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Assessment of women's satisfaction with labor and childbirth at a teaching hospital

Avaliação da satisfação de mulheres com trabalho de parto e parto em hospital de ensino

Evaluación de la satisfacción de las mujeres con el trabajo y el nacimiento en hospital de enseñanza

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ABSTRACT

Objective: To assess the satisfaction of puerperal women regarding labor and childbirth.

Method: Analytical and cross-sectional research carried out with puerperal women at a teaching hospital. Data were collected from October to December 2020 by a sociodemographic and obstetric questionnaire and the Mackey Childbirth Satisfaction Rating Scale. The scale has 34 items divided into six domains, with a minimum score of 34 and a maximum of 170 points.

Results: The mean score was 141 points in a sample of 243 puerperal women, with a standard deviation of 16.8. There was high satisfaction among women in all domains of the scale and low adherence to the best practices in labor and childbirth care currently recommended.

Conclusion: The women were satisfied upon the experience. The limitation of the health education process during prenatal care may reduce the parturient' discernment and critical judgment.

Keywords: Women's health. Parturition. Patient satisfaction.

RESUMO

Objetivo: Avaliar a satisfação de puérperas quanto ao trabalho de parto e parto.

Método: Pesquisa analítica e transversal, realizada com puérperas de um hospital de ensino. Os dados foram coletados de outubro a dezembro de 2020, por meio de um questionário sociodemográfico e obstétrico e da Escala de Avaliação da Satisfação com o Parto de Mackey. A escala possui 34 itens divididos em seis domínios, com pontuação mínima de 34 e máxima de 170 pontos.

Resultados: Em uma amostra de 243 puérperas, a pontuação média foi de 141 pontos, com desvio padrão de 16,8. Verificou-se alta satisfação das mulheres em todos os domínios da escala e baixa adesão às boas práticas de atenção ao parto e nascimento, recomendadas atualmente.

Conclusão: As participantes se mostraram satisfeitas com a experiência. A limitação do processo educativo em saúde durante o pré-natal pode diminuir o discernimento e o julgamento crítico das parturientes.

Palavras-chave: Saúde da mulher. Parto. Satisfação do paciente.

RESUMEN

Objetivo: Evaluar la satisfacción de las puérperas con respecto al trabajo de parto y nacimiento.

Método: Investigación observacional, analítica y transversal realizada con puérperas de un hospital universitario. Los datos fueron recolectados de octubre a diciembre de 2020, utilizando un cuestionario sociodemográfico y obstétrico y la Escala de Calificación de Satisfacción al Parto de Mackey. La escala consta de 34 ítems divididos en seis dominios, con una puntuación mínima de 34 y máxima de 170 puntos.

Resultados: En una muestra de 243 puérperas, la puntuación media fue de 141 puntos, con una desviación estándar de 16,8. Hubo alta satisfacción entre las mujeres en todos los dominios de la escala y baja adherencia a las buenas prácticas de atención durante el trabajo de parto y el parto, actualmente recomendadas.

Conclusión: Los participantes quedaron satisfechos con la experiencia. La limitación del proceso de educación sanitaria durante la atención prenatal puede reducir el discernimiento y el juicio crítico de las parturientas.

Palabras clave: Salud de la mujer. Parto. Satisfacción del paciente.

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INTRODUCTION

Parturition and childbirth are considered events full of personal, emotional, and sociocultural meanings, which are related to the preferences of the parturient, posture of professionals, conduct adopted during care, among other factors.

Over the years, obsolete practices and the unrestricted adoption of invasive technologies and procedures in childbirth care have been discouraged because they are not safe or beneficial to the health of women and their babies, in addition to interfering with the quality of the lived experience[1]. Several national programs have been implemented with the objective of offering more qualified care to pregnant women and, in the international scenario, the World Health Organization (WHO) published, in 2018, recommendations on intrapartum care with a view of ensuring a positive experience in this context[1].

National and international initiatives have in common the search for more respectful and safe care, based on scientific evidence and with an emphasis on the active participation of women, in addition to contemplating the appropriation of the emotional and social aspects involved in the childbirth process[2]. However, despite the increased visibility of this topic in recent decades worldwide, many Brazilian services have not yet managed to effectively implement the recommendations of science in their clinical practice, which may have a negative impact on the satisfaction of women regarding childbirth[3].

