

Obstetric nurse and the factors that influence care in the delivery process



Enfermeira obstetra e os fatores que influenciam o cuidado no processo de parto

Enfermera obstetra y los factores que influyen en la atención del proceso de parto

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ABSTRACT

Objective: To identify the factors that influence the improvement of obstetric nurse care in the delivery process.

Methods: Descriptive exploratory study with a qualitative approach conducted at a teaching maternity hospital located in the city of Salvador, Bahia, Brazil with 20 obstetric nurses from the Obstetric Center. Data was collected through semi-structured interviews between June and September 2017 and was then subjected to the Thematic-Categorical Content Analysis proposed by Franco.

Results: Six categories emerged from the analysis, which presented factors that favor the improvement of obstetric care in the delivery process and factors unfavorable to this care. These factors address power and gender relations among health professionals; recognition of obstetric nurses; physical space and bed occupation; interaction between woman/ companion, among others.

Final considerations: The factors indicated by obstetric nurses reveal the need for improvements in the working conditions by managers and changes of behavior and codes of conduct of health professionals.

Keywords: Nurses midwives. Obstetric nursing. Nursing care. Workload.

RESUMO

Objetivo: Conhecer os fatores que influenciam a melhoria do cuidado da enfermeira obstetra no processo de parto.

Métodos: Estudo qualitativo, descritivo exploratório realizado em uma maternidade escola localizada no município de Salvador, Bahia, Brasil com 20 enfermeiras obstetras do Centro Obstétrico. A coleta de dados ocorreu por meio de entrevistas, guiadas por formulário semiestruturado entre os meses de junho e setembro de 2017. Os dados foram submetidos à Análise de Conteúdo Temático-Categorial proposta por Franco.

Resultados: Emergiram seis categorias, as quais apresentaram fatores que colaboram e dificultam o cuidado da enfermeira obstetra no processo de parto. Estes abordam as relações de poder e gênero entre profissionais de saúde; reconhecimento da enfermeira obstetra; espaço físico e ocupação de leitos; interação entre mulher/acompanhante, dentre outros.

Considerações finais: Os fatores sinalizados pelas enfermeiras obstetras revelam a necessidade de melhorias nas condições de trabalho por gestores e mudanças de condutas/comportamentos de profissionais.

Palavras-chave: Enfermeiras obstetras. Enfermagem obstétrica. Cuidados de enfermagem. Carga de trabalho.

RESUMEN

Objetivo: Conocer los factores que influyen en la mejora de la atención de la enfermera obstetra en el proceso de parto.

Métodos: Estudio exploratorio cualitativo y descriptivo realizado en una escuela de maternidad ubicada en la ciudad de Salvador, Bahía, Brasil, con 20 enfermeras obstetras del Centro de Obstetricia. La recopilación de datos se realizó a través de entrevistas, guiadas por una forma semiestructurada entre los meses de junio y septiembre de 2017. Los datos se presentaron al análisis de contenido temático categórico propuesto por Franco.

Resultados: Surgieron seis categorías, que presentaban factores que colaboran y dificultan el cuidado de la enfermera obstétrica en el proceso de parto. Estos abordan el poder y las relaciones de género entre los profesionales de la salud; reconocimiento de la enfermera obstétrica; espacio físico y ocupación de la cama; interacción entre mujer / acompañante, entre otros.

Consideraciones finales: Los factores indicados por las enfermeras obstétricas revelan la necesidad de mejoras en las condiciones laborales por parte de los gerentes y los cambios en la conducta / comportamiento de los profesionales.

Palabras clave: Enfermeras obstétricas. Enfermería obstétrica. Atención de enfermería. Carga de trabajo.

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■ INTRODUCTION

The valuation of the care provided by obstetric nurses is supported by the use of good practices in obstetric care based on the relationships with others (women) and technical support. This contributes to the participation of women and the reduction of unnecessary interventions, and to ensure that obstetric nurses provide such qualified care improvements in working conditions are needed, with an increase in the number of such professionals in health institutions.

The care provided by obstetric nurses to women in childbirth is based on interpersonal relationships, as it values non-verbal languages, listening, dialogue, empathy, and technical-scientific knowledge. A study with 104 puerperal women in a university hospital in the state of Mato Grosso, Brazil analyzed the practice of obstetric nurses and the consequent maternal well-being. It was concluded that, by offering an assistance on based on scientific evidence and humanized care, these professionals provide security and comfort to these women. Thus, these nurses contribute to maternal well-being, also favoring the empowerment of these women during the delivery process⁽¹⁾.

