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RESEARCH

Humanized practices of obstetric nurses: contributions in maternal welfare

Práticas humanizadas da enfermeira obstétrica: contribuições no bem-estar materno

Prácticas humanizadas de la enfermera obstétrica: contribuciones al bienestar materno

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ABSTRACT

Objective: To analyze the practice of obstetric nurses operating in a prenatal/delivery/postpartum unit of a university hospital in Mato Grosso and the maternal welfare resulted from the care provided in this scenario. **Method:** Study with a quantitative approach, carried out in a prenatal/delivery/postpartum unit of a university hospital in Cuiabá, Mato Grosso. The data were collected through the Scale of Maternal Welfare in Delivery Situation 2, and the study included 104 recent mothers in the period from June to September 2016. The data were analyzed in Epi Info version 7. **Results:** The results indicate that the practice of obstetric nurses is based on the humanization of labor and childbirth, however, the presence of invasive and unnecessary practices in the service did not influence the level of maternal welfare, which was optimum for 76% of the women. **Conclusion:** The lack of information might make the women less critical and, therefore, influence the evaluation of the care received
Descriptors: Humanized Childbirth; Humanization of Care; Maternal Welfare; Obstetric Nursing; Childbirth.

RESUMO

Objetivo: Analisar a prática de enfermeiras obstétricas atuantes em uma unidade de pré-parto/parto/pós-parto de um hospital universitário do estado de Mato Grosso e o bem-estar materno resultante da assistência nesse cenário. **Método:** Estudo de abordagem quantitativa, realizado em uma unidade de pré-parto/parto/pós-parto de um hospital universitário de Cuiabá, Mato Grosso. Os dados foram coletados por meio da Escala de Bem-Estar Materno em Situação de Parto 2, e o estudo abrangeu 104 puérperas no período de junho a setembro de 2016. Os dados foram analisados no programa Epi Info versão 7. **Resultados:** Os resultados indicam que a prática das enfermeiras obstétricas está pautada na humanização do parto e nascimento, contudo, a presença de práticas invasivas e desnecessárias no serviço não influenciou o nível de bem-estar materno que foi ótimo para 76% das mulheres. **Conclusão:** A falta de informação pode tornar as mulheres menos críticas e, consequentemente, influenciar a avaliação da assistência recebida
Descritores: Parto Humanizado; Humanização da Assistência; Bem-Estar Materno; Enfermagem Obstétrica; Parto.

RESUMEN

Objetivo: Analizar la práctica de enfermeras obstétricas actuantes en una unidad de pre-parto/parto/posparto de un hospital universitario del estado de Mato Grosso y el bienestar materno resultante de la asistencia en esa situación. **Método:** Estudio de abordaje cuantitativo, realizado en una unidad de pre-parto/parto/posparto de un hospital universitario de Cuiabá, Mato Grosso. Los datos fueron recolectados por medio de la Escala de Bienestar Materno en Situación de Parto 2, y el estudio abarcó 104 puérperas en el período de junio a septiembre de 2016. Se analizaron los datos en el software Epi Info versión 7. **Resultados:** Los resultados indican que la práctica de las enfermeras obstétricas se basa en la humanización del parto y del nacimiento; sin embargo, la presencia de prácticas invasivas e innecesarias en el servicio no influenció el nivel de bienestar materno, que se

mostró bueno para el 76% de las mujeres. **Conclusión:** La falta de información puede hacer que las mujeres sean menos críticas y, por tanto, influir en la evaluación de la asistencia recibida.
Descriptores: Parto Humanizado; Humanización de la Atención; Bienestar Materno; Enfermería Obstétrica; Parto.

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INTRODUCTION

Over the years, childbirth has undergone several modifications, and today, even with the various initiatives that aim to change the scenario of parturition, the technocratic model is still very much rooted in professional practices. This model values technology as a sign of success, and indiscriminately uses interventionist practices, disregarding the disadvantages related to them[1].

