







Practice of obstetric nurses in humanized childbirth care in a high-risk maternity

Prática de enfermeiros obstetras na assistência ao parto humanizado em maternidade de alto risco

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ABSTRACT

Objective: to understand the practice of obstetric nurses in childbirth care for high-risk pregnant women. **Methods:** a qualitative study, with seven obstetric nurses that attend high-risk pregnant women. The data collection took place using semi-structured interviews that were submitted to content analysis for data treatment. **Results:** it has been evident that nurses knew, performed, and encouraged good practices during care, but identified factors that prevented the development of these practices in an acceptable way. They reported on the reasons for these practices and the dissatisfaction met in the course of their work. **Conclusion:** the enrolled nurses were motivated and showed interests in humanized practices, but were displeased with the distinct challenges met, such as outdated professionals and the service's organizational structure.

Descriptors: Humanizing Delivery; Nurse Midwives; Delivery Rooms; Pregnancy, High-Risk.

RESUMO

Objetivo: compreender a prática de enfermeiros obstetras na assistência ao parto de gestantes de alto risco. **Métodos:** estudo qualitativo, com sete enfermeiros obstetras que atendem a gestantes de alto risco. Dados coletados por meio de entrevistas semiestruturadas, os quais foram submetidos à análise de conteúdo para tratamento dos dados. **Resultados:** evidenciou-se que os enfermeiros conheciam, executavam e estimulavam as boas práticas durante a assistência, mas reconheciam fatores que impediam o desenvolvimento dessas práticas de forma satisfatória. Relataram sobre as motivações por essas práticas e as insatisfações encontradas no percurso da função. **Conclusão:** os enfermeiros participantes eram motivados e demonstraram interesse pelas práticas humanizadas, mas eram insatisfeitos com as diversas dificuldades encontradas, como profissionais desatualizados e estrutura organizacional do serviço.

Descritores: Parto Humanizado; Enfermeiras Obstétricas; Salas de Parto; Gravidez de Alto Risco.

Introduction

Birth is a natural event that gathers economic, social, and cultural factors, which influence the decision process through delivery⁽¹⁾. The birth model, in Brazil, over the years, has faced several changes, from being an intimate process to becoming a hospital-centered activity. This model reflected on the increase in the number of cesareans and interventions that were previously used only in exceptional situations, such as the use of forceps and episiotomy⁽²⁾.

In the year 1980 the rate of cesarean deliveries in the world was 6.0%, and 18.6% in 2016, three times higher⁽³⁾. Brazil reached a rate of 55.0% of cesarean sections in 2017⁽⁴⁾. Meanwhile, in the Northeast Region of Brazil, 409,362 cesarean deliveries occurred and the state of Piauí, 26,361⁽⁵⁾. The recommended rate of cesarean sections for the World Health Organization should be between 10.0% and 15.0%⁽⁶⁾.

The Ministry of Health carried out a set of actions, through programs and policies, targeting the improvement of obstetric care⁽⁷⁻⁸⁾. The National Program for Comprehensive care to Women's Health emerged as an answer to the health problems of the female population, prioritizing prenatal, childbirth and puerperium care⁽⁷⁾. This policy was expanded in 2004 with the release of the Policy for Comprehensive care to Women's Health⁽⁸⁾, focusing on consolidating the advances of the National Program for Comprehensive care to Women's Health, in the fields of sexual and reproductive rights, in the battle against domestic and sexual violence, among others.

The World Health Organization published good practices in childbirth care, and the Ministry of Health launched the Humanization Program for Prenatal and Birth, targeting the reinforcement of the importance of these practices. In 2011, by the program *Rede Cegonha*, these same practices were republished and reaffirmed⁽⁹⁾.

As per the recommendations of programs and public policies, it is suggestible to notice the work of obstetric nurses, who have the qualification to assist

women, during the low-risk pregnancy-puerperal cycle, also to those in high-risk pregnancies, as a member of the multidisciplinary team⁽¹⁰⁾, stimulating the women's autonomy, providing care based on evidence, thus promoting maternal well-being⁽¹¹⁾.

