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RESEARCH

Humanized Care: insertion of obstetric nurses in a teaching hospital

Cuidados humanizados: a inserção de enfermeiras obstétricas em um hospital de ensino

Cuidados humanizados: inserción de enfermeras obstétricas en un hospital de enseñanza

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ABSTRACT

Objective: to evaluate the care provided at an Antepartum, Intrapartum, Postpartum (AIP) unit at a teaching hospital following the inclusion of obstetric nurses. **Method:** transversal study, performed at a AIP unit at a teaching hospital in the capital of the Brazilian state of Mato Grosso. The sample comprised data regarding the 701 childbirths that took place between 2014 and 2016. The data were organized using Excel and analyzed using version 7 of Epi Info software. **Results:** the results suggest that including obstetric nurses contributed towards qualifying the care provided during labor and childbirth, followed by a reduction in the number of interventions, such as episiotomy caesareans sections, and resulting in encouragement to employ practices that do not interfere in the physiology of the parturition process, which in turn generate good perinatal results. **Conclusion:** inserting these nurses collaborated towards humanizing obstetric and neonatal care.
Descriptors: Obstetric Nurses; Humanized Childbirth; Humanization of Care; Hospitals, Teaching; Natural Childbirth.

RESUMO

Objetivo: analisar a assistência prestada em uma unidade de Pré-parto/Parto/Pós-parto (PPP) de um hospital de ensino após a inserção de enfermeiras obstétricas. **Método:** estudo transversal, realizado em uma unidade de PPP de um hospital de ensino da capital do estado de Mato Grosso. A amostra foi composta por dados relativos a 701 partos normais ocorridos entre os anos de 2014 e 2016. Os dados foram organizados com uso do software Excel e analisados no Epi Info versão 7. **Resultados:** os resultados sugerem que a inserção das enfermeiras obstétricas contribuiu para a qualificação do cuidado prestado ao parto e ao nascimento, uma vez que ocorreu a redução de intervenções, tais como a episiotomia e as cesarianas, havendo o incentivo ao uso de práticas que não interferem na fisiologia do processo parturitivo, gerando bons resultados perinatais. **Conclusão:** a inserção dessas enfermeiras colaborou com a humanização do cuidado obstétrico e neonatal.
Descritores: Enfermeiras Obstétricas; Parto Humanizado; Humanização da Assistência; Hospital de Ensino; Parto Normal.

RESUMEN

Objetivo: analizar la atención brindada en unidad de Preparto/Parto/Posparto (PPP) de hospital de enseñanza luego de inserción de enfermeras obstétricas. **Método**: estudio transversal, realizado en unidad de PPP de hospital de enseñanza de la capital del Estado de Mato Grosso. Muestra compuesta por datos relativos a 701 partos normales sucedidos entre 2014 y 2016. Datos organizados utilizando software Excel y analizados con Epi Info versión 7. **Resultados**: los resultados sugieren que la inserción de enfermeras obstétricas contribuyó a la calificación del cuidado brindado al parto y al nacimiento, habiéndose constatado que existió reducción de intervenciones tales como la episiotomía y la cesárea, existiendo un incentivo para la elección de prácticas que no interfieran con la fisiología del proceso de parición, generándose buenos resultados perinatales. **Conclusión**: la inserción de las enfermeras colaboró con la humanización del cuidado obstétrico y neonatal.
Descriptores: Enfermeras Obstetras; Parto Humanizado; Humanización de la Atención; Hospitales de Enseñanza; Parto Normal.

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INTRODUCTION

The technocratic hegemonic model in the Brazilian health-care sector has outlined unique characteristics regarding care provided during labor and childbirth in Brazil, which apply to the indiscriminate use of technologies and interventions, while ignoring or denying discomforts and possible adverse effects that are linked to them. The above scenario promotes the routine practice of cesarean sections, the violation of women's rights and ensures that a high frequency of maternal mortality is maintained, all these despite increasing improvements in care quality and growth in access to Brazilian health services[1-2].

The Brazilian Ministry of Health (MH) has deemed this issue as a matter for concern since the 1980s, and has been formulating a list of proposals and policies designed to reorganize and alter the state of health care, the aim of which being to humanize heath care during child labor. This objective must be based on scientific evidence, provided via care given at Normal Birth Centers (*Centro de Parto Normal - CPN*), conducted by multi-professional teams and with the involvement of and respect/appreciation for the work of obstetric nurses[2].