Thus, efforts have been employed so that the frequency of these practices is reduced, enabling a humanized type of care that has as main objectives respect to the physiology of childbirth and recovery of the autonomy and of the protagonism of women in the parturition process[2].

So that women can be protagonists and have their autonomy respected in the moment of parturition, they need to be aware of what characterizes humanized childbirth care, as well as of their rights and of which welfare practices are beneficial or not for them and their newborn (NB)[3].

In this way, the importance of prenatal care and of the attitudes of the professional in charge of it are emphasized, so that the women's concerns may be addressed, and that they may be reassured in relation to any fears or anxiety associated with pregnancy. It is well-known that childbirth is ridden with fears, uncertainties, anxieties, among other feelings; thus, the professional should be able to develop educational practices with the purpose of promoting the health of women through their empowerment[4].

This care must have continuity in the parturition process, which requires empathy between the subjects involved so that the emotional support provided is effective and bonds are formed, which is essential for the development of educational health practices that minimize stress factors[5] and promote the empowerment of women, ensuring a more harmonious and satisfactory delivery.

Empowerment increases the individual's autonomy and freedom, as it promotes reflective and critical thinking, allowing the subject to assess changes in health, as well as to pursue democratization[6].

Endowed with knowledge and autonomy, the women become able to evaluate the health services, as well as the practices that were beneficial to their quality. Thus, we highlight the importance of studies that evaluate the care provided during the parturition process, so that its quality and especially its inefficiency are recognized, with the goal of reducing maternal and neonatal morbidity and mortality, and of increasing female satisfaction in this process[7].

The obstetric nurse (ON) arises in this scenario as a professional that is able to perform more humanized care to provide greater comfort and security to the women, through active listening and supplying of information[8]. This professional has been shown to be important for the un-medicalization of labor and childbirth, for making use of practices that do not interfere in the physiology of birth, to make the parturient woman and her escorts more active and participative in this process[9].

The insertion of the ON in the care related to delivery and birth and the provision of continuous training to these professionals, aiming at the humanization and respect to the physiology of the parturition process, are measures advocated by the World Health Organization (WHO) and by national ministerial propositions[10-11].

OBJECTIVE

To analyze the practice of ONs operating in a prenatal/delivery/postpartum unit of a university hospital in Mato Grosso and the maternal welfare resulted from the care provided in this scenario.

METHOD

Ethical aspects

This research was preceded by the approval of the Research Ethics Committee of Hospital Universitário Júlio Muller, in accordance with Resolution No. 466, of 12 December 2012, of the National Health Council/MS, which regulates research involving human beings.

Design, study site, and period

This is a cross-sectional and descriptive study, with quantitative approach. It was held in an obstetric unit of a university hospital in the state of Mato Grosso, in the period from June to September 2016.

Population or sample; inclusion and exclusion criteria

The population that participated in this research included 104 mothers who had recently undergone vaginal delivery, cared for in the institution and period mentioned. The inclusion criteria were: having over four years of education (seeing as the scale of maternal welfare in situation of childbirth is self-applicable); having recently undergone vaginal delivery, conducted by both a doctor and an ON; having had no complications during pregnancy and childbirth; having remained at least 4 hours in the prenatal sector of that same institution; having given birth to a newborn without clinical complications and having opted for rooming-in. And the exclusion criteria: women with some sort of cognitive disability or psychiatric disorders.

Study protocol

The data were collected using two instruments: the first was a questionnaire with questions concerning the identification of the socio-economic data of every parturient woman, obstetric

background data, obstetric data related to the labor, childbirth and immediate postpartum processes and data related to the newborn. The data were collected through interviews with the recent mothers and through the gathering of secondary information.