Such care encourages the participation of women, supports the presence of companions, reduces the need for unnecessary interventions, and increases the number of vaginal deliveries and the use of non-invasive care technologies. Therefore, this care ensures humanized care with the adoption of good practices in childbirth and birth, reducing the chances of occurrences caused by invasive procedures and instrumental births, in addition to favoring more spontaneous vaginal births⁽²⁻³⁾.

Thus, the World Health Organization (WHO) encourages the assistance provided by obstetric nurses, as they directly impact the improvement of obstetric indicators in the care of women in labor and during childbirth. Obstetric nursing plays a key role in maternity hospitals. This professional occupation is essential, since obstetric nurses contribute to reduce maternal and neonatal morbidity and mortality rates, as they do not interfere with the physiological process, encouraging the participation of women in the parturition process^(1,4). Therefore, the initiatives launched by the WHO and Brazil's Ministry of Health have stimulated the inclusion of obstetric nurses in the care for women during childbirth and birth⁽¹⁾.

The WHO has recently published the "Nursing Now" Campaign together with the International Nurses Council and the International Midwives Confederation, in which 2020 was designated as the year of obstetric nurses and

midwives. This campaign aims to value the contribution of nursing professionals in improving health conditions, and expanding access to qualified services for women. The initiative promotes the visibility of obstetric nursing worldwide and supports the work carried out by obstetric nurses and other health care professionals⁽⁵⁾.

Obstetric nursing has acquired greater prominence in Brazil in recent years because the movement for the humanization of childbirth has been encouraged by women, managers and health professionals. The movement gained strength with the creation of the initiative "Rede Cegonha, in 2011 where the importance of the inclusion of obstetric nurses in the context of childbirth and birth was highlighted. It also reinforced the need for a comfortable and welcoming environment in health institutions for the care of women during pregnancy and the postpartum period⁽⁶⁾.

However, in order to offer qualified care, nurses have better working conditions, as these directly impact the quality of care provided to women in the parturition process. Such conditions concern infrastructure, individualized beds, availability of material and human resources, as well as gender issues, and interpersonal relationships, which may differ according to the profile of each maternity hospital⁽⁷⁻⁹⁾.

The relevance of the inclusion of obstetric nurses in and the improvement of working conditions in the care of women in parturition is therefore clear. Then, the following guiding question emerged: what factors influence the improvement of obstetric nurse care in the delivery process? Hence, the present study aims to identify the factors that influence the improvement of the care provided by obstetric nurses in the delivery process.

■ METHODS

Descriptive exploratory study with a qualitative approach conducted in a teaching maternity hospital in the municipality of Salvador, Bahia. This institution was a pioneer in obstetric-gynecologic care in Brazil, and is currently a reference for teaching-care in Obstetrics, Neonatology and Perinatal Health. This study is part of the results of the dissertation entitled "Care for women in the delivery process: conceptions of obstetric nurses".

Twenty obstetric nurses from the Obstetric Center of the referred maternity hospital participated in the study. There were 33 nurses in this sector, 23 of whom were specialists in Obstetrics and 10 in Women's Health. The following inclusion criteria were considered: obstetric nurse who provides care during the delivery process at the obstetric center, with least one year of professional experience and be

employed at the maternity hospital for at least six months. Obstetric nurses who only held administrative positions and/ or away or on a leave for any reason were excluded. Thus, three nurses did not participate in the study: 2 had less than 12 months of professional experience and one due to medical leave.

Data was collected between June and September 2017. Semi-structured interviews composed of the following closed-ended questions were used: identification of participants with initials of name, gender, age, ethnicity, color, length of professional training and experience in maternity obstetric care in years. The guiding principle of the interview (form) was the following open-ended question: tell me about the care for women in the delivery process.

The nurses were invited to participate in the study by telephone and were offered flexibility of time for the interviews. The interviews were individual and took place in a private room provided by the research institution. The researcher responsible for the study, a master's student, was the interviewer. The interviews were recorded with an electronic recorder, each one lasting on average 60 minutes. The interviews were then transcribed verbatim and identified by letter "N" (Nurse) followed by Arabic numbers, to ensure the anonymity of the participants, for example N1, N2, N3.

The data obtained was treated according to the method for categorical analysis. The starting point was the message expressed by the senses and meanings assigned to the object of the study⁽¹⁰⁾. Then, inferences and interpretations of the messages attributed to the guiding principle of the research were made. Subsequently, the statements of the participants were submitted to the process of unitarization, where a re-reading of the messages attributed to the object of study was made, in order to identify and define the units of analysis (concepts, phrases, themes or words). These units can be divided into Recording Units and Units of Context⁽¹⁰⁾.

