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Labor assistance from the perspective of obstetrical nurses

Assistência ao parto sob a ótica de enfermeiras obstétricas

Asistencia al parto bajo la óptica de enfermeras obstétricas

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The aim of this study was to evaluate the assistance of the obstetric nurses in a normal-risk maternity assistance through indicators of obstetric care, as well as to know their perspective about their insertion in the labor process. This is an evaluative and descriptive study using a mixed approach based on the assistance indicators for the period from May 2014 to December 2015, and data from interviews with five obstetric nurses working in normal-risk maternity care at Curitiba, Paraná, Brazil. The data collection occurred between August and October 2016. The indicators were analyzed through descriptive statistics and the interviews through thematic analyses. The insertion of the obstetric nurse promoted reduction of practices considered harmful during labor assistance, generating positive impacts on the change of the care model of the institution.
Descriptors: Obstetric Nursing; Nursing care; Humanizing delivery; Humanization of assistance; Obstetrics.

O objetivo deste estudo foi avaliar a atuação de enfermeiras obstétricas em uma maternidade de risco habitual por meio de indicadores de assistência obstétrica, bem como conhecer a visão dessas profissionais sobre a inserção de suas atividades nos processos de parto. Trata-se de pesquisa avaliativa, descritiva, de abordagem mista, realizada a partir dos indicadores de assistência referentes ao período de maio de 2014 a dezembro de 2015, e de entrevistas realizadas com cinco enfermeiras obstétricas atuantes na assistência ao parto em maternidade de risco habitual em Curitiba, Paraná. A coleta ocorreu entre agosto e outubro de 2016. Os indicadores foram analisados com base em estatística simples e as entrevistas por meio de análise temática. A inserção de enfermeiras obstétricas promoveu a redução de práticas consideradas prejudiciais na assistência ao parto, gerando um impacto positivo na mudança do modelo de atenção da instituição.
Descritores: Enfermagem Obstétrica; Cuidados de enfermagem; Parto humanizado; Humanização da assistência; Obstetrícia.

El objetivo de este estudio fue evaluar la actuación de la enfermera obstétrica en una maternidad de riesgo habitual por medio de indicadores de asistencia obstétrica, así como conocer la visión de estas sobre su inserción en el proceso del parto. Se trata de una investigación evaluativa, descriptiva, de abordaje mixto, realizada a partir de los indicadores de asistencia referentes al periodo de mayo de 2014 a diciembre de 2015 y de entrevistas realizadas con cinco enfermeras obstétricas actuantes en la asistencia al parto en maternidad de riesgo habitual de Curitiba, Paraná, Brasil. La colecta ocurrió entre agosto y octubre de 2016. Los indicadores fueron analizados a través de estadística simple y las entrevistas por medio de análisis temático. La inserción de la enfermera obstétrica promovió reducción de prácticas consideradas perjudiciales en la asistencia al parto, generando impacto positivo en el cambio del modelo de atención de la institución.
Descriptores: Enfermería Obstétrica; Atención de enfermería; Parto humanizado Humanización de la atención; Obstetricia.

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INTRODUCTION

The model of obstetric and neonatal care in Brazil is predominantly technical, a fact that has been increasingly discussed in the health community. Considering the high rates of maternal and child morbidity and mortality, and the constant attempts to find solutions to reduce these numbers, the discussion on the medicalization and instrumentalization of childbirth care has increased[1].

In the technical model, the processes of gestating and giving birth are seen and studied as pathological events. The woman's body is understood as incapable to develop the baby and, above all, for being responsible for the birth process, causing the health team to take on the leading role and therefore placing the woman in a position of vulnerability, insecurity and infantilization[1].

Understanding this model of attention and the damages it has imposed on care makes it necessary to expand the look on obstetric care using the humanist and holistic models of perinatal care, since the delivery should be understood as a physiological event[1].

