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Original

Development and validation of a checklist for intrapartum care

Desenvolvimento e validação de um checklist para cuidados intraparto

Desarrollo y validación de una lista de verificación para la atención intraparto

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Abstract

Objective: to develop and validate a checklist for intrapartum care based on recommendations from the World Health Organization (WHO). **Method:** this is a methodological study conducted with nine content judges, obstetric nurses, who were invited to participate through a search on the Lattes Platform and using the snowball sampling technique. The checklist validation period took place between November and December 2020, after approval by the research ethics committee. **Results:** the instrument was analyzed for its relevance using the Likert scale, as well as aspects of clarity, pertinence, and adequacy, showing satisfactory performance. Based on the evaluation, the checklist achieved a global Content Validity Index (CVI) of 0.99. **Conclusion:** the Intrapartum Care Checklist was developed and validated according to the proposed objectives, after evaluation by expert judges. It is expected that its application by obstetric nurses in clinical practice will contribute to safer care for women.

Descriptors: Checklist. Humanized delivery. Patient safety. Nursing.

Whats is already known on this?
The development of checklists for delivery safety and best practices in care is observed; however, a lack of adaptation to the reality of Brazilian healthcare is still noted.

What this study adds?
The study contributes to the development and validation of a technology for the reality of intrapartum care, considering Brazil as one of the countries with the highest perinatal mortality rates.

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Resumo

Objetivo: Objetivo: desenvolver e validar um checklist para cuidados intraparto, baseado nas recomendações da Organização Mundial da Saúde (OMS). Método: trata-se de uma pesquisa metodológica realizada com nove juízes de conteúdo, enfermeiros obstetras, que foram convidados a participar a partir da busca na Plataforma Lattes e pela técnica de amostragem em bola de neve. O período de validação do checklist ocorreu entre novembro e dezembro de 2020, após a aprovação pelo comitê de ética em pesquisa. Resultados: o instrumento foi analisado quanto ao grau de relevância utilizando a escala Likert, bem como aspectos de clareza, pertinência e adequação, apresentando desempenho considerado satisfatório. A partir da avaliação realizada, o checklist alcançou um Índice de Validade de Conteúdo (IVC) global de 0,99. Conclusão: o checklist para Cuidados Intraparto foi elaborado e validado conforme os objetivos propostos, após apreciação dos juízes especialistas. Espera-se que sua aplicação pelos enfermeiros obstetras na prática assistencial contribua para uma atenção mais segura às mulheres. importantes.

Descritores: Lista de checagem. Parto humanizado. Segurança do paciente. Enfermagem.

Resumén

Objetivo: desarrollar y validar una lista de verificación para la atención intraparto, con base en las recomendaciones de la Organización Mundial de la Salud (OMS). Método: estudio metodológico realizado con nueve jueces de contenido, enfermeras obstétricas, invitadas a participar mediante una búsqueda en la Plataforma Lattes y mediante la técnica de muestreo por bola de nieve. El período de validación de la lista de verificación se llevó a cabo entre noviembre y diciembre de 2020, tras la aprobación del comité de ética de la investigación. Resultados: se analizó la pertinencia del instrumento mediante la escala de Likert, así como su claridad, pertinencia y adecuación, mostrando un desempeño satisfactorio. Según la evaluación, la lista de verificación alcanzó un Índice de Validez de Contenido (IVC) global de 0,99. Conclusión: la Lista de Verificación para la Atención Intraparto se desarrolló y validó de acuerdo con los objetivos propuestos, tras la evaluación de jueces expertos. Se espera que su aplicación por parte de enfermeras obstétricas en la práctica clínica contribuya a una atención más segura para las mujeres.