Currently, customer satisfaction is considered an important indicator of the quality of care offered[4]. In the context of maternal health, assessing women's satisfaction with the care received during labor and childbirth is extremely relevant not only for health professionals, but also for hospital managers and public policy makers, since this data represents an important feedback that can be used to improve the quality of maternal and child health care services[5].

The concept of satisfaction with childbirth expresses the positive personal perception of the assistance received during childbirth, evidencing professional practices and attitudes implemented to the costumer[6]. However, satisfaction with childbirth is a complex and multidimensional construct influenced by several factors[4].

The literature points out variables that are related to childbirth satisfaction: accessibility, physical environment, cleanliness, availability of medicines, supplies and human resources, privacy and confidentiality, promptness, adequate emotional support, type of delivery, skin-to-skin contact with the newborn, continuous support during the process, procedures performed and information received during labor[6–7].

A concept that has also been widely used in discussions about satisfaction with childbirth is the positive experience of childbirth. According to the WHO, a positive childbirth experience can be defined as an experience that meets or exceeds the woman's previous personal and sociocultural beliefs and expectations. This includes giving birth to a healthy baby in a safe environment from a clinical and psychological point of view, and having continuous practical and emotional support, that is, being monitored at the time of birth and being cared for by welcoming professionals with adequate technical skills[1].

On the other hand, dissatisfaction with the childbirth experience has short and long-term negative effects on the woman's life, as well as on the baby and family, such as psychological and sleep disorders, post-traumatic stress disorder, impaired mother-child bonding, mood and appetite changes, sexual dysfunctions, exacerbated fear of childbirth, extended intrapartum interval and reduced interest in other pregnancies[4], which reinforces the need for studies on the topic of women's satisfaction with their childbirth experiences.

Considering that the investigation on satisfaction with labor and childbirth represents a strategy capable of offering subsidies to improve the care plan for women, guide the care practices of the service and qualify the assistance offered to women in the parturition process, the following guiding question was considered: What is the satisfaction of puerperal women in a teaching hospital with the experience of labor and childbirth? In this context, the present study aimed to assess the satisfaction of puerperal women regarding labor and childbirth.

METHODS

This is an observational, analytical, and cross-sectional research. The study report was based on the recommendations of the STROBE guide (Strengthening the Reporting of Observational Studies in Epidemiology).

Data were collected from October to December 2020, with puerperal women hospitalized in the rooming-in unit of a public teaching hospital, located in a city in the interior of the State of São Paulo. The hospital serves about 220 childbirths per month and is a reference for high-risk care for six municipalities in the region.

The sample selection criteria were: puerperal women over 18 years of age; with live newborns; at least 24 hours postpartum; who had the experience of labor (regardless of the mode of delivery); able to read the instrument (literate), and without communication difficulties (absence of pathology or

disorder that hinder speech, and/or foreign mothers whose native language was not Portuguese).

The sample size was determined considering the sample calculation methodology, in order to estimate a proportion. For that, a proportion p equal to 0.50 was considered, whose value represents the maximum variability of the binomial distribution, thus generating an estimate with the largest possible sample size. The population considered for the calculation consisted of approximately 660 puerperal women (three months of collection). A sampling error of 5% and a significance level of 5% were assumed. Thus, the sample size obtained was 243 puerperal women.

For data collection, two instruments were used. The first, a sociodemographic and obstetric questionnaire developed for the present research, whose information was collected by an interview with the woman, followed by consultation of information in medical records and prenatal booklet. The variables: color (self-reported), religion, desired mode of delivery, use of non-pharmacological methods for pain relief available at the institution (spray bath, Swiss ball, massage, ambulation), use of pharmacological analgesia (epidural), information received about childbirth during prenatal care (yes or no answer option) and completion of a preparatory course for childbirth (yes or no answer option) were asked to the participant. The other variables of the questionnaire: age (years), marital status, schooling, parity, gestational age, gestational risk stratification, mode of delivery performed, and prenatal follow-up were consulted in the medical records (admission form and partogram), in addition to the prenatal booklet.