Since 1930, public health policies for women have been discussed by the Ministry of Health (MS), and women were still treated from a reductionist view[2]. With the evolution of public policies and aiming at reducing maternal and infant morbidity and mortality, the MS launched the Cegonha Network (CN) in 2011, a network of maternal and child healthcare to guarantee women access to reproductive planning, as well an assistance of quality during gestation, childbirth, and puerperium[3]. This policy also aims to ensure a safe childbirth, as well as a healthy growth and development up to twenty-four months of life[3].

It is possible to understand the CN as a public policy that encourages change in the obstetric care model, since it reinforces in its component II, Labor and Birth, the adoption of Good Labor Care Practices[3] based on the Safe Motherhood report, which has been developed by the World Health Organization (WHO)[4] and classifies some practices into categories according to the level of scientific evidence (Category A - Practices that are demonstrably useful and that should be encouraged; Category B - Practices that are clearly harmful or ineffective and should be eliminated; Category C - Practices for which there is insufficient evidence to support a clear recommendation and which should be used with caution until more research clarifies the question, and Category D - Practices frequently used in a inappropriately way).

The various CN recommendations, regarding Component II are the encouragement to implement horizontal care teams in the obstetric and neonatal care services and the insertion of obstetric nurses in the labor and birth care[3,4], a type of profession who is gaining visibility in the health setting due to the growing discussions about humanized care.

Among the assignments of this professional are the obstetric nursing consultation; labor monitoring; providing assistance for planned home labor; hospital assistance at normal-risk labors; the follow-up of the woman and the newborn (NB) in the postpartum period[5].

In this context, the aim of the study was to evaluate the assistance of the obstetric nurse in a normal-risk maternity through indicators of obstetric care, as well as to know their views about their insertion in the labor process.

METHOD

This is an evaluative and descriptive study with a mixed approach, carried out in a public maternity hospital in Curitiba, integrated into the Mãe Curitibana Program and a reference for the care of pregnant women of normal risk.

The mixed method makes use of quantitative and qualitative elements, thus allowing to bring together different data features in favor of a single study[6]. For this, the research was divided in two stages of data collection and analysis.

The first stage considered a quantitative approach, in which the obstetric care indicators monitored by the maternity management during the period from May 2014 to December 2015 were collected. Information was obtained through secondary worksheets provided by the service management and organized in the Microsoft Office Excel® program. The data was collected from August to October 2016, analyzed by means of descriptive statistics and demonstrated using graphs.

At the second stage, interviews with five obstetrical nurses that compose the institution's staff and provided direct care during labor and birth were performed. For the sample composition, the following inclusion criteria were considered: being in the maternity ward during the data collection period, acting in the direct labor assistance.

The exclusion criteria were, to be on leave, work absence or vacations at the time of data collection, or to perform other functions (management position, continuing education, and others). This last criterion was defined because the intention of this study was to know the opinion of the professionals that compose the care team and experience the practice of obstetrics in their daily lives.

The interviews were carried out from August to November 2016, during the nurse's work, with the authorization of the nursing coordinator and in a private room where the Free and Informed Consent Form (FICF) was read. The interviews were recorded and guided

by the question: "*How do you perceive your performance in labor and birth care, as well as your role in changing the care model?*"; and later the material was transcribed.

For the data treatment, the content analysis proposed by Bardin was used. This method consists of getting information from the statements obtained during the communication process and contemplates three moments: pre-analysis, material exploration and treatment of results, inference and interpretation of results[7].

In this study, the ethical and normative aspects of researches with human beings were respected according to Resolution n.º466/2012. The project was approved by the Committee of Ethics in Research of the Municipal Health Department of Curitiba, under to protocol No. 1.608.184. To guarantee anonymity, the participants were coded according to the order of data collection interviews: EO1, EO2, EO3, EO4, and EO5.

