in Blumenau, Santa Catarina state, Brazil, with an estimated population of 357,199 inhabitants in 2019 and HDI 0.81 in 2010. The RC has been implanted since 2013 in 76 health units that offer prenatal coverage to more than 90% of the city's pregnant women. A hospital in the city assists pregnant women through SUS, an average of 300 births per month, with 60-70% of normal births, with low rates of episiotomy (between 2-4%). There is encouragement for vertical delivery, availability of some non-pharmacological methods of pain relief, obstetric nursing care for healthy parturients and compliance with the companion law, 2005, and the 2015 doula municipal law. Prenatal care for healthy pregnant women is performed in the basic network, by family doctors and obstetricians, who do not attend births at the hospital. In high-risk prenatal care, pregnant women can be attended by resident physicians and obstetricians who are also on call, but monitoring the delivery by the same professionals is a sporadic event.

This is a study with a qualitative, descriptive approach, conducted based on open interviews with a guiding theme, with women selected randomly within the inclusion criteria: single pregnancy, at term, mothers of babies aged 3-6 months, Brazilian, of legal age. They were recruited from the parturients of the RC reference hospital in the city, who were followed up in SUS primary care units, where they were invited to participate in the research. Terms of free and informed consent were offered and only women who signed the document participated in the study. We opted to stop recruiting when the reading of the material showed saturation in the speeches of the participants.

Five women participated, three were in their first pregnancy, all over the age of 20 and with high school degree, married or with a stable partner, white. Two of them had prenatal care in the private network and one had consultations in the hospital's High Risk prenatal care. Four of them had vaginal deliveries, two were accompanied by doulas. The only one who underwent cesarean section – during active labor and with an explicit desire to give birth – had two previous cesarean sections used as a justification for indicating the procedure.

Individual interviews were conducted by the first author, in a private location, so that the woman had an appropriate and comfortable space to speak without interruption, accurately and in detail, free from judgment. The following guiding

themes were used: report on the experience of childbirth, preparation for childbirth, use of groups and technology before childbirth, experiences of contact with medical staff in prenatal care and in the hospital.

All interviews were recorded on audio and the material was used for transcription and data analysis. Women were identified only with a letter / number, to preserve their identity. By reading the transcript of the interviews, the data collected were considered sufficient, since the reports and striking aspects of the experiences were repeated in the interviewees' statements, while others created contrast for their specificity and uniqueness.

Content analysis was used to read the manifest and the implicit in the data collected from the interviews (BARDIN, 2016). Operationally, it consisted of pre-analysis (floating reading for exhaustive contact and organization of the material), exploration of the material (clipping of the text in recording units, in order to observe similarities and differences in the women's reports) and treatment of the results through the referential interpretation and constitution of the empirical categories of analysis.

The research was approved by the Human Research Ethics Committee of FURB, CAAE number 80510917.1.0000.5370.

Results and Discussion

In the analysis of the interviews, three distinct issues emerged: the first concerns the notion that the parturient has in relation to childbirth, of an “experience of fear, pain and suffering”. The findings corroborate the literature (LEAL et al., 2017; TEIXEIRENSE; SANTOS, 2018) and in the imaginary of pregnant women, this is a mandatory characteristic of parturition. The second is linked to women's awareness that childbirth is a “relational experience”. Finally, we highlight the problem of the “limit of humanization of childbirth practices” to guarantee meaningful and autonomous experiences.

Pain, fear and suffering

Birth reports, both on the internet and those collected in the research, are permeated by descriptions of moments when physical pain acquires a central importance (DINIZ, 2005; CARNEIRO, 2013b; TEIXEIRENSE; SANTOS,

2018). This is what M2 reports about her experience: “I started to scream, then I spoke to my husband: he (the baby) is coming out, go and call her! So it was a very scary birth for me” (M2).

A part of the narratives mixes physical pain with psychological suffering, as if they both figured in this context from the same place and wanted to say and represent the same thing. These reports are passed on among women and influence the pregnant woman. She ‘knows’ that there will be pain and suffering involved in the experience of childbirth. In addition, there is the notion, possibly founded on biblical tradition, that this is a mandatory characteristic of parturition.

Fear of pain and suffering, as well as fear of the “dangers of childbirth”, often produce a paralyzing effect or interfere with the woman's role, as evidenced by M3's speech regarding the moment of childbirth: “[...] I locked it [stopped pushing], because I was scared”. The idea that caesarean sections would be pain-free, risk-free and with better results for both mother and baby, thus gains space in the social imaginary and of medical professionals, even against scientific evidence (DIAS et al., 2016; BELIZÁN et al., 2018).