The second instrument used was the Mackey Childbirth Satisfaction Rating Scale (MCSRS). This scale was developed in the United States and translated to several languages, including Brazilian Portuguese. The instrument was cross-culturally adapted for Brazil, underwent the Face and Content Validation process and its reliability was tested, with a satisfactory result (McDonald's omega coefficient of 0.97)[8–9]. This instrument was chosen because it is a in-depth scale, which includes several factors that can interfere with women's satisfaction with labor and the experience of childbirth. It is constituted by 34 assessment items, divided into six domains: self-assessment (Q3 to Q11); partner (Q12 and Q13); newborn (Q14 to Q16); nursing care (Q17, Q19, Q21, Q23, Q25, Q27, Q29, Q31, Q33); medical care (Q18, Q20, Q22, Q24, Q26, Q28, Q30, Q32) and overall childbirth assessment (Q1, Q2, Q34). The internal consistency of each domain was assessed using Cronbach's alpha coefficient. All domains of the scale presented Cronbach's alpha > 0.8.

The instrument was offered to puerperal women for self-completion. For each item assessed, there are five response options, graded on a Likert-type scale from 1 to 5, where "1" represents "very dissatisfied" and "5" represents "very satisfied". The maximum score of the scale is 170 points, while the minimum is 34, however, a graduation of this number was not found to classify women's satisfaction. In addition to the items in each domain, the instrument has four more questions (Q37 to Q40) that assess the experience lived by the woman. For these questions, the answers are graded on a Likert-type scale from 1 to 4, where "1" means "nothing to do with what I expected", "2" is "very little to do with what I expected", "3" represents "somewhat to do with what I expected", and "4" as "it was as I expected".

Every day, the collector (the only one for data collection) printed the list of puerperal women admitted to the unit and listed those who possibly met the research inclusion criteria. Next, the puerperal women were approached to confirm the inclusion criteria in the sample, presented to the research and then, invited to participate. In all, seven puerperal women refused to participate.

The questionnaire was applied on the Rooming-in facilities of the mentioned institution, avoiding times of procedures, so as not to disturb the unit's care routine. Data collection with women lasted about 15-20 minutes. Initially, the puerperal women answered the questions of the sociodemographic questionnaire, which were conducted by the collector, who filled in the answers. Next, the collector offered the satisfaction scale for self-completion of the puerperal woman.

All participants signed the Free and Informed Consent Form (FICF), before data collection, keeping a copy in their possession. The research followed the guidelines and regulatory standards of Resolution 466 of 12/12/2012 of the National Health Council and was approved by the Research Ethics Committee, under Opinion No.4,168,051/2020.

The statistical software Statistical Analysis System (SAS), version 9.4, and Statistical Package for the Social Sciences (SPSS), version 23, with a significance level of 5%, were used for all analyses. For comparisons between a categorical variable in relation to the scale scores, the unpaired Student's t-test or the Mann-Whitney test was applied, according to the data distribution. For comparisons between a qualitative variable with more than two categories in relation to the scale scores, the ANOVA model or the Kruskal-Wallis test was applied, according to the data distribution. Data distribution was assessed using the Shapiro-Wilk test. The correlations between quantitative variables and instrument scores were assessed using Spearman's correlation coefficient.

The domains were compared with all the qualitative variables of the sociodemographic questionnaire: color, marital status, religion, desire for the mode of delivery, type of delivery, use of non-pharmacological methods for pain relief, massages, shower, ball, ambulation, pharmacological analgesia, complications during delivery, gestational risk stratification and information about labor and delivery during prenatal care.

RESULTS

The study sample consisted of 243 puerperal women, with a mean age of 27 years, ranging from 18 to 46 years. The mean gestational age (on the day of delivery) was 38 weeks and 6 days, ranging from 35 weeks and 2 days to 41 weeks and 4 days. The sociodemographic and obstetric profile of the participants is presented in Table 1.