The inferences made it possible to establish the analyzed content of the Recording Units and/or Units of Context to support the categorization process. Thus, six categories emerged around the factors that influence the improvement of the care provided by obstetric nurses in the delivery process and that justified the description of the results.

This study is part of a larger main project called "Social actors and factors involved in the delivery process" and was evaluated by the Research Ethics Committee (REC) of the maternity hospital where it took place. The study obtained a favorable opinion issued under Protocol nor 2026663/2017 and CAAE no 65019717.90000.5543. The Informed Consent Form (ICF) was made available, and

participants' anonymity was ensured with the use of codes for the interviews. Also, the study observed the ethical and legal aspects from Resolutions 466/12 and 510/16 of the National Health Council (NHC) that regulate research with human beings.

■ RESULTS

The participants were 20 obstetric nurses, 18 women and two men that performed their duties at the Obstetric Center. Most of the participants were aged 30-36 years old and had five years of professional experience in obstetric nursing.

The statements about the factors related to the improvement of the care provided by the obstetric nurses contributed to the identification of the six categories described below:

Factors that contribute to the care of obstetric nurses in the delivery process related to (the) health professional

According to the description of the statements of the participants, the factors that contributed to the care of obstetric nurses in the delivery process are related to these professionals insofar as they emphasize the recognition of the importance of technical knowledge, commitment and satisfaction of obstetric nurses, as well as the support of the multidisciplinary team. This category led to four subcategories:

Care regarding the recognition of the importance of technical knowledge and skills

The nurses expressed the importance of technical knowledge and skills in their daily nursing practice, as it guides the care to be delivered by obstetric nursing based on the physiology of labor.

I need technical knowledge to intervene in difficult situations. If I have technical expertise I am respected in the workplace. Some professionals do not understand how I can talk to pregnant women and help them during labor. Women in labor respect me because I listen them and do what they want. I would like the health team to understand this. (N1)

I use technical expertise a lot and take all precautions so that the delivery does not have a negative outcome [...] this is very important for me and for obstetric nursing. (N6)

Technical expertise assists, drives and guides our action in the physiology of labor [...]. (N10)

Care regarding the obstetric nurse's commitment

The interviews revealed the commitment to value the human dignity of women in labor, through proximity, eye contact and listening.

Women should be treated with respect for their dignity. [...] Now a woman in labor can remember the care I give them and not merely the person who held the newborn baby in her arms. In the delivery process, women need that the health professional shows personal empathy for her as a midwife [...]. (N1)

I am willing to help and have a closer contact with a woman in labor. Looking her in her eyes, so that the woman to trust me [...]. This facilitates the development of more humanized and qualified care and assistance. (N3)

[...] in chaotic shifts I try to ensure at least a little bit of dignity for women using the available resources to assist them, to listen to them. (N4)

Care regarding the satisfaction of obstetric nurses

The care provided by obstetric nurses was pervaded by satisfaction, which can be identified in the knowledge, responsibility, desire to work in this field as it involves affinity and humanity.

In the care process, you should really like what you do and take responsibility during difficult times, complications during childbirth, deaths... we have to be prepared. We must combine knowledge with the desire to work [...]. (N12)

[...] those who dedicate themselves to obstetric nursing, do it because they love the profession and want to develop specialized care [...]. (N3)

[...] when you do what you like and the way you think is right, you do it with much more love [...] is to be fully committed to your activities. (N5)

[...] I love obstetric nursing, I consider myself human, I like to create bonds with the women and their companions [...]. (N13)

Care regarding multidisciplinary support

The multidisciplinary team was perceived as a support by the obstetric nurses, who recognized the importance of the multidisciplinary care for women in the delivery process in their daily work.

It is very good to work with an interactive multidisciplinary team, where each one offers support in their area. We try to create a bond with the woman in labor. If she doesn't want it, we call another professional to provide assistance [...]. (N12)

[...] the care is multidisciplinary, but nurses are the most active professionals.. Everyone works, the daily exercise of work is targeted to the women in labor, we also try to talk with these women during the process [...]. (N18)

[...] There is a team with several professionals who collect information and have different technical perspectives. (N2)

Factors that contribute to the care of obstetric nurses in the delivery process related to the health institution.

The participants reported institutional factors that contributed to the care of obstetric nurses, such as occupation and adequate physical space, which are described in the following two subcategories:

Care regarding appropriate bed occupancy rates

The work of obstetric nurses was facilitated when the health institution was not overcrowded and more beds would be available. In their statements, the nurses reported that they were able to provide an adequate care as midwives.