Childbirth care in Brazil is still part of a medicalized, interventionist model with little intervention by obstetric nurses⁽¹²⁾. Thus when considering that the obstetric nurse plays an essential role in the process of founding the humanized model in maternity hospitals, the question was asked: how does the practice of obstetric nurses occur in the assistance to humanized childbirth in high-risk maternity? So, this research aimed to understand the practice of obstetric nurses in childbirth care for high-risk pregnant women.

Methods

This is a qualitative study, carried out in a maternity hospital that attends high-risk pregnant women, a referral in the city of Teresina, capital of the state of Piauí, Brazil. This study pursued to explore the set of opinions, values, perceptions, representations, and interpretations of the nurse's feeling, thinking, and performing in assisting the woman who experiences a risky birthing. A comprehensive approach was sought from a focused group of professionals who presented situations and relationships in the work process, in maternities of public health system hospitals⁽¹³⁾.

A total of seven nurses that worked in an obstetric public maternity center located in a city in the northeast region of Brazil participated in the study. As part of the inclusion criterion, it was decided to be obstetric nurses working in an obstetric center, not a resident and not to be reallocated from activities during data collection. The selection of professionals took place by recommendation of the service manager; they were contacted in person or by online message.

It was used intentional sampling for the selection of the participants, which is based on the ones

that may have the essential information to answer or provide the discussion to the proposed objectives⁽¹⁴⁾. Attendants were clarified about the objectives and the importance of the study; the voluntary nature of participation and, after accepting the invitation, they consented to record the interviews and signed the Informed Consent Form.

Data collection took place between August and October 2019, by semi-structured interviews. Initially, the researchers filled out a form with the socio-demographic data of each participant. Subsequently, the interview continued, guided by a semi-structured script, having a guiding question: how does the obstetric nurse practice in the delivery of high-risk pregnant women take place? Then, the open questions comprised the themes below: i) the concept of humanization of birth; ii) motivation to work in childbirth care; iii) humanization practices during labor, delivery and postpartum; iv) training of nurses to perform humanized care during childbirth; v) the institution's internal policy to carry out humanized delivery assistance; vi) challenges, possibilities and suggestions from nurses to carry out and implement humanized delivery assistance; vii) use of non-pharmacological methods by nurses for pain relief and control, during labor and delivery; viii) institutional support, physical structure and integration among the actions carried out by the multi-professional team. The mechanism underwent a pre-test, carried out with a maternity nurse, to check the relevance of the questions and the interview script adjustments were made, after the test.

Interviews were led by the first two researchers and took place in the work unit, in a private room according to the participant's wish, with the presence of two experienced researchers in the study field. The interviews were recorded on cell phones and transcribed right after finished, lasting for an average of 30 minutes. To maintain the anonymity of the participants, the letters ON were used, followed by the identification number, ON1, ON2 ..., sequentially.

The number of participants was defined by using the data saturation criterion, during the conti-

nuous process of data analysis. Saturation started at the beginning of the interviews and considered the comparison of the questions to the objectives of the research, in the pursuit of new components. Provided the repetition of the statements and the absence of new speeches, the interviews were concluded⁽¹⁴⁾.

The content analysis technique was used for data analysis⁽¹⁵⁾, which recommends that the results be organized and selected; be revised to define the categories and sections of the register; and, finally, the data is gathered for analysis. The discussion of the results was based on the literature and an understanding approach, targeting at deepening, and broadening the comprehension of the meanings placed by the participating nurses.

In compliance with the ethical and legal aspects versed by Resolution 466/2012, of the National Health Council, ethics guided the research, including principles of bioethics, such as beneficence, non-maleficence, autonomy, and the principle of justice. The research was approved by the Universidade Federal do Piauí Research Ethics Committee, according to opinion No. 2,817,507/2018 and Presentation Certificate for Ethical Appreciation no. 94962318.0.0000.5214.