Table 1 – Sociodemographic and obstetric characterization of the participating puerperal women (n=243). Sumaré, São Paulo, Brazil, 2020

Variable	N	%
Color		
White	124	51.0
Brown	88	36.2
Black	31	12.8
Marital status		
Single	74	30.4
Married	164	67.5
Widowed	1	0.4
Divorced	4	1.6
Religion		
Evangelical	110	45.3
Catholic	77	31.7
Spiritist	2	0.8
Umbandista	1	0.4
Buddhist	1	0.4
Other	2	0.8
No religion	50	20.6
Schooling		
Incomplete elementary school	23	9.5

Table 1 – Cont.

Variable	N	%
Complete elementary school	15	6.2
Incomplete high school	30	12.3
Complete high school	155	63.8
Incomplete higher education	7	2.9
Complete higher education	13	5.3
Parity		
First pregnancy	90	37.0
Second pregnancy	77	31.7
Third pregnancy	50	20.6
Four or more pregnancies	26	10.7
Gestational risk stratification		
Usual risk	159	65.4
High risk	84	34.6
Prenatal follow-up		
Yes	241	99.2
No	2	0.8

Source: Research Data, 2020.

The participants had an average of nine prenatal consultations. Only 46.5% (n=113) received information related to childbirth during prenatal care and 1.6% (n=4) of the puerperal women took some preparatory course for childbirth during pregnancy.

Regarding the desire for the mode of delivery, 76.9% (n=187) reported intention for vaginal delivery, while 23% (n=56), for cesarean section. Regarding the completed mode of delivery, 53.9% (n=131) had vaginal delivery, 42.8% (n=104), cesarean section and 3.3% (n=8), instrumental vaginal delivery (forceps).

Regarding the use of pain relief methods, 78.6% (n=191) received pharmacological analgesia and 46.5% (n=113) used non-pharmacological methods. Among the non-pharmacological methods mentioned, 39.5% (n=96) used shower, 14.4% (n= 35) used ambulation, 11.5% (n= 28) used the Swiss ball, and 9.8% (n=24) used massages. Regarding the delivery position, 99.1% (n=241) gave birth in a horizontal position (lithotomy or semi-lying on the bed). Data regarding the expectation and assessment of puerperal women in relation to their experience with labor and childbirth (Q37-Q40) are presented in Table 2.

Table 2 – Expectation and assessment of labor and childbirth of puerperal women (n=243). Sumaré, São Paulo, Brazil, 2020

Variable	N	%
Was your experience in labor as you expected?		
Nothing to do with what I expected	46	18.9
Very little to do with what I expected	24	9.9
Somewhat to do with what I expected	68	28.0
It was as I expected	105	43.2
Was your experience in delivery (vaginal) as you expected?		
Nothing to do with what I expected	26	10.7
Very little to do with what I expected	9	3.7
Somewhat to do with what I expected	42	17.3
It was as I expected	62	25.5
Does not apply	104	42.8
Assessment of labor		
It was very negative	7	2.9
It was a little negative	28	11.5
It was a little positive	62	25.5
It was very positive	146	60.1
Assessment of delivery (vaginal or cesarean)		
It was very negative	7	2.9
It was a little negative	24	9.9
It was a little positive	67	27.6
It was very positive	145	59.6

Source: Research Data, 2020.

When invited to assess their overall experience during labor, 57% (n=138) considered themselves satisfied and 25.6% (n=62) were very satisfied. They also showed significant satisfaction with the delivery: 53.8% (n=77) considered themselves satisfied and 31.5% (n=45) were very satisfied. As for the companion's collaboration during labor, 46.6% (n=95) considered themselves very satisfied. Table 3 presents the assessment of puerperal women regarding the performance of the health team (medical and nursing).

Table 3 – Assessment of puerperal women regarding the performance of the health team (n=243). Sumaré, São Paulo, Brazil, 2020

Variable	N	%
Your participation in decisions during labor		
Very dissatisfied	10	4.1
Dissatisfied	15	6.2
Neither satisfied nor dissatisfied	24	10.0
Satisfied	131	54.4
Very satisfied	61	25.3
No information = 2		
The time it took to hold your baby for the first time		
Very dissatisfied	8	3.5
Dissatisfied	13	5.6
Neither satisfied nor dissatisfied	17	7.4
Satisfied	140	60.6
Very satisfied	53	22.9
No information = 12		
The care for your body that you received from the nursing team during labor and childbirth		
Very dissatisfied	1	0.4
Dissatisfied	1	0.4
Neither satisfied nor dissatisfied	9	3.7
Satisfied	136	56.0
Very satisfied	96	39.5
The care for your body that you received from the medical team during labor and childbirth		
Very dissatisfied	2	0.8
Dissatisfied	4	1.6

Table 3 – Cont.