***Descriptores:** Lista de verificación. Parto humanizado. Seguridad del paciente. Enfermería.*

INTRODUCTION

The pregnancy–puerperal cycle represents a period of intense physical and psychological changes and adaptations for women, driven by hormones that prepare the body up to the birth of the baby. Although in recent years women have become more aware of the policies that guarantee their rights during pregnancy and delivery, many still lack comprehensive information about how appropriate practices should occur during the prepartum, delivery, and postpartum periods.[1]

Thus, despite advances and the implementation of public policies aimed at women's health, rates of preventable complications and the performance of interventions that may result in death continue to occur at high levels.[2] Women and newborns frequently undergo unnecessary interventions, such as episiotomy, excessive use of oxytocin, and elective cesarean sections. Procedures that should be employed with caution end up being performed routinely, directly affecting the well-being of the mother–baby dyad.[3]

Maternal death can be classified into three groups of causes: direct obstetric, indirect obstetric, and non-obstetric. Direct obstetric causes are associated with complications during pregnancy, delivery, or the puerperium, resulting from interventions, omissions, or inadequate treatment. Indirect obstetric causes correspond to deaths caused by preexisting diseases or conditions developed during pregnancy that are aggravated by the physiological changes of the gestational period. Finally, non-obstetric causes include deaths resulting from accidental or incidental events.[4]

According to data from the Mortality Information System, Brazil recorded 1,738 maternal deaths in 2015 due to complications of pregnancy or delivery occurring up to 42 days after the end of pregnancy. In 2016, 1,463 deaths were recorded, representing a 16% reduction compared to the previous year.[5] This reduction, although still modest, can be observed as a result of increased investment in humanized practices, in line with the recommendations of the Ministry of Health aimed at strengthening prenatal care services and puerperal consultations.[5]

The World Health Organization (WHO) and Brazil set the goal of achieving a rate of 35 maternal deaths per 100,000 live births by 2015. However, in 2016, the state of São Paulo alone recorded a rate of 47 deaths per 100,000 live births, exceeding the projected value.[6] The situation is even more concerning in the states of the Northern region, which showed an 11% increase in deaths, ranking among the areas with the highest maternal mortality rates in the country, alongside the Northeast region.[6]

Data from the Brazilian Obstetric Observatory (BrOO) reveal that there is a significant underreporting of maternal deaths: it is estimated that around 35% of deaths of pregnant and postpartum women are not included in official records.[3,7] In 2021, for example, 347 deaths of pregnant and postpartum

women were identified up to 42 days after delivery, and 510 deaths between 43 days and 1 year postpartum that were not included in the Ministry of Health data. In addition, the maternal mortality ratio (MMR) estimated by the BrOO reached 107.53 deaths per 100,000 live births in 2021, a value almost double that of previous years, reflecting the impact of the COVID-19 pandemic.[3,7]

The excessive medicalization of delivery and the continuation of interventional practices without indication contribute significantly to the emergence of complications during this period. According to the WHO, in 2017, approximately 810 women lost their lives daily due to pregnancy and delivery-related causes that could have been prevented. In total, around 295,000 women died during or shortly after delivery that year, with 94% of these deaths occurring in resource-limited regions, where a large proportion of these deaths could have been avoided.[7]

It is noted that, with the evolution of healthcare and the approach to nursing care, technologies have been developed and applied with the aim of transforming technical-scientific knowledge into tools, processes, manuals and materials. These innovations are designed to disseminate this knowledge and, consequently, improve the quality of care provided.[8]

Thus, with the aim of reducing the occurrence of near misses and preventing harm to maternal and neonatal health, the National Health Surveillance Agency (ANVISA) recommends the adoption of several safety strategies in maternal care.[9] Among these actions, the following stand out: individual and collective training of health professionals; conducting simulations; developing protocols, guidelines and checklists; using information technologies, as well as educational activities and safety rounds.[9]

In 2017, the WHO launched a checklist focused on delivery safety, applicable to both vaginal delivery and cesarean section, covering essential aspects for patient safety.[10] This instrument was released along with an implementation guide and contains four stages for its application. Despite its effectiveness and foundation in international evidence, the checklist does not fully cover the care provided in the WHO's most recent recommendations on Intrapartum Care for a Positive Delivery Experience.[10,11]

During 2018, as a milestone, the World Health Organization released a document entitled "Intrapartum Care Recommendations for a Positive Delivery Experience".[7] This manual presents recommendations for care during birth, delivery and the postpartum period, as well as highlighting practices that are not recommended, promoting more respectful and less interventionist care, an initiative that needs to be adapted and applied in the Brazilian reality.[7-12]

In light of the above, investment in the development of a checklist is underscored by the fact that checklists function as essential tools to ensure that professionals perform the correct procedure, on the appropriate patient, and at the proper time.[12–13] In this context, the study is justified by the high rates of maternal and infant mortality and by the persistence of obstetric violence, characterized by the use of technicist and unnecessary interventions aimed at accelerating a physiological and natural process, thereby putting the safety of both the mother and the newborn at risk.