RESULTS

In the quantitative phase, the data for the years 2014 and 2015, referring to the annual mean of each indicator, was presented. The graphs were presented according to the Good Practices proposed by the World Health Organization[4]. The total of vaginal births attended in 2014 and 2015 were n = 1662, n = 1456, respectively.

In Image 1 it is possible to observe indicator averages referring to practices that should be eliminated or reviewed by professionals, while Image 2 demonstrates the indicators of beneficial practices that should be stimulated.

Image 1. Annual indicators means according to categories 'B', 'C' and 'D' of Good Practices and the Cegonha Network. Curitiba, Paraná. 2014 and 2015.

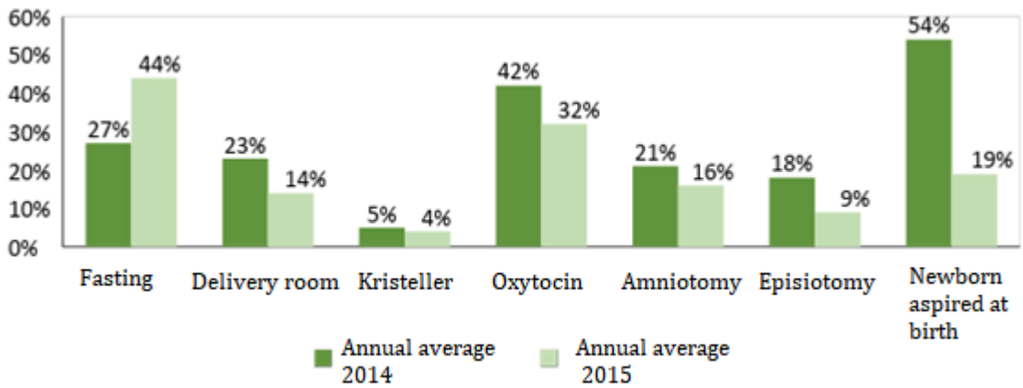
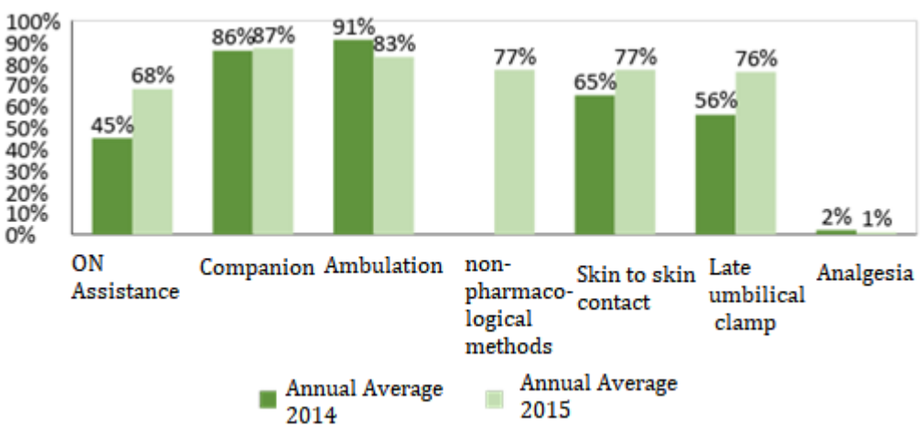


Image 2. Annual indicators means according to categories 'A' and 'D' of Good Practices and the Cegonha Network. Curitiba, Paraná. 2014 and 2015.



In the qualitative phase, the following categories emerged: *Formation; Care model change*; *Professional posture/ethics*; and, *The main role of the woman during childbirth*. Below are some statements that helped defining the categories.