The pregnancy process also receives gender interpretations that end up creating an imaginary that the pregnant body is incapacitated or reduced to weaknesses (ZIRBEL, 2016). This general idea helps to maintain the fear that, in turn, permeates decisions during childbirth care and leads to the judgment that the pregnant woman is someone totally vulnerable and unable to make important decisions, both for herself and for the baby. This contrasts with the view of the theorists of care and RA, for example, who defend an overlap of emotions and feelings in the decisions of women (and men), valued as much as reason and theoretical knowledge (GILLIGAN, 1982, 2014; DURÁN PALACIO, 2015; KUHNEN, 2014; ZIRBEL, 2016)

Thus, fear and pain, when present, need not be seen as something that nullifies the woman's capacity for autonomy and reflection. They represent an element that comes on the scene, in an episodic manner, and that must be taken into account in the reflection related to the desires and plans that this woman has for her own birth. Knowing and accepting the woman's wishes, however, depends on a series of external factors already imposed when she is hospitalized for care by SUS.

When power struggles overlap with assistance itself, the conflicting aspects of interpersonal relationships, in addition to impeding the experience and recognition of autonomy, nuance only the negative aspects of normal birth experiences. This may

be the space, still unexplored, for the construction of care relationships, based on RA (ELLS; HUNT; CHAMBERS-EVANS, 2011; HEIDENREICH et al., 2018).

The preparations for the experience of childbirth itself, anchored in the objective reality of the services to be provided, should take into account these dialogical aspects (AYRES, 2007). In the dialogue, it is possible to produce the meeting of the expectations built by women with the guidelines of the RC program and to visualize the possible and real care provided to them during their births with the teams that work for SUS.

Closer relations between women and care teams (prenatal and hospital), based on cooperation, mutual understanding and trust, can result in unique experiences, in which women have their autonomy respected and valued within a public health service, during the entire pregnancy-puerperal cycle. In addition, fear and its connection with pain and suffering tend to lose strength in speeches.

The relational experience of childbirth

In every woman's experience with childbirth, there are a number of people and types of relationships involved. One of the expectations that women have in relation to the team and the institution is to receive the individualized care expected by them. As M4 stated: "It's okay that [people] go there a lot with complaints of pain and it's nothing, but [the team should] be more careful in that part" (M4).

The sense of the comment is that she is going through this situation for the first time and it is something whose limit of normality is unknown. The woman, in this case, needed a type of care that involved explanations such as "everything is going well", despite the pain and fear she felt, and "the pain will continue for a while".

In general, when there was a failure in the dialogue since prenatal care, the assistance offered to women at the time of delivery was also perceived as insufficient. The care sought by the women heard in the research was based on the individualization of listening, the reception and the acquisition of information. There is an idea shared by all of them that the team "explains little", "talks little" and that vague explanations, such as "it's normal" are insufficient to guarantee the feeling of control over what is happening or about what will come during labor. This also appears in M1's speech:

[...] in many cases we [are] not heard, because when you get there it is all too fast, oh, or you go to cesarean section or you will be waiting, but you are not heard [...] no one stops to stay there for about fifteen, twenty minutes, to see how the mother is feeling, and what's going on, if ... I don't know, [to] give emotional support (M1).

The assistance team is seen as a mainstay. It is believed that she has a knowledge that sustains and supports women in a moment of vulnerability, lack of control and fear. With the imagery constructed and massively propagated about normal birth as being dangerous, threatening and painful (DINIZ, 2005; MUNIZ; BARBOSA, 2012), it seems obvious that the institutional and political effort must be in favor of consolidating the vision of respectful childbirth, carried out by women, humanized as defended by some groups of professionals and researchers and by RC plans (DINIZ, 2005; RATTNER, 2009; CAVALCANTI et al., 2013).

However, the interviewees' statements show the mismatch between the needs for welcoming and listening in prenatal care and in the care received in the hospital context. Prenatal care, seen only as an opportunity to diagnose treatable health problems in the mother-baby binomial, does not seem to reach its potential for health education, an opportunity for dialogue about the expectations and desires of women for childbirth, for the operationalization of choices of these women within the system (VIELLAS et al., 2014).

The hegemonic biomedical model also maintains the idea that pregnancy should be controlled based on the disease (CARNEIRO, 2013b) and does not include the level of importance that questions about normal childbirth acquire in the imagination of women, expressed in the speech of all women interviewed in the survey. The massification of care replaces the construction of care relationships. In the absence of time or willingness to dialogue, scientificism and "humanized" techniques are hierarchically imposed, and even humanized practices, when merely protocolary, can be felt and experienced as unwanted by women. This structuring tension (BONET, 1999) results from the biomedical practice in which knowledge and feeling-when-doing are polarized.

Digital tools, such as internet discussion groups and applications to monitor the development of pregnancy, are gaining ground and were mentioned by all respondents as alternatives to these ineffective or non-existent contacts within health services. As M5 tells us:

[...] the doula, she even lent me that book *O Parto Ativo* [The Active Childbirth], right. I even skimmed it and ... sometimes [I read] things from the internet ... I have that Baby Center app, right ... (M5).