Within this framework, it is important to note that the document entitled "Transforming Our World: the 2030 Agenda for Sustainable Development" was adopted at the General Assembly of the United Nations (UN). Accordingly, the seventeen Sustainable Development Goals (SDGs) were established to be pursued from 2015 to 2030, with the eradication of poverty remaining the greatest challenge, alongside hunger, health, and education.[33,34]

The SDGs are regarded as the primary means of promoting advances in public policies, programs, and governmental actions, contributing to improvements in global health systems. Thus, the relevance of this study is grounded in the SDGs, since one of their indicators is the reduction of maternal and infant mortality, which reflects the quality of prenatal care provided to the mother–child dyad and of care during labor.[34,35]

The development and validation of the material aim to benefit both the general population and the scientific community, particularly the multiprofessional team that provides intrapartum care to pregnant women, as the study will establish objective recommendations for safe care of the mother–child dyad.

Therefore, this article aims to develop and validate an intrapartum care checklist based on the recommendations of the World Health Organization (WHO).

METHODS

This is a methodological study developed in three stages based on the framework proposed by Echer.[14] The first stage involved submitting the project to the ethics committee. In the second stage, a narrative literature review was conducted, which guided the definition of the technology's content and the

selection of care measures capable of contributing to the management and recovery of patients. The third stage consisted of evaluating the developed technology by a panel of experts.

The stages of development and validation of the checklist took place between May and December 2020. During this same period, the experts completed questionnaires that were subsequently analyzed by the author.

The checklist was based on the document World Health Organization (WHO) recommendations: Intrapartum care for a positive delivery experience, which, translated into Portuguese, means *Cuidados intraparto para uma experiência positiva no parto*, and was developed from a scoping review.[7]

Accordingly, the Intrapartum Care Recommendations presented in the document were analyzed and selected by the author to underpin the checklist content, resulting in the incorporation of 29 recommendations applicable to the first, second, and third stages of labor (L). These recommendations constituted the theoretical framework of the study, and the second stage corresponded to the visual design of the checklist.

Subsequently, the third stage consisted of the evaluation of the material by experts—obstetric nurses with experience in the field and, preferably, directly involved with the topic under study. Along with the checklist, an instrument was sent to assess the content, clarity of the guidelines, and overall relevance of the material. For the validation phase, professionals with experience in obstetrics and/or women's health and, preferably, with experience in validating educational technologies were invited.

According to the framework adopted, there is no standardized or fixed number of experts required to conduct this evaluation, leaving this decision to the researcher.[15] Thus, a sample of nine experts in the area was established. This determination sought to obtain a broader and more diverse perspective on the material, without restricting the judges' region of origin, in addition to the use of an odd number of participants to help avoid tied opinions.

During the selection of experts, a list of criteria accompanied by their respective weights and scores was defined. These criteria were developed based on the scoring system used for the selection of experts, with reference to the cited study.[16] Initial identification of specialists was carried out through the Lattes Platform and the National Council for Scientific and Technological Development (CNPq), using the search terms "Delivery Care" and "Health Technologies." Subsequently, those whose major area was "Health Sciences" and whose specific area was "Nursing" were selected. Additional experts were identified using the snowball technique, in which each participant indicates another potential professional to take part in the study.[17]

In total, 23 emails containing the invitation letter were sent, through the Lattes Platform, to nurses from the Northeast, Midwest, Southeast, and South regions. Of this total, nine professionals responded to the contact; among them, eight agreed to participate as content judges and one did not accept the invitation. The remaining judges were summoned using the Snowball sampling technique, where, after selecting key informants, new participants are indicated to compose the research. In this way, contact was made with another 25 experts who accepted the first invitation via email.