The Conference on Appropriate Technology for Birth, which took place in Brazil in 1985, promoted by the Pan-American Health Organization (PAHO)/World Health Organization (WHO), was an important milestone for reviewing technologies used during child birth and labor, which led to the adoption of recommendations which contraindicate the inappropriate and indiscriminate use of invasive technologies during childbirth and the population's right to prenatal care and information[2-3].

1996 marked the time when the WHO developed and published a classification of practices used for activities regarding vaginal birth and labor, these were based on scientific evidence and provided guidelines on what should and should not be used during the parturition process. These recommendations were organized into four categories: A - Demonstrably useful practices that should be encouraged; B - Clearly harmful or ineffective practices that should be banned; C -Practices for which there is no evidence to support their recommendation and that should be used with caution until further research has been conducted to clarify the issue; D - Practices that are often improperly used. In addition, offering training and involving Obstetric Nurses (ONs) during childbirth care is recommended[4].

More recently, the Brazilian Stork Network (*Rede Cegonha*), established by the Brazilian Ministry of Health within the scope of the Brazilian Unified Health System (*Sistema Único de Saúde - SUS*), proposed that a network of care be created to ensure that women have the right to humane care throughout their reproductive process and that their newborn child/children have the right to a safe birth, growth, and healthy development[5]. This ministerial strategy placed guaranteeing that habitual-risk childbirth care, physiological and postpartum care for newborns (NB), high admission rates, all performed by a student or obstetric nurse, as one of the requirements for the working of Normal Birth Centers[6].

One investigation, whose objective was to offer theoretical help by supporting the proposal that promoting safe maternity requires the effective participation of family nurse practitioners and obstetrical nurses, demonstrated that these professionals are fundamental for advancing the humanization movement, since they provide care that is directed towards the unique needs of each woman, the objective being to enhance their autonomy and role in the parturition process[7].

In a study that described the acquisition process of practices for obstetric nurses in maternity wards in Rio de Janeiro city, during a time when a policy for the humanization of labor and birth was being implemented, these professionals were observed to reconfigure care in this area, which involved focusing on stimulating the role of women and respecting the physiology of childbirth[8].

The term 'Humanization' is a multifaceted and broad concept that, in the context of this study, assumes an idea of obstetric care that respects the physiology of labor as well as the key role of women in this process. The concept also seeks to develop the practices involved based on the best available scientific evidence as well as to disembody the technocratic model that values the use of invasive, unnecessary and damaging practices.

Based on this context of change and the search for humanized and quality care during labor and birth, while meeting the requirements of the Stork Network, a university Hospital in the capital of Mato Grosso, a site of reference for high-risk prenatal and childbirth care in the *Baixada Cuiabana* region, in 2014, created a unit called the "Antepartum, Intrapartum, Postpartum" and included obstetric nurses in all shifts.

Despite some Brazilian institutions having a integrated work system between nurses and doctors during labor and birth care, the results of these services that place emphasis on the practice of the professionals who work in this perspective are not yet understood in a systematic way[9]. Thus, this study provides a glimpse into the potential for renewing and transforming the health practices for those working in this area and aims to analyze the care provided in an Antepartum/Intrapartum/Postpartum (AIP) unit of a teaching hospital following the inclusion of obstetric nurses.

METHOD

Ethical aspects

This investigation required previous approval by the Committee for Ethics in Research at the Julius Muller University Hospital of the Federal University of Mato Grosso, in accordance with Resolution 466, December 12, 2012, National Health Council/MH, which regulate research involving humans.

Study design, location and period

This study has a quantitative approach with a descriptive and cross-sectional design. The quantitative approach represents a real picture of the research's entire target population, since it typically involves a large sample and is considered representative of the entire population[10]. This study was conducted in a AIP Unit at a teaching hospital in Cuiaba, capital of Mato Grosso, between October 2014 and 2016 March.

Population or sample; inclusion and exclusion criteria

The data collected refer to all normal births performed at the unit involved in the research, between when the unit was opened and March 2016, using a database completed by

obstetric nurses containing information relating to the births that took place at that location. Data on normal births that occurred during this period were included in this study, the exclusion criterion being miscarriages and stillbirths, leaving a total of 701 normal childbirths.