Formation

In this category the following speeches were identified:

[...] *our own formation is already different with a more holistic view of women [...] this change* [change in the model of care] *is very much related to formation too. And it is a difficult change, because the doctors are formed to act, to intervene; and we, as nurses, are not formed just for that* (EO1);

[...] because the medical professional has already been trained to intervene, but we were prepared in a different way (EO2);

[...] And the tendency, at least in our formation, I think of all the nurses here in the maternity, the tendency is for us to attend childbirth more naturally, respecting the physiology of the female body. (EO3)

Care model change

Some speeches were identified:

[...] that is why this change is very difficult, very slow, it is distressing (laughs) ... if there is no different view of the process, there is no change. (EO1);
I believe that we really came to make this change in the model, you see ... they [the physicians] *do not respect the woman as the protagonist [...] What is important for them is that the woman and baby get out alive in most cases [...] but I think that even with our insertion in this model we end up influencing the change of doctors.* (EO2);
Without her performance [obstetric nurse] *the model would still be the traditional one, because it is very difficult to change the heads of the doctors who have been there for 30 years, attending labor in the same way and believing that there is only that way of doing everything [...]* (EO5).

Professional posture/ethics

This category presented the following statements:
[...] we have to fight every day, because every day new conflicts will arise. Conflicts that maybe are personal, which are not problems of conduct, it happens because of vision of the posture of the professional. For the professional that is changing because he is made to and not because he wants to give the best service to the woman (EO1);
[...] for obstetric nurses who are engaged ... that believe that changing the model is the best for the woman, implementing all the measures that the Cegonha Network suggest [...], in short, those who are willing to do this, [...] they are fundamental (EO3);
I try to know a lot about the personality of each one of them [the physicians] *instead of fighting, because it is worse, then they [*physicians*] are going to be angry at me and will bring it to the patient (EO5).*

The main role of the woman during childbirth

The following discourses were observed:
[...] we can let the woman be the protagonist of the process, understanding the human being as holistic and not only as a hospital procedure ... (EO1);
If many professionals put the respect for the woman first, I think that everyone would be able to provide an adequate assistance ... Above all, always trying to respect their desires [...] today we already work based on labor planning, many women are already well-oriented about the maternity, so we always try to follow, discuss [...] (EO4);
*[...] I work from the principle of leaving the patient very comfortable. Trying to attend her desires, not forcing her to do anything she does not want to [...] I think that guidance is the first step to everything. I think that when you get a well-oriented patient the conduction of the labor process is totally different from when you receive a frightened, scared patient, with little or no information [...] the labor I think evolves in a better way [...] (*EO5).

DISCUSSION

The quantitative data made it possible to compare the indicators according to the Good Practices recommended by the WHO[4]. The following indicators are included in Category A: the presence of companions, immediate skin-to-skin contact, and a late clamping of the umbilical cord. The rate of women who had the presence of the companion presented a linear behavior, remaining above 85%, a fact that may be related to the Brazilian Law of the Companion[8], sanctioned in the year 2005 and, therefore, was already a maternity practice.

Regarding skin-to-skin contact and late umbilical cord clamping, they are recommended in Ordinance No. 371, dated May 7, 2014, in article 4, for the newborn with normal respiratory patterns, normal tonus, and without meconial amniotic fluid[9]. The beginning of the monitoring of these indicators in the maternity ward coincided with the publication of the ordinance, but only in the year 2015 the increase of the rates was observed, which may be related to the adaptation time of the team to the norms foreseen in the legislation.

When observing the values of the rate of aspirated babies (which presented a drop of 35%) from one year to another, it can be inferred that at least one hour of contact time of the baby to the mother's skin reduces the space for them to be taken to the procedure room and submitted to aspiration. In addition, there is no evidence that demonstrates benefit in the aspiration of healthy term newborns[10].

Excessive use of oxytocin during labor is related to early hospitalizations due to a false diagnosis of labor[11]. During the study period, the institutional protocols were redesigned, which redefined the necessary situations for hospitalization, a fact that may have impacted the 10% decrease in the use of synthetic oxytocin during labor from one year to the next.