Results

Seven nurses were enrolled in the study, between 27 and 44 years old, from which, six were female three of them declared themselves white, three declared to be brown and one black. Four of the participants claimed to be Catholics, two Protestants and one spiritualistic. Time since undergraduate degree ranged between three and 18 years, while the working time in obstetric care ranged from five months to 13 years. Participants had specialization or residency in obstetric nursing and only one of them was taking a master's degree in nursing. Two of the themes emerged from the data analysis: from motivation to the practice of nurses to assist in humanized childbirth, as well as, intrinsic factors for the practice of humanization by nurses in an obstetric center.

From motivation to the practice of nurses for assistance in humanized childbirth

It was evident in this theme, the motivation of nurses to work in obstetric care, the parturient embracement, the humanization practices performed in childbirth care and the prompt puerperium.

As for the motivation to work in obstetric care, five of the interviewees reported that the enthusiasm emerged in undergraduate school. Two of them mentioned that interest in women's health started after the experience in primary care: *I started working because of the residency program, but the motivation came before the program, when I was still a nursing student and was still taking the basic curriculum course...* (ON5). *In primary care, it has called my attention to women's health care and the opportunity for a specialization course provided by the Ministry of Health* (ON3).

About the parturient embracement in the obstetric center, four of the obstetric nurses reported that it was carried out in a humanized way, and three of them considered that user embracement was not a usual practice and neither performed by all professionals. Most nurses said they did not host visits from pregnant women to recognize the place, such practice was more usual at the Natural Childbirth Center, as reported: *Depending on the shift and the person on duty, it is indeed... It is not every professional who introduces her/himself to the patient, explains about the diagnosis, its evolution, it is not all professionals* (ON1). *Here, at the Obstetric Center, it is not a usual practice to get to know the place, although, on the other hand, at the Natural Childbirth Center it is already a practice. And I believe it would be something positive, but it just doesn't happen* (ON7).

Concerning the humanized care, the participants stated performing good childbirth care practices and two of them declared having even performed bureaucratic activities. Most nurses stated having provided guidance on the role of the companion during birthing labor, to promote involvement in the process, use of non-pharmacological methods for pain relief such as the use of massage oils, swiss ball, upright positions, bathing stimulation, also, about freedom of choice regarding the position of giving birth, of not en-

couraging directed pushing: *The humanized practices I like to perform are the non-pharmacological methods of pain relief, I try to make the woman be the protagonist of the birth itself, I offer water for her and show that she has different positions that she chooses the position to give birth, all of the those, all fours position, the use of a ball ...* (ON6). *Here, we end up getting more involved with bureaucratic issues and there are a lot of administrative bureaucratic issues that we have to deal with on duty* (ON7).

Moreover on non-pharmacological methods for pain relief, it was evident that nurse has handled this duty to other professionals, due to overwork during the shift, like physical therapists: *We are directing this task a little more often to the physiotherapists than to the nurses on duty, because here we are short-handed and, sometimes, I am alone all day long* (ON2).

The obstetric nurses enrolled in this research, reported that the presence of companions is of free choice of the parturient receiving instructions to the obstetric center upon admission, moreover, the nurses advise on the importance of the companion's support, during the evolution of labor and delivery, as previously discussed: *I can include these companions so that she/he feels co-participant, actively participating in this, because we know that in this emotional aspect the companionship is 100% of good use, so sometimes, one does not know what can be done, so, what we can do to include this companion we do* (ON5).

Most of the interviewees mentioned that the women's evaluation during the immediate puerperium state was unsatisfactory in the unit and, when performed, the instructions on lochia, on how to perform a standing shower, breastfeeding and skin-to-skin contact were emphasized: *The immediate puerperium here is frail. So, the word here is, not even the vital signs every 15 minutes, sometimes, is not done, you know?* (ON5).