Interviews were conducted with the recent mothers who were in the period of 24 to 48 hours after delivery, who had opted for rooming-in at that same institution. The instrument used was the Scale of Maternal Welfare in Childbirth Situation 2 (BMSP 2). The scale was developed by Chilean researchers[12], having been culturally adapted and validated for the Portuguese language in 2013[13]. It is self-applicable and uses a Likert-type scale, with responses ranging from five (totally agree) to one (strongly disagree) and a neutral option (I do not agree nor disagree). It covers seven domains, distributed in 47 items, and the results are obtained by adding up the scores of all items. For the sum of the items related to the domain of Depersonalized care, it is necessary to reverse the scores of the answers (reverse item). From the sum of the scores, it is possible to obtain three levels of welfare: optimum welfare (score > 200); satisfactory welfare (score between 183 and 200) and malaise (score < 183)[13].

Analysis of results and statistics

The data were organized and analyzed using Epi Info version 7. Absolute and relative frequencies and measures of central tendency, that is, mean, median and mode, were calculated as needed.

For the bivariate analysis, the association between the professional in charge of delivery and the care provided was analyzed. Chi-square test with 95% confidence interval or, when necessary, Fisher's exact test were used. A 0.05 significance level (α = 5%) was adopted as statistically relevant.

It is worth mentioning that for the descriptive analysis, the total population of the study was used, i.e., 104 recent mothers. However, for the bivariate analysis, which sought to associate the professional in charge of delivery with the care provided, only the data relating to births assisted by a nurse or doctor were used, and those with shared assistance were excluded, that is, those in which both professionals worked together at the time of delivery; thus, 96 interviews were analyzed. For the discussion, scientific evidence were used to portray the main theme of the study.

RESULTS

With regard to the socio-economic data of the women interviewed, the majority had 20 years of age or more (ages ranged from 15 to 44 years old) and 10 to 12 years of education. The mode of education level stood at 12 years, which allows saying that most had full secondary education. Most interviewees were married or in stable relationships (77.9%), and most (65.4%) were out of the labor market. The family income of 77.9% of the women was two minimum wages or less, considering the minimum wage in force at the time – R$ 880.00.

With regard to obstetric antecedents, most of the women (66.4%) were multiparous, and most had had previous vaginal delivery (84.1%). The current pregnancy had been planned by 34.6% of the women interviewed.

Of the total women, 96.2% underwent prenatal care, however, only 71% reached the minimum number of consultations recommended by the Ministry of Health (six or more). Of the 100 women who underwent prenatal care, 86% were satisfied with the care received in the consultations and 68% were given information about labor, delivery, the postpartum period and/or had their doubts cleared.

Of the total number of parturient women participating in the study, 60 had been assisted by doctors/scholars in Medicine, and 36, by obstetric nurses; 8 had been assisted by both professionals. Most women (93.3%) had an escort of their choice, their husband/partner having been elected more frequently (43.9%).

Among the parturient women, 84.6% made use of some sort of practice that does not interfere in the physiology of childbirth. The non-invasive healthcare technologies that were most often used included ambulation associated with bath and birthing ball (23.9%), present in 76.7% of deliveries assisted by doctors, while for those assisted by obstetric nurses, this percentage was 97.2% (p = 0.005).

Pharmacological methods were used by 30.8% of the parturient women, oxytocin being the most common (65.6%). Amniotomy was held in 39.4% of the deliveries, being present in 50% of the childbirths assisted by doctors and in 27.8% of those assisted by nurses (PR = 1.8; CI 95% = 1-3.22; p = 0.032).

In relation to the position of the women's bodies during the period of expulsion, verticalized positions were the most widely used (90.4%). It is important to highlight that of the 9.6% births performed horizontally, 5.8% were held in the lithotomic position. All deliveries assisted by nurses were performed vertically, while horizontal positions were adopted in 16.7% of births assisted by doctors (p = 0.006).

With regard to feeling uncomfortable during vaginal examination, 16.7% of the women who reported this complaint had their births assisted by doctors, and 2.8% by obstetric nurses (PR = 6; IC 95% = 0.8-44.94; p = 0.034).

Episiotomy was present in 4.8% of the childbirths. Eighty-percent of the women who underwent the procedure were primiparous, and 60% of them considered it favorable. This practice was not performed by nurses, having been adopted in 8.3% of the total deliveries conducted by doctors; however, this data had no significant statistical difference (p = 0.089).