After accepting the invitation letter, 33 emails were sent containing the following documents as attachments: the Informed Consent Form (ICF), the Intrapartum Care Checklist, and the Assessment Instrument. In addition, the email included the link to the assessment instrument provided in Google Form format, in order to facilitate the submission of responses digitally. The final sample of judges consisted of nine nurses residing in the Northeast region, who accepted the invitation, received the documents by email, and responded to the Intrapartum Care Checklist assessment instrument within the established deadline of 15 days, which could be extended by up to 7 days if necessary.

Data collection with the experts took place between November 2020 and January 2021. During this period, a communication network was created to clarify doubts about participation in the research and to facilitate understanding of the process. After the end of the data collection, a discursive and quantitative analysis of the information obtained through the assessment instrument was carried out.

The validation stage began with the completion of the assessment instrument by the content judges. Subsequently, the information was organized by grouping the responses provided in these instruments. Thus, the quantitative data of the scale were tabulated for the calculation of the Content Validity Index (CVI).

The CVI aims to verify the agreement between the expert judges. Thus, scholars guide the calculation of the CVI through the sum of agreement of the items by the experts, divided by the total number of responses and suggest that a value equal to or greater than 0.90 provides satisfactory evidence

of content validity.[18] Items scored by judges with scores of 3 (Relevant) and 4 (Fully relevant) were considered concordant.

The project was submitted to and approved by the Research Ethics Committee of the State University of Ceará, number: 4.209.454/2020.e CAEE: 35731220.0.0000.5534. An Informed Consent Form (ICF) was prepared, which was read and signed by the participants.

The study was conducted following the recommendations of the EQUATOR Network, using specific AGREE II (Appraisal of Guidelines for Research and Evaluation) guidelines for methodological research in order to ensure rigor, transparency and quality in the reporting. AGREE II provides guidance from the construction to the applicability, clarity, methodological rigor, and implementation of an instrument. [36,38]

RESULTS

Development of the Checklist

The material was entitled "Checklist for Intrapartum Care" and, in its initial version, includes a space designated for recording the patient's identification data (name, medical record number, age, and date of admission). Immediately thereafter, instructions for use are presented, directed to the nurse responsible for applying the instrument. The instructions for use of the material include the following text: "the checklist must be completed by the nursing professional from the moment the pregnant woman is admitted to the unit. The instrument provides guidance for the implementation of best practices during the first, second, and third stages of labor. In addition, it is important that the nurse records the patient's data at the beginning of the instrument and his own data at the end."

The checklist was intentionally designed to be completed by the obstetric nurse and, since its initial version, was structured into three main sections: Care during the first stage of labor; Care during the second stage of labor; and Care during the third stage of labor. Finally, a space was provided for identification of the professional who completed the material, including name, date, signature, and professional stamp with council registration.

The development of the material was carried out carefully, adopting clear and objective language to facilitate reading and use by nurses. The organization into columns also contributed to keeping the checklist concise, fitting it onto a single page, which favors professional adherence and prevents the instrument from becoming tiring or impractical during its application.

Validation of the Checklist

During the validation stage, the judges assessed the items of the Checklist for Intrapartum Care regarding clarity and comprehension, relevance, pertinence, and degree of relevance. A Content Validity Index (CVI) equal to or greater than 0.90 was used as the satisfactory threshold for content validity.[18]

Table 1 below presents the evaluated items and the CVI assigned to each, according to the degree of relevance attributed by the content judges. It is noteworthy that agreement was considered for ratings 3—Relevant and 4—Totally relevant, assigned to each of the items.

Table 1. Content validation of the items in the Intrapartum Care Checklist regarding CVI. Fortaleza (CE), Brazil, 2021.