Variable	N	%
Neither satisfied nor dissatisfied	11	4.5
Satisfied	132	54.5
Very satisfied	93	38.4
No information = 1		
The technical knowledge, skill, and competence of the nursing team during labor and childbirth		
Very dissatisfied	1	0.4
Dissatisfied	1	0.4
Neither satisfied nor dissatisfied	4	1.6
Satisfied	140	57.6
Very satisfied	97	40.0
The amount of explanations or information that you received from the nursing team during labor and childbirth		
Very dissatisfied	5	2.1
Dissatisfied	3	1.2
Neither satisfied nor dissatisfied	15	6.2
Satisfied	137	56.4
Very satisfied	83	34.2
The time nurses spent with you during labor		
Very dissatisfied	3	1.2
Dissatisfied	9	3.7
Neither satisfied nor dissatisfied	12	4.9
Satisfied	141	58.0
Very satisfied	78	32.1

Source: Research Data, 2020.

There was no statistically significant difference when correlations were tested between the domains of the scale with all the quantitative variables of the questionnaire (age, number of consultations, time of pregnancy, number of pregnancies and number of children).

With regard to the comparisons made between the variables of the sociodemographic questionnaire and the domains of the scale, a statistically significant difference (p=0.0163) was found for the domain "Newborn", when comparing the type of delivery (vaginal /forceps x cesarean); and the use of non-pharmacological methods for pain relief (p=0.0186). Puerperal women with vaginal and/or forceps delivery were more satisfied with the baby's health and with the time to hold and breastfeed the newborn, when compared to those who underwent cesarean section.

For the domain "Partner", a statistically significant difference was found when comparing: the use of non-pharmacological methods for pain relief (p=0.0163); use of shower (p=0.343); and receiving information about labor and childbirth during prenatal care (p=0.0229). Women who had a companion present during childbirth were those who most used non-pharmacological methods for pain relief and who received more information about labor and childbirth during prenatal care.

DISCUSSION

The study showed a high satisfaction with the labor and childbirth of the participating puerperal women. For all items assessed, the answer "satisfied" or "very satisfied" was predominant. Concurrently and contradictory, the data showed weaknesses in adhering to some good practices of care during labor and childbirth, such as offering information and preparation about labor and childbirth during prenatal care, use of non-pharmacological methods for pain relief and upright the delivery position. It was also observed wide use of pharmacological analgesia in the sample studied.

Currently, many procedures are being performed routinely and without scientific evidence, separating care from good practices and may causing undesirable and harmful results for both the woman and the newborn[10]. According to the Ministry of Health (MH) many women and their newborns are exposed to high rates of interventions, which should be used sparingly and only in situations of need, not as routine[11].

Despite almost all puerperal women had prenatal care and had a high average of consultations, less than half reported receiving information about labor and childbirth during the follow-up, and a very small portion participated some preparation course for childbirth.

It is considered that the probable scarcity of information from educational activities may represent an important limiting factor for critical assessment by these women regarding their lived experience. The gap in the educational process during prenatal care points to the need to qualify the consultation beyond the quantitative aspect. Assessing prenatal care based only on the number of consultations can hide numerous problems in the quality of this care, overestimating the effectiveness of the care provided[12].

The literature shows that women with lower purchasing power and assisted in the public sector receive less information related to birth, which makes them less empowered to make decisions during labor and childbirth, increasing their vulnerability and the risk of using more painful procedures[13].

The lack of information of the woman is one of the situations that most weakens her in the field of childbirth care, as it makes her passive in the entire process. Thus, it is understood that the lack of information, in addition to exposing women to more risks, can also misrepresent their understanding of safe and respectful care.