When the maternity hospital is not overcrowded, we can respect the women's choices and provide qualified assistance. Or else, I am able to do my job as an obstetric nurse, to attend the deliveries of these women, to talk about on vertical positions like the squatting and Gaskin maneuver, and I mention our instruments for exercises, such as the birth ball and the birthing stool (N3)

[...] As there are fewer patients in care today, and the maternity is not overcrowded, we can perform our role as midwives more easily. (N8)

The maternity hospital will undergo a renovation and perhaps a more qualified assistance will be possible, with an increase in the number of beds [...]. (N4)

Care regarding adequate physical space

The participants mentioned the importance of a physical space where the nurses would have more time to pay attention to the conditions of the women during the delivery process.

When I am in this space, where I can be alone with the woman in labor, I am more attentive because I have more time to observe non-verbal language, to realize when the woman is having contractions, what pain is bothering her. This depends on the environment and working conditions [...]. (N15)

[...] we have a more peaceful space, with freedom for women to move and have their babies. In this space, nurses can give more assistance to the delivery [...]. (N13)

Factors that contribute to the care provided by obstetric nurses in the delivery process related to the woman/companion

The factors reported by the nurses were guided by the interaction between health professional and woman/companion, as well as by the knowledge about the delivery process of these social actors mentioned in the two subcategories below:

Care regarding the interaction of woman/companion with the professional

The nurses reported that their care involved harmony, calm and pleasure. These elements were identified when the contact between professionals and the woman/companion was established, characterizing the interaction.

When health professionals, women and companions are in harmony, it is easier. When this happens, the whole delivery process is more pleasurable, but when it doesn't, it's frustrating. (N2)

[...] I always try to interact with the companion to include him in the delivery process [...]. (N11)

Women who have had previous experiences with childbirth and/or successful reports about it, accept our care more easily [...] we try to convince these women that we are there to provide all the support; interact with them, family and/or companions, integrating them into the environment. (N12)

Care regarding the knowledge of the woman/companion about the delivery process

The statements suggested the importance of prior information from women/companions about labor and delivery,

as people who had already acquired knowledge about the process were more prepared to deal with the events of natural childbirth.

Our care takes into account these changes in women's behavior. They now seek more information about humanized care; they know that they have the right to be with a companion at the time of delivery and that they can eat; they demand it. (N3)

Childbirth is successful when women are prepared to let go. I usually check the knowledge of women and their companions / families [...] we have to maintain a dialogue; there is no point in using a partogram, telling the woman in labor to walk and breathe, if you do not involve her and the companion/family in the delivery process. (N6)

Some women are prepared for labor because they have had a good prenatal and want a normal delivery. They seek information about this natural birth and their sources are social networks or their prenatal care practitioners (N7)

Factors that disfavor the obstetric nurse's care in the delivery process related to the health institution

The obstetric nurses reported that the hospital model, overcrowding, inadequate physical space, assistance and administrative demands, and the unavailable resources are institutional factors that disfavor their care for women during the delivery process. These factors are presented in the following subcategories:

Care regarding the hospital model

The statements of the participants indicated aspects related to the hospital model, which is pervaded by hospital routines, does not ensure privacy for women in labor, as it allows the presence of many health professionals/students in the delivery scenario and promotes interventions.

The health service formats the woman, collects her belongings, directs her to the bath, and makes her wear standard clothes, deconstructing her personality. (N1)

The woman enters the maternity ward, takes off her clothes and wears the clothes provided by the institution, within the established times and sometimes she cannot have a companion because of the overcrowding. . The

hospital institution exercises a lot of control over the woman's body [...] and sometimes the woman is unable to have privacy because of the presence of a doctor, a student and the health team during the delivery [...]. (N18)

As it is a teaching maternity hospital, it has a nurse, doctor, resident and medical student. It is as if there is a dispute over who will attend the delivery. No specification is made on those pregnant women at low obstetric risk. (N3).

Many interventions are made with women and we are unable to give them the ideal privacy, a favorable environment [...]. (N11)

[...] Ideally, we would like to have individualized PDP beds (Pre-delivery, delivery and Postpartum) [...] the facilities of the unit do not always allow us to put into practice knowledge about non-invasive pain management [...] we have few bathrooms for all women. (N11)

[...] We cannot offer companions for these women and work with them, because of the lack of physical space. We put women on stretchers, the turnover is high. Respect for women's choices is conditioned by this chaotic scenario, and, incredible as it may seem, a woman was once admitted to the birthing stool (N3)

Care regarding overcrowding

Overcrowding was an obstacle to the provision of care by obstetric nurses. These health workers mentioned the impossibility of meeting the demands and ensuring the privacy of women in labor, as well as the fact that they were placed on armchairs and stretchers.