Validity Items	CVI
Instructions for using the checklist	1.0
Care in the first stage of labor	
1. Definition of the stage of labor	1.0
2. Intermittent monitoring of fetal heart rate every 15 to 30 minutes	1.0
3. Vaginal examination every 4 hours	1.0
4. Use of methods for pain relief	1.0
5. Allowed fluid and food intake for pregnant women with a low risk of anesthesia	1.0
6. Encouraged movement and the use of upright positions	1.0
Care during the second stage of labor	
1. Consider the variation in the duration of the second stage of labor	1.0
2. I instructed the woman to perform the "pushing" (pushing) following her own impulse.	1.0
3. I performed techniques to reduce perineal trauma.	0.88

4. I intermittently monitored fetal heart rate every 5 minutes.	1.0
Care in the third stage of labor	
1. Use of uterine devices to prevent postpartum hemorrhage	1.0
2. Performing controlled cord traction and delay clamping, if there is no contraindication.	1.0

Source: Prepared by the author.

In short, of the 13 items evaluated by the judges, only one presented a Content Validity Index (CVI) of 0.88, which was below the satisfactory cutoff score established.[18]

At the end of the evaluation of each checklist item, a space was provided for the judges to justify the assignment of relevance scores 1 (Irrelevant) or 2 (Low relevance). Only one evaluator rated as "2 – Low relevance" the item "I performed techniques to reduce perineal trauma, such as perineal massage, warm compresses, and manual perineal support". This justification was based on the current lack of robust scientific evidence demonstrating the effectiveness of these techniques in protecting the perineum and preventing lacerations.

The remaining 12 checklist items, distributed among the usage guidelines and the three stages of labor, were validated with a CVI of 1.0 assigned by the judges. It is noteworthy that this result demonstrates a high level of agreement among the evaluators regarding the quality of the material produced.

Checklist Adaptation

In light of the changes and recommendations presented by the experts, the most appropriate way to adjust the items was evaluated without compromising the quality of the material. Overall, the suggestions were considered relevant, although some were already addressed in the Intrapartum Care Checklist. An example of this was the proposal to separate the stages of labor, as the first stage divided into the latent phase (cervix up to 5 cm) and the active phase (cervix > 5 cm) was already described in the corresponding item. In addition, based on the guidance received, it was reinforced that the nurse responsible should carry out completion of the checklist.

The suggestions to add the stage of labor at which the parturient woman was admitted and to include additional data in the identification header were accepted as a way to make the technology more comprehensive. Furthermore, the option "not applicable" was added to the checklist items.

Regarding care during the first stage of labor, the content expert's suggestion to add an item addressing the assessment of regular, effective, and rhythmic uterine dynamics was accepted.