Laceration occurred in 63.5% of the births, most having been classified as (54.5%) second degree and only one occurrence as fourth degree. The women were questioned if in a new pregnancy they would choose vaginal delivery again, and 30.8% answered negatively.

The data related to the care provided to the newborn indicate that the umbilical cord's clamping was appropriate in 76% of the childbirths. Immediate clamping was conducted in 35% of the deliveries assisted by doctors/medical students and in 5.6% of the deliveries assisted by obstetric nurses (PR = 6.3; CI 95% = 1.56-25.3; p ≤ 0.001).

Skin-to-skin contact between mother and child was allowed in 70.2% of the cases. This care was present in 88.9% of the deliveries assisted by obstetric nurses and in 55% of those assisted by doctors (p < 0.001), which favored breastfeeding, encouraged in 86.5% of the cases. Encouragement to breastfeeding occurred in 81.7% of the deliveries assisted by doctors and in 91.7% of those assisted by nurses, but this data did not show statistical significance (p = 0.146).

Table 1 presents the association between the care provided in the service investigated and the professional responsible for it.

With regard to maternal health data, it was possible to verify the questions with the worst and best score in BMSP 2. The lowest score corresponds to the domain of Depersonalized care: "I feel like procedures that do not correspond to the vaginal delivery process were carried out." This item was emphasized by 5.8% of the interviewees, who assigned it the highest score (5 – totally agree). The question that scored the highest was: "During the entire process of childbirth, the professionals guided me, told me what to do and supported me," to which 77.9% of the women assigned score 5.

In Table 2, the values obtained for each domain of BMSP 2 are shown. It should be noted that for all of them the mode was the maximum value that could be obtained.

Knowing the mean of each domain enables noting that the one with the highest score corresponds to the Conditions that allow the contact between mother and child (Domain III), and the one with the lowest score corresponds to Depersonalized care (Domain IV).

In relation to the welfare of the women during labor/delivery/postpartum, the majority (76%) reported optimum welfare, as shown in Table 3. However, it is important to highlight that 8.6% felt malaise during this period.

The lowest value of the scale was 140, the mean was 212.58 and the mode was 235 (affirming what the table shows, i.e., that the majority reported optimum welfare).

Table 1 – Association between the professional in charge of delivery and the care provided in the prenatal/childbirth/postpartum unit of a university hospital in Cuiabá, Mato Grosso, Brazil, 2016

Professional	No	Yes	Total	Prevalence ratio (95% confidence interval)	*p* value‡
Use of non-invasive healthcare technologies*					
Doctor	14	46	60	8.4 (1.15-61.22)	0.005
Nurse	1	35	36	1.0	
Total	15	81	96		
Feeling uncomfortable during vaginal examination*					
Doctor	10	50	60	6 (0.80-44.94)	0.034
Nurse	1	35	36	1.0	
Total	11	85	96		
Amniotomy					
Doctor	30	30	60	1.8 (1.00-3.22)	0.032
Nurse	10	26	36	1.0	
Total	40	56	96		
Horizontal position for the stage of expulsion*					
Doctor	10	50	60		
Nurse	0	36	36	-	0.006
Total	10	86	96		
Episiotomy*					
Doctor	5	55	60		
Nurse	0	36	36	-	0.089
Total	5	91	96		
Immediate clamping of the umbilical cord*					
Doctor	21	39	60	6.3 (1.56-25.30)	**< 0.001**
Nurse	2	34	36	1	
Total	23	73	96		
Skin-to-skin contact*					
Doctor	27	33	60	4.05 (1.54-0.63)	**< 0.001**
Nurse	4	32	36	1	
Total	31	65	96		
Incentive to breastfeeding*					
Doctor	11	49	60	2.2 (0.65-7.36)	0.147
Nurse	3	33	36	1	
Total	14	82	96		

*Notes: *Fisher's exact test; ‡ p value – Significance level*

Table 2 – Domains of the Scale of Maternal Welfare in Labor Situation of the prenatal/childbirth/postpartum unit of a university hospital in Cuiabá, Mato Grosso, Brazil, 2016