Because of the overcrowding, it is very difficult to ensure individualized care. This prevents us from having that attentive look, the sensitivity and the care to perceive the women's demands. (N5)

Overcrowding interferes a lot in our assistance and care [...] despite the adversities and limitations imposed on women in labor, on an armchair without a companion, I try to offer qualified assistance. (N18)

[...] sometimes due to overcrowding, we are unable to perform our duties as obstetric nurses. It's chaotic.

[...] We need a room and professionals to assist these women. (N13)

When the maternity is overcrowded we use extra seats. Women have no privacy as they face chairs with other women on medication, and I can't do a maneuver if necessary. And we also admit women on stretchers (N3).

Care regarding inadequate physical space

The statements of the obstetric nurses revealed the need for an adequate physical structure that allows individualized care for women, with access to separate beds and the presence of a companion.

[...] Our facilities are not good, but we try to adapt to them [...]. The beds are not separate, there are only joint beds, with other families together (N10)

Care regarding assistance demands

It was found that obstetric nurses are often asked to meet other care demands, which are not specific for monitoring women in labor and delivery.

[...] obstetric nurses are sometimes asked to perform their duties in elective surgeries, failing to provide assistance during deliveries. (N11)

[...] we usually replace the assisting nurses, on the days when they are absent to take over the procedure room. I have technical expertise, but it is not being used optimally and I have been unable to perform my duties as an obstetric nurse. (N13)

We are not always able to connect with the women in labor because there are many interruptions; someone calls you, or you may have to take care of other things.

[...] It is a little bit hard! (N5)

Care regarding administrative demands

Excessive administrative demands, which are not shared with other professionals contributed to the non-prioritization of individualized care to the women in labor.

We have many administrative demands: scale, employees who double the shift. We end up focusing on these things and leaving this more individualized care a little aside. (N5)

The non-division of demands interferes with our assistance [...] we are unable to monitor women in labor with so many demands to meet, except when we are in PPP2. I feel disappointed and helpless. (N3)

[...] when we have an assisting nurse and an obstetrician, we can work as midwives, but due to the large amount

of demands in addition to our care to women in labor, we also perform the duties of assisting nurses. (E9)

Care regarding unavailable resources

In their statements, the obstetrical nurses highlighted the lack of resources for the provision of aromatherapy and music therapy in the public service.

[...] there were no essential oils available at the institution, I had to buy them myself [...] The SUS does not provide us with the conditions to offer epidural analgesia. (N4)

[...] we cannot provide music therapy and aromatherapy ... some professionals provide these resources themselves. If more items were available for us to work with, it would be ideal. (N11)

Factors that disfavor the care of obstetric nurses in the delivery process related to the women

The participants revealed the difficulties in providing care in the delivery process, which was mediated by power relations and gender inequality, in addition to the lack of knowledge of the women in labor. Such factors are shown in two subcategories:

Power relationships and gender inequality in the care process

Regarding power relationships, the statements expressed the need for health professionals to play a central role in the delivery scenario. The presence of male obstetric nurses caused strangeness and discomfort for women at the time of the delivery. However, women can also feel comfortable with the presence of male nurses because they would remind them of their male physicians.

We health professionals have all the necessary knowledge and we want to determine what will happen, when and how. In the delivery process this is stronger! There is a need to control the process, if it gets out of control, we intervene. (N5)

For many women, the presence of men is perceived as something strange at the time of delivery. This also happens with technicians, obstetricians and residents. The women interact in a different way with female nurses. (N2)

[...] Women are reluctant to be assisted by male nurses [...] I think it is part of our professional construction. They feel comfortable with the male obstetrician, because he is a doctor. This involves power relations [...] I don't know if that happens because of this tendency to associate men with doctors and women with nurses [...]. (N4)

Lack of knowledge of women about the delivery process

Another difficulty related to the women in the delivery process was their lack of knowledge about the delivery process. The nurses reported the lack of preparation for normal delivery, pain and lack of information about techniques such as the birth ball and the birthing stool.

Women think that giving birth is suffering. They are not prepared for delivery, either normal delivery or cesarean section. So, they don't know how to deal with their own pain, they do not have a familiar understanding of everything that is going on, and they don't know the methods for pain relief. (N2)

[...] I realize that women are not very well informed about the labor process. They think they will undergo a caesarean section, because that is what happened to their neighbors [...]. (N9)

For us, the challenge of care at the moment of delivery is often to clarify doubts that women had since prenatal care. This is a failure in care (N4).