Study protocol

The data were accessed from electronic records at the Unit, where data from every childbirth performed at this location are stored. These were made available to the researchers systematizing the data, thereby creating a database with the following variables: those related to the profile of the pregnant women (age group); the obstetric antecedents (number of previous pregnancies, type of childbirth); the care received during the pregnancy study (number of prenatal consultations); and those regarding the actual childbirth (gestational age, non-pharmacological pain-relief methods, birth induction methods, company for the mother, labor position, degree of laceration, episiotomy, professional who performed the delivery).

Results and statistical analysis

The data were organized using Excel and analyzed using version 7 of Epi Info software. The analysis involved calculating absolute and relative frequencies and calculating the mean, median and mode, according to the indication. There was a discussion held based on current scientific evidence regarding good practices of care during labor and birth.

RESULTS

The results refer to the 701 normal habitual-risk and high-risk childbirths that were undertaken in the AIP unit at the selected teaching hospital. The care given to the births are here characterized and analyzed as a result of the integrated work between obstetric nurses and doctors.

The women's ages ranged from 12 to 45 years, the median being 24 years, the mean 24.6 years and the mode 20 years. The 20 to 29 years age group accounted for 52.8% of the women, with adolescent girls (under 20 years) accounting for 24.7%.

In relation to parity, most of the women were nulliparous (36.9%), with 28.4% of the pregnant women having already given birth once at some stage in their lives. In regards to multiparity (three or more previous births), 34.7% of women accounted for this, representing an significant portion of those receiving care.

Among the women who had already had some prior experience of childbirth (66.1%), 78.5% of this total was vaginal birth, 10.2% cesarean and 11.3% had experience of both forms of birth. Most of the women had received prenatal care (97.2%), with 71.9% of these having gone through six or more consultations. A significant number of births took place following a full-term pregnancy (88%), followed by the pre-term pregnancies (11.4%) and a small number of post-term pregnancies (0.6%).

Table 1 shows the use of some other demonstrably useful and suitable practices during labor and birth, in accordance to the WHO classification[4]. 88.7% of the women receiving care chose to have a companion present. In cases with a companion, the pregnant woman's partner was chosen in 38.7% of the time, 30.6% were accompanied by their mothers and 30.7% chose other family members or friends.

Most of the pregnant women used practices that do not interfere in the physiology of labor (83%). Vertical positions during the expulsive period were frequent (70.4%), followed by the semi-sitting position (44.2%).

Following birth, 76% of umbilical clampings were performed in timely fashion, 73.1% of NBs were kept in early skin-to-skin contact with their mothers and 80% of them were breastfed within the first hour of life.

In regards to birth conditions, a significant majority of the NBs had an Apgar score of more than seven in the first and fifth minute of life, corresponding to rates of 93% and 99%, respectively.

Table 2 shows obstetric practices that do not interfere in the physiology of labor used by the pregnant women in this study. The most recurrent methods were those designed to provide pain relief and relaxation, such as bathing (58.2%), deambulation (47.1%) and massage (19.5%), followed by the practices used to promote fetal progression, such as exercises with a birthing ball (54.6%) and squatting (8.8%). Few of the pregnant women used obstetric stools (2.6%) or foot baths (0.4%).

Table 1 - Demonstrably useful and suitable practices during labor and birth, Cuiabá, Mato Grosso, Brazil, 2014-2016

Practices	n	%
Companion during birth		
Total	661	100
Yes	586	88.7
No	75	11.3
Practices that do not interfere in the physiology of labor1		
Total	663	100
Yes	550	83
No	113	17
Vertical birth		
Total	668	100
Yes	470	70.4
No	198	29.6
Timely clamping of the umbilical cord		
Total	624	100
Yes	474	76
No	150	24
Skin-to-skin contact		
Total	677	100
Yes	495	73.1
No	182	26.9
Breastfeeding in the first hour of life		
Total	671	100
Yes	537	80
No	134	20

Source: Antepartum, intrapartum and postpartum database at a teaching hospital, Cuiabá, Mato Grosso, Brazil.

Note: [1] = As part of this investigation, these practices correspond to the use of the birthing balls, warm spray baths, massage, deambulation, foot baths and squatting.