Domains	Number of items	Possible interval	Obtained interval	Mode	Mean
Domain I – Quality of relationship during care	13	13-65	35-65	65	60.38
Domain II – Self-care and comfort	9	9-45	27-45	45	41.05
Domain III – Conditions that allow the contact between mother and child	4	4-20	7-20	20	18.56
Domain IV – Depersonalized care	6	6-30	14-30	30	24.97
Domain V – Continuous participation of the family	4	4-20	10-20	20	18.51
Domain VI – Timely and respectful care	6	6-30	15-30	30	26. 81
Domain VII – Comfortable physical environment	5	5-25	15-25	25	22.26

Table 3 – Domains of the Scale of Maternal Welfare in Labor Situation (N = 104) of the prenatal/childbirth/postpartum unit of a university hospital in Cuiabá, Mato Grosso, Brazil, 104

Classification	Score	n (N = 104)	%
Malaise	< 183	9	8.6
Satisfactory Welfare	183 ≥ x ≤ 200	16	15.4
Optimum Welfare	> 200	79	76
Total		104	100

DISCUSSION

There was no relationship between the result of Table 2 and the question with the highest score in the instrument used to measure maternal welfare (BMSP 2). The final result of the scale revealed that 76% of the interviewees found in our study reported optimum welfare resulted from the care received during parturition, and the question with the highest score in the instrument relates to the guidance and support that the professionals provided to the parturient woman.

This corroborates a study[14] that affirms that one of the factors that most positively influences maternal satisfaction is the way professionals welcome, comfort and care for the mothers. Therefore, satisfaction during labor is influenced by the perception of the care and support provided by the health professionals, which mitigate the anxiety experienced by the women during the whole parturition process.

Women who feel alone and abandoned, or who are assisted by a team that does not give her the due attention and care, have a higher possibility of perceiving childbirth negatively[15]. Although the pain of childbirth can influence the women's satisfaction, this association is not as significant and strong as the influence of the professional's attitude towards them, which is considered crucial for their satisfaction[16].

Another point that is worthy of attention is the influence of the skin-to-skin contact provided to the parturient women on their welfare, seeing as the domain with the highest score in this study was the one related to Conditions that allow the contact between mother and child (Domain III). This domain includes questions related to the professional's enabling of the contact between the mother and child and to their respect for the time they need to be together.

Skin-to-skin contact generates several benefits, and should be encouraged whenever there are no complications requiring immediate intervention. One of the biggest advantages of the practice is related to the encouragement of breastfeeding, which provides benefits for both the newborn and the mother[17].

In this study, immediate skin-to-skin contact was allowed more often in births assisted by obstetric nurses, corroborating the findings of a research[18] in which women assisted by an ON together with pediatricians had more chances of performing skin-to-skin contact and early breastfeeding.

In addition, skin-to-skin contact allows the creation of a bond between mother and baby and, consequently, earlier adaptation, reassuring the mother that all went well during delivery and that the newborn is healthy. However, the women need to know that this contact is a right, and this should be informed to them during the prenatal period, so that those who wish may request it at the time of parturition[19].

Prenatal care is therefore a timely period to clarify doubts, show the benefits of vaginal delivery and prepare the women for this moment. In this context, the relevance of nurses stands out for their sensitivity in the care to pregnant women, which provides greater adherence to prenatal care and ensures its quality, with subsequent improvement in the obstetric and perinatal results[20].

Women who receive information about parturition in the prenatal period tend to experience this moment with greater security and autonomy[20]. However, it is important to highlight the fact that, of the 100 women who underwent prenatal care, only 68 reported having received information about labor, delivery, the postpartum period and/or having had their doubts cleared.

The fact that 32% of the women interviewed did not receive any information about labor and delivery during prenatal care results in them being unaware of their rights and of which practices are considered to be humanized. This generates low critical capacity, making it so that the simple fact of them having received assistance during delivery would have been sufficient for the positive evaluation of the service[14].