In relation to the Kristeller maneuver, it can be said that it has been seldom used in maternity, when compared to data from the *Being Born in Brazil Research* for example, that demonstrated that the Midwest region is the one that practices this maneuver the most (45.5%), and that it is performed mostly in older and in primiparous women. The south region occupies the last position (32.3%) [12]. Although a decrease in this indicator can be observed, it has been demonstrated in a recent systematic review that there is insufficient evidence to recommend this practice, since there is no evidence of benefits for fetal well-being and, although there are not many studies, the risk of severe perineal trauma should be considered[13]

Amniotomy is related to an increase in the rate of cesareans, and did not present a statistically significant difference in the duration of labor and in the health of the baby after birth, so it is evident that the rates of this practice in maternity should be reviewed and discussed between team and management to fit with scientific evidence[11].

Even with the WHO's[4] recommendation for stimulating the supply of oral fluids during labor and delivery, Brazil presents a rate of 74.4% of normal-risk mothers who are asked to fast, and 78% of these women are from the South of the country[12]. Nevertheless, this indicator increased from 2014 to 2015 in the hospital studied.

As most preanesthetic fasting recommendations refer to elective surgeries and suggest that there should be specific protocols for obstetrics, the American Society of

Anesthesiologists (ASA)[14] has suggested a guideline of its own that, among several obstetrical specificities, is about prevention of pulmonary aspiration and its relation with the supply of clear liquids and solid foods during labor. The guideline states that liquids like water, fruit juice without pulp, carbonated drinks, light teas, coffee and isotonic beverages can be ingested in moderate amounts up to two hours before elective caesarean.

It should be emphasized that these recommendations are directed to women in labor situations without complications or with a low risk to develop them. In the case of patients with morbid obesity, diabetes, difficulty for intubation, or those with a high probability of progressing to an emergency surgical procedure, the situation should be assessed individually by the team[14].

In October 2015, at the Annual Meeting of Anesthesiologists, promoted by ASA, this topic was discussed, suggesting that the consumption of a light meal during the labor process can positively influence the birth results, favoring the caloric intake of the woman and of the fetus and preventing the development of metabolic acidosis in both of them[15].

Another frequently misused practice is the transfer of the women to the delivery room at the beginning of the second stage of labor, also called the expulsive period. This action necessarily involves placing the woman to give birth in a lithotomy position, even though, since 1996, this position is no longer recommended (WHO) [4]. The survey *Being Born in Brazil* found that 92% of women still go through the expulsive period in this position[12].

Although it is a woman's right, the practice of analgesia is classified in Category D, since it has been used with little criterion, especially in private services. A Systematic review conducted in 2011, demonstrated that despite reducing the pain sensation, analgesia is related to the increased risk of instrumental delivery.[16] In the South of Brazil, the analgesia rate is around 28.7% [12], so it can be accepted that maternity indicators are a good parameter when compared to national data.

Regarding the practice of episiotomy, in this study there was a 50% decrease in the indicators from 2014 to 2015. However, in a study published by the Brazilian Federation of Gynecology and Obstetrics (FEBRASGO), it was pointed out that although some obstetrical guidelines recommend this practice in some situations, it is important for more randomized clinical studies to be published to support it[17].

As for pain relief methods in the birthing process, the percentage of women who have access to these practices is in line with what is recommended by the WHO, [4] and is therefore an indicator classified in category A (demonstrably useful practices that should be encouraged). From the database of the Being Born in Brazil research, it was shown that 74.2% women had access to some non-pharmacological method to relieve pain and discomfort during labor[18].

Among the non-pharmacological methods used are shower bath (80%), Swiss ball exercise (72%), massage (78%), music (76%) and low brightness (82%). A study performed in a birthing house in the countryside of the state of São Paulo where deliveries are also attended by obstetrical nurses showed similar data, especially in relation to the shower bath (84%)[19]. Ball use and massage rates were slightly lower compared to the indicators in this research, but they are still in line with WHO recommendations[4].

Although it was used in 76% of births in 2015, there is no evidence that the use of music in labor significantly interferes with the reduction of the pain sensation, as demonstrated in a systematic review conducted in 2011[20].