These practices, for the most part, were not used in an isolated way, since a significant number of women (76.3%) reported using two or more of them. Thus, Table 2 shows the use of practices that do not interfere in the physiology of labor. This table does not add up to 100% as it includes results that demonstrate the use of several methods by the same mother.

Table 2 – Practices that do not interfere in the physiology of labor, Cuiabá, Mato Grosso, Brazil, 2014-2016

Practices	n	%
Birthing ball	362	54.6
Warm bath	386	58.2
Massage	129	19.5
Deambulation	312	47.1
Foot baths	3	0.4
Squatting	58	8.8
Obstetric stool	17	2.6

Source: Antepartum, intrapartum and postpartum database at a teaching hospital, Cuiabá, Mato Grosso, Brazil.

Table 3 details the use of some of the practices that are clearly harmful or are used inappropriately[4] during labor and/or delivery. This shows that a small number of women underwent episiotomy (8.8%). Among the mothers who had recently given birth who did receive this procedure, 36.2% did not present any kind of perineal trauma.

Table 3 – Clearly harmful practices or those used inappropriately during labor and/or delivery, Cuiabá, Mato Grosso, Brazil, 2014-2016

Practices	n	%
Episiotomy		
Total	680	100
Yes	60	8.8
No	620	91.2
Oxytocin		
Total	656	100
Yes	181	27.6
No	475	72.4
Birth in horizontal position		
Total	668	100
Yes	198	29.6
No	470	70.4

Source: Antepartum, intrapartum and postpartum database at a teaching hospital, Cuiabá, Mato Grosso, Brazil

The most common spontaneous perineal lacerations were second degree (59.4%) and first degree (37.4%), followed by those classified as third and fourth degrees, that occurred in 2.9% and 0.3% of women, respectively.

With regard to the use of drug therapy, synthetic oxytocin was administered in 27.6% of the cases. In regards to amniotomy being performed, no systemized records of such were found in the database concerning its use at the unit under study.

Despite the obstetric nurses' direct participation in terms of care given during labor for all pregnant women admitted in the unit, it is important to highlight that the birth was assisted by these professionals in 28.7% of cases, and by doctors in 71.3%, which can be explained by the fact that the unit is a teaching hospital.

DISCUSSION

Before the data is discussed, it is important to note that the care model at the teaching hospital under study was centered on the doctor as the primary care provider during labor and birth until the mid 2014s, which was when high rates of interventions during the parturition process were recorded, as 58.4% of births were performed by caesarean section.

It is worth mentioning that that teaching hospitals are characterized by their focus on the training process, a determining factor being rotation between who is responsible to do what in these places, with teachers, medical students, nursing students and those from other health areas being present. This form of organization that prioritizes teaching has been underlined as a factor that makes it difficult to establish a link between caregivers and patients, as it is in terms of providing humanized practices that are free of interventions without clinical indications[11].

The involvement of obstetric nurses in this AIP unit meant that care went on to be shared with the medical team, which began a process of transition in the traditional model that was up to then predominant. In this new organization, the habitual-risk pregnant women and healthy NBs are monitored by OBs and/or resident obstetric and pediatric physicians. In complicated and high-risk cases, care is shared with the doctor, who is the professional responsible for the woman during labor and delivering her child.

Concomitant to the input of these professionals, the use of non-invasive and non-pharmacological methods was introduced into care for pregnant women, which was until then unused in that context. This research noted the widespread use of these practices (present in 83% of the births), which contrasts with the data from the 'Birth Research' performed in Brazil, which found an index of just 17.8% in maternity wards in the Central-West region of Brazil[12].

Among the non-pharmacological procedures directed towards pain relief, the most recurrent were warm spray baths (58.2%), birthing ball use (54.6%) and deambulation (47.1%). These are low-cost practices that can be easily offered by health services, given that they provide a significant impact on the quality of care, especially as they can replace, whenever possible, the use of anesthetic and analgesic drugs[13]. In most cases, these methods were used in an associated way (76.3%), acting in a complementary fashion, which encourages a significant decrease in pain and greater promotion of maternal comfort, when compared with their isolated use[13-14]. The first-time pernancies and younger women (up to 30 years of age) were those who most accessed non-pharmacological methods for pain relief, which is consistent with findings from other studies[12].