The high satisfaction with the childbirth experience in low- and middle-income countries has been subject of investigation. The main reasons for these high scores in unfavorable scenarios are: met expectations associated with lack of awareness of client standards and rights, lack of exposure to different models of care in a context of low literacy, difficulty to express critical comments, time and interview location and different definitions of the concept of satisfaction[14].

With regard to preparation for childbirth, this research also showed a gap in prenatal care, since a small number of the participants took a preparatory course for childbirth. This aspect, added to the little information from prenatal care, contributes the vulnerable condition of the pregnant woman, reducing her repertory for judgment. It is worth mentioning that the data collection of this study took place during the period of the SARS-CoV-2 pandemic, which certainly generated limitations in the group activities of the health units, including the groups of pregnant women.

In addition to preparing women and promoting their understanding regarding the care received, the provision of information in preparatory courses is related to satisfaction of women in the process of labor and childbirth. A study conducted with 77 pregnant women showed that participation in a childbirth preparation program improved satisfaction with the lived experience, allowed better communication between women and health professionals, increased participation in decision-making during labor, in addition of reducing the painful perception of women during childbirth[15].

This research found a high level of satisfaction with the experience of normal delivery. As it is a service that still presents inconsistency with some practices recommended by the evidence, it would be important to investigate in-depth what were the factors considered by the women for this assessment. In many places, the delivery expected by women and considered "normal" is one in which there is immobilization, fasting, lithotomy position and routine use of episiotomy[16], all practices that are currently not recommended by the WHO[1] and MH[11]. Unfortunately, this set of actions is still routinely practiced in obstetric care in many Brazilian hospitals and is assessed as satisfactory by women[16]. This result points out to a complex scenario that is actually perpetuated and is strengthened by the little empowerment of women.

In this sample, almost all the participants gave birth in the lithotomy position, a practice not recommended by scientific evidence for some years, unless it is a conscious choice of the parturient[1,11]. This finding demonstrates a weakness of the health service, which could encourage freedom of positions for childbirth, including vertical ones, which are currently recommended, in view of the broad associated benefits[1,11]. According to the literature, vertical positions or positions that allow flexibility of the sacrum can reduce the duration of the second stage of childbirth by up to 21 minutes, and women should be encouraged[17]. Fortunately, a broad study about the advances in childbirth care in Brazil in recent years showed that childbirth in a lithotomy position is a practice that is being reduced in the Brazilian scenario, as well as others considered harmful[18].

Regarding the use of methods for pain relief, a wide use of pharmacological analgesia was observed. Despite women report high satisfaction with the management of labor, this result points to an important reflection: the naturalization of the medicalization of the female body in an essentially physiological process.

The routine use of pharmacological medication to the detriment of non-pharmacological means for pain relief is a practice described in the medicalized model of childbirth care, and which is the target of criticism by many authors, according to a current narrative review about the medicalization of childbirth[10]. This scenario may be related to the lack of preparation of women and health professionals in the management and understanding of the childbirth process as an event inherent to the maternal organism. It is urgent to value this aspect in the training process of health professionals and in the prenatal care of women, as an important strategy to change this care paradigm that considers the women's body incapable of tolerating and dealing with the pain of the labor without the use of medication.

Although the use of pharmacological analgesia has its efficacy widely recognized in the literature, a study has shown that its indiscriminate use is linked to greater neonatal risks, such as Apgar less than 7 in the first minute, need for neonatal resuscitation maneuvers and referral to neonatal intensive care unit[19]. In short, the potential benefits and risks of using pharmacological analgesia for pain management during labor and childbirth need to be known to women prior to labor, which guarantees the right to a conscious and informed choice.

It is understood that a strategy in favor of a more rational use of pharmacological analgesia is the broad incentive and guarantee of access to the use of non-pharmacological methods for pain relief. The literature shows that the rate of use of these methods has increased significantly in recent years, especially in the North and Northeast regions of the country[18]. However, in some health services, its use is still limited.