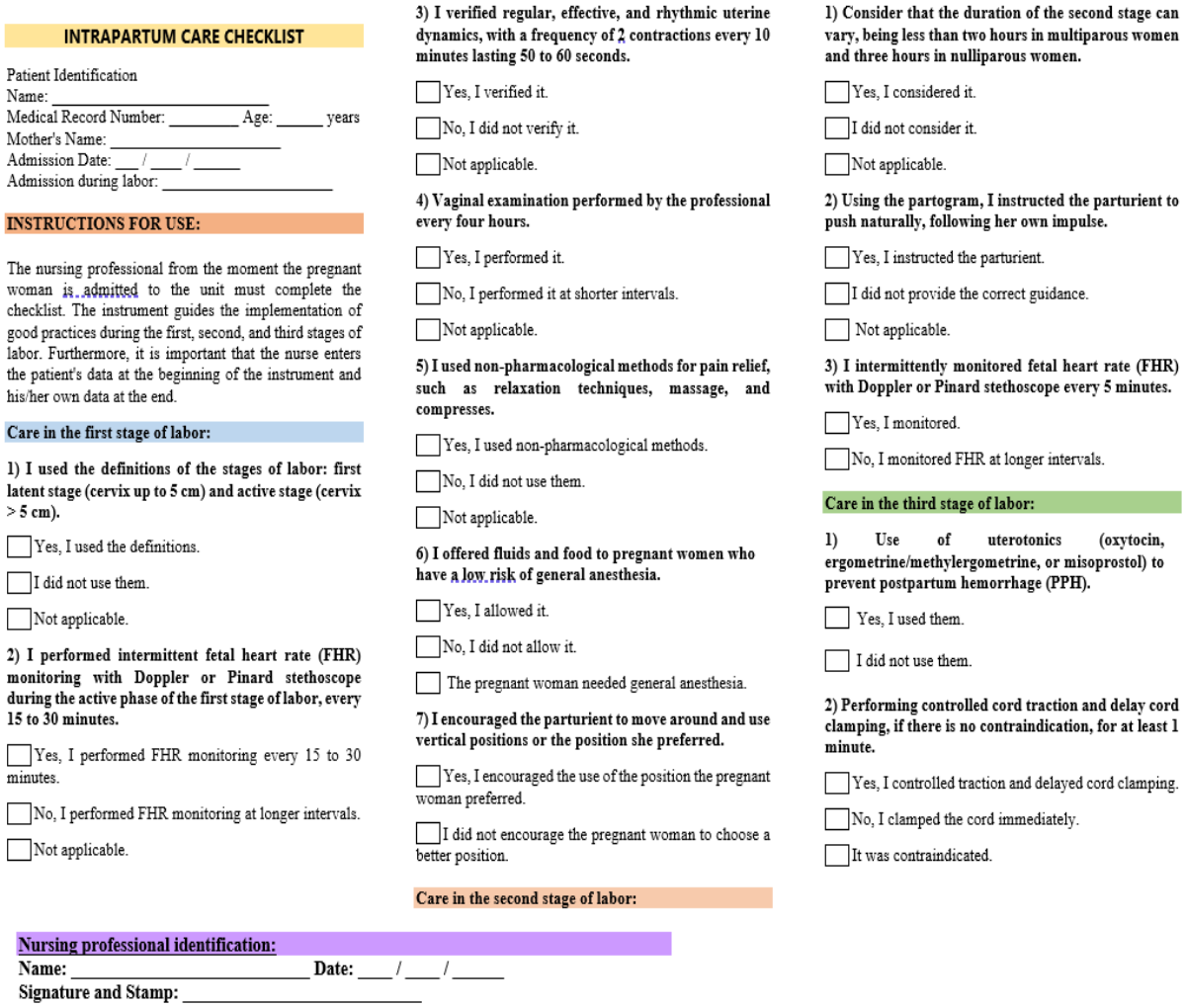
It was also specified in item 2 of the first stage of labor that intermittent auscultation every 15 to 30 minutes occurs during the active phase. Regarding item 4, pharmacological methods were removed, and only non-pharmacological methods were retained. In item 5, the verb "allowed" was replaced with "offered," as it better fit the statement.

With respect to care related to the second stage of labor, item 2 was expanded to include the use of the partograph and guidance for the woman to push naturally, following her body's spontaneous urge.

Given the divergences in the literature regarding the use of purported techniques to reduce perineal trauma and the uncertainty about their effectiveness, it was decided to remove this item from the checklist, also considering that it was the only item that presented a Content Validity Index below 0.90.

The final version of the Intrapartum Care Checklist, after adaptation to the judges' suggestions, is presented in Figure 1.

Figure 1. Final Version Checklist for Intrapartum Care. Fortaleza (CE), Brazil, 2021.



INTRAPARTUM CARE CHECKLIST

Patient Identification
Name: _____
Medical Record Number: _____ Age: _____ years
Mother's Name: _____
Admission Date: ___ / ___ / _____
Admission during labor: _____

INSTRUCTIONS FOR USE:

The nursing professional from the moment the pregnant woman is admitted to the unit must complete the checklist. The instrument guides the implementation of good practices during the first, second, and third stages of labor. Furthermore, it is important that the nurse enters the patient's data at the beginning of the instrument and his/her own data at the end.

Care in the first stage of labor:

1) I used the definitions of the stages of labor: first latent stage (cervix up to 5 cm) and active stage (cervix > 5 cm).

☐ Yes, I used the definitions.
☐ I did not use them.
☐ Not applicable.