The care given to women who did not seek information, were not informed or did not want their babies is a little different. We must explain, emphasize that labor can take a long time, as well as provide support with techniques such as the birth ball and the birthing stool, but some women don't want any of that. (N12)

Factors that disfavor the care provided by obstetric nurses in the delivery process related to (the) professional

In this category, obstetric nurses showed the difficulties related to (the) professionals who base their care on the technique, when there is professional unpreparedness and devaluation of obstetric nursing care, as exposed in three categories:

Care focused on techniques

In their statements, the obstetrical nurses reported the technocratic, invasive model used by health professionals who disregard the use of humanized care to women in labor.

In this process, we deviate from our goals and focus on technical procedures. [...] we forget to do something as simple as communicating and explaining everything about the delivery (N2)

In nursing, we have a very strong tendency to use the technocratic model. Care is not merely about assistance, medical records or doing a vaginal examination. [...] it is difficult to find someone who knows how to listen. (N1)

[...] what kind of care is provided to a woman when a non-recommended technique is used, with the sole purpose of teaching another health professional? [...] and what about the rights of this woman? They use invasive techniques in the woman's body to learn something unnecessary. (N18)

Unpreparedness of the health professional to provide care

Regarding professional unpreparedness, the participants referred to the lack of technical knowledge of health professionals to assist women in the delivery process, and the need for training of inexperienced staff.

It is necessary to think about care in an ineffective system. Some professionals do not provide assistance because they have insufficient technical knowledge or are not prepared to assist these women consistently [...]. (N4)

The professionals' difficulty in identifying and perceiving what the women need, among other things, is one of the obstacles to dialogue in the care relationship. (N2)

[...] There is no institutional support for training new personnel with no experience. (N12).

The obstetric nurses reported that they feel undervalued when there is no recognition of their care by the work team, the institution and women.

The problem is the social value that is given to care. The nursing team itself has a conception related to the identity of obstetric nursing, which is that the professionals have no technique. The care provided by obstetric nurses is not

recognized/valued by the nursing team. The nurses must deconstruct this conception (N1)

The work performed by obstetrical nurses is not valued at the institution. We are, for example, disrespected by some professionals. (N13)

The women think that obstetric nurses insist on the physiology of childbirth. However, all the care we provide is devalued when the doctor recommends a cesarean section; and the women then think that he was their savior, because he was the one who provided the best care. (N4).

■ DISCUSSION

The care provided by obstetric nurses in the delivery process involves factors related to professional commitment, for the maintenance human dignity despite the chaotic situations that occur during the shift routines. These efforts made by obstetric nurses to provide more dignified care result in involvement between the professionals and the women⁽⁷⁾. Dignity is inherent to the essence of human relationships and is associated with the humanization of obstetric practices⁽¹¹⁾. Thus, the relationship of availability for the other facilitates the development of humanized care, based on interaction, which generates care in the face of adversities between the subjects and the environment in which the relationship is established⁽¹²⁾.

This interaction is as necessary as technical knowledge, as the latter guides and drives the action of obstetric nursing. In turn, when they provide their care, obstetric nurses take into consideration the particularities of the women and their companions/families and use the technical-scientific knowledge to assist them. These characteristics of care of obstetric nurses favor the disposition for their autonomy and clinical attitude, thus promoting qualified assistance that will culminate in their professional recognition⁽⁴⁾. A study with 10 nurses from a hospital in a state of Mexico, in 2020, showed that these professionals recognize that technical-scientific knowledge is key to support the development of their work, effectively contributing to the professional nursing practice⁽¹³⁾.

The recognition of obstetrical nurses in the provision of care favors their satisfaction and it occurs when health professionals from the institution and patients value and motivate obstetric nurses in the work environment⁽¹⁴⁾. Brazilian studies show the importance of including obstetric nurses in maternity hospitals to ensure humanized care during childbirth and birth and reduce the number of unnecessary

interventions. In addition, they promote information about the delivery process, favor autonomy and a central role for women in the process^(1,4).

Corroborating this finding, a systematic review with more than 17,000 women who were assisted by obstetric nurses and midwives revealed an increase in the number of normal deliveries, a reduction in the number of interventions, a greater sense of mastery over the experienced birth and satisfaction with the care received⁽³⁾. Management support and assistance is essential for the development of training aimed at improving the performance of obstetric nurses based on current scientific evidence⁽⁴⁾.