Among the pregnant women who used non-invasive practices, most (75.8%) opted for vertical positions up to the delivery time, which is contrary to 97.3% who chose the lithotomy position, a result found in maternity wards in the Central-West region[12].

In regards to maternal postures adopted during the expulsive period, one meta-analysis showed that the vertical positions significantly reduce the rates of episiotomy and perineal lacerations, both in primiparous and multiparous mothers[15]. However, the episiotomy rate in this research did not show any great variation in terms of the childbirth position (vertical or horizontal). The pregnant women who adopted vertical positions presented a slight increase in second degree lacerations.

This finding is in line with results from a meta-analysis that investigated the risks and benefits of various positions adopted during the second stage of labor, with there being a greater frequency of 2nd degree perineal laceration in vertical childbirths or lateral decubitus births, when compared with horizontal births. This study nevertheless underlines several benefits that arise from vertical positions and recommends that women should be encouraged to make informed choices about the birthing position that they want to be in[16].

Still in the spirit of promoting the empowerment of women, it was noted that many of these individuals chose to be with a companion of their choice during the parturition period (88.7%), which is in keeping with current legislation[17] and the benefits set out in current scientific evidence. A systematic review that examined 21 randomized clinical trials indicated that this practice contributes significantly to increasing the number of spontaneous vaginal births, thereby reducing the need for intrapartum analgesia, reducing the time spent in labor, as well as providing satisfaction in terms of the maternal experience[18-19].

With regard to the interventionist practices, the episiotomy rate in the studied period was only 9.1%, which is in line the ideal standard advocated by the WHO, which suggests a rate of approximately 10% for the procedure[4]. This is a reality in several European countries, but is far from the Brazilian reality, which has rates of 57% rates among public and private maternity hospitals, more likely reaching significantly higher values[12].

One case-control study, performed with 522 women in the Brazilian city of Recife, whose objective was to obtain information regarding factors associated with episiotomy, concluded that the practice of this procedure is strongly associated with births assisted by doctors, with primiparity and instrumental delivery, with it being less common in births assisted by nurses[20].

These findings corroborate the results of our investigation, since 56.7% of the women submitted to the procedure were going through their first childbirth experience. However, there was a significant relationship found between the practice of episiotomy and the medical assistance (93%). It is worth noting that using episiotomy does not protect against trauma, but rather contributes to the likelihood of severe perineal laceration[21].

Synthetic oxytocin can be used for induction, acceleration or correction of changes in the labor process. 27.6% of cases were identified as having used this drug. The prevalence of this practice is less than what was found during a nationwide study conducted in public and private maternity hospitals (40%)[12]. High rates (54%) were also found during an investigation conducted at a municipal hospital in Rio de Janeiro - RJ, which analyzed 4,510 births[22].

Despite the evidence indicating that, in some cases, oxytocin therapy is related to a slight reduction in caesarean rates, the same evidence shows that its use should be considered, mainly due to the risk of triggering a "cascade of interventions" in habitual-risk women[12]. The indiscriminate use of this medicine at several maternity wards can be related to the strong influence of the technocratic model regarding the practices of professionals, which encourages an interventionist care model.

The persistence of such practices in services where obstetric nurses are already involved is believed to be justified, which is partly due to doctor autonomy, since the prescribing of these drugs, including oxytocin, is assigned to these professionals[9].

The data from this research also made it possible to observe the presence of humanized care practices provided to NBs. These humanized actions include the observation that the clamping of the umbilical cord was performed at the correct time in 76% of births, which is more beneficial than immediate clamping as it produces better neonatal results, the highlight being protection against anemia[23].

Early contact between mother and baby occurred for 73.1% of the subjects in the study, which promotes additional benefits over the short- and long-term, as promoting breastfeeding enables greater thermal stability of the NB, assists the placental expulsion and encourages the bond between mother and son[24]. One study, whose objective was to investigate the experience of women regarding skin-to-skin contact with their baby immediately after birth in a teaching hospital, showed that the NB calms down upon feeling the heat of his/her mother and helps develop a bond of recognition. This contact makes the baby feel relief, security and connection with the mother, thereby contributing to links being formed and mitigating the suffering of childbirth[25].