Low brightness was also considered in this study as a non-pharmacological method for pain relief. For the human organism, the absence or dimness of light implies in the production of melatonin, which is directly related to the promotion of sleep and the stimulation of sexuality[21]. Some studies also relate the induction of sleep to the production of endorphin and other female hormones[22,23]. It is important to note that endorphin acts directly in inhibiting pain during labor, since it is considered a natural opiate. Therefore, it is possible to consider the lack of light as a method of pain relief, although studies on this subject are scarce.

The ambulation rate is classified as a separate item from non-pharmacological methods[24], however, the practice of free ambulation should also be considered as a method to relieve pain and discomfort, since there is less compression of large vessels (aorta and vena cava) by the pregnant uterus, promoting improvement in blood flow and oxygenation. The standing position also provides decompression and relief of the lumbar region and accelerates the labor process[25].

The ambulation, shower bath, ball and massage are described in the Manifesto for *Active Labor*, in which pregnant women are encouraged to adopt vertical positions during labor in order to promote its physiological evolution, as well as to impact positively on the quality and safety of delivery for mother and baby, as it also influences the release of hormones such as oxytocin and endorphin, which are fundamental in the labor process.[25]

The interviews allowed to obtain knowledge about the nurse's perception

regarding the practices monitored by the indicators. It is evident that the insertion of the Obstetric Nurse had a direct influence on the labor and birth assistance, and that although it was a gradual process, it was decisive for the change of the care model in the institution[26].

The change in the care model cited in the interviews can be discussed according to the following models: technocratic, humanistic and holistic[27,28].

12 assumptions are considered in the technocratic model: 1-body-mind separation; 2-the body as a machine; 3- the patient as object; 4-alienation of the physician in relation to the patient; 5-diagnosis and treatment from the outside to the inside; 6- hierarchical organization and standardization of care; 7 - authority and responsibility inherent to the physician and not to the patient; 8- over appreciation of complex science and technology; 9- aggressive interventions with an emphasis on short-term results; 10- death as defeat; 11- a system driven by profit; and 12-intolerance to other modalities[27].

These characteristics are so strong and are so deeply rooted in society that they end up generating an environment of stress and anguish for the professionals who try to confront them, as it was put by the interviewees. This model is taught in the college courses and strengthened in medical specialization programs[27]. In this sense, groups 1 and 2 of this study point to a direct relationship between the formation disciplines and the care attention model.

In contrast to this traditionalist model, the 12 assumptions of the humanistic[27]/humanist[1] model emerge. They are: 1-body-mind connection; 2-the body as an organism; 3-the patient as a social subject; 4-connection and affection between physician and patient; 5-diagnosis and healing from the outside to the inside and vice versa; 6-balance between the desires of the institution and the individual; 7-information, decision-making and responsibility shared between the physician and the patient; 8-science and technology counterbalanced with humanism; 9-focus on disease prevention; 10-death as an acceptable outcome; 11-care directed by compassion; and 12-mind open to other modalities.

Much has been discussed about this model in health care, especially within the scope of the Unified Health System (SUS) [4]. For the participants the assistance provided by the Obstetric Nurse is, in its essence and formation, related to this model, since it considers the woman as the center of the care and that by being responsible for her health, she is also able to decide on her body.

The holistic model also suggests 12 items, which contemplate and enrich the humanistic model. 1-oneness of body-mind and spirit; 2-The body is an energy system interconnected with other energy systems; 3-healing of the whole person in a context of life as a whole; 4-an essential connection between doctor and client; 5-diagnosis and healing from the inside out; 6-organizational network structure that facilitates the individualization of assistance; 7-authority and responsibility inherent to each individual; 8-science and technology placed at the service of the individual; 9-long-term focus on the creation and maintenance of health and well-being; 10-Death is a process; 11-healing is the focus; and, finally, 12-encompasses multiple modes of healing[27-28].