It cannot be denied that the care provided at the study location was, for the most part, humanized in character, as shown by the results presented. However, some invasive and often unnecessary

technologies were used, as is the case of episiotomy, amniotomy, frequent and uncomfortable vaginal examinations, among others.

Thus, the fact that most women reported optimum welfare during parturition, even when subjected to invasive, unnecessary and uncomfortable technologies, should be questioned.

It is worth highlighting, however, the importance of ONs in the performance of practices that do not interfere in the physiology of childbirth and which are compliant with humanized obstetric care, such as non-invasive pain relief methods; use of vertical positions during the period of expulsion; immediate skin-to-skin contact between mother and child; and encouragement to breastfeeding – which were the procedures most often carried out by these professionals in the context of this study.

Although invasive and/or harmful technologies – such as episiotomy and horizontal positions during the period of expulsion – were not adopted in the births assisted by ONs, other practices, such as immediate clamping of the umbilical cord, were held in smaller proportion by these professionals.

The presence of the obstetric nurse during the parturition process is, therefore, essential for the reduction of maternal and neonatal morbidity and mortality rates, as it ensures more safety and freedom to the women, providing access to more humanized practices and making the mother the protagonist of this moment[21].

The expectation that the users have about the care received during delivery directly influences their satisfaction, which however does not specifically reflects the quality of the service[14].

As they had been served in public hospitals, their demands became less strict, since the women there do not expect to be treated in a humanized and individualized manner, that is, they do not have high expectations in relation to delivery[22].

Thus, as did they not have high expectations and requirements, when evaluating the health service, the little attention and affection they received already seemed sufficient to them. Furthermore, because they are women from the low strata of society, often what is important to their satisfaction is that delivery is carried out swiftly, even if this requires the use of interventions[22].

Thus, the aforementioned reasons may be associated with the high percentage of women who assessed parturition positively, even if they had been subjected to some practices deemed as harmful to childbirth.

The care provided by ONs during labor and childbirth allows the exercise of female autonomy and protagonism, assigning to the mother an active role through which they become the protagonists of their own delivery process, since this professional's assistance brings them comfort, security and respects the feelings of both the mother and her family[23].

Furthermore, nurses contribute to the transformation of obstetric care, making it less interventionist and more humane, through the use of their technical competence and sensitivity to engage with the women and their families[23].

It can therefore be verified that the care of ONs enables the women's empowerment in the experience of parturition, and that these professionals are essential for the humanization and qualification of obstetric care, and for the subsequent satisfaction of women during this process.

Study limitations

Considering the limitations of this research, further studies with more representative samples of empirical reality and of the populations analyzed are suggested for ratification of the data.

Contributions to the fields of nursing, health and public policies

The dissemination of the results of this research aims to contribute to the strengthening of obstetric nursing and to the social recognition of the work carried out by these professionals, who have been making a difference in the Brazilian scenario by contributing significantly to the improvement of the quality of the care provided to parturient women and their families.

CONCLUSION

The practices performed by obstetric nurses in this study are based on scientific evidence and ministerial recommendations, especially with regard to humanization, which provides greater safety and comfort to the women, promoting their empowerment and protagonism, thus contributing to maternal welfare.

Despite the significant presence of humanized practices in the scenario investigated, methods considered as invasive and unnecessary had also been used; however, the majority of the interviewees reported optimum welfare.

The women's low criticality when assessing the care received can be due to the lack of information they had about parturition. As they were unaware of their rights and of the distinction between humanized and invasive practices, they could not differentiate good from bad care provided to her and her baby.

We highlight the importance of prenatal care as a timely moment for the development of educational health practices aimed at the empowerment of women, so that they can make conscious choices about what they want in the process of parturition, as well as evaluate the care received. With this power, the women can exercise their rights, contributing to the construction of a more democratic society.

In this context, nurses arise as professionals who are able to offer humanized labor and childbirth care, as well as promote the autonomy and the protagonism of women during parturition through prenatal consultations, informing and clarifying their questions and preparing them for the moment of delivery.

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