2) I performed intermittent fetal heart rate (FHR) monitoring with Doppler or Pinard stethoscope during the active phase of the first stage of labor, every 15 to 30 minutes.

☐ Yes, I performed FHR monitoring every 15 to 30 minutes.
☐ No, I performed FHR monitoring at longer intervals.
☐ Not applicable.

3) I verified regular, effective, and rhythmic uterine dynamics, with a frequency of 2 contractions every 10 minutes lasting 50 to 60 seconds.

☐ Yes, I verified it.
☐ No, I did not verify it.
☐ Not applicable.

4) Vaginal examination performed by the professional every four hours.

☐ Yes, I performed it.
☐ No, I performed it at shorter intervals.
☐ Not applicable.

5) I used non-pharmacological methods for pain relief, such as relaxation techniques, massage, and compresses.

☐ Yes, I used non-pharmacological methods.
☐ No, I did not use them.
☐ Not applicable.

6) I offered fluids and food to pregnant women who have a low risk of general anesthesia.

☐ Yes, I allowed it.
☐ No, I did not allow it.
☐ The pregnant woman needed general anesthesia.

7) I encouraged the parturient to move around and use vertical positions or the position she preferred.

☐ Yes, I encouraged the use of the position the pregnant woman preferred.
☐ I did not encourage the pregnant woman to choose a better position.

Care in the second stage of labor:

1) Consider that the duration of the second stage can vary, being less than two hours in multiparous women and three hours in nulliparous women.

☐ Yes, I considered it.
☐ I did not consider it.
☐ Not applicable.

2) Using the partogram, I instructed the parturient to push naturally, following her own impulse.

☐ Yes, I instructed the parturient.
☐ I did not provide the correct guidance.
☐ Not applicable.

3) I intermittently monitored fetal heart rate (FHR) with Doppler or Pinard stethoscope every 5 minutes.

☐ Yes, I monitored.
☐ No, I monitored FHR at longer intervals.

Care in the third stage of labor:

1) Use of uterotonics (oxytocin, ergometrine/methylergometrine, or misoprostol) to prevent postpartum hemorrhage (PPH).

☐ Yes, I used them.
☐ I did not use them.

2) Performing controlled cord traction and delay cord clamping, if there is no contraindication, for at least 1 minute.

☐ Yes, I controlled traction and delayed cord clamping.
☐ No, I clamped the cord immediately.
☐ It was contraindicated.

Nursing professional identification:
Name: _____ **Date:** ___ / ___ / _____
Signature and Stamp: _____

Source: Prepared by the author.

DISCUSSION

The development and validation of technologies, such as checklists, have gained prominence due to their importance not only for research but also especially for healthcare practice. The checklist developed in these studies constitutes a tool applicable both in patient care and professional training, encouraging reflection on the topic and contributing to the delivery of safe and high-quality care to the patient.[19,20]

In the validation of the Intrapartum Care Checklist by experts, it was found that the level of agreement was 99% among the judges considering all items, with a general CVI of 0.99. In the study validating a postpartum care checklist, a CVI with a minimum agreement index of 70% was used.[21] Another study indicated that a minimum value of 0.90 for the Content Validity Index is required for validation, just as was used in the validation of this checklist. [22]

A study validating a checklist for safe surgery in cesarean sections showed a general index of 0.96.[12] Thus, the results show a high level of agreement among the judges regarding the Intrapartum Care Checklist, with the CVI presenting the required value, considering the validated and complete material, for subsequent application of care.

Of the evaluated items, only item 3, "I performed techniques to reduce perineal trauma, such as perineal massage, warm compresses, and manual perineal support" in the care of the second stage of labor, received a rating of 2 - "Slightly relevant" from the judge. As such, the CVI for this item was 0.88 in Table 1. The score was justified by the lack of concrete scientific evidence to support these practices for the prevention of perineal tears.