Intrinsic factors for carrying out humanization practices by nurses in an obstetric center

Within this category, obstetric nurses described adversities, easiness, suggestions, support from the multi-professional team and training for carrying out humanization practices at the mentioned obste-

tric center. Regarding the easiness for carrying out humanization practices, three of the nurses interviewed reported that the support of the nursing staff, extensionist workers and obstetric nursing residents was positive, and that the availability of materials, such as Swiss ball and, all four position, makes it easier the implementation of humanized practices: *The easiness is to deal with other professionals that agree with our same idea, isn't it? That is the staff of obstetric nursing, students, extension workers* (ON1).

About the adversities, four of the interviewees highlighted the reluctance by part of the medical category: *We still find professionals who do not allow us to offer liquids to patients during labor* (ON3). Participants complained about the sector's environment, unacceptable physical structure and lack of privacy that makes it difficult to embrace and adopt humanized practices for patients during birth: *We come across professionals that do not allow, actually, who still insist on an episiotomy, Kristeller maneuver, who are not able at changing positions, they want women to stay in that gynecological back position, isn't it? There is that still ...* (ON3). *We have many structural problems, the floor, the material here in the unit. Every day, we have a different problem, the issue of bathrooms that are also not adequate* (ON4).

Regarding the pre-delivery, delivery, and post-delivery rooms, four of the obstetric nurses reported that the unit did not have such rooms, as there were only pre-delivery and delivery rooms. One of the nurses' major disappointment was with the woman's displacement to the delivery rooms, right in the active phase of labor or expulsion: *We don't actually have pre-delivery, delivery and post-delivery rooms here at the Obstetric Center, so what we do is that they stay in the pre-delivery and, at the time of giving birth, most of the time, they have to go to the delivery rooms, because the bed is a bed that she could be used on all ways as pre-delivery, delivery and post-delivery* (ON4).

Three of the study's interviewees suggested integrating the use of aromatherapy, massage oils, improving the practice of using non-pharmacological methods for pain relief, in the correct phase of labor, avoiding unnecessary interventions and improving the privacy of parturient. It is observed in this report:

It would be better for the patient to have more privacy, because here the infirmaries are still shared. The issue of using massage oils, because here it is not freely provided, another thing would be aromatherapy, which is very interesting, and we don't have it here as well (ON4).

Most nurses said they received support from their professional team and the unit's technical manager, which enforce their performance in using humanized practices: *Not by everyone. Indeed, on the nursing side, but not always on the medical side. I will not say all doctors, but most of them do not cooperate much* (ON1). *The support I normally feel is from our technical manager, always around, is one of us and supports us* (ON6).

Regarding the preparation of professionals for the use of humanization practices, three of the interviewees declared that they did not receive training to work in maternity nursery and stated that the knowledge was acquired through theoretical classes, during graduate courses and practical experience. They also mentioned a few investments to train professionals: *My greatest experience as an obstetric nurse was during residency, so my greatest learning was really my own pursuit and in my daily practice* (ON7). *We are the ones who seek it, we have the training, we are the ones who seek it. Many residents do because the institution itself does not sponsor much. We go to congresses, courses, training, so this is how we get trained* (ON6).

Discussion

The management of the research only with obstetric nurses who worked in an obstetric center was considered a limitation. However, it is noteworthy that this study heard obstetric nurses on the humanization practices performed in service, as well as concerning the intrinsic alternatives and challenges of the practice. Besides, it is emphasized that the data gathered in this research is capable to contribute to the improvement of assistance in childbirth and improvement on institutional protocols, valuation of obstetric nurses in childbirth care, as a member of the multi-professional team and, most of all, cooperate to implement good obstetric practices in health services.

The study disclosed that the knowledge of

obstetric nurses was consistent with the major recommendations proposed by the current rules of the Ministry of Health of Brazil, which recommended actions for the humanization of childbirth⁽¹⁶⁾. Regarding humanization practices, though, during labor and delivery it was evident that the participants did not fully perform the recommended actions.