Situations in which early contact between mother and son did not occur at the unit under study, are, in most cases, due to the subject leaving to perform routine procedures, thereby demonstrating the prioritization of care focused on technique, which devalues human beings and the attention given to theirhealth[23]. It is noteworthy that for most habitual-risk births the healthy babies were recommened to be evaluated and cared for along with the mother, enabling this skin-to-skin contact while the caregiver is concerned with warming the baby, clearing the airway and creating a welcoming environment[26].

With regard to encouraging breastfeeding in the first hour of life, 80% of the NBs were breastfed, a practice that provides a vital protective effect against neonatal mortality. Among the factors that contribute to initiating breastfeeding within the first hour of life are help provided by the health care team regarding breastfeeding at birth, multiparity, prenatal screening, a normal birth and healthy weight at birth[27].

It is important to note that, despite describing the beneficial practices, encouraging skin-to-skin contact and immediate breastfeeding should not be mechanical or force the mother, who has recently given birth, to start breastfeeding very abruptly and suddenly, since humanizing care involves respecting the choice of the woman to perform this practice or not[24].

In regards to neonatal conditions, the outcome was favorable for most of the NBs, since 99% had an Apgar score of between 7 and 10 in the fifth minute of life, which reinforces the safety and benefits of using obstetric practices that do not interfere in the physiology of labor.

In this context, numerous benefits have been attributed to the collaborative model of care, since the continuous presence of the ON allows focus to be given to the physiological and emotional aspects of the parturition process, thereby providing a favorable balance between the necessary interventions and the physiological process of the birth, which is a key component of humanized care[28].

International scientific studies have shown that there is improvement in the quality of care during childbirth when these professionals are present, as was pointed out in a systematic review by Cochrane, who sought to compare the model of continuous obstetric care led by family nurse practitioners with other welfare models. The study concluded that pregnant women whose care involved the first model were less likely to suffer interventions such as episiotomy and instrumental delivery, which provides a greater sense of control over the maternal experience and offers satisfaction in terms of the care received[29].

Some of the highlighted limitations of this research include the absence of systematic registration of interventionist practices that are still used for childbirth care, such as amniotomy and reduction of the cervix, in addition to the lack of documentation regarding episiotomy rates in the period prior to the ONs' involvement at the unit under study. Despite being restricted to one single hospital reality, the diagnosis of care shared among doctors and nurses presented in this study aims to offer assistance so that managers and health professionals can evaluate the implementation of this model, the objective being to define strategies for implementing future actions that target the consolidation of humanization in the various health network units that care for the mother and her newborn baby.

CONCLUSION

Analyzing the practices implemented in the process of care during labor and birth during this study demonstrated that, despite being set in an educational scenario, in which the technocratic model tends to be adopted, the involvement of ONs has given predominance to care that could be considered humanized, suggesting that new health professionals are being trained based on this assistive perspective.

The preponderance of practices that do not interfere in the physiology of labor and those are consistent with what the MH/WHO advocates, such as the use of non-pharmacological methods for pain relief, vertical positions during the second delivery period, the woman's choice of companion and humanized practices to receive the NB, qualifies the care provided and appreciation of the work performed by the obstetric nurses, in addition to reducing the use of interventionist practices without adequate clinical indication or scientific support.

This is evidenced by the reduction of more than 10% in the rate of Caesarean sections up to the end of 2014, a period that following ONs being contracted to work at the AIP Unit, and by the low rates of episiotomy found in the study (8.8%), which meet what was postulated by MH as shown.

The relationship that was found among episiotomy, primiparity and medical care found needs to be better researched and discussed, as it is an association that points to aspects of the technocratic model that need to be overcome in order to reach a comprehensive and humanized care system. In this sense, it is also necessary to better determine the prescription/indication of synthetic oxytocin for habitual-risk labor/delivery activities.

Thus, our study shows that the care provided by the ONs has been aligned with precepts of humanization in care during labor and childbirth, while the involvement of these professionals in the studied context has reconfigured attitudes and health practices implemented by agents operating in the obstetric and neonatal field.

It is worth mentioning that the Brazilian Professional Nursing Practice Law (*Lei do Exercício Profissional da Enfermagem*), approved in 1986, supports the role of the Obstetric Nurse in comprehensive care provided during the parturition process, highlighting their autonomy and ability to providing care during labor and childbirth. Therefore, making humanization of care a reality does necessarily require that ONs be involved if such a scenario is to reach maternity wards and Normal Birth Centers in Brazil.

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