It is wrong to consider that the models cited are inflexible[1]. As observed in the interviews, Obstetric Nurses cite elements of the three models in a harmonic and weighted way. The professionals of contemporary obstetrics have the possibility to merge specific paradigms of each model, interweaving them in such a way as to create a system of revolutionary care considering the cultural miscegenation of the current society[27].

Thus, when the participants talked about the posture of the health professionals and the willingness to face the change, it is clear that it will come when each one proposes to change a little of themselves within the care practice, for this reason this process is so slow and gradual.

Linking and discussing the care model with the professional's posture becomes necessary when the uncontrolled need to medicalize hospital events makes it impossible for the health team and user to have a relationship of proximity and trust, which leads to conflicting relationships[28].

Considering that in the universe of obstetric care the protagonists of the process are the woman and the baby, it is possible to glimpse a setting close to that imagined by Davis-Floyd [27], in which specific elements of each model are called to promote a fair and safe assistance. This becomes evident when, in the statements of the Obstetric Nurses it becomes clear that their role is to ensure that women are actually the main actors, and that guaranteeing their right to information and to make decisions regarding their body ends up promoting, besides the benefits for the evolution of the work process, a greater satisfaction of the woman, since as such she exercises her freedom and power of choice[29].

It is possible to affirm that the degree of satisfaction of the woman is directly related to the presence of the Obstetric Nurse in labor and delivery, a fact that can bring to the reflection that the services need to have ONs in satisfactory numbers to meet the demand of parturients[29].

CONCLUSION

This research allowed to obtain a prospect of the assistance from the point of view of the obstetric nurse. There are studies that demonstrate the satisfaction of women and the benefits and harms of certain practices and routines, but the voices of these professionals, who are mostly women, and who are directly involved in the process of changing the model of obstetric care, are not commonly heard.

In the studied hospital, it was evident that the process of insertion of these professionals, despite having initially been conflictive, promoted irreversible advances in the practice of obstetric care in the institution. When inserting a new professional category within a service, difficulties may arise in the area of interpersonal relationships; however, management support and the creation of protocols have enabled obstetric nurses to demonstrate more safely and autonomously the quality of their work.

These professionals earned their space and the trust of the team and the community, promoting a positive impact on the quality of care provided in the maternity ward. Their commitment to the assistance setting also allowed for the creation and qualification of the institutional protocols, stimulating the discussion of important issues related to assistance with the teams.

The data presented shows that once the Obstetric Nurses began to attend the majority of normal deliveries, a series of other beneficial and scientifically proven and recommended practices had an increase in their rates, demonstrating that the performance of this professional had a positive impact on the quality of care of women and their babies.

However, it is important to recognize that fasting, still used in the institution, needs to be overcome. It is suggested for the institution to be aware of the latest national and international evidences on the subject, and to discuss and reformulate the maternity protocol to overcome this problem.

Another important issue is regarding the formation of professionals in obstetrics. As long as the professional formation continues to be rooted in the technical model, it will continue to recede in several aspects, and unfortunately, it will not contribute to the prevention and reduction of maternal and infant morbidity and mortality. Academic space makes opinions, it is a place of knowledge and should therefore be the cradle for changing the model of attention.

This study has as limitation its conduction in a single institution, through which comparative studies are suggested. It is also suggested that the constant renewal of knowledge based on scientific evidence, in the defense of women's autonomy and the right to choose the best way to give birth are important paths to be sought by professionals who wish to achieve the humanization of childbirth care and, consequently, to change the obstetric care in Brazil.

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CONTRIBUTIONS
Larissa de Oliveira Peripolli and **Marcelexandra Rabelo** worked on the conception, design, data analysis and interpretation of this study, as well as in its writing and review. **Silvana Regina Rossi Kissula Souza, Marilene Loewen Wall, Tatiane Herreira Trigueiro** and **Karin Madeleine Godarth** contributed in the writing and final review.

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