The literature points out that humanization of childbirth is understood as a practice of care on childbirth and birthing care that aims to ensure safe care, offering human care, individualized and comprehensive, in which women have desires, expectations and rights considered. Consequently, it is necessary that obstetric nurses respect the aspects of the woman's physiology, not using unnecessary interventions, explore non-pharmacological pain relief care and offer emotional support to the parturient and family⁽¹⁶⁾.

Humanization practices carried out by nurses regarding the guidelines on the use of the Swiss ball, shower, massage and encouraging the upright position, during birth, confirm the results of a study that evidenced the woman's relaxation, decrease anxiety, increased blood circulation and the use of upright positions increased cervical dilation and fetal descent position⁽¹⁷⁾.

It was evidenced that the evaluation of the woman during the immediate puerperium, still in the studied obstetric center, was unsatisfactory. This discovery refers to the results of a study that points out the main precautions that must be used in this period consists in checking vital signs every 15 minutes, observing the lochia and palpating the Pinard safety horn to prevent postpartum hemorrhages, stimulating moving in bed, checking the Homans sign for detecting thrombosis signs, besides providing guidance on hygiene, food and care during breastfeeding⁽¹⁸⁾.

All the participant obstetric nurses cited having a companion of choice of parturient meet the guidelines on humanization practices. This conclusion meets the guidelines for the right to the company freely chosen during the process of delivery, birth and postpar-

tum⁽¹⁹⁾. However, the inadequate infrastructure of the services and, especially, by the lack of preparation of the health team to host them justifies obstacles even though the presence of the companion in the humanized delivery scenario is a recommendation from the Ministry of Health⁽²⁰⁾.

Regarding visits by pregnant women to the obstetric center, the interviewees reported that it is not an allowed practice because of the restrictions of the unit which has direct access to the operating room. This is not entirely according to the recommendation of the Ministry of Health, as it advises that pregnant women should previously get to know the maternity where they wish to give birth, alleviating anxiety, makes them feel calm and safe, also by developing a relationship of trust between the pregnant woman and the involved staff⁽⁷⁾.

When it comes to the challenges, it was noticed, especially from the obstetrical nurses' view, little interest by some members of the medical team to carry out practices allied with the principles of humanization. It is important to point out that, due to the historical course of institutionalization of childbirth, pregnant woman end up enduring the mechanization of this event, that is, reduced to a simple object of intervention, required to behave according to institutionally established standards, in which interventionist practices takes course⁽¹⁹⁾.

Concerning the incorporation of humanized practices and actions that are not yet carried out in humanized assistance to parturient women in the researched unit, the study participants mentioned the benefits of using integrative and complementary practices, ruled by the National Policy of Integrative and Complementary Practices in the Unified Health System that recommends the use of drug therapies (such as medicinal herbs) and non-drug therapies (such as acupuncture, yoga, aromatherapy and other physical, mental and spiritual therapies), body massages, baths, breathing and relaxation techniques, easy touching, use of the Swiss ball, among others⁽²⁰⁾.

Conclusion

The participant professionals were motivated to practice obstetrics during the undergraduate, specialization and obstetric residency courses. They appeared interested in good practices and on the childbirth humanization, however, there had been noticed gaps in these practices, regarding the use of non-pharmacological methods, encouraging favorite positions to pregnant women, encouraging companions presences and improving immediate postpartum care. Furthermore, obstetric nurses, members of the research, pointed out disappointments with the unit's atmosphere, poor physical structure, and little privacy for user embracement, and adopting humanized practices, besides the lack of training for professionals. Finally, it should be noted that the multi-professional cooperation helps humanized practice, thus, it becomes utmost essential professionals who do not reject innovation.

Collaborations

Monteiro AS, Martins EM, Pereira LC and Jorge HMF contributed to the conception and design, analysis, and interpretation of data. Freitas JC contributed with writing the article and relevant critical review of intellectual content. Silva RM took participated in the final approval of the version to be published.

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