The recognition of the trajectories of each subject involved in childbirth care practices also stresses the need to realize that everyone's subjective experiences, with

each prenatal and delivery itself, could be of a different order, if the clashes for being able to decrease and the care was thought from the woman and not from the technical and technological environment that surrounds her (ELLS; HUNT; CHAMBERS-EVANS, 2011; ZANARDO et al., 2017; HEIDENREICH et al., 2018;).

The literature suggests that the care shared and built with autonomy by the people involved and within the limits of the assistant team and the institution (HEIDENREICH et al., 2018), is in accordance with relational aspects and person-centered medicine (STEWART; BROWN; WESTON, 2010). Ultimately, this is a view that converges with a part of the humanization ideal of childbirth and birth, which would be included in the CR guidelines (TEIXEIRENSE; SANTOS, 2018).

Safe deliveries and considered singular, claimed to be carried out by the woman, could also allow the motivation and involvement of the teams, in order to feed back the practices considered opportune, both by pregnant women and by RC. Autonomous decisions can and should be welcomed and considered as an aspect that enhances trust between all those involved, so that shared responsibilities are understood as implicated in the emancipation of women, in this specific context (ELLS; HUNT; CHAMBERS-EVANS, 2011; HEIDENREICH et al., 2018).

This is necessary so that the construction of desires for childbirth brings, in addition to meaning and fulfillment, the feeling of belonging and agency, so that the modalities of dialogue built together can benefit, in addition to women, the health teams.

Limits of humanization practices in childbirth

Another point that can be highlighted from the interviews was the limits imposed by humanization practices, proposed by the RC. M2, for example, claims that eventually gave her a childbirth experience determined by the lack of dialogue, explained in the previous speech, even though she experienced technically adequate assistance and a quick delivery.

[...] I wanted [a Caesarean], I had a choice, which I would like to be respected. And then come the rules [of] what cannot be done. But nobody thinks: ok, but why does she want to do it? (M2).

In the public service, unlike the “one-to-one” relationships of the private delivery teams, it is necessary to build a synergistic and trusting relationship at the time of delivery, since the people you meet at that time are not always known or had the

opportunity to spend time together. This relationship of trust must exist to guarantee a feeling of safety and care desired in the hospital environment governed by SUS.

[...] the care with a health insurance is one thing and SUS is another. Not all the professionals you meet at SUS are so willing to offer you good treatment (M1).

In the interviews, the idea appeared that public service was insufficient and implied lack of care. This idea was maintained even when the births had been adequate and in accordance with the guidelines of the RC. In addition, two RC recommendations, which are considered an important gain for a humanized delivery, were questioned by the interviewees: attendance by obstetric nursing and the presence of companions who were trained in non-pharmacological pain management, as is the case with doulas (DINIZ, 2005; RATTNER, 2009; BRASIL, 2011).

The work of obstetric nurses was described by the interviewees as a type of insufficient assistance and / or as a point of hierarchical conflict in the team. With praxis still undervalued, obstetric nursing finds it difficult to establish itself in the imagination of women as a safe, desirable assistance that is aligned with the precepts of humanization (MAIA, 2010).

When unnecessary procedures and excessive technology should give way to interpersonal relationships and support for maternal protagonism and autonomy, care by obstetric nursing should prevail in the case of pregnancies without pathology (CAVALCANTI et al., 2013; MARTINS et al., 2016). A scenario in which it would be easier to qualify the experience of childbirth with the subjective experiences of women, instead of describing it only from the protocol procedures common to biomedical practice (BONET, 1999; CARNEIRO, 2013b).

In the case of doulas, they were described by the parturients in two ways. First, as essential for the systematization of the knowledge acquired to prepare for childbirth, in addition to providing the physical and psychological support sought by women during labor and delivery itself:

[...] and after I [...] met (doula's name) I also started to read more about natural childbirth [...] and see reports of childbirth and watch some things, right. And then, you know, knowledge [...] is what makes us empower ourselves ... (M2).

Then, as if representing a counterpoint to the teams' beliefs or powers about childbirth and the woman, which could make it more difficult than facilitating assistance in some situations.

[...] I know that in the hospital they [doctors and nurses] don't like doulas. [...] because I think it disturbs their service a little [doctors' and nurses']. (M3).

If there is no understanding of RC policy by everyone involved in childbirth, there will also be no recognition of this new perspective on the care and objectives of assistance centered on women and on the best practical results and experiences for parturition.

The knowledge and recognition of all actors in childbirth, with respected autonomy, can be an answer to the care needs that are described in the literature on humanized childbirth and care free from obstetric violence (RATTNER, 2009; CAVALCANTI et al., 2013; ANDREZZO, 2016; MARTINS et al., 2016).