To mobilize the inclusion of a greater number of obstetric nurses, the Global Campaign "Nursing Now" promoted by the World Health Organization aims to promote more investments in nursing professionals, as well as ensure their participation in the formulation of health policies and in the empowerment of nurses⁽⁵⁾. At the same time that nurses want to be recognized, they highlight the need to value multidisciplinary care in the delivery process. Health work promotes the recognition of each professional on the team and requires the existence of a relationship between those involved to maintain systematic care and in line with the people involved in the service. Thus, the joint work between professionals from different areas of health favors the care of women in labor and delivery as it is based on humanized practices⁽²⁾.

Despite this engagement in the humanistic care of the multidisciplinary team, women in maternity wards often have to deal with institutional routines, which depersonalize and prepare them to meet their models / standards. This situation is common, as hospital institutions constantly seek to standardize people by subjecting them to imposed routines, contributing to the modeling of the subjects. The bodies of women in labor are then susceptible to dominance and vulnerable to interventions⁽⁹⁾.

Thus, pre-defined routines tend to contribute to increase the number of interventions in the women's bodies and the loss of their privacy. The hospital-centered model based on procedures favored the objectification of women, and consequently, the use of techniques in their bodies by many health professionals for learning purposes⁽¹⁵⁾. This learning enables the presence of several people (health professionals, residents, students, companions) at the childbirth scenario, which contributes to the reduction/loss of women's privacy during labor, delivery and birth. Qualitative study carried out in a teaching hospital in the northwest region of Paraná, Brazil, with 20 nursing professionals demonstrated the infeasibility of privacy in the delivery room in an educational institution⁽⁶⁾.

In addition, obstetric nurses face situations such as overcrowding of health services, inadequate spaces and the unavailability of some resources, which impact on the care provided to the women. In this regard, a study conducted in a maternity hospital that is a reference for high-risk pregnancies revealed that overcrowding interferes with the continuity of care and hinders the team's work process. This situation is a constant reality for users and workers in services that assist deliveries⁽⁸⁾. The shortage of materials, the inadequate structure and the insufficient number of professionals is also a permanent problem in health services, which interfere in the quality and safety of the care provided. Therefore, these difficulties can lead to precarious work, reflecting the violation of the rights of health professionals and women⁽¹⁶⁾.

The nursing occupation, under a precarious regime, works in degrading conditions, which impacts the safety and quality of their professional activities⁽¹⁶⁾. It is necessary to rethink the working conditions of nursing professionals, especially obstetric nurses, as they participate in the direct care of women in labor and delivery⁽⁹⁾.

Thus, factors such as excessive care and administrative demands have disfavored the care of obstetric nurses. This environment limits individualized care and the quality of care. In this regard, a study carried out in a maternity hospital in the state of Minas Gerais, Brazil showed that the work overload resulting from the high levels of demands interfered with and impacted the quality of the work performed by the obstetric nurses. This can lead to physical exhaustion, stress and personal demands, which would have repercussions on demotivation and dissatisfaction in the exercise of the profession, since nurses are unable to develop care the way they would like⁽²⁾.

Corroborating this finding, a study carried out in a public maternity hospital in Salvador, Bahia, Brazil showed that nurses reported more occupational stress compared to other nursing professionals due to the excess of assignments corresponding to the sectors of work and other maternity services, as well as for meeting more demands to make up for the lack of nursing staff. This limited the development of the daily work performed by nurses⁽⁸⁾.

In view of the above, improvements in nurses' working conditions and in the structure/bed occupancy rates of maternity hospitals can contribute to a better quality of care provided to women in the delivery process. It is known that the care provided in health institutions with adequate structure and occupancy rates gives more freedom of choice for women and greater attention to the specific needs of each woman. In this regard, a study carried out in a public hospital in the state of Rio Grande do Norte, Brazil found

that the infrastructure of services was a key factor for the development of humanized care that respects the choices and autonomy of women⁽¹⁷⁾. Thus, the study corroborates data from another research developed in a public maternity hospital in the city of Fortaleza, Ceará, Brazil showing that the lack of adequate physical structure, in addition to generating dissatisfaction among professionals, negatively interferes in the provision of qualified and humanized assistance to women in labor⁽⁷⁾.

When the woman and her companion are more informed and aware of their rights when they attend the health services, their interaction with professionals collaborates with the care of obstetric nurses. The presence of the companion, a person known to the woman within the hospital provides more security to her, and if this companion also has popular, media and/or scientific knowledge, he/she will tend to participate actively, transmitting security and assisting in the delivery process. Hence, this is a facilitating factor in the care process of obstetric nurses in all their places of operation, especially in the institutionalized field such as the maternity service⁽¹⁸⁾.