In this scenario, the study indicates that the hands-off technique (without perineal protection) appears to be more effective in preventing perineal tears, positioning it as an alternative to traditional

management since it does not involve manipulation of the perineum.[23] A randomized clinical trial conducted in Iran, involving 600 nulliparous women, compared the protective effects of two types of management: hands-on (perineal protection technique) and hands-off. It was observed that women who underwent the hands-on technique had twice as many episiotomies and third-degree tears compared to those who did not receive manual protection.[24,25] Still, further comparative studies are needed to assess the effectiveness of these techniques more consistently, considering the different degrees of tearing.[26]

Therefore, it is considered that there is insufficient evidence to support that hands-on techniques prevent tears. It is possible that the use of the hands-on technique may help prevent injuries in specific cases of delivery, but in other cases, it may even worsen the situation, as in the case of multiparous women.[27] Given the increasing number of studies showing the ineffectiveness of perineal protection techniques (hands-on), it was decided to remove this item from the Intrapartum Care Checklist.

The study highlights the need to assess uterine dynamics, recording the duration, frequency, and intensity of contractions, as well as monitoring fetal heart rate (FHR) during and after each contraction. [28] Thus, considering the relevance of verifying the effectiveness and regularity of contractions throughout labor, the content judge's suggestion was accepted and the corresponding item was included in the checklist.

Another change present in the final version of the material was the reformulation of the item "I used methods for pain relief, such as parenteral opioids and non-pharmacological measures, such as relaxation techniques, massage, and compresses". One of the content judges, a specialist in the area, recommended separating pharmacological methods from non-pharmacological methods. Thus, it was decided to keep in this item only the approach to non-pharmacological methods used by obstetric nurses for pain relief during labor.

The use of non-pharmacological methods of pain relief, as well as freedom of position, movement and the offering of fluids orally, are examples of useful practices that should be encouraged by professionals who are assisting the parturient.[29] Research has shown that methods such as acupuncture, hydrotherapy, Swiss ball and perineal exercises considerably reduce pain levels during labor.[30]

In addition, pain relief can be provided through physical and emotional support, offering guidance on the stages and progress of labor. The presence of a companion, in itself, provides comfort and a greater sense of security to the parturient, contributing to better pain control.[31]

Regarding the partogram, it is considered a useful practice that should be encouraged, being an illustration of the labor process. Its use allows monitoring the progress of labor and identifying possible complications, as well as what actions should be taken to correct a given situation.[32] In this perspective, one of the judges suggested adding the term “use of the partogram” to item 2.

In this way, it is highlighted that pregnant women should not be instructed to perform voluntary pushing, as this is a behavior that occurs spontaneously, according to their own will.[2] Thus, item 2 was adjusted, including the use of the partogram to record the natural manifestation of pushing.

During the course of the study, a limitation related to the applied method was observed, since in some cases it was necessary to contact the content judges more than once, reinforcing the importance of participation in the research.

The checklist, therefore, can be used as a healthcare technology that assists in providing care during delivery. Moreover, it promotes greater safety and guidance for the nursing professionals providing care.

CONCLUSION

In conclusion, at the end of this study, the research objectives were achieved. The experts considered the checklist on care for assistance during labor and delivery valid in terms of content.

The validation, which resulted in an overall Content Validity Index (CVI) of 0.99, demonstrated that the material reached the expected level of relevance. In addition, several content judges highlighted, at the end of the evaluation, positive aspects such as the completeness, clarity, objectivity, and ease of understanding of the technology. All suggestions and observations were also understood and considered pertinent to improving the material, consolidating the information in line with current research available in the literature.

The study limitations included difficulties in obtaining responses from the content judges within the deadline established in the methods. Many specialists did not respond to the invitation letter, which initially hindered the collection of data for the checklist validation.

It is expected that the checklist can be used in obstetric nursing practice, promoting improvements and generating new, more in-depth studies, thereby benefiting the scientific community through clinical validation based on data collected from the use of this material. At the management level, the checklist may contribute in the future to reducing maternal mortality rates and obstetric violence, in accordance with the Sustainable Development Goals (SDGs). Finally, the Intrapartum Care Checklist is intended to benefit not only the professionals involved but also, above all, women, who need to receive safe and high-quality care during this unique moment that is the birth of a life.

CONTRIBUITIONS

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