A time of listening and interaction, which all women interviewed described as essential for the expression and acceptance of their desires, can also support an obstetric care in the SUS that is technically adequate and, at the same time, recognized as being played by women.

[...] you are not heard [...] the doctor [...] does not stop to stay there for about fifteen, twenty minutes, to see how the mother is feeling, and what, what's going on, if, I don't know, give emotional support [...] it's just that period [...] he came, touched, said it was normal, you're going to have a cesarean or normal delivery and then he was gone... then the mother doesn't have much confidence in that, I think. (M3).

Final remarks

The Rede Cegonha institutionalized some demands of groups of activists for humanized childbirth, turning important measures into protocols for the change of the obstetric model in the country, carried out by SUS. However, the women interviewed for this research, and who had their births in a hospital in which RC is implanted, highlighted in their speeches the limits of this care during their attendance.

It was evident, during the review of the material and during the interviews, that pain and fear are still very present feelings in the birth reports, even when public policy seems to be aligned with the demands of humanization. The desire to have a singular service, with space to discuss issues related to this period of the woman's life, appeared as a claim by the women heard in the study, finding an echo in the literature.

In an obstetric context, within a public policy to encourage the use of evidence-based medicine and a counter-hegemonic model of health care, autonomy thought from an individualistic perspective does not seem to be able to resolve ethical

dilemmas that arise in practice. Likewise, the idea that the woman can decide for herself the direction of the delivery itself, does not match the reality inside the hospital. Many questions are present at this moment and, specifically in this study, address some types of relationship: that of the parturient with the baby, with the assistance team and with the hospital, as well as those of the medical team with each other and with the institution.

The needs and wants of the pregnant woman can be silenced, distorted, tutored and manipulated in the hospital environment. It is a strange environment and in which it is common to have discrepancies between the agents involved, devaluation of nursing praxis in relation to medical practice, as well as different views of the ongoing phenomena. In this scenario, it is necessary to recognize, for example, the asymmetric power relations between the actors and actresses present in the delivery scene, with a disadvantage for women in relation to the medical team, at various levels.

The indication to write a Childbirth Plan, to ensure that the parturient's wishes are respected and avoid obstetric violence (ANDREZZO, 2016; TESSER et al., 2015), is in the text of the implementation of the RC. The indication starts from the premise that it is necessary to reflect and know these desires in advance in order to be able to discuss them based on a significant reference for that woman and that particular family.

Childbirth Plans, thought beyond the prescription of procedures and ambience desired or not, could be constructed contextually and understood as a materialization of informed decisions and manifest wishes during prenatal care, within the reality of the assistance in question. A possible dialogue interface between all actors involved and in dispute at the delivery scene. They could serve as an instrument that, concretely, would signal the woman's search for a delivery that she understands as her own (protagonist, significant, chosen), instead of something imposed by the circumstances of hospitalization (ANDREZZO, 2016).

Strengthening dialogue as an essential tool between parturients and the health team within institutional spaces, built for this purpose, and registering the converging points between wishes and clinical protocols, as a way of expressing and materializing the construction of women's autonomy in the face of childbirth, it can culminate in a real experience of humanization and care in SUS institutions where Rede Cegonha is implanted.²

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Notes

¹ Routine cut in the perineum and pressure on the pregnant woman's belly to supposedly help the baby out.

² M. C. Bachilli: conception, planning, collection, analysis and interpretation of data, writing of the article. I. Zirbel: data analysis and interpretation, writing of the article. E. T. de Santa Helena: conception, planning, analysis and interpretation of data, writing of the article.

Resumo

Autonomia relacional e parto humanizado: o desafio de aproximar desejos e práticas no SUS

A Rede Cegonha é um programa de assistência do SUS que visa diminuir a mortalidade materna e neonatal por meio de práticas obstétricas humanizadas e baseadas em evidências. No entanto, ainda parece haver um distanciamento entre os desejos das mulheres no momento do parto e o que é oferecido pela equipe de assistência. Este estudo se propõe a desvelar os limites da autonomia da mulher no momento do parto em um hospital da Rede Cegonha. As puérperas responderam a perguntas abertas em uma entrevista pessoal e relataram sua experiência de parto. A análise de conteúdo foi utilizada para organizar os discursos em categorias de análise. O medo da dor (que interfere no protagonismo da mulher), a falta de diálogo com os profissionais de saúde (percepção de não ser ouvido) e o desconhecimento das orientações da Rede Cegonha apareceram nas entrevistas como barreiras à significativa experiência do parto. Para uma verdadeira experiência de humanização, é necessário fortalecer o diálogo entre as parturientes e a equipe de saúde, a fim de reunir desejos e protocolos clínicos, como forma de afirmar a autonomia da mulher diante do parto.

► **Palavras-chave:** parto humanizado; autonomia relacional; obstetrícia.