Although the above mentioned factors collaborate for the care of obstetric nurses, there are other factors that disfavor the referred care, such as power relations. In this perspective, care is usually connected to the exercise of the power of those who promote it over those who need it. This power relationship is sustained because care is strictly based on technical-scientific knowledge. Thus, the health professionals, who master this technical-scientific knowledge, provide care based only on the use of technical procedures, without taking into account the uniqueness of each woman, failing to create bonds with the women and to provide comprehensive and qualified care for them⁽⁴⁾.

These power relationships can be built within the hierarchy, where the professionals are recognized as the owners of knowledge and the care relationship becomes a process of control over the women's bodies. The female body is controlled by health professionals, who under the perspective of a biomedical and technocratic model, dominate and manipulate the bodies of women in labor favoring unilateral care. This culminates with the disqualification of women regarding the knowledge about their bodies, their exclusion from the care process and the loss of the central role during the delivery process⁽⁹⁾.

This situation reveals a gender inequality supported by the power relationships between women and health professionals. The statements of the male obstetrical nurses in this study show how the presence of a male figure generates distrust and discomfort for women in the delivery scenario, which may be related to the feelings of shame and discomfort

generated in the female imagination when undressing in front of male nurses⁽¹⁹⁾

On the other hand, women in the delivery process can also associate male nurses with the male obstetrician's image, due to a historical issue of the presence of this professional in deliveries in the hospital setting. This social imaginary created refers to the idea of knowledge, intelligence, ethical-professional respect, as well as to the technical, social and financial valorization of the doctor's work to the detriment of the care of obstetric nurses represented by the female gender. This can make women feel safe when assisted by a male doctor or nurse, who are represented by the male gender^(5,15,20).

The opposite occurs when the patients think that a female doctor who attends them during a delivery process is a nurse. This situation can be explained by the fact that historically the nursing profession has been composed mainly of women, who were influenced by attributes of gentleness, patience, maternal instinct and submission to medical work, which contributed for nursing to be perceived as a less important occupation⁽²⁰⁾.

These asymmetries can contribute to the devaluation of obstetric nurse care by both the women and the institution/health professionals. Nurses are sometimes overshadowed because their historical trajectory was supported by the hegemonic paradigm guided by biomedical values, and so they face the lack of recognition and appreciation of their activities, which can directly interfere in their efforts, contributing to a misrepresented view on the part of patients about their work^(9,14)

■ FINAL CONSIDERATIONS

This study shed light on the factors that favor and disfavor the improvement of obstetric nurse care in the delivery process. Thus, regarding professional issues, the nurses reported as collaborative factors the importance of the support of the multidisciplinary team and the technical recognition of the obstetrical nurse who has professional commitment and feels satisfaction in performing her function.

Regarding institutional factors, the nurses show the impact of care associated to occupancy rates adequate physical space, as this allows a relationship between health professional and women without external interference. The factors related to the woman/companion show how prior information about the delivery process is essential to provide physical/emotional preparation for women and their companions, as well as the importance of the interaction between these social actors that improve obstetric monitoring.

Obstetric nurses warn of factors related to care, such as difficulties related to the hospital model that standardize women, care centered on techniques, excess of care and administrative demands, lack of resources, devaluation of obstetric nurses, asymmetries in power and gender relations, and the unpreparedness of women and their companions about the delivery process.

These factors are relevant for the dissemination of knowledge among managers and professionals, to assist in decision-making for the reorientation of norms, protocols, routines and institutional conduct of health services, in order to value obstetric nurses, ensuring improvements in working conditions, so that they can develop care based on good obstetric practices recommended and encouraged by the WHO. This recognition of the work is important because managers and governments will include a greater number of obstetric nurses in health services and provide training / qualification that contribute to safe and humanized care for women.

Moreover, the findings of this study allow several professional categories to understand that the care of obstetric nurses is not limited to individualized responsibilities. The health work must be shared in order to benefit the quality of care for women. This assumption suggests changes in the approaches on the role of obstetric nurses in the delivery scenario in the teaching spaces (universities, specialization/training courses) for university students and health professionals, collaborating for their recognition. In addition, changes in interpersonal relationships between professionals of the multidisciplinary team are necessary; professional and woman, so that the commitment to obstetric care based on good practices in childbirth and birth can be extended to the different health areas.

A limitation of this study is the fact that it was conducted at a teaching maternity hospital of the public health service. Thus, the improvements in care for women in the delivery process, mentioned by obstetric nurses, are related to aspects of this institution, which may not portray the reality of other maternity hospitals in Brazil.

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