In this sample, the wide use of pharmacological analgesia may be related to the women's lack of information about the potential effects of less invasive relief methods. The literature shows that there is a lot of lack of knowledge about non-pharmacological pain relief methods among women. Research conducted in a teaching maternity hospital in São Paulo revealed that 77% of women had never heard of any non-pharmacological method for pain relief during childbirth[19].

The little use of methods may also indicate discredit on the part of the health service, which may be linked to the different perspectives on the childbirth process and its management. Thus, it must be considered that the use of pharmacological analgesia (which immobilizes and calms the parturient) reduces the active management of the health team and denotes an impression of care for the woman, which is not always true.

It is believed that the early and routine use of pharmacological analgesia replaces the maternal experience with other possible resources. The lack of information about the physiology of childbirth, the potential for action and the benefits associated with the use of non-pharmacological methods lead women, once again, to choose for the resource that is apparently more effective. Thus, as long as women do not understand the physiological process of childbirth and its consequences, which includes labor pain, all pain mitigating mechanisms will be positively assessed.

In the sample, women who had vaginal delivery were more satisfied with the time to hold and breastfeed the newborn. This result can be explained by the better health conditions of the puerperal woman and the baby who experience normal delivery, since it is a physiological process and low risk that must be promoted and protected to improve health indicators.

The rate of women's satisfaction with the presence of a companion was also high in the sample studied. In addition, it was found that accompanied women made more use of non-pharmacological methods than those who were alone. This result is corroborated by the literature, as women who receive continuous support during labor are less likely to use pain relief medications and are more likely to feel satisfied[18].

The items that assessed the care provided by health professionals were those that obtained the highest satisfaction scores from users, covering both practical care and the relationship built with the medical and nursing team at the time of delivery/childbirth. This is an important feedback for the institution's staff.

The literature points out some important aspects for a good interpersonal relationship between parturient and health professionals: respect, cordiality, patience, solicitude, constant presence, willingness to answer questions and actions to deliver tranquility and calm[20]. On the other hand, distance, disinformation, hostility and disrespect are factors that impair the relationship and seem to be linked to the personal postures of professionals[20]. Considering that one of the goals of obstetric care is to provide a physiological and meaningful experience, professionals must be prepared to understand the impact of their work on subjective aspects of this experience in the lives of women and families.

The research scenario maintains service qualification strategies with the objective of generating changes in its care model and qualifying the care offered, through the dissemination and encouragement of good practices in childbirth care, offering updating courses to the health team and encouraging the awareness of the professionals involved. However, the data show that care for women in prenatal care, as well as throughout labor and childbirth, still maintains practices of a model of care that should have already been replaced.

As for the limitations of the study, one can point out the size of the instrument, with many questions for reading, which may have been tiring to fill out and may have influenced the answers indicated. It was also noticed a certain discomfort of the participants in assessing their experience during their stay at the institution, which may have generated less discerning answers.

CONCLUSION

This study allowed to identify a high level of satisfaction in the experience of labor and childbirth in 243 women attended at a public teaching hospital, according to the Mackey Childbirth Satisfaction Rating Scale. Although all the investigated items presented high satisfaction, aspects of care were identified in disagreement with current scientific evidence, such as low adherence to non-pharmacological methods of pain relief, predominance of deliveries in the lithotomy position, little information about good practices on care for labor and childbirth in prenatal care and medicalized care.

The women's perception on satisfaction with the experience may have been influenced by the lack of information, which is a consequence of the failure of the educational process during prenatal care. This condition may diminish the discernment and critical judgment of parturients about their lived experienced.

The results of this research contributed to the identification of care practices in childbirth that are in disagreement with the scientific evidence and possible gaps in the educational process in the health of pregnant women, which need to be overcome in the care and management scope. In this sense, it is recommended to maintain and encourage more investments in the qualification of the health education process, whether in the pre-pregnancy or gestational period, so that women can increase their level of knowledge about physiological aspects and the management of labor and childbirth. This strategy will contribute to women make their choices in a more informed and conscious way, reducing vulnerability at the time of childbirth and increasing interest in appropriate technologies for labor and birth. It is also highlighted the need to qualify the professional training process, in addition to the development and implementation of monitoring strategies for health teams to comply with good practices in prenatal care, labor, parturition and birth.

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